Later-life Accounts of Drug Use

"I never thought I'd reach 40"

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Declaration

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Abstract

Older people who use drugs have become an increasingly visible population in the UK, yet existing research has focused predominantly on health risks, mortality, and service needs. This has left a significant gap in understanding: how older people themselves make sense of drug use across the life course, and how the meanings they attach to drug use are shaped and reshaped by ageing. Without this understanding, policies and services risk responding to demographic trends without engaging the lived realities behind them.

This thesis addresses that gap by combining a review of UK policy and service contexts, a systematic mapping of recent UK qualitative drug-use literature, and biographical-narrative interviews with 28 individuals aged between 40 and 79, living in the UK with histories of drug use. Guided by a social constructionist epistemology and employing a narrative–biographical research approach, the analysis was conducted using reflexive thematic analysis.

The findings suggest that drug use cannot be understood through linear models of escalation, recovery, or decline but include early life experiences, such as insecurity, loss, and trauma, that do not deterministically explain later drug use and form part of a broader biographical context that continues to shape adulthood. Lifecourse milestones during adulthood, including relationships, parenthood, work, and contact with the criminal justice system, often reconfigure rather than resolve these earlier experiences. In later-life, ageing emerges as a process through which participants reinterpret their past, negotiate bodily changes and maturity and make sense of survival in the context of proximity to death and past health problems.

The contribution of this thesis is threefold: it extends UK qualitative research on drug use by centring older people as narrators of their own lives; it develops a life-course account of how drug use meanings shift across time rather than converging on a single trajectory; and it demonstrates how class, stigma, and institutional responses shape whose drug use is visible and whose needs are met. These findings have direct implications for harm reduction, social work practice, and the design of age-responsive drug services.

Keywords: Ageing, Drug Use, Lifecourse, Narrative-Biographical, Reflexive Thematic Analysis

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Reflexive Prologue

When I began this doctoral journey, I brought with me a particular way of seeing. My academic background was addiction studies in Türkiye, where I had been trained in quantitative research methods; surveys, scales, statistical analysis, the careful measurement of variables. That training taught me to look for patterns across populations, to reduce complexity into manageable data, and to find meaning in numbers. It was rigorous, and I believed in it.

But I also came to this research as a social worker. And social workers know how to listen. Sitting with people, holding space for difficult stories, staying present through discomfort, this was not unfamiliar territory. What was unfamiliar was what came next: the analytical move from listening to interpretation. In my professional life, listening had a purpose that was immediate and practical. You listened in order to assess, to identify need, to plan a response. The listening had a destination. In biographical-narrative research, the listening is only the beginning. The harder work is sitting with what you have heard and asking: what does this mean? Not what does this person need, and not what category does this fit, but what is this person's account actually telling me about the social world they inhabit, and how do I place that meaning honestly without imposing my own framework onto it?

That question, how to place meanings on data, became the central intellectual challenge of this research. My quantitative training had given me methods for finding patterns, but those methods assumed that the meaning of a variable was relatively stable and agreed upon. Drug use, in a survey, means what the instrument says it means. In a biographical interview, drug use means something different to every person who describes it, and something different again at different points in the same person's life. Learning to work with that plurality, to resist collapsing it into familiar categories while still making analytical sense of it, required a fundamental shift in how I understood my own role as a researcher.

In quantitative research, the researcher's position is, at least in principle, kept separate from the data. You design an instrument, administer it, analyse the results, and the numbers speak independently of who you are. Qualitative research works entirely differently. There is no instrument standing between the researcher and the participant. My presence, my questions, my silences, my reactions, all these shape what participants share and how they share it. I had understood this intellectually before I began. What I had not fully understood was how much my specific position, as a social worker, as someone trained in addiction, as an international researcher working in a UK context, was itself a kind of analytical lens that needed to be examined rather than simply acknowledged.

My social work background shaped the questions I initially assumed were most important. When I began designing this research, I found myself instinctively drawn toward questions about turning points, crises, and help-seeking, the architecture of a social work assessment

translated almost unconsciously into an interview guide. It was only through the research process itself, and through my supervisory relationship, that I came to see how much that framework had oriented me toward harm and away from meaning. Participants did not narrate their drug use primarily as a problem. They narrated it as a response; to fear, to belonging, to pain, to the particular social worlds they had grown up inside. Staying with that and finding analytical language for it that did not reduce it back to a professional category, was the most demanding interpretive work of the study.

Coming to this research from Türkiye also meant coming to it as an outsider to the specific social and institutional landscape of UK drug use. I did not grow up with the particular history of UK drug policy, had no embodied sense of the postcode-level geography of stigma that several participants described, and did not know intuitively what it meant to collect a prescription from a pharmacy under the gaze of other customers. In some ways this was a limitation I had to work against; learning contexts, asking participants to explain references I did not share, researching institutional histories that a British researcher might have taken as given. But there were also ways in which the outsider position was generative. Because I genuinely did not know, participants explained. Most participants had lived for long periods in the UK, and many narrated their experiences through British or Scottish social and institutional contexts; however, I do not assume that all participants shared a single British cultural identity. Because my accent marked me as someone from elsewhere, some participants spoke more openly about things they might have assumed a British researcher already understood; the class dynamics of service encounters, the unspoken rules of drug-using communities, the specific texture of stigma in particular settings. My foreignness created a kind of permission to ask basic questions, and basic questions sometimes produced the most revealing answers.

There is one further dimension I want to name. Moving from quantitative to qualitative methodology was not only a technical transition, but it was also an ethical one. Quantitative addiction research, however rigorous, tends to produce accounts of drug-using populations from the outside. Qualitative biographical research produces accounts from closer to the inside. Throughout this study I have been accompanied by an awareness that the people I interviewed have been, for much of their lives, spoken about rather than spoken with; measured, assessed, categorised, and managed by systems that understood their expertise as residing outside the people they studied. This research is a modest attempt to do something different: to take seriously what it means to be an older person whose life has been shaped by drug use, and to let that experience speak in its own terms.

That attempt has shaped everything that follows, the methodology, the analysis, and the conclusions. I hope making it explicit here helps the reader understand not just what this thesis argues, but where it comes from.

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Chapter 1 Introduction

The motivation for this research is grounded in several interrelated social, demographic, and policy developments. First, the UK population, in line with global demographic trends, is ageing. Recent projections from the Office for National Statistics indicate that the share of older adults in the UK will continue to rise substantially in the coming decades: the proportion of the population aged 65 and over is expected to increase from around 18–19% today to nearly 25% by 2040, and the number of people aged 85 and over is projected to almost double between 2022 and 2047 (Office for National Statistics, 2025). These demographic changes have important implications for health systems, social care, and policy planning, especially in understanding the needs and experiences of older adults.

Second, drug use represents a significant and growing public health concern in the UK. Dame Carol Black's two-phase Independent Review of Drugs (2020), which heavily informs the UK government's current 10-year drug strategy From Harm to Hope, highlights that drug-related deaths are at the highest level ever recorded in the UK. Additionally, problematic drug use can cause many health problems such as blood-borne viruses (Dickson-Spillmann et al., 2016), cardiovascular diseases (Darke et al., 2017), as well as social consequences such as homelessness and social exclusion, all of which place substantial demands on public services. For some, drug use is associated with pleasure, coping, routine, or ways of managing everyday life (Public Health Wales NHS Trust, 2021). Later-life drug use therefore cannot be understood through a single model of decline, dependence, or recovery or only as an individual behaviour or treatment issue but must also be situated within wider social and structural conditions.

In a European context, drug-related mortality rates in the UK are notably high. Compared with other European countries, the UK reports significantly higher numbers of drug-related deaths, with Scotland experiencing the highest rates within the UK (HM Government, 2021; UK Government, 2021). Data from the *Drug-Related Deaths and Mortality Technical Report 2021* indicate that, based on 2018 figures, the UK's drug-related death rate was almost three times higher than that of the country with the second-highest rate, Germany (EMCDDA, 2021), as summarised in Figure 1.

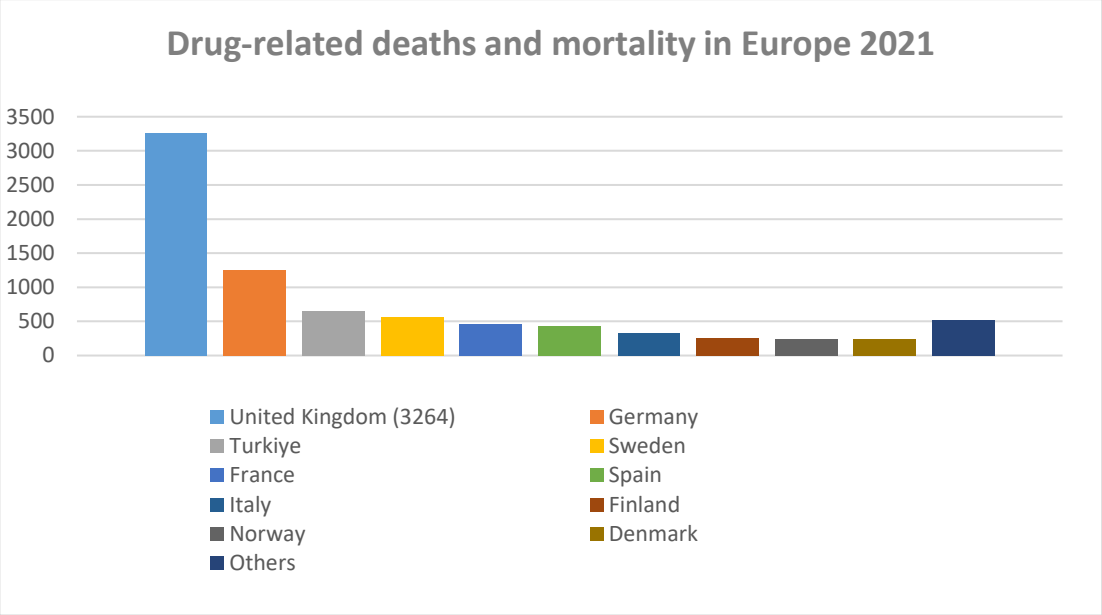

Figure 1 Drug-related deaths and mortality in Europe 2021 (EMCDDA, 2021)

Crucially, these trends also reflect a clear ageing of the drug-using population. Over the past two decades, the age profile of drug misuse deaths has shifted significantly, with the average age at death increasing from 32 in 2000 to 45 in 2023 in Scotland. Deaths are now concentrated primarily among those aged 35 to 54, and the growing proportion of deaths among people aged 55 and over highlights how drug use and its associated harms increasingly intersect with ageing processes and later-life health inequalities (National Records of Scotland, 2024).

While drug use can lead to serious health and social harms, it is important to recognise that drug use experiences are not universally problematic. Some individuals are able to maintain relatively stable and balanced lives while using drugs, whereas others experience significant difficulties. Despite this diversity of experiences, there remains a notable gap in research focusing on older drug users. Drug research has historically prioritised younger populations, often excluding older people from study samples (Royal College of Psychiatrists, 2018a; Wadd and Galvani, 2014). However, the lived experiences of older people themselves, and the meanings they attach to both drug use and ageing, remain insufficiently explored.

Existing studies suggest that older people with problematic drug use may experience heightened stigma and social exclusion (Atkinson, 2016; Roe et al., 2010). That can result in adverse psychosocial experiences such as shame and fear, loneliness and depression

(Matheson et al., 2017). However, the voices and lived experiences of older people who use drugs remain underrepresented in the literature. The limited research base has practical consequences. If older people who use drugs are understood mainly through evidence generated with younger service users, services may fail to recognise how drug use is shaped by ageing bodies, long histories of use, pain, bereavement, isolation, medication, and accumulated stigma. The problem is therefore not simply that older people are missing from research, but that their absence can shape how services are designed. Older people may be offered support in settings where the pace, language and assumptions are organised around younger users; their symptoms may be read as ordinary ageing rather than substance-related harm; and their long experience of drug use and treatment may not be recognised as a form of knowledge. Reviews of older people and substance use have raised similar concerns, noting the need for age-sensitive, integrated and non-discriminatory responses rather than provision that assumes one model of treatment will fit all age groups (Royal College of Psychiatrists, 2018; Advisory Council on the Misuse of Drugs, 2019; Hafford-Letchfield et al., 2020).

Dame Carol Black's Independent Review of Drugs (2020) is a landmark document for the current UK policy context, particularly because it shaped the government's ten-year strategy, From Harm to Hope. The review did not place ageing at the centre of its analysis, but it is still relevant to this thesis because it identified serious weaknesses in the treatment and recovery system, including fragmentation, underinvestment and difficulty sustaining recovery over time (Black, 2020; HM Government, 2021). Read alongside the Advisory Council on the Misuse of Drugs' ageing cohort report (2019), this raises a more specific concern: if the wider treatment system already struggles to provide stable, coordinated and long-term support, older people with histories of drug use may be especially disadvantaged because their needs often cross drug treatment, primary care, mental health, pain management, housing and social care. If services are designed mainly around younger users, these issues may be missed or treated separately. Drug-related symptoms may be read as ordinary ageing, while ageing-related needs may be overlooked within drug treatment settings. Mixed-age treatment spaces may also feel unsuitable for some older people, particularly where they experience younger service users as chaotic, intimidating, or distant from their own stage of life. For this reason, the absence of older people's accounts from research is not only an academic gap. It affects how need is recognised, how services are organised, and whose experiences become visible within policy.

This thesis addresses that gap by focusing on how older people in the UK with experiences of drug use understand their drug use and ageing across the life course. This is not only a matter of academic interest. The absence of qualitative, life-course research on older drug users has concrete consequences. Services and policies designed without knowledge of how drug use is lived and understood in later-life risk misreading need, misattributing symptoms, and offering responses calibrated for younger populations (Advisory Council on the Misuse of Drugs, 2019; Royal College of Psychiatrists, 2018b). Hafford-Letchfield and colleagues (2020) demonstrate in a systematic review that interventions specifically designed for older people with problematic substance use are rare, and that mixed-age provision frequently fails to address the distinctive needs of ageing communities. When services are not designed with older people in mind, older drug users are more likely to disengage, to go unrecognised, or to receive responses that reinforce stigma rather than address it (Ayres et al., 2012; Matheson et al., 2019).

Without understanding how people themselves make sense of drug use across a life, services will continue to respond to symptoms rather than to the biographical and social conditions that shape them.

The overarching aim of this thesis is to explore how older people in the UK with histories of drug use understand and narrate the relationship between drug use and ageing across the life course. Specifically, it asks how the meanings attached to drug use shift over time, and how biographical experiences of early life, adulthood, and later-life shape and are shaped by drug use. Four interrelated research questions guide the study:

- How do participants describe the development and changing meanings of their drug use across the life course?
- How do early life experiences, family and social relationships, classed environments, and adult transitions shape drug use trajectories over time?
- How do participants understand the relationship between ageing and drug use in later-life, including changes in the body, health, social life, and identity?
- How do stigma, social inequality, and institutional responses shape later-life experiences of drug use?

The thesis uses literature in a deliberately focused way. Because the study is located in the UK and asks about experiences of drug use, ageing, stigma and services in that context, UK

policy, demographic and service literature is used in this chapter to establish why the topic matters now. This includes literature on drug-related deaths, the ageing cohort of people who use drugs, treatment provision, harm reduction and older adult services. Chapter 2 then turns to peer-reviewed UK qualitative research on drug use published since 2010. Chapter 2 aims to identify what is already known about lived experience, motivation, identity, stigma, treatment, recovery and social context, and to show where older people's accounts remain weakly represented. Wider international literature is used more selectively, especially where it provides conceptual tools for thinking about stigma, life-course processes, intersectionality, trauma-informed practice and qualitative methodology. This approach allows the thesis to remain grounded in the UK policy and practice context while also drawing on wider theoretical debates where they help interpret the participants' accounts.

Lived experience is central to this research. Using qualitative biographical - narrative interviews, the thesis foregrounds participants' own accounts of how they make sense of their histories, their present lives, and their expectations for the future. This approach makes it possible to attend to the diversity and complexity of participants' experiences, and to explore how meanings shift over time rather than assuming a single or universal trajectory. It also enables the thesis to examine not only what happened in participants' lives, but how they interpret those experiences in relation to ageing, social relationships, stigma, and identity. Lived experience accounts can offer perspectives that may be overlooked in observational or survey-based research or in data collected through third parties (O'Leary and Tsui, 2022).

In examining drug use in later-life, this study also recognises that people's experiences are shaped by intersecting forms of inequality. Ageing and drug use do not occur in isolation from wider social positions and structural conditions. Experiences are shaped by class, gender, family relationships, health, stigma, and institutional responses, as well as by the social and material environments in which people live. For this reason, intersectionality provides an important framework for the study, allowing for an analysis of how multiple dimensions of inequality interact in shaping later-life drug use and ageing. However, I need to point out that my data is limited on reflecting intersectionality. Further explanation is in the intersectionality section

This chapter therefore sets out the broader context for the thesis. It introduces the demographic, social, and policy developments that make this study important, and begins to

establish the conceptual foundations for the analysis that follows. In doing so, it argues that a qualitative, life-course study of older people with histories of drug use is necessary in order to understand not only the harms associated with drug use, but also the meanings, relationships, inequalities, and forms of survival through which drug use and ageing become intertwined over time.

1.1 Drug Use

The term *drug* in drug use studies generally refers to psychoactive substances and World Health Organisation (2024, para.1) defines psychoactive drugs as "*the substances that, when taken in or administered into one's system, affect mental processes, e.g. perception, consciousness, cognition or mood and emotions*". These substances include nicotine and alcohol. However, in this study, drug use refers to illicit drugs and non-medical use of prescription and over-the-counter medication. Alcohol and nicotine were excluded from the primary definition of drug use adopted in this study. This decision was not intended to suggest that alcohol or nicotine are pharmacologically or socially distinct from other psychoactive substances, or that they are unimportant in later-life substance use. Alcohol use may intersect significantly with illicit and prescribed drug use, particularly in relation to polysubstance use, health complications and co-morbidity in later-life (Bareham et al., 2019; Holton et al., 2017; Wu and Blazer, 2011). However, alcohol has an extensive and comparatively distinct body of research, policy and treatment guidance in the UK (Department of Health & Social Care, 2025; National Institute for Health and Care Excellence, 2011). Nicotine was likewise outside the primary scope of the study, which focused on illicit drugs and the non-medical or problematic use of prescribed and over-the-counter medications. Including alcohol or nicotine as a primary substance of interest would therefore have considerably broadened the scope of the study and potentially obscured its specific focus on experiences of illicit drugs and the non-medical or problematic use of prescribed and over-the-counter medications. The exclusion was consequently an analytical and practical boundary rather than an assumption that alcohol is not a drug or is irrelevant to the experiences of older people who use drugs.

Drug use can be both non-problematic and problematic. Currently, the European Monitoring Service for Drugs and Drug Addiction (EMCDDA) (2024) defines problem drug use as *"recurrent drug use that is causing actual harms (negative consequences) to the person*

(including dependence, but also other health, psychological or social problems), or is placing the person at a high probability/risk of suffering such harms".

Problematic drug use has been defined in many ways, for example, addiction, misuse, dependence, and abuse. However, regardless of the terms –there is a stigma around drug users (Schlag, 2020). The term problematic drug use is a relatively more recent term compared to others, and it aims to prevent the stigmatisation of drug users (Seddon, 2011). Additionally, Seddon (2011) stated that problematic drug use focuses on problems related to drug use rather than drug use itself and excludes non-problematic drug use.

The different approaches to drug use in academic research also reflect on the social attitude towards drug use (Caiata-Zufferey, 2012). Askew (2016) stated that including non-problematic drug use in research can have a positive effect on societal stigma and stereotypes. Moreover, she points out that the lack of research on non-problematic drug users might be because of the lack of funding. She stated that because non-problematic drug use does not necessarily present adverse effects on society, organisations might not prefer to spend their limited funding on non-problematic drug use research.

Another distinction in drug use research is the onset of use. The cut-off points for late and early-onset drug use are not set in the literature. For example, Anthony and Petronis (1995) recruited people aged between 18 and 24 for their early-onset drug use research. Chen, Storr and Anthony (2009) observed differences in drug dependence problems among recent-onset users, and they highlighted that adolescent-onset users (<18) and adult-onset users (>18) show different risk factors. However, EMCDDA (2010) refers to people who start using drugs in their late 20s or 30s as late onset users. Additionally, they refer to early-onset users as survivors and late-onset users as reactors (EMCDDA, 2008). The starting age of drug use can lead to different experiences. For example, Anthony and Petronis (1995) found out with their survey-based research that early-onset users are more likely to experience drug problems compared to late-onset users. Evidence suggests that late-onset users often start their drug use in response to negative life events, such as bereavement and isolation and then typically display fewer dependency characteristics (EMCDDA, 2008).

Even though the legalisation of psychoactive substances is not the focus of this study, it is an inevitable part of it. How the legal system treats drug use and people's broader perspectives on drug use are connected. Therefore, understanding the legislation, policies and experiences

of non-problematic drug users' perspectives around this subject, alongside their experiences of problematic drug use, is essential to reflect lived realities in research.

1.1.1 History of Drug Policies in the UK

The history of drug policy in the UK is important for this thesis because it shows that drug use has never been understood in a fixed way. Rather, it has been framed differently across time through changing medical, moral, criminal justice, and public health perspectives. These shifting policy frameworks have shaped not only how drug use has been regulated, but also how people who use drugs have been understood, treated, and governed.

Until the late nineteenth century, substances such as opium were widely available and commonly used in Britain (British Medical Association, 1997). The first major legal restrictions emerged with the Pharmacy and Poisons Act 1868 (*The Pharmacy and Poisons Act*, 1868), followed by further controls in the early twentieth century. From this period onward, the state increasingly sought to regulate the possession and supply of certain substances, while also preserving a role for medical practitioners in prescribing drugs for treatment purposes (Bennett, 1988; *Dangerous Drugs Act*, 1920; Lloyd, 2010). The Rolleston Report of 1926 was especially significant in this regard. It supported the idea that heroin and morphine could be prescribed in some circumstances to people with addiction, and this became associated with what was later described as the "British System." (Bennett, 1988; Glatt et al., 1967; Ministry of Health, 1926) Although this approach was often presented as more medicalised and less punitive than North American models, it was never uncontested and remained shaped by debates about legitimacy, dependence, and the boundaries of proper treatment (Barton, 2003; Glatt et al., 1967; MacGregor and Ettore, 1987; Pearson, 1991).

From the 1960s onwards, policy concern intensified as patterns of drug use changed. Reports suggested a younger and more visible population of drug users, alongside anxieties about overprescribing and the growth of new drug subcultures (British Medical Association, 1997; Glatt et al., 1967; Royal College of Psychiatrists, 1987). In response, the UK introduced tighter controls through the Dangerous Drugs Act 1967 (*Dangerous Drugs Act*, 1967) and, later, the Misuse of Drugs Act 1971 (*Misuse of Drugs Act*, 1971), which remains central to the legal framework today. These developments marked an important shift: drug use was no longer understood primarily as a limited medical issue, but increasingly as a wider social

problem requiring stronger regulation and surveillance (Barton, 2003; Kidd and Sykes, 1999).

During the 1980s and 1990s, UK policy moved further toward law enforcement and control, particularly in the context of Thatcher-era social and political change (Barton, 2003; Farrall et al., 2017; Gamble, 1986; Harrison, 1983). Drug use became more explicitly politicised, and strategies such as *Tackling Drug Misuse* and later *Tackling Drugs Together* framed the issue through crime prevention, enforcement, and social protection (HM Government, 1995; Home Office, 1985). At the same time, the rise of HIV/AIDS among people who injected drugs pushed policy toward harm reduction, highlighting tensions within UK drug policy between punishment and public health (Berridge, 1996). This tension has remained central ever since.

More recent policy has continued to reflect these competing logics. Contemporary UK drug strategies combine treatment, recovery, criminal justice, and harm reduction, but they also sit alongside increasing concern about historically high drug-related deaths and the ageing of the drug-using population (HM Government, 2021). In this context, policy has become more attentive to people who have lived with long-term drug use and who are now ageing with complex health and social needs. This is particularly important for the present study. The policy history of drug use in the UK is not simply background context; it forms part of the wider framework through which older people with histories of drug use are seen, managed, and responded to in the present. Understanding this history therefore helps to situate the thesis within the shifting social and political conditions that have shaped both drug use and the lives of those who use drugs over time.

The contexts shaping drug use experience extend well beyond drug policy. For people aged 40 and over, the political economies, welfare structures, cultural climates, and moral frameworks of the eras through which they have lived have all shaped what drug use meant, what was available, and what consequences it carried. A life-course analysis demands that these conditions be made visible. Table 1 maps the social, political, and cultural landscape from the 1950s to the 2020s which is the full span of participants' lives up to research date while setting out for each era its broader context, its drug use landscape, and its specific salience for reading the biographical accounts in this study.

Table 1 Social Political and Cultural Context of 1950s-2020s

ERA	SOCIAL, POLITICAL AND CULTURAL CONTEXT	DRUG USE LANDSCAPE	SALIENCE FOR PARTICIPANTS AGED 40 AND OVER	References
1950s-60s	• Post-war welfare state expansion: NHS (1948), social housing, free education • Full (male) employment; manufacturing and heavy industry dominant • Rise of youth culture, rock and roll, early counterculture • Racial segregation and immigration tensions (Windrush generation; 1958 Notting Hill riots)	• Opium and cannabis use associated with jazz subcultures and migrant communities • Pharmaceutical amphetamines (Benzedrine) widely available and used by housewives, students, musicians • Heroin prescribed medically under the "British System" (Rolleston Committee legacy)	Participants now in their 60s and 70s were born into a period of genuine welfare optimism and relative working-class stability. Early childhood security or its absence through poverty, domestic violence, or early industry decline forms the biographical foundation. The NHS and social housing were newly present as safety nets that would later be eroded.	(Berridge, 1999; Glatt et al., 1967; Ministry of Health, 1926; Webster, 2002)

	• Gender norms rigidly enforced; limited women's economic independence • Relative social optimism and upward mobility narrative in working-class communities	• Drug use largely invisible, medicalised, or racialised in public discourse • Misuse of Drugs Act not yet passed; relatively permissive medical framework		
1970s	• Economic crisis: oil shock (1973), stagflation, industrial unrest, three-day week • Rise of organised labour; miners' strikes; collapse of post-war consensus • Punk counterculture: nihilism, "no future", anti-establishment identity • Second-wave feminism and early gay liberation	• Heroin use rising among working-class youth in post-industrial areas • Cannabis and LSD central to youth counterculture • Misuse of Drugs Act 1971 criminalises possession; shift from medical to criminal framing • Barbiturate misuse widespread; early benzodiazepine prescribing	Participants now in their mid-50s to mid-60s came of age during economic instability and the fracturing of the post-war settlement. The punk generation carried a specific cultural nihilism ("no future") that may have shaped early drug-using identities. The criminalisation of drug possession under the 1971 Act means this cohort was among the first to experience	(Barton, 2003; *Misuse of Drugs Act*, 1971; Pearson, 1987; Young, 1971)

	movement (Gay Liberation Front, 1970) • IRA campaigns; political violence normalised in Northern Ireland and mainland UK	• Solvent abuse (glue-sniffing) emerging as a youth phenomenon	drug use as a criminal rather than medical identity.	
1980s	• Thatcherism: deindustrialisation, mass unemployment (3 million+), privatisation • Closure of mines, steelworks, shipyards; devastation of working-class communities • Miners' strike (1984–85): defeat of organised labour; multigenerational community despair • Inner-city riots (Brixton 1981, Toxteth 1981,	• Heroin epidemic in post-industrial areas — cheap, smokeable brown heroin floods northern England and Scotland • Direct link between unemployment, socioeconomic despair, and heroin initiation • HIV/AIDS among injecting drug users: public health emergency and heightened stigma	This is the most formative era for many participants now in their 40s and 50s. Economic devastation was geographically concentrated in exactly the communities where heroin became widely available. Participants from affected communities who began using drugs in this era carry the specific biographical inheritance of structural abandonment. HIV/AIDS adds a specific layer of mortality, shame, and stigma — particularly salient for gay	(Berridge, 1999; Dorn and South, 1987; Gamble, 1986; Home Office, 1985; Pearson, 1987; Peck and Plant, 1986; Stimson, 1995)

	Handsworth 1985): race, poverty, policing • HIV/AIDS crisis: initially framed as a "gay plague"; moral panic and stigma • Section 28 (1988): criminalisation of "promotion" of homosexuality in schools • Rise of neo-liberal ideology: individual responsibility replaces structural explanations	• Crack cocaine emerges in UK cities (mid-to-late 1980s) • Government response punitive rather than harm-reductive; "Just Say No" messaging • First needle exchanges piloted (1986) as pragmatic harm reduction response to HIV	participants. The neo-liberal framing of individual responsibility continues to shape how participants narrate and judge their own histories.	
1990s	• New Labour (1997): Third Way politics; "Cool Britannia"; optimism and economic growth • Rave culture and ecstasy generation; drug use	• Ecstasy and rave culture: drug use by middle-class youth becomes culturally mainstream • Crack cocaine and heroin markets consolidate in deprived urban areas	The rave generation normalised drug use across class lines but the consequences fell unevenly. Middle-class ecstasy users rarely entered treatment systems; working-class heroin users did. This class bifurcation	(HM Government, 1995; Measham et al., 1994; National Records of Scotland, 2024; Parker, 1999; Scottish Government, 2018;

	normalised in mainstream youth culture • Good Friday Agreement (1998): end of main IRA campaign; political stabilisation • Scottish devolution (1999): new political context for drug policy in Scotland • Welfare reform: shift from universal entitlement toward conditionality • Rise of celebrity culture; early internet; globalisation of culture • Section 28 not repealed until 2003; continued legal discrimination against gay people	• First national drug strategy: *Tackling Drugs Together* (1995) enforcement plus treatment • Methadone maintenance becomes widespread; harm reduction gains institutional legitimacy • Growing awareness of poly-drug use and alcohol-drug combinations • Drug-related deaths begin sustained rise in Scotland	of who gets treated as a recreational user and who gets treated as an addict is directly relevant to participants' accounts of stigma and differential treatment. The expansion of methadone maintenance in the 1990s means many participants have been on substitute prescribing for 25–30 years with implications for identity, stigma, and the meaning of "recovery".	Strang and Gossop, 1994)
2000s	• War on Terror post-9/11; Iraq War (2003) and	• Recovery agenda dominates drug	When many experienced key adult responsibilities:	(Advisory Council on the Misuse of Drugs,

	widespread public opposition • Economic boom followed by global financial crash (2008) • New Labour drug strategy: *Drugs: Protecting Families and Communities* (2008) abstinence emphasis • Civil Partnerships Act (2004): legal recognition of same-sex relationships • CCTV expansion, ASBOs, increased surveillance and criminalisation of public behaviour • Housing boom followed by repossession crisis; rise in homelessness post-2008	treatment policy: abstinence as goal replaces harm reduction • Cocaine use rises across all social classes; normalisation of "recreational" cocaine • Prescription opioid misuse growing; OxyContin-type medications entering UK market • Drug-related deaths in Scotland escalating; ageing of heroin-using cohort visible • ACMD advisory function weakened after David Nutt dismissal (2009)	parenthood, housing, employment, criminal justice contact. The financial crash of 2008 hit those with existing vulnerabilities disproportionately. The shift toward abstinence-focused drug policy from 2008 onwards reshaped the treatment landscape that many participants were navigating, moving away from harm reduction toward "recovery" metrics which may have intensified the stigma around ongoing substitute prescribing.	2019; Home Office, 2008; National Records of Scotland, 2024; Nutt, 2009)

2010s	• Conservative-led austerity from 2010: deep cuts to public services, welfare, social care • Universal Credit rollout: delays, conditionality, sanctioning of vulnerable claimants • Food bank use rises 2,000% over the decade; child poverty increases • Brexit referendum (2016) and prolonged political crisis: polarisation, identity politics • Marriage Equality Act (2014): same-sex marriage legalised in England, Wales, Scotland	• Drug-related deaths in Scotland reach crisis levels, highest in Europe by 2015 • New psychoactive substances (legal highs) banned under Psychoactive Substances Act (2016) • Spice/synthetic cannabinoids emerge as a crisis in prisons and among homeless populations • Naloxone distribution programmes expanded in Scotland • Drug treatment capacity reduced: residential rehabilitation beds cut significantly	Austerity is the defining structural context of this era for participants. The simultaneous cutting of drug treatment funding, mental health services, housing support, and welfare provision created a compounding of vulnerability for people with complex needs, precisely the population in this study. Many participants were in their 40s during this period, meaning the support they needed as they aged into greater health complexity was being actively withdrawn. The Scotland-specific drug deaths crisis makes this era particularly salient for Scottish participants.	(National Records of Scotland, 2024; Public Health England, 2017; Scottish Government, 2018; Transform Drug Policy Foundation, 2021)

	• Mental health services under severe pressure; long waiting lists; beds reduced • Drug treatment funding cut by 35%+ between 2010 and 2019	• Heroin-assisted treatment (HAT) piloted; drug consumption room debate begins		
2020s	• COVID-19 pandemic (2020–21): lockdown, isolation, grief, disrupted services • Cost of living crisis from 2022: energy, food, housing costs rise sharply • Drug policy reform debate intensifies: Scotland pushes for harm reduction powers devolved • *From Harm to Hope* (2021): UK Government 10-year drug	• Pandemic accelerates drug-related deaths: isolation, supply disruption, service withdrawal • Methadone and buprenorphine policy liberalised during lockdown: takeaway doses, reduced attendance • Drug Related Deaths Taskforce (Scotland) and ACMD reports on older drug users	This is the context in which the study was conducted and in which participants were interviewed. The pandemic disrupted both drug use patterns and service access which several participants noted this directly. The cost of living crisis compounds material precarity for older drug users on fixed or limited incomes. The policy shift toward including lived experience voices represents the political moment in which participants' biographical	(Advisory Council on the Misuse of Drugs, 2019; HM Government, 2021; National Records of Scotland, 2024; Scottish Government, 2021)

	strategy, supply disruption + treatment investment • Long COVID and NHS backlog: health system under sustained pressure	• Nitazene analogues and other novel opioids entering supply chains • Growing cross-party support for drug consumption rooms and decriminalisation • Scottish Government's *Rights, Respect and Recovery* strategy emphasises lived experience	accounts are being asked for and, through research like this thesis, being heard	

1.1.2 Trends in Different Types of Drugs

This section outlines the main categories of substances relevant to the thesis: illicit drugs, prescription medication, and over-the-counter medication. Distinguishing between these categories is important because later-life drug use is not limited to one type of substance. Rather, older adults may have experience of illicit drugs, prescribed psychoactive medication, and non-medical use of over-the-counter medicines, sometimes separately and sometimes in combination. For a life-course study of drug use and ageing, it is therefore important to recognise that substance use in later-life may involve a wide range of substances whose meanings, risks, and functions change over time.

1.1.2.1 Illicit Drug Use

Illicit drug use remains a significant social and public health issue in the UK. Dame Carol Black's review of drugs highlighted the substantial social and economic costs associated with illicit drug use, including criminal justice costs, health harms, drug-related deaths, and wider impacts on families and communities (Black, 2020). At the same time, recent treatment and hospital data indicate that the age profile of people affected by drug use is shifting. In England, a substantial proportion of adults in treatment are now aged 50 and over (Office for Health Improvement & Disparities, 2021a, 2021b), while in Scotland hospital admissions among older age groups have increased sharply over time (National Statistics, 2019).

These trends are important because they show that drug use is increasingly intersecting with ageing. Older adults who use illicit drugs may experience not only the cumulative effects of long-term use, but also the changing effects of ageing itself. Existing research suggests that older people with problematic drug use may have poorer physical and mental health, lower expectations of services, and more complex needs than younger groups. At the same time, older adults are often absent from research and policy discussions, which means that their experiences can remain poorly understood (Beynon et al., 2009, 2007; Fitton et al., 2018; Nicholas and Roche, 2014; Raja Badrakalimuthu et al., 2012; Rao and Roche, 2017).

For this thesis, illicit drug use is important not only because of its health and social harms, but because it forms part of the life histories of participants and helps illuminate how the meanings of drug use change over time. As the later chapters show, illicit drug use can be associated with pleasure, belonging, coping, routine, survival, or distress at different points in

the life course. The significance of illicit drugs in this study therefore lies not only in their legal status or risk profile, but in how they are lived, interpreted, and re-evaluated in relation to ageing.

1.1.2.2 Prescription medication

The later-life drug use cannot be understood through illicit drugs alone. Prescription medication misuse is a problem that has gained attention over the last decade in the UK (Wood and Dargan, 2021). In later-life, many people are prescribed medication for chronic pain, sleep problems, anxiety, or other health conditions, and this creates a different set of possibilities and risks. Prescription medication misuse has received growing attention in recent years, particularly in relation to opioids, benzodiazepines, and sleeping medication.

This is especially significant for older adults. Ageing is commonly associated with multimorbidity, increased medication use, and physiological changes that may heighten sensitivity to psychoactive substances (Advisory Council on the Misuse of Drugs, 2019; Bonanno et al., 2025). As a result, prescribed medication may become entangled with pain management, emotional distress, sleep, dependence, or attempts to maintain everyday functioning. Older adults may also be more vulnerable to adverse reactions, interactions between substances, and difficulties associated with long-term use.

In the context of this thesis, prescription medication misuse highlights how drug use in later-life may be connected not only to pleasure or illicit consumption, but also to health problems, medical systems, and attempts to cope with the body and mind in older age.

1.1.2.3 Over-the-counter medication

In the UK, there are two categories of over-the-counter (OTC) medications: "P" medications, which must be supervised by a pharmacist and are only available from licensed pharmacies, and "GSL" medications, which can be sold to the broader public from non-pharmacy retailers (Reed, 2011, cited in Cooper, 2013). Being able to buy OTC medication eases the burden on general practitioners and uses pharmacists' knowledge by providing appropriate treatment and medication to the patients. However, it is known that OTC medication is open to misuse and abuse, and patients might minimise the potential side effects. Not requiring a prescription can lead people to think that OTC medications are harmless or “safe” (Hill et al., 2018). Non-medical use of OTC medications can occur as misuse. Misuse might result from patients’ lack of awareness or information (Wright et al., 2015).

Patients might feel reluctant to see their general practitioner and try to treat their symptoms themselves (Cooper, 2013). It can also be seen when the general practitioner stops a treatment the patient believes should continue, and the patient may try to replace the medication. Additionally, individuals may self-medicate with various over-the-counter medications for conditions such as insomnia, chronic pain, and depression. (Derry, 2000).

The prevalence of non-medical use for OTC is unknown in the UK. Wright et al. (2015) investigated the problem by investigating the community pharmacy surveys and comparing the results with past surveys (1995, 2000, 2006, and 2014). They found that pharmacists believed 80% of medication in the pharmacy is being misused, which is 10-12% higher than in previous years. The same study stated that patients who misuse OTC medications are typically female, between the ages of 41 and 60, and employed (Wright et al., 2015).

The findings of this thesis do not focus on differences between drug types. However, it is important to acknowledge that drug use in later-life is not limited to illicit substances. Older adults may also have experience of prescribed psychoactive medication and non-medical use of over-the-counter medicines, sometimes separately and sometimes alongside illicit drug use. Where participants raised these experiences in interview for example, in relation to pain management, mental health, or transitions between prescribed and illicit substances, these accounts are included in the analysis. A full account of prescription and over-the-counter medication misuse in later-life falls outside the scope of this thesis, but the boundary between illicit and licit drug use in participants' lives was not always clear, and this is acknowledged throughout the findings.

1.1.3 Drug use across the life course

Drug use is best understood as a process unfolding over time rather than as a fixed condition or a single event. A life-course perspective is useful because it directs attention to trajectories, continuity and change, transitions, and turning points, rather than assuming a uniform movement from initiation to dependence and then to recovery or cessation. Although relatively few UK studies explicitly frame their work through life-course theory, a number of longitudinal, qualitative, and mixed-method studies nevertheless show that drug use pathways are shaped by changing social roles, shifting environments, and the accumulation of earlier experiences across different stages of life (Neale et al., 2012; Vojt et al., 2025; Williams and Parker, 2001).

One important contribution of UK research has been to challenge linear assumptions about transitions into adulthood. Williams and Parker's (2001) longitudinal work with English young adults showed that recreational drug use did not simply disappear as participants moved beyond adolescence. Instead, some patterns of use persisted, some reduced, and others were reconfigured in relation to work, leisure, and emerging adult identities. Related work on the normalisation of recreational drug use similarly suggested that some forms of illicit drug use had become accommodated within the lives of otherwise conventional young adults, complicating the idea that adulthood naturally brings disengagement from drugs (Parker et al., 2002). Together, these studies indicate that transitions into adulthood may modify the meaning and pattern of use, but do not automatically constitute decisive turning points.

Three frameworks have been particularly influential in shaping how drug use across the life course has been understood, and all three are challenged by the findings of this thesis. First, *progression models* assume a predictable arc from initiation through escalation to either recovery or deterioration, implicitly treating drug use as a condition that moves in one direction (Room, 2005; Strang, 1989). Second, the *maturation hypothesis*; associated with Winick's (1962) early work and reflected in later UK discussions of "maturing out" proposes that people naturally disengage from drug use as they age into adult roles and responsibilities (Dennis, 2021). Third, *recovery stage models*, such as DiClemente and Prochaska's (1998) transtheoretical model, structure the change process into sequential stages that simply a forward-moving journey from contemplation through to maintenance. It is worth noting that transtheoretical model presents an advance on earlier linear state thinking, explicitly accommodating relapse and recognising that change is rarely straightforward (DiClemente and Prochaska, 1998; Prochaska et al., 1992; Prochaska and DiClemente, 1983). However, even within this framework, progression remains oriented toward a defined endpoint which is abstinence or maintained drug use. In this research's context, the framework is recursive rather than strictly linear, but it nevertheless retains an underlying orientation towards behavioural change and maintenance/termination (Sutton, 2001). It fails to recognise social, relational and biographical conditions that shape what drug use means at different life-course stages, or with the possibility that drug use might be continuously reinterpreted rather than simply maintained or abandoned (Elder et al., 2003; Hser et al., 2007).

While each of these frameworks captures something real, they share an underlying assumption that drug use follows a directional trajectory. A life-course approach begins from

a different premise: that trajectories are non-linear, context-dependent, and shaped by the accumulating weight of biography rather than by any fixed sequence of stages.

Longitudinal cohort evidence from the UK further supports the importance of continuity across the life course. White and colleagues (2020), using data from the 1970 British Birth Cohort Study, found that illicit drug use in adolescence was associated with a wide range of later socioeconomic and criminal justice outcomes in adulthood, including continued illicit drug use, homelessness, and offending. This is useful for a life-course review because it shows that early drug use cannot be treated as an isolated youth behaviour without longer-term consequences. Rather, it may become part of a broader trajectory through which disadvantage, exclusion, and continued substance use are reproduced over time.

At the same time, the place of trauma within life-course research requires careful treatment. Macleod and colleagues (2013), using the Edinburgh Addiction Cohort, found that later injecting drug use was strongly associated with childhood adversity, especially disrupted family structure, public care, violence from parents or carers, and early conduct problems. More recently, Karamanos and colleagues (2022) showed that adverse childhood experiences were associated with adolescent drug use in the UK regardless of socioeconomic position or ethnicity. These studies are important because they demonstrate that trauma and adversity can shape early pathways into drug use. However, they do not justify a deterministic reading in which trauma becomes a single-origin explanation for all later use.

Indeed, qualitative UK work suggests a more complex relationship between trauma and trajectories. Hammersley and colleagues' (2020) life-story study with people in recovery in Scotland shows that severe violence and trauma were not only part of childhood experience but also frequently occurred during drug-using lives themselves. One consequence is that trauma may function not just as a prelude to drug use, but also as something produced and intensified within drug-using environments, with continuing implications for escalation, coping, and later recovery. This is significant for a life-course perspective because it suggests that trauma should be understood as temporally layered rather than fixed at the beginning of biography. It may shape initiation, but it may also be reactivated, compounded, or reinterpreted through later experiences.

That trauma is so consistently present in life-course accounts of drug use raises a further question that this thesis takes seriously, whether services are designed to recognise and

respond to it. The principles of trauma-informed practice (TIP) offer one framework for thinking about this gap; proposing that effective responses require engagement with biographical adversity rather than only with presenting behaviour (Sweeney et al., 2018). How well this is achieved in practice, and what older people's accounts reveal about the consequences when it is not, are questions that run through the empirical chapters and are taken up directly in the discussion chapter.

Some studies also complicate the idea that turning points are singular or inherently transformative. Research on parents who use drugs has shown that transitions such as parenthood do not automatically redirect lives away from drug use. Rather, they generate new forms of moral accountability, concealment, negotiation, and pressure (Rhodes et al., 2010). Similarly, Neale, Nettleton and Pickering's (2012) work on recovering heroin users demonstrates that transitions out of problematic heroin use are rarely lived as one-off moments of transformation. Recovery is instead shown to involve the slow reconstruction of everyday practices, relationships, temporal routines, and future aspirations. Related work by Nettleton, Neale and Pickering (2011) on sleeping practices among recovering heroin users reinforces this point by showing that transitions in drug use status are also embodied and mundane, involving disrupted daily rhythms rather than only major psychological shifts.

Further UK work suggests that non-linear pathways continue well beyond the transition to adulthood. Nettleton, Neale and Pickering's (2013) analysis of "normality" among recovering heroin users shows that recovery is often narrated not as a clean break from the past but as a struggle to achieve a sense of ordinariness after prolonged disruption. More recently, Vojt and colleagues' (2025) Scottish qualitative study of people who inject drugs after hepatitis C treatment identified a range of post-treatment life trajectories, including sustained improvement, fragility, and decline, depending on wider circumstances such as housing, support, treatment engagement, and social context. These studies are especially useful because they make clear that change can be partial, reversible, and contingent. Turning points do not sustain themselves, their longer-term effects depend on the material and relational conditions in which they occur.

Taken together, UK research suggests that drug use across the life course is characterised less by a single pathway than by uneven movements shaped by timing, biography, trauma, and social context. Trajectories may involve persistence, reduction, relapse, interruption, and

reconfiguration rather than straightforward progression in one direction. Childhood adversity and trauma clearly matter, but the literature also shows that trauma cannot be treated as a total explanation, since later experiences, adult transitions, everyday routines, and structural conditions all contribute to continuity and change. A life-course perspective is therefore especially useful because it accommodates both long-term continuity and the non-linear, contingent character of drug use pathways over time (Hammersley et al., 2020; Macleod et al., 2013; Williams and Parker, 2001).

1.2 Ageing

Within UK research, ageing and drug use have most often been brought together through concerns about the ageing cohort of long-term drug users, particularly people with long histories of opioid use (Advisory Council on the Misuse of Drugs, 2019; Dennis, 2021). This literature has been shaped in part by demographic change: treatment populations have aged, drug-related deaths have become increasingly concentrated among older adults, and policy discussions have become more alert to the implications of an older drug-using population (Advisory Council on the Misuse of Drugs, 2019; Office for Health Improvement & Disparities, 2024; Office for National Statistics, 2022). The Advisory Council on the Misuse of Drugs' report on the ageing cohort of drug users reflects this policy concern directly, emphasising that older adults with histories of drug use often present with multiple and interacting needs spanning physical health, mental health, pain, medication use, housing, and social care (Advisory Council on the Misuse of Drugs, 2019). In this sense, the emergence of older drug users as a topic in UK policy and research has not simply reflected an increase in age, but a growing recognition that later-life introduces forms of complexity not well addressed by services designed with younger users in mind (Advisory Council on the Misuse of Drugs, 2019; Dennis, 2021).

A central theme in the UK drug use literature is the relationship between ageing and deteriorating health (Ayres et al., 2012; Beynon et al., 2009; Matheson et al., 2019; Roe et al., 2010). Beynon et al.'s (2009) qualitative interview study with illicit drug users aged 50 and over in Merseyside identified poor self-reported health, multiple chronic conditions, and frequent service contact as key features of older users' lives. Roe et al. (2010) similarly found that older drug users' experiences were shaped by changing health, quality of life, and relationships, with ageing prompting reflection on survival, damage, and the deaths of contemporaries. Ayres et al.'s (2012) Bristol study further highlighted the treatment

experiences and needs of older drug users, showing that later-life was associated with pain, worries about health, and reluctance to seek support in contexts where symptoms could be interpreted as drug-seeking. More recently, Matheson et al.'s (2019) Scottish study of older people with a drug problem identified chronic pain, depression, anxiety, loneliness, and multimorbidity as recurring concerns. Overall, this body of work suggests that later-life drug use in the UK has most often been understood through health decline, physical vulnerability, and increasing service need.

However, the UK literature does not reduce later-life drug use entirely to decline (Ayres et al., 2012; Roe et al., 2010; Shaw et al., 2022). Some studies point toward a more complex picture in which ageing changes not only the risks of drug use but also its meaning. Roe et al. (2010) show that later-life may prompt reflection on health, survival, and relationships, while Ayres et al. (2012) suggest that older users may continue to use substances in ways bound up with pain management, self-regulation, and everyday functioning. Shaw and colleague's (2022) qualitative work with women in mid-life and older age in recovery is especially important here because it pushes the literature beyond service needs and morbidity. Her research shows that ageing bodies are not experienced only as damaged bodies; they are also bodies through which women renegotiate recovery, femininity, identity, and belonging over time. In a second study, Shaw (2023) further demonstrates that mid-life and older age recovery is closely connected to changing forms of connection and belonging, suggesting that later-life may involve not only decline and loss, but also reworking of selfhood and social identity. These studies broaden the field by showing that ageing is not simply a biomedical condition but an embodied, relational, and interpretive process.

A further theme in the literature concerns the social dimensions of ageing with a history of drug use. Older adults may experience shrinking social networks, bereavement, and loneliness, but the literature also suggests that reduced sociality is not always straightforwardly negative (Matheson et al., 2019; Shaw, 2023; Smith et al., 2022). Matheson et al. (2019) identify social support deficits and isolation as major concerns among older people with a drug problem, while Shaw's (2023) work shows that later-life recovery may involve the active rebuilding of belonging rather than simple social withdrawal. At the same time, the wider UK recovery literature suggests that social support, peer networks, and identity change are often actively constructed through recovery communities rather than naturally inherited in later-life. This is important because it indicates that ageing may narrow

social worlds, but the meaning of that narrowing depends on biography, recovery context, and the kinds of relationships available to people as they grow older. Later-life quietness may therefore be experienced as either peace or absence, depending on the social and material conditions in which it occurs.

Despite these important contributions, the UK literature remains limited in several ways. First, much of the work on older drug users has been driven by treatment, health, and service concerns, which means that older adults often appear primarily as an ageing service population rather than as narrators of their own lives. Second, there is still relatively little UK qualitative research that places ageing and drug use together within a life-course frame, tracing how early experiences, adult transitions, bodily change, family relationships, stigma, and later-life identities shape one another over time. Third, although some studies highlight pain, social isolation, or recovery identity, fewer bring these concerns together in a single account of what it means to age with a history of drug use. As a result, the literature is stronger on identifying problems than on understanding how older people themselves interpret the changing functions and meanings of drug use in later-life (Ayres et al., 2012; Beynon et al., 2009; Dennis, 2021; Matheson et al., 2019; Roe et al., 2010; Shaw, 2023).

These demographic trends are compounded by significant barriers to treatment and help-seeking, which are examined in the following section.

Treatment and Help-Seeking Behaviour of Older Drug Users

Older adults may have more difficulty seeking help than younger drug users. There is a stigma around older drug users, and many people avoid voicing their problems, which could be caused by experienced shame, guilt, or fear of ostracisation, which can lead people to refrain from seeking help (Wu and Blazer, 2011). Ayres et al. (2012) explored treatment experiences of older drug users in Bristol, UK. They interviewed 20 participants over the age of 55 who were current drug users. The findings showed that people had negative views of themselves because of their ages and drug use experiences. Shame and embarrassment negatively affected people's help-seeking behaviour. Additionally, heroin was commonly used for pain management within this group, and illegal drug use was high. Participants' treatment experiences included fear of judgment and a sense of not receiving fair treatment. Researchers suggested a study focusing on age-specific stressors would be useful (Ayres et al., 2012).

Another reason older adults have low admission prevalence may be a lack of awareness among health professionals, as well as stigmatising and discriminating behaviour.

Symptoms of drug use and symptoms of health problems that older people experience when they get older may be confused (SAMHSA, 2020). This may lead to healthcare workers missing drug use or related mental health problems because they interpret them as symptoms of more widely expected health problems in this age group, such as ageing, fatigue, loss of weight and appetite. Similarly, mood swings and energy deficiency can be mistaken for physical or psychological health problems (Rao and Arora, 2015).

Monitoring medication consumption of older adults can be problematic because of their chronic and comorbid conditions, since older adults tend to use multiple medications daily and for lengthy periods (Simoni-Wastila and Yang, 2006). Therefore, observing medication misuse, dependence, and addiction may become challenging. (Rao et al., 2019). Consequently, healthcare workers may fail to recognise substance use and refer their patients or clients to suitable treatment facilities (Kuerbis et al., 2014). As mentioned before, current treatment practices are mostly tailored around younger drug users (Royal College of Psychiatrists, 2018b). This could lead older drug users to feel forgotten, ignored, or even punished (Corrigan et al., 2017; Ginn and Clark, 2017; Matheson et al., 2017). Additionally, the increasing population of older adults in the context of increasing life expectancy should result in more older people having access to health and social care services. Yet, data shows fewer people receive care from the services compared to previous years. According to the NHS Confederation's report (Bosch and Isden, 2023), the number of people who receive adult health care decreased by 4% between 2017/18 and 2021/22. Furthermore, a report published by AgeUK stated that 1.6 million older adults (aged 65 and over) could not receive health care for their needs (Reeves et al., 2023). To sum up, it can be seen from available data that there is a higher demand for health and social services than is currently being offered by the NHS. Therefore, if the increase in the ageing population continues, without improvement of health and social care services, inevitably, more older people will experience problems accessing appropriate support when they require it.

Finally, most treatment facilities organise their services for younger age groups (Royal College of Psychiatrists, 2018b). In the general population, the number of younger drug users is higher than the number of older drug users, which is why organisations need to focus on

the younger generation can be understandable. However, this leaves older adults with limited treatment options. Drug use treatment is a multifaceted process that must be suitable for target populations to be successful (EMCDDA, 2010a).

Taken together, this literature shows that ageing is central to understanding later-life drug use, but it also highlights the need for a broader conceptual account of what ageing itself means. Much of the existing drug-use literature has approached ageing through health decline, service need, multimorbidity, and physical vulnerability, while a smaller body of work has begun to show that ageing also involves changes in identity, relationships, belonging, and the interpretation of past experience. Gerontology provides the conceptual tools to develop this understanding further. Rather than treating ageing solely as chronological or biological change, sociological, critical, and narrative gerontology examine how ageing is shaped by social conditions, inequality, cultural expectations, accumulated biography, and the meanings people attach to growing older. The following section therefore draws on gerontological theory to establish a conceptual framework for understanding ageing as an embodied, social, structural, and interpretive process, which can then be brought into dialogue with the literature on drug use across the life course.

1.3 Gerontology, the Sociology of Ageing and Identity in Later-Life

1.3.1 Understanding Ageing

Ageing has historically often been understood through a biomedical lens, with later-life associated with physical decline, dependency and loss of social roles (Phillipson, 1998). Earlier gerontological theories reflected this perspective by treating withdrawal and declining capacity as relatively natural features of growing older. Although these ideas have been widely challenged, assumptions that ageing primarily involves decline remain influential in popular, policies and professional understandings of later-life (Biggs, 1993).

Critical and sociological gerontology challenged this individualised understanding of ageing by showing that later-life is shaped by wider social and structural conditions (Estes, 1979; Phillipson, 1998; Townsend, 1981). They challenge the idea that the problems that experienced in later-life such as poverty, isolation, poor health, marginalisation are not solely related the declining health but also a consequence of structural inequality, ageist assumptions, and inadequate social provision.

This perspective is directly relevant to my study. My participants' experiences of ageing were shaped not only by changes in their bodies or by their histories of drug use, but also by poverty, criminalisation, stigma, service provision and other social conditions. A critical gerontological perspective therefore helps avoid interpreting difficulties in later-life simply as the consequences of individual choices or ageing itself.

1.3.2 Critical Gerontology and the Politics of Later-Life

Critical gerontology builds on the foundational insights of Townsend and Estes to develop a broader theoretical framework for understanding how power, inequality, and social position shape the experience of ageing. Drawing on political economy perspectives, feminist theory, and critical race theory, critical gerontology argues that later-life is deeply stratified by class, gender, race, and other dimensions of social inequality (Calasanti and Slevin, 2001; Minkler and Estes, 1999; Walker, 1981). The accumulation of advantage and disadvantage over the life course means that the inequalities of earlier life are often amplified by ageing. For example, those who were most disadvantaged in middle adulthood tend to be most disadvantaged in old age, while those who accumulated resources, health, and social recognition in earlier life are better positioned to age well (Dannefer, 2003).

Dannefer's (2003) concept of cumulative disadvantage is particularly relevant here. Drawing on life-course sociology, Dannefer argues that inequalities do not remain static across the life course and tend to diverge over time: small advantages early in life generate larger advantages later, while small disadvantages compound into larger ones. For people who have spent decades navigating the intersecting disadvantages of poverty, criminalisation, stigma, and inadequate services, cumulative disadvantage means that later-life arrives as the point at which the accumulated costs of those disadvantages become most acutely felt in the body, in social relationships, in financial precarity, and in access to care.

Critical gerontology has also questioned dominant ideas of "successful ageing". The successful ageing framework has emphasised continued health, independence, productivity and social engagement in later-life (Rowe and Kahn, 1999). However, critics argue that such approaches can create normative expectations that give insufficient attention to inequality and the very different resources available to people as they grow older (Holstein and Minkler, 2003). For older people with histories of drug use, bodily vulnerability, reduced income, social marginalisation or continuing service use should therefore not automatically be

understood as evidence of ageing unsuccessfully. These experiences may instead reflect particular life histories and unequal social conditions.

1.3.3 Narrative Gerontology and the Storied Self

While critical gerontology draws attention to the structural conditions of ageing, narrative gerontology focuses more closely on how people understand and interpret their lives. Narrative approaches suggest that identity develops through the stories people tell about who they are and how they understand their past and present experiences (Freeman, 2010; Kenyon and Randall, 1997).

This perspective is particularly relevant in later-life because growing older can provide a different position from which earlier experiences are reconsidered. Events that were understood in one way when they occurred may acquire different meanings when viewed from later points in the life course. Ageing therefore involves not only chronological or bodily change, but also the ongoing reinterpretation of biography.

This is especially important for the participants in this study. Some had lived through long periods of drug use, poor health, loss and proximity to death and had not necessarily expected to reach later-life. Reaching their 40s, 50s, 60s or beyond created a new position from which earlier experiences could be reconsidered. Participants' accounts of regret, survival, recovery and self-acceptance therefore show that later-life can involve a changing relationship with one's own past rather than simply continuity or decline.

1.3.4 Identity in Later-Life

The question of identity and how the self is maintained, disrupted, and reconstructed across the ageing process has been central to gerontological theory since Erikson's (1994) influential account of the life cycle. Erikson proposed that later-life is characterised by a tension between "ego integrity" which is the capacity to accept one's life as it has been, with its particular mixture of success, failure, and contingency and "despair" the sense that life has been wasted or that insufficient time remains for meaningful change. While Erikson's stage model has been criticised for its universalising assumptions, the underlying insight that later-life involves a distinctive relationship to the accumulated past has remained generative for gerontological thinking about identity.

More recent theorists have moved away from stage models toward more processual and contextual understandings of identity in later-life. Gidden's (2003) "reflexive self-identity" argues that identity, selfhood, is highly connected with engagement with one's own biography.

Kaufman's concept of the "ageless self" offers a further dimension. Based on interviews with older Americans, Kaufman (1987) argued that despite bodily change and social repositioning, people maintain a sense of continuous selfhood in later-life, a core identity that persists across the discontinuities of ageing and that provides a stable reference point for making sense of change. What changes is not the self but its social and physical context.

Weiss and Bass (2002) and later Rowe and Kahn's (1999) "successful ageing" framework have been influential in policy and popular gerontology, proposing that later-life can and should be characterised by continued engagement, productivity, and the maintenance of function. As mentioned before, this concept has been challenged by critical gerontologists for its implicit normative standards.

1.3.5 Ageing, Stigma, and Social Recognition

Goffman's (1963) foundational account of stigma as a deeply discrediting attribute that reduces the bearer from a "whole and usual person to a tainted, discounted one" has been extensively applied in gerontological contexts to understand how older people navigate the stigma of age itself. Minichiello et al. (2000) demonstrated that older people in Australia actively resisted ageist stereotypes and managed stigmatised identities through strategies of distancing, humour, and selective disclosure strategies that map closely onto those documented in the drug use literature.

The concept of "double stigma" is particularly relevant to this study. Two overlapping and mutually reinforcing forms of social devaluation that compound to produce a distinctive form of social invisibility: drug use stigma and stigma of ageing (Beynon et al., 2008). They are too old for drug services oriented toward young people, and too drug-involved for ageing services organised around different assumptions about what later-life looks like. This double marginalisation is both administrative inconvenience and identity challenge. It denies older drug users access to the social recognition and narrative resources through which a coherent and valued sense of self in later-life might be constructed.

Taylor's (1995) philosophical account of recognition which is the argument that identity is partly constituted through the recognition of significant others, and that the withholding of recognition is a form of harm provides a further lens through which the experiences of participants in this study can be theorised. When services, institutions, families, and communities fail to recognise older drug users as complex biographical persons and when they are seen only as problems to be managed, risks to be assessed, or cases to be closed the harm is not only practical but existential. It is a denial of the social conditions through which a valued self can be sustained.

These gerontological frameworks help to explain how later-life is shaped by structural inequality, cumulative disadvantage and the narrative resources people have available to make sense of their lives. What they do not fully explain is the specific mechanism through which older drug users come to be positioned, excluded and devalued within services, institutions and everyday social life. Several of the theorists discussed above point towards stigma as part of this mechanism. Structured dependency, cumulative disadvantage and narrative foreclosure all describe processes that can be reinforced, or in some cases produced, by the stigmatising classifications attached to drug use and to age. Double stigma, in particular, suggests that these two stigmatised identities, ageing and drug using, intersect and compound one another. To understand this intersection properly, and to understand how it shapes the biographical possibilities available to participants in this study, a more developed account of stigma is needed than the brief discussion in section 1.3.5 allows. The following section sets out this account, moving from Goffman's foundational framework through more recent structural and political reformulations of stigma, before the chapter turns to the empirical literature on older drug users' lives.

1.4 Stigma as a Social and Structural Process

1.4.1 From Spoiled Identity to Social Machinery: Rethinking Stigma

The foundational account of stigma in the social sciences remains Goffman's (1963) *Stigma: Notes on the Management of Spoiled Identity,* which defined stigma as a deeply discrediting attribute that reduces the bearer from a "whole and usual person to a tainted, discounted one." (p.3) Goffman's framework introduced essential conceptual tools, the distinction between those who are discredited (whose stigma is visible) and those who are discreditable (whose stigma can be concealed); the management strategies through which stigmatised individuals

navigate social interaction; and the concept of "passing" as a form of identity work performed to avoid stigmatisation. These tools have been enormously productive in drug use research, where they have been used to understand how people who use drugs manage visibility, disclosure, and the threat of social rejection in everyday life (Room, 2005; Simmonds and Coomber, 2009).

However, Goffman's framework has been extensively critiqued for its focus on the stigmatised individual's management of a pre-existing attribute, which tends to locate the problem of stigma in the person who bears it rather than in the social structures and power relations that produce it (Link and Phelan, 2001; Tyler, 2020). By attending primarily to the interactional strategies through which stigma is managed, Goffman's account risks reproducing the very individualising logic it seeks to analyse, treating stigma as a property of persons rather than as a product of social organisation. More recent stigma theory has moved decisively beyond this limitation, developing frameworks that attend to the structural, political, and historical dimensions of stigmatisation as a form of social control.

Link and Phelan's (2001) influential reconceptualization argues that stigma exists when elements of labelling, stereotyping, separation, status loss, and discrimination co-occur in a context in which power is exercised. Crucially, they argue that stigma is not simply an interpersonal phenomenon; it is a structural one. Stigma operates through institutions, policies, and social arrangements that systematically disadvantage labelled groups regardless of whether individual prejudice is present. This structural understanding shifts analytical attention from the management of stigma by individuals to the production and reproduction of stigma by social systems; a shift that is directly relevant to understanding how older drug users are positioned within treatment services, criminal justice, health systems, and social care.

1.4.2 Tyler's Stigma Machine: Oppression, Power and Social Abjection

The most significant recent theoretical development in stigma studies for the purposes of this thesis is Imogen Tyler's (2020) *Stigma: The Machinery of Inequality.* Tyler offers a radical reconceptualization of stigma, arguing that it is not primarily a social psychological phenomenon but a political and economic technology through which inequality is produced, naturalised, and reproduced. Drawing on a range of historical and contemporary examples, Tyler argues that stigma functions as what she calls a "machinery of oppression": a set of

practices, representations, and institutional arrangements through which particular groups are marked as inferior, degraded, and deserving of their marginalisation, in ways that serve the interests of dominant social groups and political-economic systems.

Tyler's framework builds on Bourdieu's concept of symbolic violence: the process through which the dominated come to experience and accept their domination as natural and legitimate and extends it through an engagement with theories of abjection (Kristeva, 1982) and what Tyler calls "stigma power." Stigma power describes the capacity of dominant groups to impose stigmatising classifications on subordinate groups, and to do so in ways that are experienced as natural, inevitable, or even deserved by those who bear them. This is a structured social relation in which some groups have the power to define, classify, and degrade others, and in which those classifications are institutionalised in law, policy, professional practice, and popular culture.

For the analysis of drug use stigma, Tyler's framework is transformative. It shifts the analytical question from "how do people who use drugs manage stigma?" to "how is the stigmatisation of people who use drugs produced, sustained, and reproduced as a form of social control, and in whose interests?" This reframing is particularly powerful when applied to the experiences of older drug users, whose stigmatisation cannot be understood apart from the broader political-economic conditions within which drug use developed and within which the "drug user" as a stigmatised social category was constituted. Tyler's account makes visible the political work that stigma does: it naturalises inequality, deflects structural critique onto individual behaviour, and produces a population that can be safely abandoned, managed, and controlled without political cost.

1.4.3 Forms of Stigma

Building on these foundational accounts, stigma research has identified several analytically distinct forms of stigmatisation that are relevant to the experiences of older drug users. Each operates through different mechanisms, at different social levels, and with different consequences for the individuals who experience them.

Structural stigma refers to the ways in which societal-level conditions such as laws, policies, institutional practices, and cultural norms and they constrain the opportunities, resources, and wellbeing of stigmatised groups, regardless of whether individual prejudice is present (Corrigan et al., 2004; Link and Phelan, 2001). In the context of drug use, structural

stigma operates through the criminalisation of drug possession and use, the design of treatment services that prioritise abstinence over harm reduction, the exclusion of drug users from certain housing, employment, and insurance markets, and the legal and institutional barriers that prevent people with drug use histories from accessing services, opportunities, and rights available to others. Hatzenbuehler and Link (2014) demonstrate that structural stigma has measurable effects on health outcomes independently of interpersonal stigma that people who live in more stigmatising structural environments have worse health, even when they report fewer experiences of individual discrimination. For older drug users, structural stigma means that decades of criminalised drug use have generated legal records, treatment histories, and institutional identities that continue to shape access to housing, employment, and care in later-life.

Attributed or applied stigma (enacted stigma) refers to the direct experience of discrimination, rejection, or hostile treatment by others on the basis of a stigmatised identity (Scambler, 2004). In the drug use literature, enacted stigma has been extensively documented in healthcare settings, where people who use drugs report being treated with hostility, disrespect, or indifference by medical professionals; in social interactions, where drug use histories generate social withdrawal and relational rupture; and in institutional encounters, where drug users describe being treated as untrustworthy, manipulative, or beyond redemption (Lloyd, 2013; Simmonds and Coomber, 2009). For older drug users, enacted stigma in healthcare settings is particularly consequential, given their increasing reliance on health services and their heightened vulnerability to the dismissal or inadequate treatment of complex health needs.

Internalised or self-stigma refers to the process through which stigmatised individuals come to accept and apply to themselves the negative stereotypes and devaluing judgements directed at their group (Corrigan and Watson, 2002). Self-stigma involves the internalisation of shame, the reduction of self-esteem, and the development of a sense of self as fundamentally flawed or inferior, what Goffman (1963) described as the stigmatised person becoming their own oppressor. In the drug use context, self-stigma has been associated with reduced help-seeking, withdrawal from social relationships, and the internalisation of an "addict" identity as a master status that overshadows all other aspects of selfhood (Lloyd, 2013). For older drug users, self-stigma may be particularly deeply embedded, having accumulated across decades of social judgement, institutional treatment, and the internalisation of dominant

cultural narratives about drug use as moral failure. Tyler's (2020) framework suggests that self-stigma is not simply a psychological response to social rejection but a political outcome of stigma power, the success of the stigma machinery in producing self-regulating, self-blaming subjects who do not challenge the structural conditions of their marginalisation.

Vicarious stigma (courtesy stigma or associative stigma) refers to the stigmatisation experienced by people who are associated with a stigmatised individual or group, even though they themselves do not share the stigmatised attribute (Goffman, 1963; Gray, 2002). Family members, partners, and friends of people who use drugs are known to experience vicarious stigma through their association with someone whose drug use may expose them to social exclusion, relational difficulties and the management of a discrediting association (Corrigan et al., 2001). For the participants in this study, vicarious stigma operates in two directions simultaneously: they have experienced the vicarious stigma directed at them through their families' associations with their drug use, and their family members, particularly children, have experienced vicarious stigma through association with them. Several participants described profound shame about the stigmatising consequences their drug use had carried for the people they loved, which is itself a dimension of how stigma extends beyond the individual to reshape relationships and family systems across generations.

Intergenerational stigma refers to the transmission of stigmatised identities, social positions, and their associated disadvantages across generations (Pemberton, 2015; Tyler, 2020). Where structural stigma produces conditions in which particular families and communities are repeatedly and systematically disadvantaged, the consequences of that stigmatisation are passed from parent to child through the structured reproduction of inequality. In the context of drug use, intergenerational stigma is evident in research showing that children who grow up in households affected by problematic drug use are more likely themselves to experience poverty, educational disadvantage, involvement with child protection services, and elevated risk of later drug use (Bancroft et al., 2004; Velleman and Orford, 1999). Importantly, intergenerational stigma does not operate through genetics or simple behavioural modelling. It operates through the structural conditions such as poverty, inadequate services, housing instability, criminalisation that are reproduced across generations when families are systematically deprived of the resources needed for stable and supported development. For older drug users whose own early lives were shaped by poverty, family disruption, and structural disadvantage, intergenerational stigma names both the

conditions they inherited and, in many cases, the conditions they fear having transmitted to their own children.

1.4.4 Stigma, Drugs, and the Moral Ordering of Society

Drug use stigma has a specific history and a specific political function that distinguishes it from other forms of stigmatisation. Room (2005) traces the historical construction of the "drug addict" as a moral category: a figure whose degradation served to reinforce the moral boundaries of respectable society and to naturalise the social control of populations associated with drug use. The term "drug addict" is a figure produced through the intersection of medical, legal, and moral discourse in ways that serve to legitimate the criminalisation, exclusion, and surveillance of particular, predominantly poor, racialised, and already marginalised populations (Tiger, 2013; Tyler, 2020).

Lloyd (2013) argues that drug use stigma is qualitatively different from many other forms of stigmatisation because it is organised around the attribution of moral responsibility: unlike the stigma of physical illness or disability, drug use stigma typically includes the assumption that the stigmatised person is responsible for their condition and therefore deserving of their social exclusion. This attribution of responsibility makes drug use stigma particularly resistant to challenge and particularly damaging to self-concept, because it forecloses the possibility of understanding oneself as a victim of circumstance rather than an author of one's own degradation. Tyler's (2020) framework connects this moral attribution to the broader political function of stigma: in a society in which poverty and inequality are increasingly explained through individual failure rather than structural conditions, the attribution of moral responsibility for drug use naturalises and justifies the withdrawal of support from those most in need.

This analysis is directly relevant to the biographical accounts of participants in this study, many of whom came of age during the precise historical period, the 1980s and 1990s, in which the neo-liberal individualisation of social problems was most aggressively promoted. The structural conditions like deindustrialisation, unemployment, community devastation within which their drug use developed were simultaneously being reframed in public and political discourse as matters of individual character rather than political economy.

1.5 Intersectionality, Social Class, and the Limits of the Data

Intersectionality offers a useful analytical framework for this study because people who use drugs are not a homogeneous group, and their experiences are shaped by the intersection of multiple social positions (Collins and Bilge, 2020; Crenshaw, 2013). Age and drug use do not exist in isolation; they are always lived through class, gender, race, housing, geography, and institutional history. An intersectional perspective resists reducing experience to any single axis and draws attention to how these dimensions interact and compound one another.

However, it is important to be clear about what this thesis does and does not deliver on intersectionality. The data gathered for this study allow a sustained analysis of social class and, to a significant extent, gender. Class emerged as the most consistently visible dimension of inequality across the interviews; shaping who could hide their drug use, who was criminalised, who could access private treatment, and who was subject to public surveillance. Gender shaped the specific moral burdens carried by women around parenthood, shame, and respectability, and is analysed in relation to those themes throughout the findings. Race and ethnicity, sexuality, and disability are less represented in the data, partly because of limitations in the diversity of the sample and partly because these dimensions were not always foregrounded by participants in their accounts.

This is a genuine limitation and is acknowledged as such. The analysis does not claim to offer a fully intersectional account. What it does offer is a life-course analysis that is attentive to the unequal social conditions shaping later-life drug use, with particular attention to class and gender as the dimensions most consistently present in participants' own accounts.

1.5.1 Social Class

Social class is a central but often underexplored dimension of drug use research in the UK. Much of the qualitative literature focuses on heavily marginalised or criminalised populations without making class explicit as an analytical category which is a tendency that can inadvertently reinforce the assumption that drug use is primarily a problem of poverty or social exclusion (Shildrick et al., 2012; Tyler, 2013).

Class shapes drug use in multiple ways. It determines the material conditions in which drug use begins and continues; neighbourhood, housing, access to services, exposure to criminal justice, and economic security all mediate the consequences and visibility of use. Middle-class drug users may be able to maintain employment and social respectability, access private

treatment, and avoid criminalisation in ways that working-class users cannot (Askew, 2016; Measham and Shiner, 2009). In this sense, the same behaviour which is drug use in specific context carries very different biographical consequences depending on social position. Related literature has shown this most clearly in studies of recreational drug use among professionals, which suggest that functionality and discretion can insulate middle-class users from the institutional responses and public stigma experienced by those in more precarious circumstances (Askew, 2016; Shiner, 2009).

For this thesis, class is not a background variable but a shaping force. As the findings show, class differences emerge in how drug use is narrated, concealed, managed, and judged; both by participants themselves and by the services and institutions they encountered. An explicit attention to class is therefore necessary in order to avoid producing an account of later-life drug use that treats participants as undifferentiated, when in practice their experiences were shaped by quite different positions within the social structure.

1.6 Summary

In conclusion, this thesis aims to address the multifaceted issues surrounding drug use among older adults in the UK. Meanwhile, the study is attentive to intersecting inequalities, particularly class and gender, while acknowledging the limits of the available data. By exploring the life stories and experiences of older individuals, this study seeks to shed light on the complex dynamics that shape drug use experience in later-life.

Thesis Outline

Chapter 1 introduces the background and context of drug use and ageing. It gave a historical background of drug use policies and trends in different types of drug use. Additionally, the chapter discusses how stigma and intersectionality affect the research subject and process.

Chapter 2 explores recent qualitative drug use research in the UK. It discusses factors that affect the drug use experiences and how researchers investigate the drug use experiences in the UK.

Chapter 3 describes this study's methodological approach. It explains the research's epistemological standpoint—social constructionism. Additionally, it discusses the research approaches employed in data collection and analysis processes, such as the narrative

biographical approach. Lastly, this chapter delved into data collection and analysis processes and ethical considerations.

Chapter 4 presents findings on participants' early life contexts, societal influences, and first drug use experiences. It explored how childhood and adolescence were narrated through family dynamics, neighbourhood environments, socio-economic conditions, and early exposures to substances, showing how participants located their "beginnings" within broader social and relational worlds. The chapter examined how first drug use was described not only as an individual choice but as shaped by belonging, coping, curiosity, social learning, and local norms. This chapter established the early life-course foundations that later inform how participants interpret adult turning points, stigma, and identity.

Chapter 5 examines drug use experiences through adulthood, focusing on turning points, responsibilities, and shifts in identity and meaning. It explored how adult roles (e.g., work, partnership, parenting) interacted with drug use practices, sometimes producing attempts at control, concealment, reduction, or change, and at other times intensifying pressures, conflict, or risk. The chapter also considered how institutional encounters—particularly criminal justice and treatment systems—shaped life trajectories and self-understandings. It showed adulthood as a period in which drug use meanings were repeatedly renegotiated, rather than moving along a simple linear pathway of "progression" or "recovery."

Chapter 6 focuses on later-life, exploring ageing, survival, health, and changing relationships to drug use over time. It examined how participants narrated ageing as a biographical milestone—sometimes unexpected—linked to survival, loss, reflection, and shifting priorities. The chapter discussed how health changes, reduced social networks, stigma, and service engagement shaped later-life experiences, while also highlighting themes of self-acceptance, re-evaluation, and redefinition of what "a good life" or "stability" means. This chapter positioned ageing not simply as decline, but as a context in which drug use, identity, and meaning can be reworked.

Chapter 7 presents the discussion of the thesis. Drawing together the biographical, thematic, and analytical threads developed across Chapters 4 to 6, it offers a life-course synthesis of how drug use is experienced, narrated, and renegotiated from early life through to later adulthood. The chapter examines how turning points in adulthood including parenting, work, and criminal justice contact reshape the meaning and function of drug use without necessarily

ending it. It analyses how ageing reshapes drug use through the body, through unexpected survival, and through processes of self-acceptance and social reorganisation. It also argues that later-life drug use is profoundly shaped by stigma and unequal social location, showing that class, gender, and visibility determine whose drug use is treated as pathology and whose is not.

Chapter 8 concludes the thesis by returning to the research questions and summarising the study's main arguments. It sets out the thesis's original contribution to knowledge, particularly its development of a life-course account of later-life drug use that centres older people as narrators of their own lives. The chapter also identifies implications for policy, harm reduction and social work practice, arguing for responses that are age-responsive, trauma-informed, biographically aware and attentive to stigma, class and social inequality. In doing so, the conclusion emphasises that later-life drug use should not be understood only through risk, treatment need or decline, but through the changing meanings people attach to drug use, ageing, survival and selfhood across the life course.

Chapter 2 Literature Review

2.1 Chapter Overview

This chapter investigates the literature on drug users' experiences of different aspects of life in the UK in the last 15 years. As explained in Chapter 1, this review focuses on UK qualitative drug-use research because the thesis is concerned with lived experience in a specific policy, service and social context, rather than with producing a global review of drug use and ageing. This chapter provides a systematic-style mapping and narrative interpretive synthesis of recent UK qualitative research on drug use. It is not intended to be a full systematic review or a global review of drug use and ageing. Rather, its purpose is to identify how qualitative research in the UK has examined lived experiences of drug use, and to consider how far this body of work helps explain drug use as a changing biographical and social experience across the life course. The review therefore asks how has recent UK qualitative research examined people's experiences of drug use, and what does this literature reveal or leave underdeveloped about ageing, life-course change, stigma, social context, and service encounters?

This question shaped both the search strategy and the organisation of the chapter. The aim was not only to identify topics already covered in the literature, but to examine how drug use has been framed analytically: whether as motivation, identity, recovery, risk, treatment experience, social exclusion, or life-course process. The chapter first maps the main characteristics of the reviewed studies, including location, method, age range and gender. It then synthesises the literature thematically around motivation, identity, cyclical patterns, environmental factors, personal circumstances, and service and treatment perspectives. The final section draws these strands together to show where the current study contributes: by centring older people's own accounts and by examining how drug use and ageing are narrated together over time.

The articles discussed in this chapter were accessed by systematic research of the Scopus database. Research limitations such as language (English), location (the UK or sub-regions), and date range (from 2010 onwards) were added to exclude irrelevant studies. The following research string utilized to reach out to relevant peer-reviewed articles that published in the last 15 years: TITLE-ABS-KEY (drug OR substance OR medic* OR cannab* OR heroin OR cocaine OR lsd OR ecstasy OR GHB OR ketamin OR mdma OR opioid OR stimulant) AND

TITLE-ABS-KEY (intervie* OR ethnograph* OR "focus group" OR "focus groups") AND TITLE-ABS-KEY (experience OR stor* OR use OR user OR inject OR addict*).

This investigation reviews articles systematically and is mainly interested in only qualitative studies. Additionally, because of the differences between illicit drugs and alcohol/tobacco misuse in relation to the legality of the substances and different levels of social acceptability, the research included the use of illegal substances and non-medical medication use. This research resulted in 4,167 hits. After reading titles and/or abstracts, 50 articles were identified as relevant studies. These 50 articles were downloaded and read in full, and 9 of them were excluded later because they employed mixed methods and/or included alcohol or tobacco use. At last, 41 articles were read again, and data was extracted for further investigation. At the last stage of the thesis writing phase, same search was conducted on Scopus with the same key words and same process was applied to new results for the articles published between the time this chapter was initially written and the time the chapter was updated (10.03.2026). As a result, 9 more articles were included in the chapter. 50 articles were reviewed in scope of this chapter. The characteristics of the included articles can be found in appendices (Appendix 1)

Most of the studies (40) employed qualitative interviews, and 10 of them combined other methods (focus groups, case studies, observation, and think-aloud) with interviews. Additionally, more than half of the studies were conducted in England. Table 2 summarizes the geographical and methodological focus.

Table 2 Summary of study characteristics

Study Location	*Number of Studies*	*Main Methodological Approach*	*Number of Studies*
England	*28*	Qualitative Interviews	*40*
Scotland	*9*	Combined methods (qualitative	*10*
Wales	*3*	interviews and others - focus	
N. Ireland	*2*	group, observation, narrative	
England and Wales	*1*	writing, case study, think aloud)	
UK; exact site not clearly specified	*7*		
Total	**50**	**Total**	**50**

Figure 2 shows the participants' age ranges. These data do not represent the study's original age inclusion criteria, only the recruited participants' ages at the time of the study.

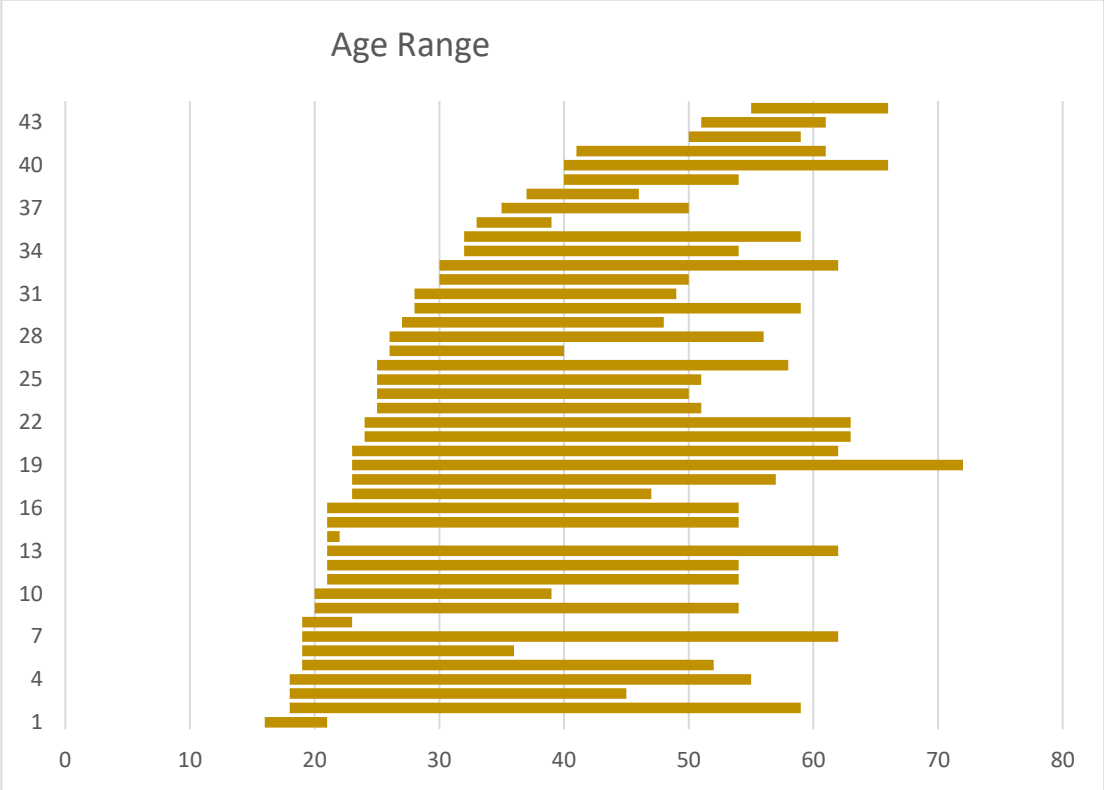

Figure 2 Age range of the participants in the included studies

Six studies did not state the ages of their participants; therefore, the figure only includes 44 studies. As can be seen from the figure, mostly people who are aged between 20 and 55 were recruited, and only 3 studies included people over the age of 65. The lack of older people's representation in the studies can be the result of different reasons, such as the study's age inclusion criteria, older people's hesitation to talk about their drug use experience and not being able to access or recruit older participants because of fewer visibility in drug use services and organisations. Regardless of the reasons, evidence on older people's experiences of drug use, recovery and treatment is limited in the UK. Although the reviewed studies illuminate motivations, identity, routines, environmental pressures, personal circumstances, and service experiences, the UK qualitative literature remains uneven. It is weighted towards younger and mid-life participants, heavily shaped by heroin/crack injecting populations, and gives only limited attention to ageing, later-life meaning-making, and the ways drug use is reinterpreted across the life course.

When the gender of the participants was explored, it was seen that the majority of them were male (see Figure 5) 702 male participants in total and 379 female participants. One article was excluded from this figure because it did not provide data on participants' gender.

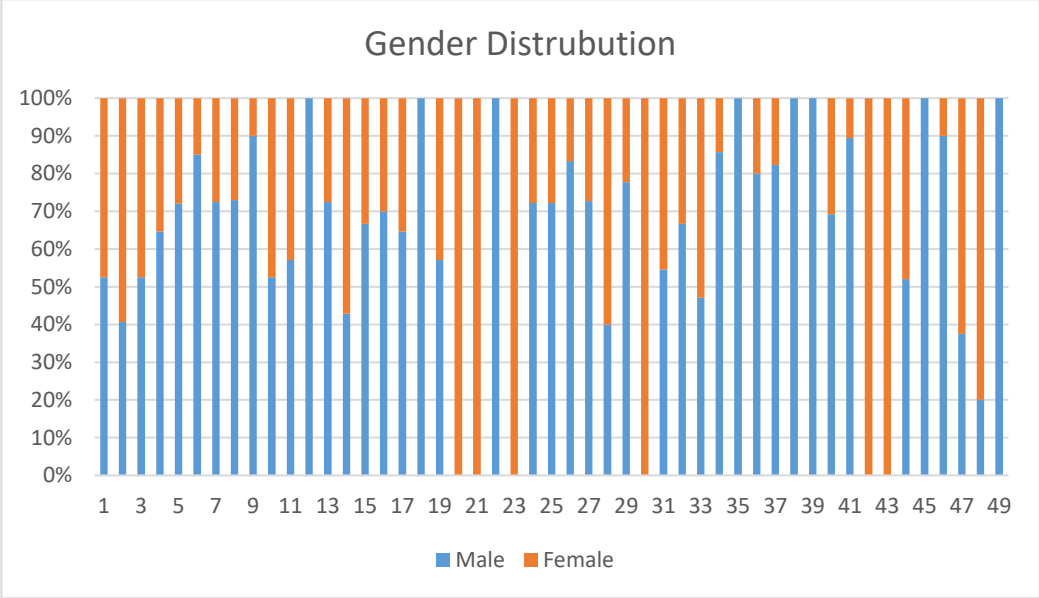

Figure 3 Gender Distribution of included articles

Similar to age distribution, recruiting female participants can be challenging for drug use research. Therefore, it is not surprising to see the male majority among participants.

Many articles discuss the effects of dwelling locations such as shelters, streets, and prisons. However, they fail to recognise the gendered experiences. To sum up, it can be understandable not being able to access fully equal gender distribution while recruiting participants; however, not recognising the female experience in drug use research can lead to insufficient understanding of needs of female drug users.

18 articles focused on injecting drug use (mostly heroin and crack cocaine), 21 articles investigated poly drug use, and the rest identified focused drug type as cannabis (3), opioid (3) class A (1), amphetamine-type stimulant (2), injecting drugs (1). Lastly, one article did not state the type of specific drug.

The six themes presented in this chapter; motivations for drug use, identity, cyclical patterns, environmental factors, personal characteristics, and service and treatment experiences were derived inductively from the reviewed literature. The decision to organise the chapter around

these six themes was based on three considerations. First, these were the areas most consistently addressed across the reviewed studies. Second, they were the areas most relevant to the research questions of this thesis, particularly questions about how drug use is given meaning across time, relationships, social context, stigma and service encounters. Third, these themes made it possible to examine not only what the literature has already established, but also where it remains uneven. For example, the literature is relatively strong in showing that drug use is shaped by coping, identity, environment, relationships and treatment encounters. It is less strong in explaining how these dimensions change across the life course or how they are reinterpreted in later-life. The themes were therefore not selected only because they appeared frequently, but because they helped identify the analytical space into which this thesis contributes.

The chapter therefore reads the literature with three questions in mind: what kinds of drug-use experiences UK qualitative studies made visible; what assumptions about age, identity, treatment, recovery and social context shape this body of work, and what remains underdeveloped when older people's life stories are placed at the centre. This means that the chapter does not treat the reviewed studies as a neutral collection of findings. It considers the strengths of this literature, especially its attention to lived experience and social context, while also examining its limits, particularly its tendency to focus on younger or mid-life participants, treatment populations, heroin/crack cocaine, injecting drug use and immediate service concerns.

The next sections will explore motivation for drug use, identity, cyclical patterns, environmental factors, personal characteristics and circumstances, and service and treatment perspectives.

2.2 Motivations for drug use

Motivations for drug use in the UK qualitative literature are diverse, layered, and often change over time. The studies reviewed do not suggest a single or stable explanation for drug use. Instead, participants describe motivations that move across curiosity, pleasure, functionality, social belonging, self-medication, and the management of dependence. This is important because the reasons people give for initiating drug use are often different from those that sustain continued or dependent use (Addison et al., 2021; Parkin et al., 2023; Scott and Oliver, 2022).

Several studies show that earlier or more occasional drug use may be motivated by curiosity, pleasure, and opportunity. In Addison et al.'s (2021) study of amphetamine-type stimulant use, initiation was linked to pleasure, curiosity, boredom, and the desire for improved mood or energy. Some participants also described stimulant use in functional terms, such as helping with domestic tasks, work, or study. Similarly, Scott and Oliver (2022) found that first experiences of class A drug use were often tied to curiosity, nightlife, friendship groups, and more subtle "micro-pressures" to fit in socially. These accounts challenge any assumption that drug use begins only in response to crisis or pathology. Instead, some participants described drugs as offering excitement, sociability, or enhancement of everyday life (Addison et al., 2021; Scott and Oliver, 2022).

However, the literature also shows that drug use is frequently motivated by attempts to cope with distressing circumstances or difficult embodied states. Participants across the reviewed studies described using drugs to manage poor mental health, emotional pain, stress, sleep problems, and physical discomfort. Prison-based accounts similarly suggest that substances may be used to manage stress, suicidality, sleep problems, or the emotional pressures of incarceration, particularly where participants felt that other forms of support were unavailable or inadequate. In this sense, drug use may function not simply as recreation, but as a situated response to suffering, unmet need, or difficult social conditions (Deuchar and Densley, 2024; Morris, 2020).

Additionally, different types of motivations can result in the use of different types of drugs. In Addison et al.'s (2021) study that focused on amphetamine-type stimulant use, one of the motivations was increasing energy levels. Participants preferred to use drugs to complete house chores faster or accomplish better academic achievement. In contrast, McPhee and colleagues (2013) discussed how heroin is preferred to escape reality. Heroin, as an opioid, leads people to mellow out or experience the 'gouching' state as Eric stated in Nettleton et al.'s (2011a, p.1369) study:

> *"It was like a blanket, it was like being wrapped up in a blanket and nothing can get through it, nothing can bother you, it was sort of comfortable, although I was throwing up and all the rest of it! I suppose oblivion - that I'd been searching for in alcohol and all the rest of it - was what I got from the heroin." (Eric, 39)*

In heroin-focused studies already included in this review, heroin was often associated with relief, comfort, or temporary oblivion, while cannabis could be framed as a more "natural" substance and discussed in ways that downplayed risk and emphasized self-control.

The literature further suggests that motivations often shift once dependence becomes established. Nettleton et al.'s (2011a) analysis of "habit, crisis and creativity" is especially helpful here, because it shows how the body's demand for heroin can reorganize everyday life around repetitive cycles of scoring, using, and managing withdrawal. In this context, drug use is no longer driven only by pleasure or experimentation, but by the need to restore bodily equilibrium and resolve crisis. Parkin et al. (2023) make a similar point in their study of non-prescribed substance use during the early stages of depot buprenorphine treatment. Participants described continued heroin use in relation to withdrawal symptoms, pain management, and experimentation with treatment effects, while crack cocaine use was linked to craving and social connections. This suggests that later drug use may be sustained less by hedonistic motives alone than by the immediate demands of dependence, discomfort, and routine (Nettleton et al., 2011a; Parkin et al., 2023).

A tension runs through this section that the literature rarely names directly. Studies that foreground pleasure, curiosity, and choice, such as Addison et al. (2021) and Scott and Oliver (2022), tend to recruit participants from recreational or stimulant-using populations. Studies that foreground coping, self-medication, and dependence tend to recruit from treatment or crisis populations. The result is a literature that appears to offer multiple accounts of motivation, but which may actually reflect different populations, drug types, and recruitment contexts rather than a genuine diversity of motivations within any one person's trajectory. A life-course reading, by contrast, suggests that these motivations are not alternatives, they are different moments in the same biographical story.

Overall, the literature suggests that motivations for drug use are dynamic rather than fixed. They are shaped by drug type, stage of use, social setting, and personal circumstance, and may shift from curiosity or pleasure to coping, self-medication, crisis management, or the maintenance of dependence. A life-course reading is therefore important, because the meanings attached to drug use can change substantially over time, even within the same person's narrative (Addison et al., 2021; Parkin et al., 2023). This is especially relevant for

the present thesis, which is concerned not simply with why drug use begins, but with how its meanings develop, persist, and are reinterpreted across the life course.

2.3 Identity

Problematic drug use can take over a person's life. One of the aspects that gets affected by it is identity. Morris (2020) stated that a person's identity can revolve around drug use. Before moving to some of the key characteristics of drug use, it is important to recognise that these characteristics are often associated with heroin and crack cocaine use in included research. Not all illicit drug users experience these characteristics and identity types.

The literature also suggests that identity is shaped by hierarchies of drug use and by wider moral distinctions between "acceptable" and "unacceptable" forms of consumption. This matters because participants were often not simply managing a spoiled identity, but managing its gradations. Some accounts positioned heroin and crack as especially stigmatising, while cannabis or recreational use were framed as more controllable, natural, or socially legitimate. Such distinctions appear to serve an identity-protective function, allowing participants to distance themselves from the most discredited images of the "drug user." People who receive constant stigma for their drug use can internalise these characteristics and make them a part of their identity, which can cause problems later in life. For example, Ms K. identifies drug users as "*hopeless addicts, endlessly repeating the same behavioural patterns" as* a drug user herself because (McPhee et al., 2013);

> *"Cos a lot of people who do use drugs are like that" (Ms K)*

Stigma plays a great role in drug user identity. McPhee et al. (2013) reveal that many of their participants stated that people saw drug users as "*dangerous, bad people*".

Differences between various drug types can be seen in drug use identity also. A study focused and homelessness and drug use identity of young people revealed that drug use identity is accepted and celebrated among participants; however, heroin use was degraded and stigmatised even among drug users of other drugs (Hoolachan, 2020). This distinction between types of drugs can be a result of protecting the identity. Goffman (1963) discusses it as 'spoiled identities'. He states that perceived stigma can be internalised and spoil the self-identity (Goffman, 1963). Therefore, to protect self-identity, people can set barriers between people who receive the stigma for drug use and themselves.

A similar case is discussed in cannabis focused study. People can downplay cannabis use and try to shift to stigma around it to protect self-identity (Morris, 2020).

> *". .it is as if God gave me it [cannabis] in, it's part of creation. But as in many things you'll find that, for many conditions there are natural cures that exist in nature, you know. [. . .]" (Danny)*

Once the drug user's identity is accepted, people might want to protect it. Wakeman's (2015) work on prescription heroin revealed that losing drug user identity might be a barrier to treatment. People might prefer drug users' identity over 'patient' identity. This can be caused not only by fear of adopting the 'patient' identity but also by protecting the characteristics that come with dealer parts of drug use. The economic part of drug use can help people establish a social circle, and people might want to protect these social ties (Wakeman, 2015). m and Coomber (2015) support these findings with their study. They state drug users might prefer to deal drugs for several reasons. They identify three types of users – dealer typologies: the dealer's apprentice, the opportunist and the nominated buyer. These typologies are shaped around the profit they make from dealing. Similarly, Morgan and Bennett (2022) identify dealers' identities as 'top boys' who establish 'credible public identity'. Additionally, the study conducted in a marginalised group highlighted that a 'real addict' identity can be meaningful for people, considering they identify themselves as know how to survive and skilled people (Wakeman, 2015). The transition between these identities can be wanted or unwanted and under control or out of control (Morgan and Bennett, 2023).

Relatedly, the loss of this accepted drug user identity can be problematic for some people. In McPhee et al. (2013)'s study it presented itself as struggling to let go of drug user identity with parenthood.

Wilson et al. (2016) discuss the drug user identity for ex-users among professionals who work in the drug use field. The participants stated that they prefer not to disclose their ex-drug user identity in a professional setting because of the potential stigma around it, and they prefer to be known for their professional skills rather than their lived experience skills.

> *"I don't want to wear the tag of ex-service user either really, you know, cos I'd like to think I'd have made a pretty good worker even if I hadn't been a service user." (Harry)*

Importantly, stigma does not disappear once problematic drug use has reduced or ceased. Walmsley (2025) shows that people in recovery continue to manage anticipated stigma in employment, friendships, and intimate relationships, particularly where criminal records, visible bodily traces, or shared social histories make concealment difficult. Disclosure becomes an ongoing identity task: individuals must decide whether to conceal, selectively disclose, or reframe their past in ways that protect them from rejection while still allowing for authenticity and connection. From this perspective, recovery identity is not a settled endpoint but a continuing negotiation shaped by the persistence of social stigma. This is especially relevant to my study because it suggests that later-life reflection on drug use is likely to involve not only memory and meaning-making, but also continuing efforts to position oneself in relation to dominant narratives of failure, recovery, respectability, and ageing.

Overall, the literature suggests that identity should be understood as a dynamic and socially mediated dimension of drug use experience. Drug use may become a source of stigma, marginalisation, and spoiled identity, but it may also offer belonging, competence, routine, or status in particular contexts. Likewise, movement away from problematic drug use does not simply erase earlier identities, but often requires ongoing work of reinterpretation, disclosure, and self-repair. A life-course perspective is therefore important because it allows identity to be understood not as fixed at one moment of drug use or recovery, but as something repeatedly produced, challenged, and revised across changing biographical and social circumstances.

2.4 Cyclical Patterns

Many participants from different research characterised drug use with routines and habits – identical days. Wake up, withdraw, find the money for drugs and 'score', the next day, do the same thing (Harris, 2020; McPhee et al., 2013; Nettleton et al., 2011a; Wagstaff et al., 2023).

> *"You're damned if you do and you're damned if you don't! It's-it's, I dunno [. . .] it's just a horrible, horrible circle. It really is" (Nigel)*

Nettleton et al. (2011b) identified this process as habit, crisis, and creativity. Drug-using participants stated that when they experience a crisis – not having drugs -they get creative to manage the crisis. Creativity refers to different ways of accessing drugs or money, such as borrowing money from close ones, shoplifting, and not eating.

> *"…as you will forget about everything else apart from scoring [buying drugs] again. You kind of become an autopilot, you kind of like, your, I think your conscious thoughts just become, wake up, use, score, wake up, use, score, wake up, use, score over and over, that's all you do when you're using" (DET04, 28).*

Harris (2020) highlights the "…as you will forget about everything…" part with their study investigating the lack of help-seeking for medical care among injecting drug users. Participants often talk about not having time and/or not caring about their serious medical needs.

> *"When have I got time for hospital?" (Jay)*
>
> *"I ain't got time for nothing except for drugs innit?" (Kirsty)*
>
> *"I was too busy … I was in a lot of pain … I didn't have time" (Jade)*
>
> *"You ain't got time to run around [seeking care] if you need to make money and go and score and stuff like that." (Dean)*

In addition to not having time, the fear of withdrawing while waiting for or getting medical care is another obstacle. Participants are afraid of not being able to score during their hospital stays or not receiving the substitute medication before they feel the withdrawal (Harris, 2020). This fear is not unreasonable; Nettleton (2011b) compares the crisis between people who use drugs actively and people who are in recovery. One of the differences they highlight is while people answer the crisis with habited behaviours and end the crisis on relatively short notice, recovering people tend to experience more complex, longer crises. In addition to these, they have to be creative in other ways and respond to this crisis other than their habited behaviours.

Another highlighted routine behaviour is sleep. Sleep is a big part of life, and it can be connected to drug use. 'Gouching' and inducing sleep with drug use can become another aspect of drug use to care for during recovery. People expressed their frustration and effort around their sleep cycle in recovery (Nettleton et al., 2011b).

> *"…fight the duvet, have you never heard that term? You can't stop moving, you're hot, you're cold, freezing cold but you're sweating, and*

you are hot, still sweating, and when you're lying in bed on your own…"
(Tony, 35, Detoxing)

The discomfort of withdrawal and detoxing is also highlighted by Walmsley (2022) in a prison setting. In limited conditions and away from medical care -for various reasons- people get creative to manage their symptoms. Their techniques include exercise and moving around in the cell to manage limb pain and sweat out the drug smell and 'poison' in the body. Another technique that helps them to feel 'cleansed' is urination. Participants state that drinking a lot of water and urinating makes them 'cleaner' (Walmsley, 2022).

Some participants employ harm-reduction practices as part of their routines. They pay attention to their drug supplies and work with people who have well-established relationships (Moxon and Waters, 2019). Additionally, some pay attention to not sharing their paraphernalia with others to prevent blood-borne viruses (McGowan et al., 2013).

It is worth noting a limitation in this body of work: the studies reviewed tend to focus on active problematic heroin or crack cocaine use, and cycles are presented as near-universal features of that experience. This risks overgeneralising. Participants in studies of recreational, functional, or late-onset drug use describe far less cyclical patterns, suggesting that the cycle is not inherent to drug use as such, but specific to certain relationships between substance, social context, and dependence. The existing literature has not fully theorised this distinction.

2.5 Environmental factors

Environmental factors are not simply a backdrop to drug use experience. Across the reviewed literature, place emerges as an active condition shaping how drug use is initiated, sustained, managed, and understood. The studies draw attention to a range of environments, including prisons, hostels, streets, shelters, supported accommodation, and marginalised communities, and show that these settings influence not only access to drugs but also safety, stigma, belonging, and opportunities for recovery. Read together, this literature suggests that drug use experience is inseparable from the material and social environments in which it unfolds.

Prison is one of the clearest examples of environment shaping drug use experience. In the reviewed studies, prison was not described simply as a contained setting in which pre-existing patterns of drug use continued unchanged. Prisons were described as hypermasculine environments that required special attention to stay safe by the participants. Some of them

preferred to continue their drug use to escape reality and cope with the crowded, unsafe space (Deuchar and Densley, 2024), and some of them preferred to self-detox to stay away from the drug scene and keep it to themselves. People who prefer to self-detox often reference their past experiences as inmates and view their prison sentence as an opportunity to reclaim their bodies back and fix broken relationships with others. Additionally, people who preferred to detox for safety reasons talked about how showing withdrawal in prison can become a problem because the limited access to drugs in prison leads them to experience withdrawal more than usual (Walmsley, 2022).

> *"If someone sees you walking around half clucking you're a target basically a victim and you know from previous from going prison from a young age before I even got onto heroin and stuff if you are a victim on day one you are a victim forever.." (Matt)*

Homelessness and insecure accommodation form another major environmental context in the literature. The studies reviewed do not present homelessness simply as the absence of housing. Instead, homelessness appears as a condition structured by instability, exposure, weak privacy, and repeated negotiation with services, institutions, and other residents. Stevenson's (2014) study of hostel accommodation found that people who were homeless and used drugs often reported poor treatment, lack of privacy, infantilisation, and unprofessional conduct from staff, all of which impeded the development of social capital. Searches, surveillance, constant intrusion, and weak control over personal space made it difficult for residents to feel secure or respected in the hostel environment. These experiences mattered because they could intensify distrust, damage autonomy, and slow or disrupt progression through the hostel system (Stevenson, 2014).

Relatedly, Stevenson and Neale's (2012) work on intimate relationships in hostel accommodation shows that hostel systems are often poorly designed for couples and can complicate rather than support emotional and relational stability. Hostels may formally accommodate single people while ignoring the lived reality that many homeless drug users are in relationships and move between hostels, rough sleeping, squats, or temporary arrangements. This means that place is experienced not only through shelter, but also through the pressure it places on intimacy, care, and social support. In practice, people may endure rough sleeping or unstable accommodation in order to stay together. Environmental

instability therefore affects not just drug use, but the forms of relational life that are possible within homelessness (Stevenson and Neale, 2012).

Hoolachan's (2020) ethnographic work adds an important identity dimension to this discussion. The study of young people in supported accommodation shows that homelessness, youth, and drug use were experienced together rather than separately, and that participants negotiated both "spoiled" and "celebrated" identities in the hostel environment. This is useful because it shows that homelessness is not only a physical housing condition, but also a stigmatised social location. Hostel environments can therefore shape drug use experience through territorial stigma, youth marginality, and the need to manage one's self-presentation in relation to both other residents and wider society (Hoolachan, 2020).

The literature also indicates that homelessness and drug use can become mutually reinforcing. Wagstaff et al.'s (2023) study of homeless people who use psychoactive substances identified family influence, cyclical patterns, low self-worth, and mistrust in people and society as recurring themes. Their participants' accounts suggest that homelessness and drug use can combine to produce a vicious cycle in which stigma, low self-worth, poor treatment by services, and unstable living conditions sustain one another. Importantly, mistrust of professionals and institutions did not emerge as a secondary issue but as a central part of the environment in which drug use and homelessness were lived. This moves the discussion beyond housing status alone and toward the broader emotional and institutional climate surrounding homelessness. (Wagstaff et al., 2023).

Alongside these institutional environments, the literature also points to the importance of belonging. Belonging is not reducible to simply having a stable address. Blank et al.'s (2016) work on belonging among people with mental health problems and drug use experience shows that belonging may be experienced as "at-homeness," ease, validation, safety, and trust, whether in a synagogue, a recovery meeting, or another accepted space. This is helpful because it suggests that place matters not only materially but affectively. Drug use environments can be damaging when they intensify exclusion, but recovery-oriented or affirming spaces may offer people a sense of welcome and recognition that alters how they understand themselves. Conversely, some individuals may find familiarity, comfort, or ownership in harmful practices or marginal spaces, which complicates any simple assumption

that movement out of homelessness or drug use necessarily produces immediate belonging elsewhere (Blank et al., 2016).

A further point that should be made more explicitly is that environmental factors are also structural factors. O'Mahony's (2025) more recent study is particularly valuable here because it argues that social and economic disadvantage should not be understood only as background variables associated with later harm. Rather, participants themselves described harms in the education system, the family home, and the local community as actively conditioning later experiences of drug-related harm. The article interprets this through structural violence, suggesting that lived experiences of abuse, neighbourhood disorder, exclusion, and community deprivation may be more relevant than abstract "deficits" such as poor education or low resources alone (O'Mahony, 2025). This is an important intervention for the present literature review because it sharpens the environmental argument: place is not merely where drug use happens, but one of the processes through which harm is patterned and reproduced.

There is a productive tension here between structural and agentic accounts of drug use environments. Studies that emphasise structural violence, deprivation, institutional failure, cumulative disadvantage risk underplaying the forms of agency, creativity, and meaning-making that participants exercise within those environments. Conversely, studies that emphasise belonging, peer choice, and situational factors risk de-politicising the environments in which those choices occur. The strongest studies in this review, including Nettleton et al. (2011a) and Wagstaff et al. (2023), hold both in view; showing environments as structurally constraining while also taking seriously what people do within those constraints. This thesis similarly attempts to hold both levels of analysis together across the biographical accounts.

This more structural reading is reinforced by Thom et al.'s (2026) study of shared care and drug-related deaths in Scotland. Although that paper sits partly within service literature, it is also highly relevant here because it shows how environments of extreme deprivation, fragmented services, weak communication, and limited resources shape the conditions in which drug use occurs and constrain effective care. Their findings highlight that cumulative social and health inequalities are not external to drug-related harm, but central to it. In other words, the environment of drug use includes not only prisons, hostels, and streets, but also the wider unequal systems through which support is accessed or denied (Thom et al., 2026).

Overall, the reviewed studies suggest that environmental factors should be understood broadly. They include physical settings such as prisons, hostels, and streets, relational settings such as couples' arrangements, peer networks, and staff–resident interactions and structural settings shaped by deprivation, exclusion, and unequal access to care. These environments do not simply surround drug use. They shape the meanings, risks, and possibilities attached to it. A stronger environmental reading of the literature therefore supports a life-course understanding of drug use as embedded in place, inequality, and changing conditions of safety, recognition, and belonging.

2.6 Personal characteristics and circumstances

Personal characteristics and life circumstances are discussed across the reviewed studies as important influences on drug use experience, but they are rarely experienced in isolation. Age, gender, ethnicity, family relationships, parenthood, and intimate partnerships intersect with broader social and structural conditions to shape how drug use is lived, interpreted, and responded to. The literature suggests that these characteristics matter not because they mechanically determine drug use, but because they affect exposure to stigma, access to support, bodily vulnerability, and the meanings attached to both drug use and recovery.

Age

Age is one of the clearest examples of uneven representation in the reviewed literature. As noted earlier in this chapter, most studies recruited participants between the ages of 20 and 55, and only a very small number included participants over 65. This means that UK qualitative research provides only a limited account of later-life drug use, recovery, and treatment. Where older participants are included, however, the studies suggest that age is not simply a demographic characteristic but a lived condition that shapes shame, embodiment, help-seeking, and treatment expectations. Older participants sometimes described embarrassment about still needing support, discomfort about being placed with younger service users, and anxiety about the physical demands of detoxification, particularly where they felt their bodies were no longer strong enough to cope with withdrawal.

The literature also shows that older drug users may have distinctive preferences and forms of expertise that are not always recognised by services. Ayres et al.'s (2012) work suggests that some older users preferred age-specific treatment environments because they experienced younger users as chaotic, noisy, or intimidating, and because they wanted calmer spaces in

which their needs would be understood. Participants also drew on long histories of drug use and treatment, and sometimes expressed frustration when professionals failed to value this experiential knowledge. Rather than being passive recipients of care, older users often understood themselves as knowledgeable about what had and had not worked for them across time. This highlights the importance of seeing age not only as a risk factor, but also as a dimension of accumulated experience and perspective.

Additionally, they expressed concern regarding being around younger people in treatment settings, referring to higher levels of energy of younger people; they identified it as chaotic. A similar concern was observed in the prison setting also. Matt (participant) stated as "*prison is a young man's game*" (Walmsley, 2022, p. 249). When some participants were asked about their preferences for age-specific treatment, they expressed the need for being around peers and having control over more personalised treatment options (Dawood and Done, 2021).

Physical characteristics of older age can present themselves in fear of detoxification. Some participants tend to think, their bodies are not strong enough to go through the detoxification process which can lead them to avoid possible treatment options (Ayres et al., 2012, p. 26).

> *"my age and my health, think I'll be on my medication for the rest of my life. I have thought about it, I have reduced, but when I get to 10–12 ml my body hurts, joints ache, I'm scared . . . it would kill me'."*

More recent work further complicates the tendency to treat older age mainly through decline, frailty, or "ageing cohort" risk discourse. Dennis (2021) argues that the increased attention to older heroin users in drug-related death debates can too easily naturalise age as a self-evident cause of harm. The participants did describe changing bodies, health concerns, and long drug-using histories, but they also described greater responsibility, altered routes of administration, increased valuing of health, and a more reflective relationship to drug use. Dennis (2021) therefore cautions against reducing later-life risk to biological ageing alone, redirecting attention to treatment fatalism, feeling unheard, and the inflexibility of treatment systems. This is particularly important for the study because it suggests that ageing should be understood as a biographical and institutional issue, not merely a physiological one.

At the same time, some of the literature suggests that older people may be less visible within drug services and research settings (Ayres et al., 2012; Dennis, 2021; Moxon and Waters, 2019). Hidden or socially withdrawn older users may be harder to recruit, may prefer privacy,

or may avoid services that feel designed for younger people. This helps explain why evidence on older adults remains limited, but it also indicates that later-life drug use may be under-recognised rather than rare. Overall, the reviewed studies suggest that age shapes drug use experience through bodily change, stigma, treatment fit, and accumulated biography, yet these issues remain relatively underdeveloped in UK qualitative research.

Gender

As noted in the overview of this chapter, the reviewed literature is predominantly male in its participant composition, with 702 male participants compared to 379 female across the studies surveyed. This imbalance is not incidental; it reflects a broader pattern in drug use research where women's experiences have historically been rendered invisible or subsumed within male-dominated samples. As several UK studies have argued, failing to account for gender as a structuring dimension of drug use experience risks producing findings that are presented as universal but are in practice partial (Kreis et al., 2016; Russell et al., 2025; Shaw, 2023).

Where women do appear in the literature, their experiences are frequently shaped by gendered expectations around care, motherhood, and respectability in ways that differ substantially from men's accounts. Kreis et al. (2016) show that women's pathways into drug use are often mediated by relational trauma, insecure attachment, and shame, while Russell et al. (2025) demonstrate that women in recovery navigate a particular moral burden around maternal identity; managing not only substance use but the social judgement of being a mother who uses drugs. Shaw (2023) similarly shows that recovery for women in mid-life and older age is inseparable from the renegotiation of selfhood, relationships, and gendered expectations of ageing.

These findings suggest that gender does not simply add onto drug use experience from the outside. Rather, it shapes the meanings attributed to use, the routes taken into and out of dependence, and the forms of stigma encountered along the way. Women who use drugs may face particular barriers to help-seeking where services have been designed around male norms of presentation and risk, and where the fear of child protection intervention can deter engagement entirely (Chandler et al., 2013; Kreis et al., 2016).

Race and ethnicity

Race and ethnicity are much less developed in the reviewed literature than age or gender. Most of the included studies recruited predominantly White British participants, and even where ethnic diversity existed in samples, the role of ethnicity was often not discussed in the analysis. As a result, there is relatively little UK qualitative evidence on how racialised experience shapes drug use, recovery, stigma, or treatment. This is a significant limitation because it leaves questions of structural racism, exclusion, and cultural difference comparatively underexplored in a body of research that is otherwise attentive to marginality and inequality.

Where ethnicity and minority status do appear, they suggest that these issues matter in important ways. Roy's (2013) work with Bobby, in which structural racism was normalised within the participant's earlier life experience, and Notley et al.'s (2012) discussion of marginalised communities in which privacy, internal problem-solving, and distrust of outside intervention shaped help-seeking. These studies indicate that race and ethnicity may influence drug use experience not only through identity, but also through the social organisation of support, visibility, and stigma (Notley et al., 2012; Roy, 2013). However, the evidence base remains too thin to support strong generalisation.

Family and intimate relationships

Family relationships and intimate partnerships are another key dimension of personal circumstance in the reviewed literature. These relationships do not simply sit in the background of drug use. Rather, they often shape motivations for use, access to emotional or material support, and experiences of loss, responsibility, and stigma. The relationship between family and drug use is not one-way: difficult family backgrounds, parental drug use, conflict, lack of support, and the feeling of not belonging may contribute to drug use, while drug use can in turn damage family ties, parenting, and intimate relationships. This reciprocal relationship is important because it places drug use within a broader relational biography rather than isolating it as an individual behaviour (Kreis et al., 2016; O'Dowd et al., 2025; Russell et al., 2025; Stevenson and Neale, 2012).

The more recent research strengthens this point, especially in relation to gendered family experience. Russell et al.'s (2025) study of mothers with addiction who had children removed from their care is particularly important because it shows how child removal was experienced through fear, loss, unsafe service contact, and changing identity. Their themes of *safe/unsafe*,

changing identity, *loss*, and *no way to win* are highly relevant to understanding how personal circumstance becomes entwined with service systems, shame, and maternal selfhood. The study also argues that services are more likely to support better outcomes when mothers experience continuity, clarity, consistency, and respect, regardless of whether children are removed or returned. This is useful because it shows that family-related drug use experiences are not only emotional, but also institutional and relational (Russell et al., 2025).

A related but slightly different point comes from O'Dowd et al.'s (2025) study of mothers of people who use substances. Their work distinguishes between courtesy stigma and parent-blame, showing that mothers may be judged not only because they are associated with a stigmatised drug user, but because they are seen as somehow responsible for that person's condition. The consequences included shame, isolation, fear of judgment, and a sense of being left alone to navigate complex family dynamics. This is especially important for the present review because it demonstrates that drug-related stigma often radiates outward into family relationships, and that mothers in particular may carry moral blame in ways that are distinct from the stigma attached to drug use itself (O'Dowd et al., 2025).

More broadly, the literature suggests that intimate relationships may function as both support and risk. Existing studies already discussed in this chapter show that family conflict, bereavement, problematic relationships, and the loss of children can shape drug use trajectories, while intimate partners may also influence initiation, continuation, or attempts at change. The importance of personal relationships therefore lies not simply in whether they are positive or negative, but in how they structure belonging, obligation, dependency, and emotional survival. Taken together, these findings suggest that personal characteristics and circumstances should not be treated as isolated background variables. They are part of the social and biographical conditions through which drug use and recovery are lived over time.

2.7 Service and Treatment Perspectives

Service and treatment experiences are a major theme across the reviewed literature, but they are represented unevenly. Because much of the UK qualitative evidence base is dominated by studies of heroin and crack cocaine use, and especially injecting drug use, service-related discussions are often shaped around opioid treatment, substitute medication, and contact with drug treatment services rather than a broader range of drug-specific interventions. This is important because it means that the literature says more about treatment for dependent opioid

use than it does about service experiences linked to other substances. Even so, a number of common themes recur strongly across the reviewed studies, including ambivalence towards substitute medication, distrust of professionals, unmet physical and psychological needs, stigma in service settings, and the need for more person-centred and joined-up care.

One of the clearest themes in the literature is ambivalence towards substitute medication. Many participants across articles expressed their problems with substitute medication use. First, some of them stated that substitute medication use can cause them to lose clarity of mind and prevent them from experiencing their emotions. When Tanner et al. (2011) investigated differences between two substitute medications – methadone and suboxone – it showed some participants favoured one over the other because they viewed the emotional growth as part of recovery and felt more confident.

Substitute medication being viewed as a replacement habit caused people to have trust problems also. Some participants viewed substitute medication, especially methadone as another addictive substance, or even more addictive substance. Some even believed that methadone could cause delays in treatment (Deuchar and Densley, 2024; McPhee and Fenton, 2015; Neale et al., 2019; Tanner et al., 2011).

Lastly, participants were afraid of either lowering the dosage of the medication or detoxification. They feared needing heroin again or experiencing withdrawal symptoms. This created a mistrust in both medication and services (Deuchar and Densley, 2024; Neale et al., 2019; Notley et al., 2012; Tompkins et al., 2019; Varty and Alwyn, 2011). These accounts matter because they show that medication is not experienced only pharmacologically. It is also lived socially and morally through surveillance, dependence, and questions of control.

The literature further suggests that treatment engagement is shaped by the quality of relationships with professionals. Participants repeatedly described the importance of being heard, respected, and treated as a whole person rather than simply as a "drug user." Where workers were consistent, validating, and non-judgemental, participants were more likely to describe services positively. Dawood and Done's (2021) study is especially helpful here, as it shows that psychosocial intervention was valued not only for helping people stop or reduce drug use, but because therapeutic relationships allowed participants to feel understood, emotionally held, and capable of imagining a different future. In their analysis, trust, compassion, and authenticity were central to the treatment process.

Two specific scenarios stand out – substitute medication supervision (McPhee et al., 2013) and hostel staff (Stevenson, 2014; Wagstaff et al., 2023). Participants stated that when they get urine tested and cannot receive the desired results, they immediately feel a shift in the attitude of the service professionals. For the hostel staff, many participants stated that they receive unprofessional and degrading treatment from hostel staff; even one participant said that staff enjoy evictions and room searches and their personal space is invaded constantly. This aligns with several of the studies already reviewed in the chapter, in which people described wanting professionals to understand their history, circumstances, and practical needs rather than focusing narrowly on compliance or abstinence.

At the same time, many studies portray services as fragmented, difficult to navigate, and insufficiently responsive to complex needs. Thom et al.'s (2026) recent study of shared care in Scotland is particularly important because it shows that engagement problems are not simply matters of individual motivation. Instead, patients, practitioners, and family members described a system shaped by poor communication, weak collaboration across services, unclear pathways, stretched resources, and the cumulative effects of deprivation and inequality. Their findings suggest that people who use drugs often require support that is simultaneously medical, psychological, social, and practical, yet shared care systems do not always succeed in joining these elements together. This is a significant point for the present review because it shifts the focus away from ideas of "non-engagement" as an individual failing and towards the structural conditions that make engagement difficult to sustain.

Another strong theme across the literature is the persistence of stigma within treatment and support settings. Existing studies already discussed in this chapter describe participants feeling degraded during supervised consumption, urine testing, pregnancy-related care, or interactions with pharmacists and hostel workers (Ayres et al., 2012; Dennis, 2021; Deuchar and Densley, 2024; MacVicar et al., 2017; McPhee et al., 2013; McPhee and Fenton, 2015; Notley et al., 2012; Tanner et al., 2011; Tompkins et al., 2019). Dennis's (2021) study of older heroin users is especially valuable here because it shows how participants linked disengagement and treatment fatigue to feeling unheard, judged, or pushed into narrow and inflexible treatment goals. Rather than supporting care, these arrangements could produce what Dennis (2021) terms treatment fatalism or despondency. This insight is important because it suggests that stigma in treatment is not only emotionally damaging; it may also

reduce openness, weaken trust, and make people more likely to engage superficially or withdraw altogether.

The literature also highlights the extent to which physical and psychological needs remain unmet within many treatment systems. Participants in the studies reviewed described difficulties accessing adequate support for pain, mental health, sleep, trauma, and broader wellbeing. These needs were often treated as secondary to drug treatment rather than as integral to it. Yet several studies indicate that these wider concerns are inseparable from drug use trajectories. Where services focused narrowly on medication or compliance without addressing pain, trauma, housing instability, fear, grief, or emotional regulation, participants often felt that treatment did not fit the realities of their lives (Deuchar and Densley, 2024; Gore et al., 2015; Waters et al., 2014). This helps explain why some people valued more holistic or informal forms of support, such as therapeutic spaces, peer-based support, recovery cafés, or community settings where they could speak openly and be recognised beyond their substance use.

A further gap in the reviewed literature concerns trauma-informed practice (TIP). Despite the prominence of trauma in participants' accounts across UK qualitative drug use research, relatively few studies explicitly evaluate whether services engage with trauma in a sustained or structured way. Sweeney and colleagues (2018) argue that trauma-informed care requires services to move beyond symptom management and toward an understanding of how adversity accumulates across the life course; recognising that what presents as drug use, aggression, or disengagement may be a response to earlier harm rather than a personality trait or treatment failure. Muskett (2014) similarly shows that even where TIP principles are formally adopted in policy, implementation in practice often remains superficial, with staff lacking training, time, or organisational support to apply them consistently. Together, these studies suggest that the gap in the literature is not only about knowledge of trauma's role in drug use, but about whether services are equipped to respond to it. This is especially relevant for older drug users, whose biographical histories of adversity may be longer, more layered, and less visible to services organised around acute episodes rather than life-course context.

All things considered, the reviewed studies suggest that treatment and service experiences are profoundly relational and structural. They are shaped by the meanings attached to substitute medication, by whether professionals are experienced as respectful and trustworthy, by

whether support is fragmented or coordinated, and by whether wider needs are recognised. The literature therefore challenges any simple assumption that treatment success depends only on individual readiness or willpower. Engagement is more accurately understood as something co-produced between service users, workers, institutions, and the unequal social environments in which care is delivered. For the purposes of this thesis, this is particularly significant because it shows that drug use and recovery are shaped not only by personal biography, but also by the organisation of care, the experience of stigma, and the extent to which services can respond to people's lives as they are actually lived.

2.8 Synthesis and Gaps in the Literature

The UK qualitative literature reviewed in this chapter provides important insight into drug users' motivations, identities, routines, environments, personal circumstances, and treatment experiences. Taken together, these studies show that drug use cannot be understood as a single or uniform experience. Rather, it is shaped by shifting motivations, cyclical patterns of dependence and withdrawal, stigma, family and intimate relationships, and contact with services across a range of social settings. The literature is particularly strong in showing how drug use becomes embedded in everyday life, how identities are negotiated in relation to stigma and recovery, and how treatment experiences are shaped by dignity, trust, and the quality of relationships with professionals.

At the same time, this review also reveals important limitations in the existing evidence base. The studies are heavily weighted towards heroin and crack cocaine use, particularly injecting drug use, and most participants are aged between 20 and 55. Only a very small number of studies include participants over the age of 65, and women are underrepresented across much of the reviewed literature. Ethnicity is also discussed only rarely and often without sustained analysis. As a result, although the literature offers rich accounts of drug use in the UK, it remains uneven in its ability to explain how drug use is experienced in later-life, how age intersects with stigma and treatment, and how gendered and racialised differences shape experience.

The review further suggests that some of the most useful recent developments in the literature come from work that connects individual experience to wider structural conditions. More recent studies complicate narrow or individualised understandings of harm by showing how deprivation, housing instability, prison environments, fragmented systems of care, and long-

term social inequality shape drug use and drug-related harm. O'Mahony's (2025) analysis is particularly important in this respect because it shows that participants understood later drug-related harm not simply through individual deficit, but through harms located in the education system, the family home, and the local community. Similarly, Thom et al. (2026) show that engagement with treatment is shaped not only by individual willingness, but by trust, poor communication, resource constraints, fragmented services, and cumulative deprivation. Dennis's (2021) work on older heroin users is especially valuable because it cautions against reducing later-life risk to biological ageing alone, redirecting attention to treatment fatalism, inflexible systems, and the wider social conditions in which ageing with a history of drug use occurs. The reviewed literature also shows that much UK qualitative drug use research has been shaped, implicitly or explicitly, by progression and recovery frameworks that assume a directional arc through drug use. While individual studies complicate linear assumptions, the literature as a whole has not yet produced a sustained life-course account that traces how the meanings attached to drug use are continuously renegotiated across early life, adulthood, and later-life. This thesis addresses that gap directly.

What remains comparatively underdeveloped, however, is a sustained qualitative understanding of how older people in the UK with histories of drug use make sense of drug use and ageing together across the life course. Existing studies illuminate important aspects of ageing, such as shame, bodily change, treatment fit, and service barriers, but ageing is still too often approached through risk, treatment need, or health deterioration rather than through later-life interpretation, biography, and changing meaning. Likewise, family, gender, and stigma are clearly important, yet they are often treated as separate issues rather than analysed together as part of a broader life-course process. In this sense, the literature is stronger at identifying themes and problems than at explaining how past and present drug use experiences and ageing shape one another over time.

This review therefore informs the thesis in two ways; it identifies the substantive gap around older people's lived experiences of drug use in the UK, and it provides the analytical starting point for examining drug use not as a fixed behaviour, but as a meaning that is made and remade across biography, social context and later-life ageing.

It is also important to acknowledge the limitations of this review and of the broader research base on which it draws. Although the chapter provides a systematic overview of UK

qualitative research published since 2010, it is restricted to English-language, peer-reviewed studies identified through Scopus, and therefore does not claim to be exhaustive.

This thesis addresses that gap by focusing specifically on older people in the UK with histories of drug use and by examining how drug use is understood and reinterpreted across the life course. In doing so, it builds on the existing qualitative literature while also extending it in three important ways. First, it centres older adults, a group that remains weakly represented in the UK evidence base. Second, it examines drug use and ageing together rather than treating ageing as a secondary or background issue. Third, it attends to the interrelationship between biography, social inequality, stigma, family and institutional responses in order to understand how drug use and later-life are mutually shaped.

A limitation of the present research is that, although it is attentive to intersectionality, it does not examine all intersecting dimensions of experience equally. Across the findings, participants' narratives most consistently highlighted ageing, stigma, classed environments, difficult family relationships, embodied change, and institutional encounters. These became the main analytic threads of the thesis. While gender shaped some experiences, and ethnicity remains an important but underexplored dimension, the study was not able to develop these as fully as issues of age, class, and stigma. The thesis should therefore be understood as offering a detailed account of how older people with histories of drug use narrated drug use and ageing across the life course, while also indicating the need for future research that more explicitly centres gendered and racialised differences. The following chapter therefore moves from reviewing what is already known to exploring how these issues are narrated and made meaningful in participants' own accounts.

Chapter 3 Methodology and Methods

3.1 Chapter Overview

This study aims to explore the life experiences of older drug users. Therefore, hearing their life stories and interactions with their families, friends, and services is important. As discussed in the literature review chapter, many aspects of life and experience of drug use can affect each other. These effects can be positive and negative. To explore the drug use experience in later-life, it is essential to have an in-depth look into life course experiences.

This study uses a qualitative design with a biographical-narrative approach. The study method is one-on-one, semi-structured interviews (in person, online, or over the phone). This chapter explains the study's and my methodological position and why I chose these approaches. First, the research problem and rationale are identified. Then, attention turns to the research methodology, the research tools, recruitment, data collection, limitations, and data analysis.

3.2 Statement of the problem

This study intends to delve into the multifaceted aspects of drug use among older adults by examining their life stories and experiences. My literature review presented that both globally and nationally, the population is ageing. Relatedly, the number of older drug users is increasing. However, research on older people with drug use experience is limited in the UK. Therefore, my main aim was to get a better understanding of the life experiences of ageing people with drug use experiences. Alongside this, I was curious about how different personal characteristics and circumstances affected both drug use and ageing experiences. Therefore, by utilising narrative and biographical approaches, I aim to uncover the subjective realities constructed by older individuals in relation to drug use within the context of their lives (Creswell, 2007; Czarniawska, 2004). Additionally, I acknowledge the socially constructed nature of reality which is explored in the next section and the importance of considering societal influences on individuals' perceptions and behaviours regarding drug use in later-life by incorporating social constructionist epistemology (Giacomini, 2010).

The research is guided by four interrelated questions. The first asks how participants describe the development and changing meanings of their drug use across the life course. This question requires a method that allows participants to narrate their experiences, in their own sequence and with their own emphasis, rather than responding to researcher-imposed

categories. Biographical-narrative interviewing is specifically designed for this, because the open invitation to tell one's story allows participants to move across time and to prioritise what they themselves regard as significant (Rosenthal, 2018).

The second question asks how early life experiences, family relationships, classed environments, and adult transitions shape drug use trajectories. This question requires the method to be able to hold multiple life periods within a single account and to treat biography as a connected whole. A brief qualitative interview focused only on the present, or a survey measuring specific variables, could not capture how a participant connects childhood adversity to adult turning points and later-life meaning-making. The biographical-narrative approach is built precisely for this kind of temporal layering.

The third question asks how participants understand the relationship between ageing and drug use in later-life. This question requires participants to reflect on bodily change, identity, social life, and their own history simultaneously. Again, a form of reflection that structured instruments are not designed to elicit, but that biographical storytelling naturally produces.

The fourth question asks how stigma, social inequality, and institutional responses shape later-life experience. This question requires the method to attend to what participants say about their encounters with services, systems, communities, and other people, treating these accounts as socially situated rather than purely individual. A social constructionist epistemology, developed in the next section, underpins all four questions by treating participants' accounts not as transparent reports of events, but as meaning-making practices shaped by the unequal social worlds they inhabit.

To sum up, I aim to provide insights into the subjective realities of the life course of ageing people and contribute to a deeper understanding of the complexities surrounding drug use in the later stages of life.

3.3 Epistemology - Social Constructionism

This research employed a social constructionism. Understanding drug use in later-life requires a nuanced epistemological framework that acknowledges the socio-cultural contexts shaping individuals' behaviours and perceptions of reality. Social construction offers a lens through which to examine the intricate interplay between societal influences, individual experiences, and the construction of reality (Gergen, 1985; Slater, 2017). A simple definition

of epistemology is the theory/study of knowledge and how researcher and reality/truth interact with each other (Giacomini, 2010). Exploring a researcher's epistemological standpoint within a study provides an understanding of why and how the research questions are asked and how they will be answered.

Social constructionism proposes that knowledge is based on human experience, which is transferred through language, history, and culture; therefore, there could be more than one truth (Berger and Luckmann, 1991; Galbin, 2014). It suggests that interpretation of circumstances by different people can lead to different knowledge, which does not necessarily mean that one is more real/true than the other (Burr, 1995). For example, different people can describe the same event differently, and their descriptions can have different focuses and/or perspectives, which shape the reality they experience and know (Phillips, 2023). Social constructionism allows us to understand that different perspectives can coexist, and we should be critical "*of taken-for-granted ways of understanding the world"* (Burr, 2015, p. 223). As a researcher, I have a similar view on the issue. It can be because of my educational background in social work; I believe people's experiences are individual, and their perspectives can affect how they understand reality. Social constructionism posits that reality is not an objective, fixed entity but rather a product of social interactions, language, and shared meanings within a particular cultural context (Berger and Luckmann, 1991; Slater, 2017). This perspective rejects the notion of absolute truth and emphasises the importance of understanding how reality is collectively constructed and negotiated.

Vivian Burr (1995) defended that there are four fundamental assumptions of social constructionism. These are:

1. A critical stance towards taken-granted knowledge
2. Historical and cultural specificity
3. Knowledge is sustained by social processes
4. Knowledge and social action go together

A critical stance towards taken-for-granted knowledge highlights that what we observe from the world might not always be the reality. Burr (1995) gives the example of gender identity; binary categorisation of gender does not represent the reality. Therefore, a researcher should consider that even though there is a known fact about a subject, it might not represent reality, and we should be open to other possibilities. This stance also should be considered for this

research. One of the arguments of this study is that the majority of the evidence on drug use study focuses on younger people, and the knowledge existing in the literature might not represent the reality for older people.

Our understanding of the world is shaped by culture and history. Different cultures and periods can have different perspectives (Burr, 1995). For example, the idea of problematic drug use has changed over time. While some of the drugs, such as opioids, were socially acceptable in much of 1800s Britain, it became an illegal activity for some substances in the same country in the following century (see Section 1.1.1). Therefore, our ways of understanding are relative to our cultural and historical context, and we should not assume they are superior to others (Burr, 1995).

The third assumption focuses on personal interactions. Burr (1995) states that what we know is shaped by the interactions we have. Internalised stigma can be an example of this social process. People can shape their ideas about themselves according to the reaction they receive from other people or the stereotypes the society has about that specific characteristic (Livingston and Boyd, 2010). Thus, personal interactions such as language, facial expressions and body language play an essential role in social constructionism. An example of this can be drug use stigma. As it was discussed in the drug use and stigma heading, social understanding of drugs and perspective can shape the stigma around it (NIDA, 2024).

Lastly, knowledge and social action go together, and this assumption argues that knowledge affects the reaction. Burr's (1995) example for this assumption is highly related to my study. Burr (1995) points out that the view on alcohol use changes the policy around the subject. Similar changes can be seen in UK drug policy as well. Viewing problematic drug use as a medical condition or as a social problem has shifted the policy regarding drug use within the country. As outlined in Section 1.1.1, when drug use was viewed mainly as a medical condition, policies had a medical focus; when the view on problematic drug use changed in the UK, specifically in the 60s and the 80s, policies took a turn towards criminalisation.

Adopting a social constructionist framework also requires acknowledgement of the potential criticism of relativism. If meanings and categories are socially constructed, this might appear to imply that material harms and structural inequalities are themselves merely matters of interpretation. This thesis does not take that position. Following Burr (2015), I distinguish between the social construction of meaning: how drug use, ageing, recovery and stigma are

categorised and interpreted and the material and structural conditions within which those meanings are produced. Experiences such as homelessness, incarceration, chronic illness and bereavement have concrete biographical consequences. A social constructionist analysis does not deny these conditions; rather, it examines how they are interpreted, attributed and explained, including the ways in which structural harms may be reframed through discourses of individual pathology and moral responsibility.

To conclude, social constructionism represents my standpoint in this research. I believe there is more than one reality for people. To understand these individual realities, I need to understand why people's perspectives are shaped in certain ways and how personal circumstances affect their experiences. As mentioned before, I aim to explore life experiences of older people with drug use experiences. To be able to capture the closest picture to reality, I decided to collect my research data directly from my research population – older people with drug use experiences.

I choose a qualitative research approach for this study because it enables an in-depth examination of individuals' experiences, perceptions, and meaning-making processes within their own social and cultural contexts (Cooper and White, 2012). A qualitative approach is grounded in the assumption that social reality is not a fixed and objective structure but is constructed through interaction between individuals and through language (Lim, 2025). Accordingly, the aim of my study is not primarily to identify relationships between measurable variables, but to explore the meanings participants attribute to their lived experiences and how these meanings are produced. Through its flexible data collection techniques and capacity for contextual analysis, qualitative research made it possible for me to address the multidimensional and dynamic nature of the phenomenon under study in a holistic manner (Chand, 2025; Makateng and Mokala, 2025).

I believe employing interviews is beneficial to examine these individual perspectives and gain an in-depth understanding of older people's drug use experiences. As this section outlined, personal experiences shape the lived reality, which I aimed to understand with this research. Therefore, collecting evidence from the people who experienced the said reality is an important part of my research.

3.4 Biographical – Narrative Interviews

The biographical method is a hypernym for different terms such as life stories, oral history or narratives, which often co-exist in research (Bornat, 2008). The biographical approach is a powerful qualitative research method that aims to make sense of individuals' life stories and life trajectories within their social relationships and contexts (Rosenthal, 2018). It is a similar case for my research. The biographical and narrative approaches operate in parallel within my study. Nonetheless, by explaining these two approaches, I aim to explore their contributions to the study. The biographical approach focuses on the life course of individuals. This includes data collection and interpretation of the data to represent people's lives as wholes or specific parts of a life (Given, 2008). Additionally, the biographical approach brings individuality to the research. It aims to explore the experience on an individual level (Bornat, 2008) and specifically, when my study is considered, individuality may help participants express their experiences within their life circumstances and context and highlight the social constructionist approach and acknowledge personal circumstances.

The narrative aspect of the study describes the told experiences of the participants. Narrative inquiry contains biographical aspects naturally. It centres people's life stories in a way similar to the biographical approach. Any text or conversation may be referred to as "narrative," or it may refer to text that is part of a qualitative research method of inquiry (Chase, 2011). The common point is that it focuses on the stories told by people (Polkinghorne, 1995). Czarniawska (2004, p.17) states, "*narrative is understood as a spoken or written text giving an account of an event/action or series of events/actions, chronologically connected.*" In my research, it presents itself as spoken and then, transcribed into written text. Research methods that centre narratives focus on capturing the lived experiences of individuals. Narratives are being utilised commonly in social research focused on marginalised groups, such as women's issues (e.g. Women's Word (Gluck and Patai, 1991)), LGBT+ communities (e.g. Queer Narratives and Minority Stress: Stories from Lesbian, Gay and Bisexual Individuals in Norway (Synnes and Malterud, 2019)) or drug use (Stories of change in drug treatment: a narrative analysis of 'whats' and 'hows' in institutional storytelling (Andersen, 2015)) for decades. It gives the opportunity to hear lesser-heard voices and perspectives in research and policy. As the introduction chapter established, older people's voices have been less heard in research and policy on drug use in the UK and this research is an attempt to begin addressing this gap, allowing older people

with experience of drug use to tell their stories and share their perspectives. Therefore, the biographical-narrative interview is a valuable tool to look into the experiences of the ageing population (Lieblich et al., 1998, p. 5).

The data are collected directly from people who are participants in this study. Their experiences on the subject are organised in chronological order or life course stages during the data collection process or later by the researcher. Narrative research usually includes a small sampling size (Subedi, 2021); however, the amount of data collected from even one interview can be unique. The transcription and analysis process requires multiple times of listening to the recordings and organisation of the transcription (Lieblich et al., 1998). Narrative research has several types, and a biographical study is considered the most appropriate method for this particular study because it looks into drug use experiences of older adults and pays attention to the intersectionality of ageing, drug use and other personal circumstances. Asking people about their life stories with open-ended questions creates an environment for the participants to reflect on the parts they value as important. This allowed me to learn more about the circumstances that affected their lives. Therefore, I have decided to employ a narrative biographical approach to grasp an in-depth understanding of participants' lives.

Creswell (2007) summarises the biographical-narrative study as aiming to learn and record people’s experiences, which the research hopes to achieve. Therefore, I employed a biographical-narrative approach, meaning that the semi-structured questions are prepared in a way that allows and encourages participants to tell their stories as they want. The narrative and biographical approach is not limited to the interview process. I treated each interview as a narrative. Narratives inform my analysis process.

3.5 Challenges in Researching Drug Use in Later-Life

Researching drug use in later-life presents challenges that begin before recruitment and shape every stage of the research process. Older people who use drugs are a population that is frequently hidden from formal services, unlikely to identify with institutional categories such as "drug user" or "in recovery", and often reluctant to discuss experiences that carry significant social stigma (Dennis, 2021; Moxon and Waters, 2019). Unlike younger drug-using populations, who may be more visible through treatment services, criminal justice contact, or youth-focused community organisations, older drug users frequently manage their

drug use privately, away from institutional gaze (Moxon and Waters, 2019; Ayres et al., 2012). This means that a single recruitment route does not reliably reach this population, and that methods developed for younger or more service-connected groups would not be efficient. Researching populations located at the intersection of age, stigma, and social withdrawal requires adapted, flexible, and trust-based approaches (Liamputtong, 2007).

These structural challenges were compounded, in this study, by a series of specific decisions and adjustments that shaped the research over time. Three are worth discussing here: the definition of who counted as an "older" participant; the initial scope of the study and how it was revised; and the practical barriers encountered during recruitment. Together, these decisions illustrate how research with hard-to-reach populations often requires methodological reflexivity not as an afterthought, but as a core part of the research process itself (Creswell, 2007; Patton, 2015).

Defining "older": the age threshold decision

One of the earliest challenges was determining what "older" meant in the context of drug use research. Chronological age thresholds vary considerably across the literature. The term "older adult" in European policy contexts typically refers to people aged 65 and over, but this threshold is not consistently applied in drug use research, where age cut-offs between 40 and 50 are common (Wadd and Rao, 2014). Chronological age is a poor proxy for 'later-life' in the context of long-term drug use. The Advisory Council on the Misuse of Drugs (2019) explicitly notes that people with extensive histories of drug use may experience biological, social, and health processes associated with ageing considerably earlier than the general population and sometimes that can be described as accelerated ageing. Beynon and colleagues (2009) similarly argue that individuals with long drug use histories in their 40s may present with the health profiles, service needs, and social circumstances more commonly associated with people a decade or more older.

This study initially set the age inclusion criterion at 50 and over, in line with much of the existing UK literature. However, during recruitment it became apparent that this threshold was limiting access to a broader population of older drug users whose experiences were analytically relevant to the research questions. Following discussion with supervisors and with ethics committee approval, I decided to lower it to 40 and over. This decision was also shaped by the practical challenges of recruiting a hidden and stigmatised population, but it

was not only a pragmatic decision. The decision to use 40 is consistent with some of the UK drug use literature, is theoretically justified by the accelerated ageing argument. It reflected a substantive judgement that the life-course processes my thesis is interested in, the accumulation of biography, the renegotiation of identity, the changing meaning of drug use in relation to mortality and the body, may begin earlier for this population than a conventional 'older adult' threshold would capture. The phrase “I never thought I’d reach 40” captures this point directly, as for some participants reaching mid-life was itself narrated as a significant biographical threshold rather than a neutral chronological marker.

I accept that the phrase 'later-life' in the title creates some tension, and in retrospect a qualifier such as 'mid- and later-life' might have been more precise. However, I would argue that my thesis uses 'later-life' as a biographical and interpretive category rather than a purely chronological one and that framing is theoretically consistent with a life-course approach that treats age as socially and biographically constructed rather than solely fixed one.

Revising the study scope

A further challenge arose from the study's original focus on older LGBTQ+ people with histories of drug use. Despite a theoretically grounded rationale for this focus, 24 months of targeted recruitment across more than 60 LGBTQ+, ageing, and drug-use organisations produced only one participant. This was not a reflection of the importance of the question, but of the practical difficulty of accessing a population located at the intersection of multiple stigmatised and sensitive identities which is a well-documented challenge in research with marginalised communities (Kneale et al., 2021; Liamputtong, 2007). With supervisory support and ethics committee approval, the inclusion criteria were broadened to older people in the UK with histories of drug use, while retaining analytical attentiveness to inequality, stigma, gender, and social location. This shift clarified the need for a flexible qualitative design and reinforced the principle that which dimensions of identity became analytically significant should be determined by participants' own accounts rather than fixed in advance.

Practical barriers: online recruitment and community presence

Even with the broadened criteria, recruitment remained challenging. Online and organisational recruitment produced uneven results. In-person contact with organisations consistently generated stronger engagement than remote approaches, reflecting the role of trust and visibility in accessing sensitive populations (Liamputtong, 2007). Online

recruitment, while initially productive, generated a separate problem in the form of suspected imposter participants which is individuals who appeared to be responding to the financial compensation offered rather than meeting the eligibility criteria. After investigating the literature on this emerging methodological challenge (Roehl and Harland, 2022; Santinele Martino et al., 2024) and confirming that the pattern I encountered matched documented experiences in other studies, I made the principled decision not to respond to emails I had strong reason to believe were not genuine. This decision was taken transparently, with supervisory oversight, and is discussed further in Section 3.6.

The most productive recruitment strategy ultimately proved to be volunteering at a local recovery café, which is discussed as a methodological approach in its own right in Section 3.6.3. Across all of these challenges, the consistent theme was that accessing older drug users requires sustained presence, relationship-building, and a willingness to adapt; qualities that are methodologically significant, not merely logistical.

3.6 Application of Methods

3.6.1 University Ethics Approval

Before any interviews were conducted, the University of Strathclyde Ethics Committee's university-level ethics approval was obtained. The ethics application included the location of the interviews, reimbursement to participants, ethical considerations, informed consent, and potential hazards (see Appendix 2).

The considerations were addressed with appropriate preparations, which the ethics committee approved. For consent, anonymity and remuneration, I provided a consent form and information sheet (see Appendix 3) to participants before the interview. I provided the consent form and information sheet to participants when they expressed interest in my research. By providing them with the information sheet, I explained that all the information regarding the research can be found on the sheet, and they are free to ask me any question related to the research and interview process. Additionally, I verbally reviewed the core parts of the information sheet before the interview.

The application consisted of an ethics application form, information sheet, consent form, advertisement flyer, debriefing sheet, risk assessment form and interview schedule. The approval was obtained on 20 June 2023. The Ethics Committee was informed of the changes made to the research after this date regarding recruitment barriers, which are explained in

barriers to recruitment sections, such as lowering the age cut-off point to 40 from 50 (explained in more depth in Section 3.6.3), expanding the research population beyond the LGBT+ community, providing participants with compensation, and conducting face-to-face interviews.

As my research focuses on experiences of drug use—an area that is sensitive and potentially associated with vulnerability for participants—ethical considerations were addressed with particular care at every stage of the research process. In this context, issues of informed consent, anonymity and confidentiality, the minimization of potential harm to participants, and remuneration were examined in a comprehensive manner.

Written informed consent was obtained from all participants prior to the interviews. Participants were provided with clear and accessible information about the purpose, scope, and methodology of the study, the data collection process, as well as potential risks and anticipated benefits. They were also informed that participation was entirely voluntary and that they had the right to withdraw from the study at any stage, without providing a reason and without any negative consequences. Given that the study addresses drug use, a topic associated with significant stigma, ensuring that participants were able to make informed and autonomous decisions about their involvement was treated as a fundamental ethical priority.

Protecting participants' identities and ensuring the confidentiality of the information they shared were core ethical principles throughout the research process. To prevent the direct or indirect identification of participants, pseudonyms were assigned and all identifying personal information was removed from the dataset. Audio recordings, interview transcripts, and all other research materials were stored in encrypted and secure digital environments accessible only to the researcher. During the reporting of findings, particular care was taken to avoid the inclusion of contextual details that could lead to participants being recognized. This approach aimed to protect participants from potential social, or psychological risks associated with participation in research on a socially sensitive topic such as drug use.

Due to the qualitative and biographical nature of the study, inviting participants to reflect on past experiences and personal life events carried the potential to evoke emotional distress. For this reason, participants' psychological and emotional well-being was prioritized throughout the data collection process. Interviews were conducted in settings where participants felt safe and comfortable, and participants were reminded that they could decline

to answer any questions they found distressing or terminate the interview at any point. Where appropriate, participants were informed about relevant social services and support mechanisms to which they could be referred if needed. This approach is consistent with the core social work principles of empowerment and non-maleficence and reflects a commitment to conducting research in a manner that minimizes harm while respecting participants' dignity and agency.

To support the well-being of participants and reduce any potential harm, I utilised my interview skills as a social worker. I looked for signs of feeling upset or emotional during the interviews. When participants showed any signs, I reminded them that taking a break is an option. None of my participants showed signs of anger or aggression during my interviews. At the end of the interview, I provided a debriefing sheet (see Appendix 4) that explained what would happen to the data they provided. This debriefing sheet also included a list of drug use and ageing organisations that participants could reach out to if they like.

Providing compensation was an ethical dilemma I faced during my research. I decided to provide £15 gift vouchers to my participants as a thank-you for their time. In the literature, there are mixed opinions on research compensations. Some believe that any payment other than expenses should be considered unethical since participants' only motivation for the research should be contribution (Chambers, 2001). However, the majority of the research argues that with the right circumstances, providing compensation can be an ethical practice (Elliott and Abadie, 2008; Grant and Sugarman, 2004). Therefore, I made sure that the compensation I provided did not act as a coerce technique. To be able to ensure that, I decided on an amount that is suitable for the time the participants will participate. I offered £15 gift vouchers for one to two hours of interviews. During my online advertisements, I refrain from sharing the amount of the compensation on my advertisement fliers, and the information related to compensation did not stand out more than other research-related text and images. Additionally, I highlighted that I would provide compensation regardless of whether the participants decided to withdraw at any stage of the interview or after the interview. None of my participants expressed interest in withdrawing from the research.

I provided e-gift cards for my online interviews and physical gift cards for my in-person interviews. Some of my participants expressed their surprise when I handed them the gift card at the end of the interview and stated that they forgot that I was providing compensation.

Although participant payment did not appear to create coercion among genuine participants, it did generate a separate ethical and practical challenge in the form of suspected imposter participants responding to online advertisements. I received around 200 emails from potential imposter participants after my online advertisements. The reasons why I believed they were imposter participants are explained in Section 3.6.3. The literature review I made around the issue led me to think this issue occurred because I offered financial compensation and I made the decision not to reply to potential imposter participants because of my limited resources and time. Additionally, I did not include suspected imposter participant interview in the dataset. No payment was issued because the interview was terminated when serious concerns arose regarding the participant's identity and eligibility.

Lastly, I volunteered at a local recovery community to learn more about the community I was studying and to help me overcome some of the challenges I was experiencing with recruitment. To prevent unethical practices, I made sure to be open about my identity as a researcher and inform my fellow volunteers and visitors of the café. I was careful not to approach potential participants directly; I only talked about my research during communal sharing times and informed people that they were free to contact me if they were interested. Inevitably, after recruiting people from the local recovery community, I kept volunteering and working with my participants. I never talked about their interviews after the interview, even with them. I did not want to make them feel uncomfortable and led them to think that the information they shared could be discussed again at the premises where we volunteer.

3.6.2 Interview Schedule

I chose to undertake qualitative biographical-narrative, semi-structured interviews for this study, it aims to explore the complex dimensions of drug use among older adults. Patton (1980) suggests, "*we use interviews to find out from them those things we cannot directly observe, as we cannot observe behaviours that took place at some previous point in time*" (p.196). Multiple qualitative interview types exist, such as structured/standardised and unstructured interviews. The critical part of choosing the interview style is deciding the appropriate level of structure (Flick, 2023). Interviews can present multiple ethical and practical problems. For example, interviews are not conversations in that two parties exchange information. The researcher seeks information regarding the study subject through interviews, which can turn into interrogation (Czarniawska, 2004). Kvale (1996) argues that the cause of this can be the power difference between the interviewee and interviewer. If the

interviewer is seen as an expert or professional within the interview process, the power balance might shift, which Kvale (1996) calls a "professional interview". However, we should remember that the participant is the expert on the subject, and the researcher is the one seeking information (Czarniawska, 2004). Additionally, Silverman (2014) brings a different approach to interviews. He suggests that information flow does not have to be one-way. The interview process can be an exchange of information and knowledge as long as the observation of the conversation can serve the purpose of the research (Silverman, 2014). In this research, the possibility of two-way information flow was kept in mind. However, all of the participants seemed happy to share their stories, and there was no need for this approach.

The preparation and structure of the interviews can vary. The difference between them is usually based on the prepared structure of the interview. However, Parker (2005) argues that there is no possibility of having fully structured interviews (p. 53) since it is impossible to have total control over what participants say. Furthermore, Parker (2005) also argues that every interview is semi-structured because even with unstructured interviews, the researcher creates a structure with follow-up questions because there is a purpose to the interview, and the researcher asks related questions to the research aims.

Semi-structured interviews allow the researcher to set an agenda and guide for the interview but also give participants some space to add aspects of their stories that were not covered by the questions in the interview schedule, which can improve the interview process and produce new information (Brinkmann, 2018). Therefore, I chose semi-structured interviews as the most appropriate tool for data collection. During the process of data collection, as the literature suggested, I prepared an interview draft. Later, with pilot interviews, I checked the flow of the interview draft and organised the questions based on the feedback I got. This process involved broadening the questions. Additionally, following discussion with my supervisors after the first few interviews, I made the interview guide broader and less directive. For instance, rather than asking narrowly about specific health impacts of ageing, I introduced more open questions about the negative and positive sides of getting older, which enabled participants to raise issues such as invisibility, bodily change, and shifting social expectations in their own terms. While doing these revisions, the purpose of the semi-structured interview was kept in mind, and participants were encouraged to lead the interviews when needed.

As mentioned above, this study employs a narrative-biographical approach. Therefore, questions were constructed to be open-ended and organised as drug use-related questions and ageing-related questions. The questions aim to help participants recall their stories related to the study. An information checklist was also included at the end of the interview schedule to verify essential information such as participant's pronouns, age, gender identity, trans status, sexual orientation, health status and living circumstances. Considering this is a semi-structured interview, not all questions were asked during the interview. Some questions were answered naturally, and I skipped the answered question or added more questions that were born from an answer/personal story.

Drug use-related questions focused on life stories around drug use, relationship with drugs, family and social circle, and lastly, experiences with services; ageing-related questions explored the process of ageing and the experiences of changes in life in general and related to drug use (see Appendix 5).

The interview schedule provided to the ethics committee also included verbal ethical reminders and consent at the start of the interview. I utilised the interview schedule at every interview. It gave me a guide to follow. However, I did not use every question during the interviews. Some of the questions were answered naturally, and I skipped the answered questions. At the same time, I explored the aspects born from participants' replies with follow-up questions.

Pilot Interviews

I conducted three pilot interviews with peers to ensure the interview had a good flow, the questions complemented each other, and they were not repetitive. The pilot interviews were utilised to confirm that I use appropriate language – avoid heteronormative phrases, use the correct pronouns, and taking a neutral stance and using a respectful language. Moreover, I made sure to practice de-escalating a situation if a participant showed signs of feeling upset; to support participants and minimise potential harm. I found that my interview skills as a social worker became helpful with this practice. I was able to read the signs of discomfort during the pilot and actual interviews. Therefore, I was able to utilise my interview skills and de-escalate the situation. The participants who became emotional during the interviews expressed it by crying. When that happened, I reminded them that taking a break from the interview was an option if they preferred. All of them opted out and wanted to keep talking

about their experiences. Additionally, I brought tissue papers to in-person interviews for participants and offered them when they were needed.

Lastly, I practiced ensuring that participants were verbally reminded about their rights, such as withdrawing, taking breaks and refusing to answer a question if they felt uncomfortable.

One of the main focuses of the pilot interviews was to determine how I played a role in the interview process. Apart from the interview flow and language, I requested feedback on myself as the interviewer. One of my concerns before the pilot interviews was English being my second language, potentially affecting the interview process. After the pilot interviews, I decided to record all interviews with the consent of the participants because, even though my speaking and listening skills did not present a problem during the interviews, it was challenging for me to take in-depth notes and actively listen to participants' replies at the same time. Therefore, to capture all data, I decided that I needed to record all interviews and transcribe them verbatim. This was explained in the information sheet and the consent form and I got my participants' verbal consent before I started the recording.

One of the feedback points from the pilot interviews was a need for broader questions. Initially, I prepared my interview questions for more specific answers. However, during the pilot interviews, I realised that these specific questions prevented participants from sharing some experiences they valued. Additionally, even though my questions were open-ended, the answers to these detailed questions led to very short answers. After discussing this barrier with my supervisors, I broadened my questions and got the more detailed information I needed with follow-up questions. For example, rather than asking the participants about how health problems in later-life affected their journey, I asked them about the negative sides of ageing. Most of the time, participants reflected on their health problems; some reflected on different experiences, such as feeling invisible.

3.6.3 Sampling and Recruitment

Purposeful sampling aims to reach suitable participants, which can provide insight and understanding of the study phenomenon (Creswell, 2007). This sampling method provides “information-rich cases” that can bring an in-depth view of the subject (Patton, 2015). The purposeful study is beneficial to 4 types of study styles: pilot studies, intensive case studies, critical case studies and hard-to-find population studies (Bernard, 2013). I consider this research group as a hard-to-find population research because of the reasons mentioned in the

study rationale, and my recruitment challenges reinforced this sense. I set a few criteria for reaching out to participants suitable for this study. These sampling criteria are being aged 40 and over, living in the UK, and current or past drug use. The reason for age criteria is explained in the previous section.

Recruitment

Due to the sensitive nature of the study, untargeted recruitment from the general population was unlikely to make sense. Therefore, I employed multiple, more specific methods of recruitment. Before I broadened my subject to the general population (other than LGBT+), I contacted 99 community-based and charitable organisations which work to support one or more of the following communities: LGBT+, older people, and substance users in the UK. I asked these organisations if they could help support study recruitment by sharing/displaying information about the study in newsletters, communal rooms, and emails or by displaying hard-copy flyers in meeting areas. Seven of these organisations advertised the research in various ways, such as sending out emails organisation-wide, displaying hard-copy flyers in common areas, sharing them in their newsletter, and informing potential participants. The organisations` role in the research was limited to advertising it. I offered to share a brief report of findings with each participating organisation after completing the study. I also used social media channels such as Facebook and X (Twitter) to put out calls for potential participants. Enrich Scotland - an organisation that supports research related to care homes, reached out to me to offer their support after seeing social media advertisements. Lastly, flyers were displayed in public places, such as LGBT+ cafes, pubs, or recovery cafes, which may attract the target population.

During the recruitment process, I encountered problems, which are discussed in section 3.5. As a result of these problems, I decided to expand the research population outside of the LGBT+ community and provide remuneration to the participants (details in Section 3.6.1). Later, I included in-person interviews in my research as a request from my potential participants. All changes are made with the ethics committee’s approval.

Once my research took its current shape, I contacted the ageing and drug use organisations again with new research subject and recruitment criteria and conducted online advertisements.

Lastly, I volunteered at a local recovery café for seven months and recruited multiple participants in person. The decision to volunteer was based on previous recruitment experiences. Before the decision to expand the research population, I had problems with recruitment, which is explained more in the next section. Therefore, I decided that being present within the community could be beneficial for trust.

The aim of volunteering was to grasp a better understanding of the drug use community and build trust with potential participants. I was open about my position as a volunteer – a person without drug use experience who is academically interested in the area. Additionally, I expressed my interest in observing recovery café practice in Scotland as a social worker. Most of my relationships were built with fellow volunteers who told their drug use stories on different occasions. At the recovery café, volunteers and visitors have designated times to sit together and share about their day and weeks. During these meetings, I expressed my interest in the community as a researcher and gave brief information about my research. I stated that anyone interested in becoming a participant could contact me. People who were willing to share their life stories and drug use experiences approached me, and I provided them with an information sheet and consent form and answered their questions.

It is important to acknowledge that recruiting the majority of participants through a single recovery café setting has analytical implications that go beyond sample size. Recovery cafés are spaces organised around particular ways of narrating drug use; they encourage storytelling, they value accounts of trajectory and change, and they embed participants in a community that has developed shared frameworks for making sense of drug use histories (Neale et al., 2012). Participants who regularly attend and volunteer at such spaces are therefore likely to be more practised in narrating their drug use biographically, more comfortable with reflective retrospection, and more oriented toward frameworks of recovery, survival, and meaning-making than participants recruited from other settings.

This does not invalidate my data, but it does shape it in ways that require acknowledgement. The accounts collected from recovery café participants may reflect what Riessman (2008) calls a particular narrative environment. It is a social context that rewards certain kinds of storytelling and discourages others. Active drug users not engaged with recovery services, hidden older users who manage their drug use privately (Moxon and Waters, 2019), and people who do not narrate their drug use through frameworks of trajectory or change are

systematically less represented in the sample. My sampling is not limited to the participants who were recruited from a recovery café; therefore, my data sets offer insight more than said narrative environment. However, it is worth acknowledging that the findings should therefore be understood as reflecting the mainly perspectives of older people with drug use histories who are, to varying degrees, engaged with recovery communities; rather than as representative of the full range of later-life drug use experience.

Overall, I recruited 28 participants aged between 40 and 79 who had experience of drug use. Recruitment continued alongside data collection and preliminary analysis. I concluded recruitment when later interviews were no longer generating substantially new themes or insights relevant to the research questions, suggesting that sufficient thematic depth had been reached. The final sample of 28 therefore reflected both the aims of the qualitative study and the point at which additional interviews were providing diminishing analytical returns.

Table 3 Participant Characteristics

Pseudonym	Age	Gender	Location	Current Drug Use	First Drug Use Age	Recruitment Method
Alice	42	Female	Glasgow	No	12	Recovery Café
Emily	72	Female	Manchester	Yes	16	Through Organisations
David	50	Male	Glasgow	No	12	Through Organisations
Sam	49	Male	Cardiff	Yes	15	Through Organisations
Andrew	66	Male	London	No	14	Online
Harry	47	Male	UK	No	20	Online
George	65	Male	England	Yes	17	Through Organisations
Amy	48	Female	Scotland	No	14	Recovery Café
Laura	44	Female	Edinburgh	Yes	13	Online
Oliver	45	Male	UK	Yes	12	Online
Noah	79	Male	Edinburgh	Yes	32	Online

Ava	42	Female	Scotland	No	11	Recovery Café
Oscar	50	Male	UK	No	16	Online
Jack	49	Male	Glasgow	No	10	Recovery Café
Leo	52	Male	Birmingham	Yes	14	Online
Lucy	45	Female	Glasgow	No	37	Recovery Café
Charles	62	Male	Glasgow	No	12	Recovery Café
Arthur	47	Male	Glasgow	No	14	Recovery Café
Edward	52	Male	Glasgow	No	13	Recovery Café
Will	61	Male	England	No	15	Recovery Café
Tom	43	Male	Glasgow	No	13	Recovery Café
Henry	53	Male	Glasgow	No	13	Recovery Café
Anne	56	Female	Glasgow	No	20	Recovery Café
Fred	52	Male	Glasgow	No	12	Recovery Café
Jane	46	Female	Glasgow	No	16	Recovery Café
Walter	55	Male	Glasgow	No	12	Recovery Café
Richard	44	Male	Glasgow	No	10	Recovery Café
Simon	55	Male	Glasgow	No	12	Recovery Café

Barriers to Recruitment

I encountered multiple barriers to recruitment within the study apart from the recruitment problems discussed in section 3.5. I found that meeting in person plays a big role in recruitment. When I met with organisation members in-person, I received more support from the organisation. Participants and organisations may hesitate to collaborate with a researcher without building rapport and trust. Specifically with sensitive subjects similar to my research. Additionally, my online advertisements were successful after expanding the research population, and I was able to recruit people from all over the UK. However, during the online advertisement, I met with another barrier. I started to receive dozens of participant requests in two days. It was unexpected and seemed unlikely for my research subject, given the challenges I had faced up to that point. After examining the emails I received, I realised many

of the emails were very similar, and some were even identical. The sender's email addresses were also very similar. In short, I received around 100 emails within two days, and I suspected around 80 of these to be imposter participants.

Most of these email addresses were structured as first name, last name, and three numbers. For example, joebloggs123@.... Lastly, I received 10 - 12 emails in a minute at a time. All of this caused me to suspect that these potential participants were not genuine. It was not possible for me to interview all the potential participants and analyse their interviews to determine their genuineness because of the time and funding limitations. Thus, I interviewed one of them to understand the situation. During the interview, the participant presented multiple reasons that led me to believe they were not the person they claimed to be. First, they refused to turn on their camera, and when they turned it on, they were visibly substantially younger than they claimed to be. Additionally, they were joining the meeting outdoors, where it could be seen that it was in a warmer climate because of their clothes, and at the time of the interview, it was winter in the UK. When this was questioned, thinking they might be on vacation, they stated that they were in Manchester. Lastly, when I expressed my concerns about the genuineness of their identity, they left the meeting and did not return, which was something they did – leaving the meeting and joining back within a few seconds when asked a question – throughout the interview. All of this left me convinced that they were an imposter participant, perhaps motivated by the small reward I was offering to participants to thank them for their time.

With the increase in remote interviews, other researchers have reported similar challenges. For example, Roehl and Harland (2022) explained how imposter participants presented themselves in Roehl's doctoral research, and Santinele Martino and others (2024) gave examples of their experiences in disability research. Their experiences were very similar to mine. Short participation request emails, waiting for a few seconds before answering questions – in my experience, participants left the online meeting and joined a few seconds later (Santinele Martino et al., 2024).

Both researchers supported the idea that imposter participants choose to participate in research where participants are given compensation for financial reasons. Roehl and Harland (2022) pointed out that although the research compensation might seem low (£15 for my study and $20 for Roehl's study), these amounts can have higher values in other countries

because of the currency exchange. Additionally, from my experiences, I have received multiple (ten to twenty) emails within one to two minutes, which led me to believe that they were coming from the same source. Therefore, getting multiple compensations from one research can sum up to a more significant amount of money (Santinele Martino et al., 2024).

To conclude, after investigating the literature about the imposter participants and realising the similarities to my research, I decided not to reply to emails I highly suspected were from imposter participants. I did respond to emails that I was less sure about (16 of them) to request more information about people's identities before the interview, but I did not receive any further information.

Once I stopped replying to imposter emails, I stopped receiving them. However, anytime I shared my study advertisement online, I received more imposter emails. The last time I shared my research advertisement online, all the participants I received were imposter participants. Therefore, I mostly focused on other recruitment methods—volunteering—and recruited the rest of my participants with it.

Table 4 Recruitment Methods

Recruitment Method	**Number of Participants**
Through Organisations	4
Online Advertisement	7
Volunteering	17
Total	**28**

3.6.4 Interview and Transcription

During the interviews, I verbally summarised the information sheet and asked for their consent to interview and recording. Additionally, I ensured that participants had time to ask questions about the study if they had any and answered them in detail. In keeping with the relational and non-extractive ethos of the study, I prepared an accessible summary of the findings to share with participating organisations and, where appropriate, with participants who expressed interest in receiving study outcomes. I shared the summary of findings with organisations and participants who wanted to be informed about the study outcomes.

During the interview, I tried to speak as little as possible and give participants the freedom to express their stories while ensuring all research topics were covered. Additionally, I gave verbal and non-verbal cues throughout the interview to maintain active listening. The interview was recorded on Zoom, Teams Meeting, or a password-protected voice recorder, and I transcribed them later.

The relationship between me and the participants varied depending on the recruitment method. The rapport and communication with participants who contacted me through social media advertisements felt limited compared to those recruited via other methods. I informed them about the research and the interview process through emails, and communication prior to the interview was short and solely focused on the research. However, with the participants who were recruited through volunteering, I was able to build a rapport with most of them before the interview process. Most of the participants I recruited through recovery cafes were fellow volunteers, and the rest were regular visitors of the cafes. The rapport and relationship between us were supported by the community organisation I was volunteering at. The volunteers at this organisation mostly built friendship-like relationships. Most of them volunteered multiple days a week and sought the support of other volunteers as well as supporting other visitors to the recovery cafes. The community organisation provided training to all volunteers to teach them about building healthy relationships with other volunteers and visitors. These trainings included establishing boundaries, using correct language and learning more about the roles of volunteers. Therefore, it was relatively easy to establish a healthy rapport with fellow volunteers. They were as careful about boundaries as I was. Additionally, my position was slightly different. My fellow volunteers knew that I did not have direct drug use experience, and I was volunteering at the recovery cafes to learn more about the drug use community, support the community and build networks. Because of my studies, I was only able to volunteer once a week, whereas they were volunteering multiple days a week. Despite these differences, other volunteers' and visitors' reactions to me always seemed positive. They seemed happy to have a person within their community who was trying to learn more about how to support their needs. Therefore, when I informed them about my research, most of them reached out to me to participate and support my research. However, these differences in relationships did not appear to affect the interview process. People who contacted me through social media came across as wanting to share their stories and support my research. Reflecting on this, they seemed open to talking about their

experiences, while most of the participants that I recruited through recovery cafes were familiar with sharing their drug use stories. Recovery cafes encourage volunteers and visitors to share their stories for multiple reasons, such as helping new visitors, opening up to more people, and giving them a space to ask for support if needed. I was part of these recovery meetings, and most of my participants were already comfortable with my presence prior to our interviews. The rapport between us helped us to establish reciprocal trust. Therefore, I did not meet many barriers during the interview process.

Transcription protocol

I transcribed all recordings after the interviews. To ensure data protection, I did not use any type of transcription programme or company. I avoided this method because these programmes require voice recording files to be uploaded online, and participants shared identifiable personal information during the interviews, which I anonymised during transcription. Therefore, voice recordings contained personal information that I did not want to upload to an online platform. After the initial transcription, I listened to the recordings and read the transcriptions simultaneously to check the accuracy of the transcription.

I prepared a transcription protocol to ensure all interviews were transcribed and analysed systematically and consistently. This protocol (see Appendix 6) is a guideline for transcribing the audio and video recordings to textual data. The reason why I decided to use a protocol was to transcribe all the interviews in the same way. I conducted my interviews and transcribed them at different times. I followed this protocol to make sure that I transcribed non-verbal and verbal cues in the same way for all my interviews.

3.6.5 Data Analysis

This section discusses the research data analysis process. I choose to employ reflexive thematic analysis in this research (Braun and Clarke, 2019, 2006). Thematic analysis is a qualitative data analysis technique that identifies, analyses, and interprets patterns or themes in textual data. Unlike other forms of thematic analysis, reflexive thematic analysis emphasises the importance of reflexivity, which involves reflecting on the researcher's perspectives, biases, and assumptions throughout the analytical process (Braun and Clarke, 2006). I will discuss my position in the research in the following section.

I aimed to explore the life experiences of older drug users, and as explained before, I utilised biographical-narrative interviews to capture the participant's life events and drug use experiences. Therefore, it was expected that my interviews would explore different aspects of participants' lives. To identify these different aspects, I utilised reflexive thematic analysis. As Boyatzis (1998) argues, thematic analysis is a useful method to identify different prospects of the research subject. Braun and Clarke (2006) suggested that thematic analysis is a tool that can be used to understand complex and rich data. After years of research and publication, Braun and Clarke decided to refer it as "Reflexive Thematic Analysis" to highlight the importance of the researcher's position in the research (Braun et al., 2018; Braun and Clarke, 2019).

Reflexive thematic analysis was chosen over several alternative qualitative approaches for reasons specific to the aims and design of this study. Interpretative Phenomenological Analysis (IPA) was considered but set aside because it is most suited to small, homogeneous samples exploring a single, bounded experience in depth; the diversity of participants in this study and the breadth of the life-course focus made IPA's idiographic approach less appropriate (Smith et al., 2008). Grounded theory was not selected because the study was not aiming to generate a new substantive theory from the ground up, but rather to interpret existing biographical experiences in relation to established life-course framework (Charmaz, 2012). Framework analysis, while well-suited to applied policy research, imposes a predetermined structure on the data that was inconsistent with the inductive and exploratory spirit of this study (Ritchie and Spencer, 1994). Narrative analysis was perhaps the closest alternative, given that the data were collected through biographical-narrative interviews (Lieblich et al., 1998). However, narrative analysis typically preserves and foregrounds the sequential structure of individual stories as its primary unit of analysis, whereas the aim of this study was to identify patterns of meaning across a diverse dataset of twenty-eight participants. Reflexive thematic analysis offered the flexibility to move between individual accounts and cross-case patterns, to remain attentive to the biographical context of each participant's narrative, and to make the researcher's interpretive role explicit throughout; all of which aligned with the epistemological commitments of the study (Braun et al., 2018; Braun and Clarke, 2006).

I acknowledge that combining biographical-narrative data collection with reflexive thematic analysis involves a methodological tension that requires explicit justification. Biographical-

narrative methodology, as articulated by Rosenthal (2018) and Wengraf (2001), is premised on preserving the sequential and relational integrity of individual life stories, the assumption being that meaning is produced not only in what is said but in how events are ordered, connected, and narrated across a whole biography. Reflexive thematic analysis, by contrast, works across cases to identify patterns of meaning, necessarily fragmenting individual narratives in the service of cross-case comparison (Braun and Clarke, 2006, 2019).

To ensure that the biographical integrity of individual accounts is preserved during data collection and initial familiarisation, each transcript was read as a whole biography before any coding began, and the thematic map was built upward from individual accounts rather than imposed downward from prior categories. However, the final analytical structure is cross-case and thematic rather than biographical and sequential. The epistemic consequence is that the thesis produces a life-course account of patterns across biographies rather than a set of individual biographical portraits. This represents a deliberate analytical choice: with 28 participants, individual case-level narrative analysis would be analytically rich but unable to address the cross-case questions about how drug use meanings shift across the life course that the research questions require. The approach therefore trades some biographical depth for analytical breadth, and this trade-off shapes what the thesis can and cannot claim.

Braun and Clarke (2019) explicitly position reflexive thematic analysis as a method suited to studies where the researcher's theoretical and personal positioning is integral to the analytic process, which is consistent with the reflexive and constructionist approach taken here.

During the reflexive thematic analysis, I used Braun and Clarke’s (2006) six-step guide for thematic analysis. These steps are:

1. Familiarizing with data
2. Generating initial codes
3. Generating themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

The thematic analysis aimed to generate themes through interpretive engagement with the dataset and investigate the developed themes, meanings, and patterns of meaning. The first step of the guide was to transcribe the data and read/reread the transcription. This step aimed

to look for initial themes before coding while doing active reading. In this process, I was determined to understand which parts of the interview focused on different subjects and how I could code these chapters. After familiarising myself with the data, I moved the document to NVivo for initial coding. At this stage, I moved to the second step of the analysis. I uploaded the transcriptions to NVivo 14 and created child and parent codes for relevant excerpts. Parent codes – principal codes and child codes – minor codes helped me to organise the codes. Later, NVivo 14 allowed me to see the excerpts from different transcriptions that were marked by the same codes, and this helped me generate themes.

Table 5 Initial Coding Sample

Data Extract Segment	**Initial Code**
"the only way I could cope"	Drug use as a coping mechanism
"lost my job"	Employment loss
"family wasn't talking to me"	Family breakdown
"felt completely alone"	Social isolation
"drugs gave me some kind of escape"	Drugs as emotional escape
"even though I knew it was damaging me"	Awareness of harm

After completing the initial coding, I started to generate themes. At this stage, I identified similar codes and separated them into different themes. In this stage I focused on the meaning behind the codes, example of this as below.

Table 6 Exploring Themes

Codes Grouped Together	**Candidate Theme**
Drug use as coping mechanism Drugs as emotional escape	Drugs as a means of survival
Employment loss Family breakdown Social isolation	Accumulating social losses
Awareness of harm	Tension between survival and self-destruction

As Braun and Clarke (2006) suggested, I used visual help from the initial thematic map in the meantime. Creating a thematic map helped me discover links between themes and subthemes, so I created the initial themes in full (Appendix 7).

The next step consists of two levels. First, I looked at the collected data under each candidate theme and evaluated their accuracy and coherence. Once satisfied with the emerging themes and subthemes, I moved to level two. At this stage, I observed the whole dataset and themes together. At this stage, I aimed to determine if the prepared thematic map represented the whole dataset. Additionally, I ensured that all relevant data was included within the thematic map and themes. I continued this process until I was satisfied with my thematic map.

The fifth step is defining and naming the themes. At this stage, I aimed to explore the "essence" of the themes. This stage required me to write a detailed analysis for each theme. While writing the analysis, I reevaluated what themes tell us about the dataset and removed overlapping subthemes and added new ones when needed. This stage finalised my thematic table (Appendix 8)

The last step of the thematic analysis is writing up the thesis. The critical part of this step is combining themes carefully to present the study subject to its best. Additionally, the data collected from the study should be supported by the existing evidence in the literature (Braun and Clarke, 2006). At this stage, I aimed to report on how my study fit into the existing literature and what my study captured from the research population.

I recognise the criticism of the misuse of reflexive thematic analysis by Braun and Clarke. They argue that people tend to use reflexive thematic analysis as a set guide for the analysis of qualitative data and neglect the reflexivity within the research (Braun and Clarke, 2019, 2019). I tried to reflect on my stance as the researcher at every step of the process. I believe my stance on the subject is clear. I tried to approach the issue from a broader perspective and recognise my effect on the study alongside society's effect on it with social constructionism. I believe there is more than one truth for my research subject, and the interactions between people shape it. I tried to capture these perspectives with the interviews I conducted. The following section summarises the factors I have taken into consideration during the research in terms of reflexivity.

3.6.5.1 Researcher Positionality

This chapter explores my position as a researcher. I had to position myself carefully in the research, considering that I employed a reflexive thematic analysis. Additionally, the questions I chose to use during the interviews and how I conducted the interviews inevitably affected my beliefs and knowledge regarding the subject.

I am conducting this research as an international PhD student. Therefore, there is an undeniable cultural difference between the participants and me. I recognise that cultural differences can affect the research process. The positive effect of the cultural differences from my experience is that I am unfamiliar with local stereotypes regarding my research participants, and as Wigginton and Setchell (2016) suggested, having a limited understanding of the community may present a lack of understanding of the issue. However, at the same time, they argue that this limited understanding can be turned into a useful tool by interview skills. Asking questions about "taken-for-granted" experiences and information can help participants to investigate their experiences on a deeper level. I had similar experiences with my participants. Some of my participants mentioned "thinking like an addict" or "addict mind", and when I asked further questions about these statements, they gave a deeper explanation of the way of thinking during active addiction and recovery process. To utilise this, I constructed my questions as broad and open-ended as possible and let participants shape the interview process. For example, the first question I asked my participants was, "can you tell me your story with drug use?" with this question, I aimed to hear what participants viewed as important in their drug use journey. Additionally, I realized that, from time to time, my participants provided me with more detailed information about their past living conditions because, in their eyes, as a foreigner, I lacked the "Scottish" or "British" experience. This led me to hear how they interpreted the culture they grew up in and how they place the said culture in their stories. My position as an international researcher may also have shaped how participants interpreted my social location. In Britain, accent can function as a strong marker of region and social class. Because I did not speak with a British accent, participants may not have been able to place me as readily within local class hierarchies. This may have affected what they assumed I knew, what they chose to explain, and how they narrated classed aspects of their lives.

My educational background is a significant aspect that I needed to reflect upon. My bachelor's degree in social work greatly impacted how I viewed the study subject, and the

skills I learned during my education helped me overcome some of the barriers. I believe my former education is the reason why I am focused on the environment and external factors of a person's life (NASW, n.d.) and why I am using social constructionist epistemology. On top of these, social work education provides interviewing skills (Carpenter, 2011) that helped me throughout my data collection process. Additionally, I have to acknowledge how my educational background shaped the interview and analysis process. As a social science researcher, my questions did not include medical history or drug type. I realised that I was not interested that information as long as it affected their life stories. And after completing my interviews, I observed that participants talked about related experiences own their own because they saw those medical experiences or drug types related to their life stories, or some did not mention it because they were not relevant according to themselves.

After completing my master's degree in addiction and continuously engaging in scientific studies on the subject, I unintentionally formed expectations from the participants. For instance, I anticipated that they might have experienced stigma at some point in their lives. Additionally, at the beginning of my research, unintentionally, my focus was mainly on the problematic drug use and the expectations I have shaped around the problematic drug use. This affected the literature review process and the language I used while writing. However, with the guidance of my supervisors and the insights gained from the interviews, I was able to recognise these expectations more clearly and reflect critically on how they shaped my initial thinking.

Lastly, at the end of the second year of the study, I started volunteering at a local recovery café to learn more about the community and built rapport with people from the community I was studying at and to help me overcome some of the challenges I was experiencing with recruitment (as discussed in Section 3.5, above). I visited and worked at the same recovery café for months and participated in multiple training sessions with the other volunteers. As a result, I networked with fellow volunteers, key workers, and visitors of the recovery café. Most of these new relationships were with older people who have/had drug use experience at some point in their lives. I joined their recovery meetings occasionally and had the chance to observe and witness the recovery process in person. The highlight of my observations was how social relationships play a significant role in the recovery process. It may be because the organisation I volunteered at is a recovery community, and their purpose as a community is to support each other. However, during my conversations with other visitors and volunteers

and interviews with participants, I learned that whether a problematic drug use started with a traumatic event or a leisure activity, family and social networks inevitably are affected by drug use, and for some people, recovery means leaving these connections behind to start a new beginning in their lives. That is often why they seek the help of these types of organisations, and that is why they volunteer. More than one volunteer stated that they wanted to pay their debt to the community since it helped them greatly at the beginning of their journey. Additionally, many of the participants mentioned environmental factors. For example, they talked about growing up in 'schemes' (a low income, often local authority planned, housing estate) and how, if they were a member of a different social class, their drug use experiences could be different.

This opportunity deeply affected the research process. First, it showed me how qualitative researchers cannot isolate themselves from the research subject and participants. This research was asking people to share their personal information and highly sensitive, sometimes traumatic, experiences with a stranger – me. Understandably, people need to find a personal connection or trust in the researcher. The volunteering opportunity allowed me to build that trust and personal connection with potential participants and expand my sample size. Additionally, it was an excellent opportunity to understand the local values and circumstances, leading me to have a better understanding of the culture and participants' experiences in Glasgow and the UK.

3.7 Summary

In this chapter, I have set out the methodological and procedural framework of the study designed to explore the life experiences of older people who use drugs. By clarifying the research problem and its rationale, I explained why a qualitative design was necessary for the study and how a social constructionist epistemology offered a suitable basis for this research. In line with this epistemological position, I emphasised that I approached older individuals' experiences of drug use not as fixed or singular realities, but as meanings constructed across the life course through social relationships, cultural contexts, and personal circumstances.

To this end, I explained how adopting a biographical–narrative approach enabled me to listen to participants' life stories in a holistic manner and to consider drug use alongside other life domains such as ageing, family, friendships, and interactions with services. Through the use of semi-structured interviews, I aimed to maintain a clear research focus while also creating

space for participants to foreground experiences they themselves considered important. I noted that framing interview questions in broad and open-ended ways allowed participants to shape the flow of their narratives and enabled me to interrogate experiences that might otherwise be taken for granted in greater depth.

The chapter also addressed sampling and participant recruitment processes in detail. Given the sensitivity of the research topic and the "hard-to-reach" nature of the target group, I presented both effective and ineffective recruitment strategies transparently and explained how the research question evolved over time and the reasons for this development. In relation to ethics, I discussed key issues such as informed consent, confidentiality and anonymity, minimising potential harm, and participant remuneration, demonstrating how the responsibilities involved in researching a sensitive topic were reflected in my methodological decisions.

Finally, I outlined my rationale for selecting reflexive thematic analysis for data analysis and described the key analytic steps involved. I emphasised that while NVivo was used as a tool to organise and manage codes, the development of themes was not a mechanical process of classification, but one that emerged through my interpretive labour and ongoing engagement with the data. At this point, I also made my researcher positionality explicit, reflexively discussing how my identity, educational background, relationships formed in the field, and expectations about the research context shaped the analytic process.

It is worth acknowledging, however, that applying reflexive thematic analysis to biographical-narrative data involves a degree of methodological tension, where biographical - narrative inquiry preserves the sequential and relational integrity of individual life stories, thematic analysis works across interviews to identify patterns, which inevitably foregrounds cross-case meaning at the expense of some of the longitudinal coherence of each participant's account.

This methodological framework clarifies the epistemological grounding and methodological processes through which the findings presented in the following chapter were produced. The next chapter will present in detail the themes generated from participants' life stories and examine how these themes illuminate experiences of drug use in later-life.

3.8 Introduction to Findings

The three findings chapters that follow: Chapter 4: Growing Up: Context, Societal Influences and First Drug Use Experiences; Chapter 5: Drug Use and Turning Points of Adulthood; and Chapter 6: Recovery Experiences and Later-life are organised according to the life-course framework. Together, they move through three biographical periods: early life and adolescence, adulthood, and later-life. This sequential structure is not intended to imply that participants' lives followed a linear or predetermined progression. A central argument of the thesis is precisely that drug use trajectories resist linear models (Elder, 2003; Moxon and Waters, 2019). Rather, the three-chapter structure reflects the analytical logic of life-course inquiry, in which earlier experiences are understood not as causes that mechanically produce later outcomes, but as biographical foundations that continue to be reinterpreted, reproduced, and reworked across time (Laub and Sampson, 2006; Rosenthal, 2018).

The three chapters collectively address the four research questions set out in Chapter 1. The first research question: how do older people with drug use experience narrate the relationship between their life histories and their drug use? is addressed across all three chapters, since it is answered through the biographical accounts as a whole rather than within any single period. The second research question: what meanings do participants attach to drug use across different life-course stages? is addressed within each chapter as it examines how the meanings of drug use shift from early initiation, through adult renegotiation, to later-life re-evaluation. The third research question: how do structural factors, including class and stigma, shape these experiences? is woven throughout all three chapters and is addressed most directly in Chapter 4's examination of neighbourhood and class, Chapter 5's analysis of criminalisation and correctional services, and Chapter 6's exploration of compound stigma in later-life. The fourth research question what are the implications for harm reduction, social work, and policy? is developed across the findings and drawn together analytically in the discussion (Chapter 7) and conclusion (Chapter 8).

Each findings chapter follows the same analytical approach. Themes were developed inductively through reflexive thematic analysis (Braun and Clarke, 2006, 2019), and are presented in combination with extended participant quotations that ground the analytical claims in participants' own words. Participants are identified by pseudonym throughout, with demographic details available in Table 3 (Chapter 3).

Chapter 4 examines the early life contexts: familial, social, geographical, and economic contexts within which drug use first became meaningful for participants. It is organised around three main themes: family life, social circle and neighbourhood environment, and social class and income differences.

The first theme explores how participants narrated their family lives and the early relational worlds in which they grew up. These accounts reveal a range of experiences; from parental drug and alcohol use, domestic violence, and neglect, to more stable family contexts in which drug use was not associated with adversity. A central analytical finding is that early family life shaped not only the emotional environment in which drug use was first encountered, but the sense of safety, trust, and belonging or their absence that participants carried forward into later-life. Connecting experiences of childhood trauma and insecurity to later drug use patterns is common in the literature (Blank et al., 2016; Fitton et al., 2018; Larkin et al., 2017), and participants' accounts largely support this, though not in a simple causal way. Several participants explicitly resisted the idea that early adversity was the sole explanation of their drug use, instead placing it as one thread within a more complex biographical fabric.

The second theme examines the role of social circle, community, and neighbourhood particularly the Scottish 'schemes' in shaping access to and normalisation of drug use in early life. For many participants, early drug use was not a transgressive or solitary act but a social and relational one, shaped by belonging, local availability, and peer norms. The chapter shows how neighbourhood environment functioned as a structural context within which drug use was both available and meaningful in ways that were not always experienced as harmful or deviant.

The third theme examines social class and income differences, including how material deprivation, limited educational and employment prospects, and differential access to legal and social resources shaped the early conditions within which drug use began. The chapter argues that early drug use cannot be fully understood without attention to the classed geographies of risk, availability, and consequence within which it occurred, a finding that is carried forward analytically through Chapters 5 and 6.

Importantly, Chapter 4 is not read as a chapter about causes. It is read as a chapter about biographical contexts: the early social and material conditions that participants themselves

drew on when narrating the beginnings of their relationship with drug use, and which continued to reverberate in their accounts of adulthood and later-life.

Chapter 5 examines how drug use was experienced, managed, and renegotiated across the key turning points and responsibilities of adult life. It is organised around five themes: different prospects of drug use; social interactions in active drug use; drug use and life responsibilities (including parental role, intimate partnerships, and work); experiences with correctional services; and perspectives on addiction.

The chapter's organising argument is that adulthood was not simply a later stage in which drug use either continued unchanged or was resolved, but a period of ongoing renegotiation. As participants took on the roles and responsibilities associated with adulthood, becoming parents, partners, workers, and citizens drug use was repeatedly re-evaluated in relation to those roles without necessarily being abandoned. The chapter shows how the meanings attached to drug use shifted as responsibilities accumulated: from pleasure, belonging, and coping in early adulthood, toward concealment, conflict, guilt, and the management of competing demands in mid-life. This is consistent with the life-course concept of 'role transitions' as contexts in which the meaning and practice of behaviour is renegotiated rather than automatically transformed (Elder, 2003; Laub and Sampson, 2006).

The theme of parental role is analytically significant. For many participants, becoming a parent produced intense moral reckoning around drug use: a sense that drug use had now become incompatible with identity and responsibility yet this reckoning did not straightforwardly produce cessation. The chapter shows how guilt, shame, and the management of parental identity in relation to drug use were experienced as ongoing biographical tensions rather than resolved moments. For female participants in particular, the maternal role was a site of compound stigmatisation, shaped both by drug use and by gendered norms of maternal respectability (Russell et al., 2025; Shaw, 2023).

The theme of correctional services is equally important. For approximately half of participants, contact with the criminal justice system, including imprisonment emerged as a significant adult experience. The chapter challenges the assumption that criminal justice contact functions as a corrective turning point: while imprisonment temporarily interrupted drug use for some participants, for others it deepened drug use, produced new traumas, and reinforced cycles of exclusion and distrust. These findings are consistent with the desistance

literature's critique of incarceration as a mechanism for change (Deuchar and Densley, 2024), and they carry particular weight when read alongside the class analysis developed in Chapter 4, since contact with the criminal justice system was heavily skewed toward working-class participants in the sample.

Chapter 5 closes by connecting its themes back to early life, showing how patterns of insecurity and mistrust established in childhood were sometimes reproduced in adult relationships and institutional encounters and forward to later-life, showing how unresolved adult tensions, criminal records, and the cumulative weight of responsibilities formed the biographical foundation from which participants entered later-life.

Chapter 6 examines how participants experienced drug use, recovery, ageing, and identity in later-life. It is organised around two main sections: the first explores participants' experiences of getting older across six sub-themes: financial security and satisfaction; social expectations, stigmatisation and narratives of 'maturity'; ageing and change in social life; health concerns and physical change; positive and negative ageing experiences; and self-acceptance and psychological freedom; the second examines participants' perspectives on drug use policy and services from a later-life perspective.

The chapter's organising argument is that later-life is not simply a period of physical decline or recovery consolidation, but a biographical stage in which the meanings of drug use, survival, and selfhood are actively renegotiated. Several analytically significant themes run through the chapter.

First, survival as an unexpected biographical experience. For a substantial number of participants, ageing itself was narrated not as a natural continuation of the life course but as a surprise. Amy's statement *'I never thought I'd reach 40'* captures this orientation most directly: it positions later-life not as an anticipated destination but as an arrival at a stage that had not been assumed. For participants whose earlier lives had been marked by overdose, imprisonment, peer death, and cumulative health damage, surviving into later-life carried a specific biographical weight that shaped how they understood themselves, their past, and the future.

Second, the ageing body as a new site of meaning and limit. Participants across the sample described how physical change; chronic pain, organ damage, COPD, reduced tolerance, slower recovery from withdrawal made the body newly visible as a constraint. These

accounts do not support a simple decline narrative rather, they show how bodily change became a context in which the meaning of continued drug use was renegotiated, for some participants producing reduction or cessation and for others producing a changed understanding of risk and limit.

Third, self-acceptance and psychological freedom. For a significant number of participants, later-life was narrated not only through loss, damage, and decline, but as a stage in which self-acceptance became more available: a reduced concern with others' judgements, a greater willingness to acknowledge need, and a renegotiated relationship with shame and identity. This finding challenges models that position later-life drug use only through deterioration and crisis, and is consistent with Shaw's (2023) work on mid-life and older age recovery as involving the active reworking of identity and belonging.

Fourth, compound stigmatisation. The chapter shows that later-life introduced a new layer of stigmatisation onto the drug use and class-based stigma already examined in Chapters 4 and 5: the specific shame of being an older drug user — of still needing services, of having a long visible history, of inhabiting a social position that services and social norms did not expect or adequately accommodate (Ayres et al., 2012; Dennis, 2021).

The second section of the chapter examines participants' perspectives on drug policy. Because many participants spoke from positions of long personal experience and, in some cases, professional involvement in drug services, their policy perspectives are analytically rich. Key themes include critiques of age-blind services, the damaging legacy of criminalisation, the inadequacy of current harm reduction for older users, and the value of peer-based and community provision. These themes connect directly to the policy and practice implications developed in Chapter 8.

Throughout the three chapters, participant quotations are presented at length rather than selectively clipped. This is a deliberate analytical choice, consistent with the biographical-narrative orientation of the data collection. Longer quotations allow participants' own framing, pace, and meaning-making to be visible to the reader alongside my interpretation, reducing the risk that the analytical commentary overrides the biographical texture of the accounts. Where analytical commentary follows a quotation, it is offered as an interpretation grounded in the data rather than as a definitive reading.

Chapter 4 Growing Up Context, Societal Influences and First Drug Use Experiences

In this chapter, I explore participants' growing up environment and the early years of their drug use stories. The exploration consists of the relationships with family and friends, as well as the participants' perspectives on neighbourhoods, schemes, and class differences. This chapter aims to understand the context of their stories and shed light on how participants' backgrounds that shaped their motivations and progressions of their drug use.

Most of my participants had their first drug use in late childhood or early adolescence. Therefore, the environment they grew up in affected their drug use experiences deeply. This environment is not only limited to family and social circles. Many participants reported that neighbourhoods and schemes (local authority housing estates in Scotland) played a significant role in the introduction to drug use culture and, later, the progress of the drug use story. In this chapter, I solely focus on the life circumstances of participants' early years of drug use. It is also important to note that many participants reflected on these experiences retrospectively from positions shaped by recovery, long-term reflection, or professional work in drug services. This often gave their narratives a high degree of reflexivity. Participants did not simply recount events; they interpreted them, revisited them, and connected them to later developments in their lives. That interpretive quality is significant in itself, because it shows how early life experiences are not just remembered as background facts, but actively re-read from later-life positions. In that sense, this chapter is concerned not only with what happened in participants' early years, but with how they now understand those years as part of longer drug use trajectories.

Before I move on to the earlier life accounts of my participants, I need to point out the difference between participants with problematic and non-problematic drug use. Even though there is not a collective distinction between the two in the literature, it is mainly identified as a problem of drug use harming functionality and life, such as work life, social and family life (EMCDDA,2024). I do not aim to identify this distinction. However, the participants often pointed out the experience differences between different drugs and why those drugs became problematic for them if they identified them as problematic drug use. Therefore, I do recognise that this research investigates a spectrum of experiences, and the participants had

different experiences and different perspectives on specific subjects, which I will explore more in-depth throughout their life stories.

4.1 Family Life

According to more than half of the participants (16), their family relationships or the traumatic event they experienced at a young age directly affected the start of their drug use story. These participants often described the emotions and circumstances they could not cope with. Many of them talked about growing up in an environment that featured addiction, violence and other forms of dysfunction. For some, it was the relationship with their family, and for some, it was the lack of relationship. In this part, I will explore the different early life circumstances of my participants. Some of these experiences were directly related to the drug use experience positively and negatively.

For Alice, the murder of her father was a significant traumatic event that impacted her emotional state the most, alongside worsening her living conditions. She mentioned being in care prior to this event, and she identified her family as dysfunctional. Similarly to some other participants, she described these dysfunctional living conditions leading to adverse emotions, which she did not know how to deal with, followed by a turn to drugs and alcohol as a coping mechanism.

> *"I was brought up in a dysfunctional family. Due to that stuff, been removed from my mum's care and put in a like women's refuges and stuff like that. Coming back, my dad was brutally murdered to- Stabbed 61 times to death and that's where I would say my major trauma came from. I didn't know how to deal with my feelings and my emotions and stuff like that. So, I found alcohol initially." – Alice,42*

Alice later in the interview pointed out that at the early stages of her drug use, people did not understand her mental state or past trauma. She recounted being labelled as the *"problem lassie (girl)"* and was not offered any support. Alice's example of experiencing trauma and adverse emotions in the family home and turning to drug use and the drug use community for external support is not the only one in my study. Many other participants also reported traumatic early life experiences.

Alice's account is a clear example of the labelling process described in Chapter 1. What Frost (2011) calls structural stigma; where institutions respond to a person's social position rather than their individual circumstances; is already visible here, not in relation to drug use, but in relation to family background, care experience, and poverty. Alice was stigmatised before her drug use began, which matters for understanding why drug use later became meaningful to her as a source of belonging rather than simply a cause of harm.

In Jack's case, his father's lifestyle and relationship problems between his parents resulted in adverse emotions.

> *"...there's a lot of stuff going on in my house that I see as a young kid and it makes me scared, makes me feel of fear, and I can't be trust the people that are meant to love me. I don't feel safe. […] And this fear gets worse and worse throughout my lifetime […] Never knowing what's going to happen and when I find that first substance just takes all that stuff away. Makes it easier. The best way I could describe it. […] Was scared of my dad. I was really, really scared. Yeah. Kind of because he was in prison, and he would come home. Big, loud voice in the house, could be violent as well. I suffered a lot of violence as a child […] Again, that stuff affecting me [INAUDIBLE] because I never knew when you're gonna hit me, you know what I mean, I was always on edge. So, I never really got along with my dad"-Jack, 49*

The adverse emotion that he struggled with was mainly fear. His relationship with his father revolved around fear, and his solution to not being able to feel safe at his own house was drugs. In his own words, "*drugs made it easier"*. Additionally, he later pointed out the other aspects of his life that were affected by these dysfunctional living conditions. Fearing a parent also affected his trust in other people. As he describes, constantly being on edge and not knowing what was coming led him to seek comfort from drugs.

> *"So, I don't know, I can't explain that we- I think a lot of early childhood trauma. And I don't know if it makes me an addict, right, but it certainly didn't help. It made me- it affected the way I see the world, affected my trust in humans and adults...The best way you can describe it is- is never comfortable for a young age because all that stuff and my own skin and*

> *the only thing that made me feel comfortable was taking a substance." - Jack, 49*

This view was aligned with accounts of two other participants who grew up in similar conditions. Charles and Edward summarised it as having to walk around on eggshells. For both, their father's drinking habits and violence in the households resulted in fear.

> *"Both my parents were alcoholics. I grew up in quite a complex household. And some violence and alcohol and- I swore I would never do any stuff like that. No, because I didn't like the environment, and it was like walking on eggshells. My parents were always fighting and all that. They wouldn't speak to each other for weeks. So, me and my siblings, it's- it's- not a very good environment to be brought up in." -Charles, 62*

> *"He (my dad) would go to the pub, he would never drink in the house, he would go to the pub after his work, he came home, and I was always looking for something that wasn't there. All the love, but I couldn't see it, you know… (My dad) lifted his hands to my mum if things were not going his way, and he- he'd lift his hands to us as well. …walking around on eggshells, walking around on eggshells, scared." -Edward, 52*

These accounts connect directly to the life-course perspective outlined in Section 1.1.3. Rather than treating early adversity as a straightforward cause of later drug use, the life-course framework draws attention to how insecurity, fear, and distrust are carried forward and reworked through later relationships and circumstances (Macleod et al., 2013). What Charles and Edward describe is not a simple pathway from abuse to addiction, but a pattern in which the emotional consequences of early life become part of how the world is navigated which is a pattern that continues to shape meaning-making well into adulthood.

Violence was also a factor in Noah's early years. For him, realising the trauma took years. When he started his recovery, he realised the importance of working on early childhood trauma and started to get professional help. He talked about the trauma in one of his therapy sessions.

> *"I remember walking in saying [THERAPIST NAME], the strangest thing happened. And that it was like a stage setting. The curtain dropped and I*

> *can see my dad as I'm telling you, now on the left side of the stage with a young 5-year-old in front of him. And he's laying into this five-year-old verbally and physically. And on the right-hand side of the stage is my mother. I can even tell you what she's wearing. And she's doing nothing to stop it. The noises that started to come out of me, I was howling and wheeling and snorting and embarrassed that I'd lost control."-Noah, 79*

Later in his life, he realised that he wasn't remembering the physical violence he endured. He was remembering the violence his older brother experienced and witnessing that violence led to fear, and he shaped his life at a young age to avoid that violence, which affected his life story for years.

> *"…when I started recovery, and I started writing my journal, and then it hits me. That wasn't me. That was my older brother, who is five-year-old. And if he was five, I was three. And the three years old, I'm witnessing it. Traumatic. That's when I left my body that I'm aware of- floated up into the sky. I didn't want to get beaten up like that. I became such a people pleaser, Mr. Nice guy. Everybody else is more important than me. And drugs and alcohol and nicotine and all the others kept me there. -Noah, 79*

During the interview, he also mentioned that he was happy that he found the drugs because his brother could not deal with the problems he faced in life and took his own life. To him, drugs helped him to cope with his life and kept him alive.

Lastly, Laura recounted feeling unsafe at home when her mother got violent after her divorce. Laura describes her parents' divorce as a traumatic event for her. However, she also states that her mother's actions pushed her towards her own community.

When participant's early childhood trauma was investigated, many forms of abuse arose from the data. As mentioned before, physical and emotional abuse was a part of some of the participant's growing-up environments. However, some participants experienced sexual abuse also. Ava, Lucy, and Will reported experiencing sexual harassment and abuse. For Ava, the trauma was multifaceted. She was sexually abused by her stepfather and at the same time, she was introduced to drugs by her abuser. This abuse continued for 4 years, and later, she moved out of her family house at the age of 16.

> *"So, I started using drugs when I was about 11. I was introduced to them by my stepdad who actually sexually abused me, this is how the drug use started basically. So, it was by my abuser…the sexual abuse went on from about age 10 to 14... I started using drugs, it gave me like a gateway." - Ava, 42*

Lucy was another participant who experienced sexual harassment. She did not disclose the assault to anyone until her family found out about her drug use. She was still having a hard time talking about the experience at the time of the interview, and she stated that it was something she was still working on. Lucy is the only late-onset drug user in my research. Her drug use started after the birth of her last child, at the age of 37, and she was eight months pregnant at the time of the interview.

> *"I was addicted to cocaine after I had my last child. There were trauma in my teenage years and never, ever been dealt with. And obviously, I- this gave me confidence, and it made me feel good about myself, and I was able to speak to other people, whereas I was quite quiet and reserved…And I eventually told them that I've been, like, groomed and sexually abused by a man and pretty much all my teenage years…When I fell pregnant because I started having like flashbacks, nightmares. I suffered the PTSD as well, so we've- we've done all that for me, so I still get back to my counselling…" -Lucy, 45*

For Will, the assaulter was a stranger, and by his words, he was at the wrong place at the wrong time. However, prior to the assault, he lived in care for a while and already has been using drugs. Therefore, he did not speak up about assault because he did not think others would believe him because of his drug use and chaotic past. Additionally, he wanted to protect his family by keeping this assault to himself.

> *"I didn't have a dad. When I was born, it was just me and my mom…I was in care- in care… had abandonment issues…trauma I got about-I was raped...when you are in the house you don't tell no one, nothing… I just knew keep my mouth shut. Who is gonna believe me anyway. That's what I was thinking because I was already on drugs. I was already not going to*

> *school. I was already doing stupid things anyway…No way. Well, I kept that finger away from my family." -Will, 61*

Like Will, Oscar also grew up in the care system and was abused as a child. He was taken into the care system at a young age, and he talked about how that was a stigma at the time.

> *"It's stereotyped because I was in the children's home, he's a bad kid, he's a bad kid, even my friend's- I remember one friend's mother telling him that he must be a bad child because he's in the children's home instead of actually thinking that it might not have been anything to do with me." - Oscar, 50*

Growing up in a children's home resulted in lack of role models in Oscar's life, which he sees as one of the reasons for his drug use. When I asked him about the life circumstances of his first drug use, his immediate response was the lack of a role model.

> *"When I was 16. I was living in children's home because I was taken off my parents quite young. I rebelled a lot because I've never really had any role models." – Oscar, 50*

Later in the interview, Oscar also stated that he had been abused as a child and made connections between his drug use and his upbringing circumstances.

Oscar's account illustrates how structural stigma, introduced in Chapter 1, operates before drug use begins. Being in local authority care was itself a stigmatised social position that shaped how institutions, neighbours, and peers read him. This is consistent with Tyler's (2013) analysis of how certain populations are positioned as already suspect; not because of what they have done, but because of where they come from. The consequence for Oscar was that stigma attached to his social location preceded and then merged with the stigma later attached to his drug use, making the two very difficult to separate.

In Jane's experience, she and her brother got adopted when she was 10 and six years later, she was asked to leave her family house, which was the start of her drug use.

> *"I started it at 16 and a half. I've been kicked out the house to make room for my dad's girlfriend and her kids. So, I end up in the hostels on the first night. I don't- they- they just take marijuana, I take- I took ecstasy, I took*

> *acid, I took everything I could get that night. I- I stayed away from my family. I did. I stayed away. I didn't know my mum anyway because we were kept away from her as kids. But that's a whole different story. -Jane, 46*

Besides being asked to leave her home and start an independent life at a young age, Jane also felt responsible for her younger brother. At the time, she felt guilty for leaving without her brother and later in the interview, she reported that, at times, her brother was her reason for staying alive.

> *"…but always something made me feel guilty. I think it is because I had to leave [BROTHER], my brother, my blood brother. We were adopted together, you see. I had to leave him. I couldn't take him with me as I wasn't in the right place." -Jane, 46*

Growing up without parental support can take different shapes. For Tom, his relationship with his parents was non-existent. He grew up with his grandparents and kept his "street life" hidden. Both not having parental support and not having siblings led Tom to look for protection. In Tom's case, it is crucial to take the neighbourhood into consideration. Having access to "feared people" made Tom want to be one of them; therefore, Tom sought safety and connection from others.

> *"I was young, and I was small, and I had no brothers or sisters, and I was brought up in this skewed mentality where it was a dog-eat-dog world. You had to stand up for yourself, you had to- and everybody else run about me or had a big brother, big sister or whatever. And I just did me. So, I was always attracted to let's call it the wrong people who was always attracted to being with the people that people feared because then that put me in that category and then I could use that as a defence mechanism to them." – Tom, 43*

For George, the parental relationship was damaged when his father remarried after the loss of his mother. Not being able to establish a healthy relationship with his stepmother and going to a boarding school he did not like led him to look for an escape.

> *...in my teens, there was a stepmother who came along, and I didn't get on with. I was at grammar school of academic, very kind of old school. I didn't really like that. I didn't enjoy that. And I, yeah, I- I found some ways of escape through substances just kind of "Oh, that fits" – George, 65*

Later in the interview, George recounted losing touch with his family at the age of 15. In Simon's case, a relationship with the parents was established; however, lack of supervision led Simon to get involved with older heroin users and crime. Unlike many other participants, the first drug Simon tried was heroin, which is a high risk drug, at the age of 12 after being offered by an older man.

> *"I was third youngest. I used to get away with things my brothers and sister would never get away with. And looking back at it now, I was- I was just- I am not criticizing my parents, I was- I was just left to my own" - Simon, 55*

Amy experienced the similarities when her mother gave birth to her younger sister. After asking for a sibling for a long time, sharing her parent's attention with her sister angered her, and additionally, that shared attention enabled Amy to socialise with the drug user community at a young age.

> *"...then my mum fell pregnant when I was 11 and my sister was born, and I hated her. Yeah, because I was spoiled, like, and she took all the attention, which in a way I didn't like her for that. But in a way, it made it was easier for me because I had that be a bit more freedom cause my parents were quite strict. So obviously gone to secondary school. I got that wee bit more freedom. I- I started hanging about in a different area. And that's when obviously the drugs come in." – Amy, 48*

Another participant with a similar experience was David; when he was 16, his mother and stepfather decided to move out of the scheme they were living in, and David stayed behind for his job. Previously, he described the scheme as a small community; therefore, he had to be careful about what he was doing. However, with his words, when the "*big brother left*", he did not have to be careful anymore, which progressed his drug use.

One interviewee argued the opposite. Fred defended that the interest in drugs mostly stems from the family. In his experience, he never met someone who offered him any drug for free. All his connections and interests came from within the family. Criminal behaviour and substance use are seen in many families of the participants. However, for Fred, this was the main reason for his problematic drug use. Throughout the interview, Fred referred to his family and how they shaped his expectations in life.

> *"I came from a family that are involved in businesses and stuff like that, but they all smoked cannabis, so for me that wasn't- I didn't see it as a thing-, that's I think- that's just one of the things that I thought- I just thought you would done. Just as the same way as coming from my criminal family. People have asked me the question what do you want to be when you grow up. Oh, all I wanted to be was a criminal because I thought that was the same for everybody." -Fred, 52*

This also affected the other relationships he built in his life. The drug use and crime culture were not limited to the family. The community and his family carried similar values, and they also had an impact on his social life.

> *"Really the people that- really the people, the relationships I had were based around criminality. They weren't based on real friendship, you know. I was either trying to exploit somebody or they were trying to exploit me or together we were trying to exploit somebody else, you know. And I was just- I was just manipulating and exploiting. That's just the way I lived my life, you know… And that includes family members." -Fred, 52*

Fred's narrative introduces a dimension that the motivations literature in Chapter 2 does not adequately capture. Section 2.2 documents curiosity, pleasure, and coping as motivations; but Fred's account suggests something different: that drug use and criminality were not chosen from a menu of options but were part of the only social world he knew. This is more consistent with the environmental determinism argument in Section 2.5, and with the structural violence reading offered by O'Mahony (2025), than with individual motivations frameworks. The social and cultural environment did not merely influence Fred's choices; it also shaped the conditions under which those choices were possible.

The impact of community was seen among other participants, and it will be discussed in the next part.

Family trauma does not only stem from neglect or abuse of the parents. For Arthur, it was the loss of a parent that made him struggle. He described his upbringing as "*with lots of moral and values*". However, an interest in the drug use community in his neighbourhood gave him access to fast money and excitement, so drugs became a part of his life at an early age. However, not being able to cope with parental bereavement caused him to transition to heroin.

> *"And then I had a traumatic event when I was 17. My dad took his own life. And the- the drugs I was taking weren't they taking that pain away, emotions and pain away that I was feeling. So, I started taking other drugs…Any drug that took away how I was feeling was a drug I was going to take and it just kept progressing forever."-Arthur, 47*

At the time of his father's death, Arthur had been using drugs for three years. However, the "high" feeling of previous drugs was not enough to cope with the loss of his father; therefore, he started use higher risk drugs.

Not all participants had dysfunctional family relationships or traumas. Almost half of the participants reported that they had a good upbringing and that their motivation for drug use was not coping with adverse life events. Some of them preferred to use drugs for various other reasons such as curiosity, excitement, finding their own identity, desire to be “edgy”, or solely enhancing joy. Motivations for drug use will be investigated in depth in the next chapter.

During the interview, when Sam asked about his drug use story, his response regarding his family was directly related to their substance use habits.

> *“…you know my parents weren’t in any way, shape or form, drug users or particular drinkers…” -Sam, 49*

The way he phrased his response was interesting to me. At the time of the interview, he had been working at a homeless charity for years, and throughout the conversation, he referred to the observations and experiences he gained through his work multiple times. He was informed about drug use research and evidence around drug use. Therefore, he had the need

to clarify that his drug use did not stem from his family life without being asked. The rest of his response is shaped by this need also.

> *"...my dad and my mom split up when we were 15, 16. So again. I suppose that you could look at that as one of the reasons that I started using substances, it wasn't." – Sam, 49*

Another aspect of experiencing trauma is not everybody responds to similar experiences the same way. As Sam stated, the divorce of his parents did not affect him majorly and has no relation to his drug use. It was also Harry's experience. His parents divorced when he was seven years old, and he did not recall any dysfunctional or traumatic event related to his family. However, in Laura's story, the divorce of her parents was her major trauma. Even though they experienced similar things at the same time, and both had drug use experience at similar ages, their response to these experiences and their motivation for drug use were very different. For Sam, his motivation was "*being a shy kid*" and his desire to be more sociable, and for Harry, it was socialising with older kids at his school. For Laura, the desire to be different and edgy led her to experience drug use. She referred to that desire as "…*they (drugs) were very much just tools with which to rebel…*". Additionally, she reflected on the political environment and popular culture at the time of this desire. She connected this desire to rebel against authority with having a "*slightly radical vision*" and identifying as a goth.

Andrew, Anne, David, Oliver, Leo, Richard, Walter, Henry and Emily did not include adverse experiences with their families in relation to the stories of their lives before drug use and early drug use years. Even though Emily talked about falling out with her family because of her coming out as a lesbian, she did not indicate any connection between the two experiences. Her experiences and observations around drug use in the LGBT community were mostly about the personal responsibilities and exclusion of LGBT people in her youth.

Throughout this chapter, I investigated the dysfunction in family life, early life traumas and related adverse emotions in relation to early drug use. However, as I mentioned before, some of the participants with problematic drug use histories did not experience any traumatic events before their drug use and were motivated to use drugs for other reasons. One of the significant factors that affect these motivations is the environment. Whether participants experienced adverse emotions and sought drugs to cope with them or only wanted to experience drug use for recreational reasons, availability affected their stories and the types

of drugs they used. For example, in Simon's story, his socialisation with older heroin users at a young age led him to start his drug use with heroin or in Tom's story, when he needed to feel protected, the location he lived in – schemes led him to seek safety from people who were known to cause fear and relatedly criminality and drug use. For Richard and Walter, the primary motivation was "*everybody was doing it*", and they were not the only ones who experienced this view. Amy, Noah, Edward, and Will also discussed the same trend. As these examples suggest, just focusing on one aspect of participants' lives is not sufficient to understand the beginning of their drug use. Therefore, we need to explore the societal and environmental factors also.

4.2 Social Circle, Community – Neighbourhood and Schemes

Twenty-two participants shared how their social circles and neighbourhoods influenced their early drug use experiences. Considering the participant's age range of the first drug use experience, which is 9 to 18/19 (excluding Anne and Lucy. Lucy did not include her social environment at the time of her first drug use in her story, and for Anne, her romantic relationship was a factor rather than her social environment) societal factors can play a big role in young people's lives. This was also the case in my research. Many participants talked about how using drugs was highly accepted within their local communities, and a variety of drugs were available to them. Additionally, some participants argued that around those ages, they viewed the drug use community as "cool people", and they wanted to be part of the community. And lastly, a few of them referred to people who they encountered at the start of their drug use as the wrong people. I would like to highlight that almost all my participants (all except Emily) experienced problematic drug use at some period of their lives. For some of them, it was a period that lasted for a couple of months and some of them it was the most of their lives. Furthermore, where some of them only experienced "party drugs" and the problematic part of the drug use was the physical and/or social problems, some of them involved in criminal activities and prison life related to drug use. These distinctions will be investigated in depth in the next chapter. However, it is worth reminding that my participant's drug use experiences are a big spectrum, and the people they encountered, or the term drug use community, do not represent a homogenous group. It only represents the people they encountered.

Nine participants recounted the drug use culture in their local community. Amy talked about how societal influences affected her life choices.

> *"Where I came from that was- that was the culture. That was what you done. You grew up looking at these people and I never had any ambitions like I used to- I did have one ambition. I used to singing. Used to sing for the Scottish National Orchestra. So, I did in between all that like I would go away and do that but. To where I came from that wasn't what you done. You didn't do things like that because it was just snobs that done that. So, I get slagged for it. So, I popped away for it and I was running about with people that were older than me, people that sold drugs. And that was- that was all I knew." - Amy, 48*

In this quote, she was talking about how she started selling drugs, which for her, it started at the age of 15. Her interest in singing ended because her community viewed "things like that" as things done by snobs, which is a form of class-based stigma at a societal level. Her example not only represents the influence of the community but is also an example of lost opportunities. Arthur reported a similar experience.

> *"And it just- I'm not blaming the area that was brought up, but where I was brought up, there was a lot of drugs, and it was a lot […], a lot of gangsters stayed in my area. […] And I was very good at sport growing up like I could have made it as a football player. But when drugs come into play, my sport went." -Arthur, 47*

He mentioned that he found that drug and gangster life exciting. His interest in this excitement brought drugs into his life, and after a while, it took over other aspects of his life. Like Arthur, Jack also recounted being in a similar community. However, he also argued the other aspects of these local communities.

> *"Where I came from, Asena. Like everybody was doing something. Do you know what I mean? Alcohol, drugs, and it was very common where I lived. It was a lot of poverty. A lot of social issues, unemployment was really bad when I grew up as well. And we were kinda placed in what we call housing schemes. So, we've kind of felt forgot about, you know what I mean and we're just kind of left to go on there and kind of conditioned by environment I grew up in, and so all the role models in my life were taking drugs. And it was kinda became normal... -Jack, 49*

His views on his local community consist of broader societal and financial problems. Throughout his interview, he made comments regarding the community he grew up in and how it affected his opportunities in life. Similar to Amy and Arthur, when he started using drugs, he had other plans for his future. He also highlighted another aspect as a long-time drug user from a community where drug use is common,

> *"Why me? Why did any of them die? Why I didn't die?"- Jack, 49*

When he talked about his social group, he talked about the guilt he felt. Many long-time drug users in my research talked about losing friends to drug use. In Jack's case, he felt guilty for surviving because the people he lost to drug use were his childhood friends, and he shared a similar upbringing with them. Therefore, he questioned his survival.

Richard also felt the neighbourhood effect. Societal influences showed themselves as peer effects in Richard's life. He refrained from labelling it as peer pressure because he phrased it as "*not being dragged into it*," and he specifically said that he enjoyed that social circle and that it was fun for him. *"...the area I grew up in was quite rough and I just kind of followed to suit with Glasgow life as the scheme and stuff and gang fight*." Later in his response, he also mentioned the effect of his social circle and society on the type of drug he was using.

> *"And then when I went, I moved on to secondary school with, like people from different areas and like. People are buzzing solvents and the and- and LSD was about in the 90s because it was a big change in music, and everybody started like taking LSD with the music. […] I used to really enjoy taking drugs because the environment I was in drugs were always there, but it progressed very quick and" – Richard, 44*

For him, changing schools and meeting new people opened doors for new types of drugs. Additionally, like some of the other participants, he also pointed out the effect of music culture on drug use experience. The effects of music culture will be discussed, among other macro factors, in the next heading. Like Richard, Oliver also addressed the music culture in his story.

> *"I grew up at a time when dance music scene was kind of first- first emerging. Where there were outside parties going on for- for days, uhm,*

> *where illegal drugs were commonplace. [...]And at that time, I was kind of like, really fascinated, - Oliver, 45*

Additionally, Oliver mentioned growing up in a pub and observing how legal drugs like alcohol and tobacco made people happy regardless of their physical consequences. His observation and fascination led him to question why one set of drugs was socially and legally acceptable and the other set was stigmatised and banned. Later, this interest led him to both experience drug use at the age of 12 and pursue a career in drug use.

Even though Will, Edward, Walter and Fred did not describe their local community in depth, they also commented on growing up in an environment where drug use was common. For Will, "*they were all doing it. Well… I wouldn't say all. I just fell into that code. We are doing it. It is just going up 70s. [...] Music, all that kind of stuff. Beatles, stuff like that.*" Walter's words were like a summary of it all: "*Everybody in the scheme was experimenting, and I've done it as well."* This was very similar to Edward's statement, "Where I was brought up, there were *drugs that sold every corner, you know, and it was normal*." And lastly, as mentioned in the previous heading, Fred was born into a family that was highly involved with the drug dealing business, and he felt the community's effect in his life also.

> *"…where I come from [NEIGHBOURHOOD] in Glasgow was rife with drugs and it was bad. […] we didn't even go through phases like sniffing drugs you know. We went to hard drugs like, you know, needles." -Fred, 52*

Another sub-theme that emerged from the data was the availability of the drugs. For some of the participants, growing up in a community with high drug use meant that drug dealing was also frequent. Therefore, even at a young age, it was easy to access drugs. David described it as "*something that you didn't have to walk for it*". David also grew up in one of the Scottish schemes, and "it was readily available" to them. He also made a comparison between legal drugs and illegal drugs. He argued that when they tried to buy alcohol at a young age, they had to find someone over the age of 18 and trust that person with their money, and they had issues with trust related to their environment. Whereas with Marijuana, he would know someone who sells it directly or the dealer's brother. Therefore, it was a safer choice for them.

One interviewee pointed out the violent side of some of the neighbourhoods. Many participants who experienced drug dealing alongside their drug use talked about the violence that comes with it. The next chapter will explore it in depth; however, it is worth discussing the appealing side of that violence for young people. Some of them were attracted to those crowds because of the status, money and protection that came with the violence.

> *"Always attracted to being with the people that people feared, because then that put me in that category and then I could use that as a defence mechanism to them. Basically, keep me safe and secure […] And that was just 0the way [GLASWEIGAN NEIGBOURHOOD NAME] was in the 90s. It was a- it was one these dead gang- gang related incident in the whole- between there and Castlemont was the- the two biggest places for violence and violent deaths in the whole of Scotland and the UK. And- and it was- it was mental. -Tom, 43*

This view is supported by Simon also. He mentioned having a reputation among his peers as someone who can enter other neighbourhoods, even though it was highly dangerous.

> *"I had a quite the reputation when I was young. Known for [..] I could fight. You couldn't get it in the [NEIGHBOURHOOD] and people were scared to go anywhere else. I knew how to get it in [SCOTTISH TOWN]." – Simon, 55*

Later in the interview, he also told his stories about the time he went to [SCOTTISH TOWN] and "being jumped" by older men when he was 14.

Others' experiences were slightly different. They did not grow up in an environment where drug use is frequent. They became a part of it later in their lives for various reasons. For Jane, the reason was moving out of her family house and moving into a hostel. She described her father as a strict parent. She did not have any drug use experience when she was living with her father. However, the night she moved into the hostel, she tried multiple drugs on the same night and soon after, it became an every-night event for her.

The introduction to a broader variety of drugs happened in school for Harry and Edward. Both talked about being able to access drugs in school through their peers. For Harry, the music scene also played a role. His interest in music led him to socialise with other older

boys in his school. He stated that his experience wasn't a result of peer pressure. With his words, he "happily and enthusiastically run towards these drugs", and he add that was the start of his drug use. And Edward recounted going to school every day and knowing there would be a supply of marijuana.

> *"And end up going that bad that are we going to school in the morning knowing I could get a bit of cannabis off one of the boys in school and we would just disappear at school at 9:00 in the morning. That's you know. That was me all day, every day. Carries you straight through school years" – Edward, 52*

Oscar also shared a similar experience. However, unlike Harry and Edward, his experience took place in a university setting. At the time he started his bachelor's degree at the age of 24, he already had past problematic drug use experience; however, a couple of years prior to his degree, he decided to control his drug use. At the start of his university life at the [UNIVERSITY], he was introduced to campus life.

> *"…But then it was, you know, you're gonna live on campus and party central. You can get whatever drugs you want. So, things just started spiralling again, then cannabis became just a part of my life from the moment I woke up in the morning, I would be smoking cannabis. But then started taking amphetamines again. Then progressed on to cocaine. Didn't really think. There wasn't too much wrong with me because everybody was doing it." – Oscar, 50*

Even though his introduction to drug use did not take place in the University setting, he gained access to a wider variety of drugs and like-minded people. This access was given to Henry when he was 15. He stated prior to that, he only experimented with marijuana with his friend when they broke into a car. However, when he established social connections with people who were selling cannabis, he was able to access other drugs, also.

One of the participants pointed out the policy difference about the over-the-counter medication between now and 70 years ago.

> *"And from then onwards, as far as I remember, I would be buying over-the-counter medications which weren't as strict as they are now." -Noah, 79*

Noah stated that his interest in drugs started when he was offered alcohol at a family function when he was nine. Trying alcohol led him to seek other substances, which for him was over-the-counter medication.

For some of the participants, the drug use community seemed appealing for different reasons. Ava, Edward, and Arthur thought people they encountered "*looked cool*" and wanted to be part of that community. For Ava, the desire to be part of that group was not limited to drug use. Shoplifting and gang activity seemed exciting to her. It was also the case for Arthur. He described it as "*…and I found that exciting. You know, and I used to see the money, I used to see the flash cards on the floors*."

As mentioned before, some participants who experienced problematic drug use identified the people they encountered at the start of their drug use as "wrong people" and "wrong crowd".

Alice, Arthur and Tom believed that as a result of their life circumstances, they ended up socialising with people who were involved in drug use and crime. For Alice, it was the mental breakdown her mother had after her father's death. Her mother coped with her husband's death with alcohol use, which made Alice feel unsafe. Therefore, she started to look for other methods to cope with her feelings. *"…I found alcohol initially. I drank and then I get in with the wrong crowd, the wrong people."* Tom also felt unsafe within his community because of the lack of siblings and parental relationships. Therefore, he sought safety from the other people in his local community. "*So, I was always attracted to let's call it the wrong people who was always attracted to being with the people that people feared, because then that put me in that category and then I could use that as a defence mechanism to them.*" Whereas Arthur was only interested in an interesting lifestyle. *"And then it gravitated me towards living a wrong way of life because at that point I'd only ever seen people living wrong way my life apart from my parents."*

One interviewee – Anne, reported that her romantic relationship affected her view on drug use. Her drug use started later than most of the research participants. She tried the drugs for the first time when she was 20. Similar to Simon, her first drug was heroin. After observing her partner, who is a heroin user, she felt curious about the substance and decided to try it.

> *"I've done it myself, just went in at all and done it myself. It was IV injection- myself and nothing happened, and I was like, why yous take it for? Why yous do that for? That's- and I never took it again till after I had my daughter." – Anne, 56*

Data shows that the effect of romantic relationships on drug use is a more significant factor in drug transition in my research, which will be investigated in the next chapter.

When participants gave information on their social environment, they often reflected on the neighbourhoods and broader social phenomena. Some participants expressed strong opinions about the class differences. However, even though the class is not limited to socioeconomic differences, these strong opinions are primarily shaped by material inequalities. Therefore, although the term class used in this study is not limited to financial status, it mostly refers to different income levels.

According to the Office of National Statistics (2014), income inequality grew between 1979 and 2009/10. I am interested in this time period because it captures the period when most of the participants experienced drug use for the first time. According to Manstead (2018), the financial condition people grow up in affects how they identify within the community, their perspective on the social environment and personal behaviours. Therefore, it is important to understand the circumstances in which the participant was brought up.

The significance of schemes and neighbourhood environments in these accounts connects directly to the social class argument that Chapter 1 sets out. Class is not only a matter of income; as Shildrick and colleagues (2012) show, it is also a matter of territory, expectation, and institutional legibility. Growing up in a scheme shaped not only access to drugs but also what kinds of futures participants could imagine for themselves, how they were read by services, and what social worlds were available to them. Next seciton develops this further, but it is worth noting here that class shapes these early chapters before drug use even begins.

4.3 Social Class and Income Differences

Initially, social class-related questions were not included in the interview draft. However, after completing the first few interviews, I realised that it was emerging as an essential aspect of participants' stories, so I decided to include questions about social class and income differences in subsequent interviews. It is therefore important to acknowledge that not all

participants were explicitly asked about the class differences. In total, 18 participants shared the class they see themselves in. Ten stated they were part of the working class, four from what they described as 'the lower class and four from the middle class. One interviewee, Fred, argued that he wasn't a part of any social class. He placed himself in society based on his past drug use.

> *"I'm just an addict. […] I'm just another guy who is just trying to get a day clean" – Fred, 52*

Fred seems to be suggesting that drug addiction marks people out as separate from the rest of society. The "addict" and "drug user" identity recognised and valued also by some other participants. For Fred, this identity represents his place in the society.

When participants were asked about their views on social class differences and drug use experience, nine of them gave statements about labelling, opportunity, and stigma. Additionally, four participants shared their opinions around income differences, and their view on social classes was limited to financial differences and experience of drug use. The nine people who shared their opinions on social classes had different personal characteristics.

At the time of the interview, Emily was involved in a housing project at an LGBT+ organisation in Manchester. She owned a house and identified herself as being originally from the working class. She mainly focused on the lack of change in social classes over time in England.

> *"I mean, class is the unspeakable. […] It's the one we don't talk about. Because the class and privilege set up in England. I don't know about Scotland, but in England the same people in power now, as their families were 200 years ago, they don't share." -Emily, 72*

In her statement, she points out the normalisation of class differences in Britain. She also argues that being in the middle or educated working class is challenging. Emily was the first person I interviewed. For her, seeing the lifestyles of both the 'upper' and 'lower' classes cause people to work hard to either refrain from moving to the lower class or try to move to the upper class.

> *"If you're in that middle bit of the class system, where you can see there's above you, and you can feel what's below you. You have to keep on trying to climb the greasy pole…" -Emily, 72*

Her reflections on social classes in Britain informed me as a researcher. I also believe that me being a researcher with a different background led Emily to give more insight into the British social classes because she knew I did not grow up in Britain. Her insights led me to consider including interviews questions about the social class in the interview draft and following interviews gave me more reason to include them.

Noah also mentioned the desire for social mobility among middle-class people when sharing his experience of being in the middle class. Noah experienced a wide range of social mobility in his life. At the peak of his problematic drug use, he had a highly established business in London, and when he started his recovery process, he realised the nature of his work damaged his recovery process; therefore, he decided to change his line of work and go to university. This change affected his financial status. He talked about being in the middle class while managing his business, but he added that he was trying to give the impression of being in the upper class. Relatedly, he stated that, when he started his recovery and experienced social mobility, he wanted to hide it from people. He did not want to lose his social status.

> *"I felt embarrassed and ashamed. I wouldn't let anybody know how the low self-esteem and the self-hatred - you would never have known. So, no, I never received it from anywhere. I just hid it so well. […] I didn't want anyone to see what a piece of garbage I thought I was. Terrible low self-esteem. -Noah, 79*

This statement also highlights the impact of drug use stigma on drug users. Noah experiences with internalised stigma is a result of societies perspective on drug use and therefore, he decided to hide his drug use rather than seeking help because of the shame.

Jack mentioned the differences in opportunity and focused on the challenges of social mobility. As mentioned before, Jack believed that his local community affected his life opportunities. However, these limitations were not only related to drug use. He pointed out the class differences and how being a working-class young person affected his opportunities to improve his life circumstances.

> *"And when I grew up, Asena, there was a massive unemployment. And then, I leave school, and I try to get a job and just can't get a job, and it's like, I was judged a lot, but you are judged for the way you speak, where you come from, your postcode. […] I think being working class condemned to your life either low wages or you are on benefits." -Jack, 49*

Additionally, Jack also commented on the circumstances in Glasgow in his youth. At this point of the interview, his focus shifted from the local community to a wider perspective. According to him, he felt hopeless in Glasgow when he was growing up because people educational background could not support themselves financially.

> *"When I was growing up, Glasgow was internally declining. And there was no work for people that were unskilled, haven't been in the university. It was a horrible time and at the same time, the drugs pouring. So, it was a perfect storm, hopelessness. So, taking drugs, because there's nothing else, […] I might not have found heroin. And I might- I went on to go to university because I did want to. My plan was to become a lawyer, but drugs took over, and that dreamed out" -Jack, 49*

David, who is a year older than Jack, described the structural and financial environment similarly. His argument was Britain-wide, and he also commented on the political circumstances around the time he was 13.

> *"In Britain… (There) was nothing to do. […] a lot of minor strikes going on. You had lots of stuff going on and on and on. And Maggie- Margeret Thatcher was in government. And the- the outlook for my age at 13 was terrible […] Shut all the big steelworks doing all that stuff. Teachers were on strike, so we were at- we were at school all the time. Somehow, I just knew, by the way, somehow, I just knew, you know, all the strikes, you know, that was like that back then. […] Yeah. So it was a release, it was a- It was get away from that. -David, 50"*

As Jack stated, being "*judged for the way you speak*" refers to labelling and being stereotyped according to the first impression. Other participants also highlighted the importance of the first impression and speech. Emily quoted George Orwell and said,

"Within 5, 10 minutes of one English person meeting to another, they could actually, you know, absolutely place them in class terms." This view echoed in Laura's perspective on class, too. When she was talking about the class differences and drug use community, she referred to herself as *"I'm white, and I'm middle class, I grew up in an upper-middle-class area […] I went to a private school, and I have a posh accent",* and she stated that these characteristics affected how she did not get profiled by the police.

> *"...like I don't get stopped by the police, I don't- you know I don't get profiled basically. So that's had a massive effect." – Laura, 44*

For Laura, this was a positive factor. Her characteristics prevented her from being profiled by others.

Oscar's take on being white and middle-class is similar to Laura's. He argues that classes are *"outside of your control really, you're kind of born into a class",* and he was lucky in that society was built for people like him to succeed. His take on this also included gender. In his view, as a white, middle-class man, he had more power relative to others. However, as a person who grew up in the care system he acknowledged the social mobility and stigma around people who grew up in care. He was one of the participants who experienced social mobility.

> *"I've been told that I sort of stepped out of the light chances that I was born into […] So, an old social worker once told me that I'm, you know, the life chances you were born into which suggests you're going to end up the life of crime, life of drugs. […] He said you're the only person who's going to have anything close to a normal life. So, you sort of stepped out to the life chances that you were born into. It's a classism." – Oscar, 50*

Later in the interview, Oscar acknowledged the prolonged physical effects of not being born into a privileged family. According to him, having worked in factories and jobs that required physical effort led him to struggle with back pain in his 50s. Therefore, even though he experienced social mobility and started working in a less physically demanding job, his past experiences continued to affect his life.

For Richard, the class effect was seen in the environment. Richard described how shops in lower-income neighbourhoods offered an unhealthy lifestyle.

> *"Think if you go to any working-class area in Glasgow, you'll see a pub, bookies, a kebab shop, a chippy – like, things designed for poor health. Whereas you go to another affluent area like [REMOVED] where my sisters stay, and you don't see that stuff […] I think people say that addiction doesn't discriminate, but I think it does." -Richard, 44*

His take on class was not limited to unhealthy lifestyles. He made a direct connection between problematic drug use and being in the working class. To him, being exposed to lower-income areas increased the chance of problematic drug use. He also highlighted the need to acknowledge class differences. He stated that class difference was a commonly discussed topic among people in recovery.

> *"No, I was quite - I'm quite happy that you asked the class thing. I- I think that all the person really speaks about that in recovery." -Richard, 44*

A connection between growing up in what he called 'lower' class communities and drug use was also identified by Walter. He believed that drug use was more prevalent in 'lower' class communities

> *"Not in recovery, no because there's no- There's a lot more drug use in lower class, that I know anyway. People on the streets trying to get onto their rehabs. You know all that. They come to the cafes. Hopefully this is the start of the journey they enter." -Walter, 55*

When asked about how being in the part of what he termed 'lower' class communities affected his drug use journey, he focused on his current condition, which is being in recovery. At the time of the interview, he was actively attending and volunteering in multiple recovery cafes. Therefore, he was spending significant time with other people in recovery. During this time, he said he had observed that people in similar conditions as him were in similar social classes. Another observation he made was that drug users in lower-class communities were struggling to access the support they needed like rehabilitation centres , and were utilising the recovery cafes instead. My experience with participants in this research project was similar.

Lucy was another participant who shared her experience with class differences. Her observations were focused on drug use stigma. Lucy, as a nurse, talked about drug use stigma

in medical care in ways that reflected her personal experiences and her workplace observations from other nurses and patients.

> *"...if I hadn't worked and things like that, you know, I would have been treated worse than my [INAUDIBLE]. You know, I think in my profession, earns respect, you know, and that's something I'm good at. I'm good at my job, you know." – Lucy, 45*

Lucy's view on class seemed to be revolve around stigma, and her understanding of social class stemmed from the "*respect*" her profession received. Additionally, even though she felt her profession improved the way she was percieved by others, and she did not experience discrimination as much as others, stigma was her main focus when asked about social class. Her qoute "I hadn't worked and things like that, you know, I would have been treated worse…" was her first response to my question about her social class.

The importance of the intersection of professional identity with social class identities was also highlighted by Alice, Jane and Anne. Alice focused on her work life after her treatment. While in recovery, she worked on her qualifications and started to work in the drug use area herself. For her, being able to earn money or being on benefits directly was directly connected to class.

> *"Recovery period probably. How does it affect? Because I feel worth now to hold a job and being working, be classified as a worker rather than somebody still in benefits and- and taking benefits. […] Because I feel society- But I feel what is the word, productive. I feel like earning my money now, rather than I'm just taking from the government..." -Alice*

Her statement did not refer to the amount of money she earns. The difference stemmed from feeling "worth to hold a job". As a person in recovery from problematic drug use, being able to be hired and be productive led her to experience social mobility. Jane also points out the importance of productivity. When asked about her social class, Jane stated that she felt she belonged to different classes at different times. For her, the financial part of her life belonged to the 'lower' class; however, at the same time, she was regularly involved in recovery cafes as a volunteer at the time of the interview. It is worth mentioning that she preferred to use "normal" to refer to the middle class. To her, being in the middle class was the normality. At the same time, I had to recognise the direction the interview took her. When she used the

term normal, I brought the middle class into the conversation to clarify the term, and she approved.

> *"Researcher: And what class do you see yourself in?*
>
> *Jane: Huh?*
>
> *Researcher: What class? Middle class, lower class, upper class?*
>
> *Jane: Hoity toity. [LAUGHS] No, I'm fake. I'm normal.*
>
> *Researcher: Normal? Middle class?*
>
> *Jane: Yeah." – Jane, 46*

Later in the interview, she stated that she felt she belonged to different groups rather than seeing herself in one class, depending on her way of thinking at the time.

> *"Jane: …Because I've lived in lower class and I- I still live- money for the lower class, you know what I mean. But other parts like cafes and stuff, so I can be both depending on my state, you know what I mean.*
>
> *Researcher: There is no difference.*
>
> *Jane: (Nodding) It just depends on the state that my mind works. You know what I mean, my minds are fickle place." -Jane, 46*

She valued productivity—recovery cafes and income level as indicators of social class. Additionally, she prefer to refer herself as "minds", which another indicator as she sees herself with multiple identities.

Anne's take on working life and class was connected to her upbringing and her experiences as a drug user. She placed herself in the 'working' class, and she talked about how her drug use affected it.

> *"See, because I was brought up to work, I not scared from the hard work. No, no ex-drug users scared from the hard work. We're all in it together. But that affected mine. I had a shop around the corner. It's still there, but it's not mine anymore. And I regret it because I used- used to go- used to go down, open the shop up, as soon as somebody paid for something, I*

> *was- shop was down, around the corner for jelly babies. In the toilet, injecting a minute to myself, going up me, shoot it up fine." -Anne, 56*

She valued being in the working class as people who were not scared of her work. Like others, her value was not related to monetary gain. It stemmed from having a job and doing the "hard work." Her drug use interfered with the work she put in and resulted in the loss of her business.

Lastly, Laura expressed her view on class differences. However, unlike the other, she pointed out a positive side of drug use on social class. She pointed out how drug use affected the relationship between people from different classes.

> *"…when I was in the clubbing scene, […] I'd be sitting next to this dude from like pure dead working, Scottish, class like fuck, going on. You know, and we'd just be pals because it was all there was, none of that" – Laura, 44*

She argued that in her drug use community, class differences did not play a role because those characteristics were not a factor while *"clubbing"*. It is worth mentioning that, unlike many other participants, Laura's opinion on social class did not depend only on income level. Before this statement, she placed her family in the middle class and added that she grew up *"poor"*. For her, the class was not related to financial status; it was based on education. These differences did not affect the socialisation in the club scene.

As mentioned, some participants only commented on the financial differences between social classes. They stated that income differences affected their drug use story in various aspects.

4.3.1 Financial Differences

When asked about classes, Ava focused on her financial circumstances in the recovery process. Her example was owning a car, which benefited her recovery. At the time of the interview, Ava had five children, three of whom were under her care. Therefore, being able to care for them (e.g., school drop-off/pick-up) and attending the recovery cafes to maintain her recovery was essential.

> *"I know there's a lot of people like more in poverty than me, so for me I've got a car, so I've been able to access more than other people, probably in recovery, so I've gotta kind of like I-I've got- that's a bit of a*

> *benefit for me if-if I didn't have my car I think that would really have affected me getting my recovery I really do believe that because where I am, the recovery is so poor…– Ava, 42*

Her need for a car was not only related to her responsibilities as a mother. The lack of recovery support in her local area was insufficient, and she needed to travel to other regions for services. Therefore, accessing these services was a sign of a higher class—a similar view echoed by Harry. Harry focused on the drug use stigma in medical and social care.

> *"Rich people don't die from drugs. Lots of rich people take drugs, but look at the indices of deprivation. And we know that stigma kills people. Because you have to turn up to mainstream drug services if you can't afford to go private, and you've got to stand in line like everyone else for your methadone and everything else. Whereas rich people don't have to do that, they go and get a private prescription. And you- you can-You can't do those things like I think class very much has a big issue on stigma." – Harry, 47*

His argument also revolved around the opportunities people have. Being able to prevent experiencing stigma was an indicator of survival for him; having the opportunity to afford private care and receiving a stigma-free service was significant in his drug use experience. Later in the interview, he recognised that there might be a difference between income differences and social class.

> *But the idea that stigma creates- stigma just kills people all the time, and I guess if you are more- I don't know whether it's class or whether it's affluence, there might be a difference between those two things. If you have more money, then you have more opportunity in terms of different types of treatment, different ways of diverting from those things, […] just got enough money to carry on buying your drugs, and it's not a problem. So, I think maybe- maybe it isn't class that creates stigma. Maybe it's around affluent. – Harry, 47*

Overall, his opinion on class mainly was focused on wealth, and he argued that apart from having more opportunities in recovery, financial differences were a factor in stigma during active drug use.

Commenting on class differences and drug use experience, two other participants focused on active drug use experiences. They argued that if they were a part of a higher social class, their experiences of drug use would be less problematic.

Sam reported that if he had the financial means, he might have continued his drug use.

> *"I mean, yeah, to be honest, if it comes down to money, really, doesn't it? Like, you know, if I- if I was, if I was a multimillionaire and I could afford to get heroin every day for the rest of my life, and it didn't stop me travelling where I wanted to go and stuff like that. Maybe, I, you know, I might still be taking along and using it, you know. Not like the- But, you know, being realistic, I suppose the- the problematic bit is- is that you know the substance takes over everything else, doesn't it? You know you are. You are focused on the use of that substance. Above and beyond everything else, sort of thing." -Sam, 49*

His quote highlights his perspective on the problematic part of his drug use. If he did not worry about financing his drug use, he would not consider it as problematic drug use; therefore, having a higher income could mean the continuation of his active drug use. In his perspective, the higher social class presents a better financial status. His scenario is affected by his understanding and experience of problematic drug use.

Amy supports this idea and includes stigma in the scenario. When asked about how being in a higher social class would affect her drug use, she mentions the possibility of continued drug use.

> *"It might be different, but I still think it would. There would have been drugs involved. […] It may have been different drugs, and it may have been more acceptable. And probably- maybe a bit easier if you've had the money for it or the time." – Amy, 48*

Like Sam, she also talks about having more money and means. She also added that her choice of drugs could have varied if she had a better financial status. And lastly, she supported Harry's perspective on experiencing less stigma in higher social classes.

4.4 Summary

This chapter explored participants' early life contexts, societal influences, and first drug use experiences. As the findings showed, the beginning of drug use cannot be understood only through one aspect of participants' lives. For some participants, family trauma, violence, neglect, abuse, care experience, and difficult emotions were important parts of their stories. For others, the beginning of drug use was more closely related to curiosity, excitement, belonging, identity, or the desire to rebel. At the same time, neighbourhoods, schemes, social circles, class differences, and the availability of drugs were also significant. Therefore, this chapter has shown that early drug use was shaped by a combination of personal, relational, and environmental factors rather than by a single cause. This is also in line with literature showing that early trauma alone does not explain later drug use and that social environment, class, neighbourhood, and available support also shape how drug use becomes meaningful in people's lives (Notley et al., 2012; Roy, 2013; Wagstaff et al., 2023; Waters et al., 2014).

At the same time, these findings suggest that early life experiences should not be understood in a simple deterministic way. Similar experiences did not always lead to the same motivations, meanings, or patterns of drug use. Some participants connected early adversity directly to their first drug use, while others did not. This is important because it shows that early life experiences form part of the background of later drug use trajectories, but they do not fully determine them. Instead, these early experiences continue to shape how participants relate to trust, safety, belonging, coping, and self-worth across the life course. In that sense, Chapter 4 provides the early life-course foundation of the thesis. The next chapter builds on this foundation by exploring adulthood, where drug use is no longer only connected to early environment and first experiences, but is renegotiated through work, relationships, parenting, responsibilities, and institutional encounters. As some literature also suggests, the effects of early trauma and insecurity do not remain fixed in childhood, but continue to be reshaped through adult roles, relationships, and systems over time (Blank et al., 2016; Dennis, 2021; Fitton et al., 2018; Larkin et al., 2017; Morgan and Bennett, 2023)

Chapter 5 Drug Use and Turning Points of Adulthood

In this chapter, I explore how drug use interacted with key turning points in participants' adult lives. In Chapter 4, I showed that the beginning of drug use was shaped by early life circumstances such as family relationships, trauma, neighbourhoods, social circles, and classed environments. However, these early experiences did not remain fixed in childhood or adolescence. As participants moved through adulthood, drug use continued to be shaped and re-shaped through new roles, responsibilities, and relationships. Therefore, this chapter focuses on adulthood not simply as a later stage of life, but as a period in which drug use was negotiated in relation to parenting, romantic relationships, work, and contact with correctional services.

Adulthood is a broad period in this research. In the UK, adulthood is legally recognised from the age of 18, although this can vary in some circumstances in Scotland (*Age of Legal Capacity (Scotland) Act*, 1991; *Family Law Reform Act*, 1969).

At the same time, as I explained earlier in the thesis, I treat the age of 40 and above as later-life for the purposes of this research. As a result, adulthood in this study covers a wide age range. To make sense of that range, I focus on turning points in participants' lives. This allows me to examine how drug use was experienced not only across time, but also through changing adult expectations, responsibilities, and identities.

Most of my participants were early-onset drug users. All except two started using drugs between the ages of 9 and 20, meaning that the majority had already entered adulthood with established drug use experience. Lucy and Noah were the only two participants who started using drugs later, at the ages of 37 and 32 respectively. This is important because it means that, for most participants, adulthood was not the beginning of drug use, but a period in which earlier patterns, motivations, and vulnerabilities were carried forward into new life circumstances. At the same time, considering the age range of participants (42–79), the wider social, cultural, and political contexts surrounding these experiences were not identical. These differences are taken into account where they are relevant.

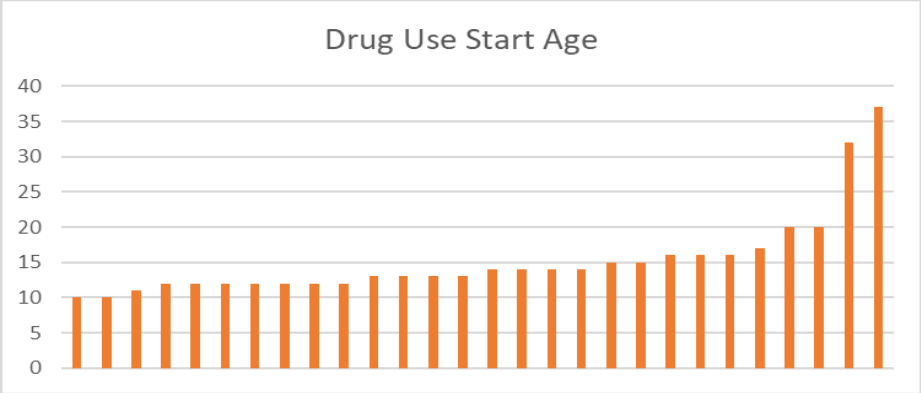

Figure 4 Participants' drug use start ages

The chapter begins by exploring the different aspects of drug use that participants identified as significant in their adult lives, including changing understandings of control, frequency, dependency, and the meanings attached to drug use. It then moves on to social interactions in active drug use, before examining the relationship between drug use and adult responsibilities such as parenting, intimate relationships, and work. After this, I explore participants' experiences with correctional services, including police contact and prison, as these were important parts of many adult drug use trajectories. Lastly, I examine how some participants understood and described their experiences specifically through the language of addiction. Overall, this chapter shows that adulthood did not simply intensify drug use or resolve it. Rather, adulthood brought drug use into closer contact with responsibility, stigma, care, work, and institutional control, making it a key stage for understanding how participants' drug use trajectories developed across the life course.

5.1 Different Prospects of Drug Use

Most of the participants (26) reported that drug use affected some aspects of their lives negatively. The length and extent of the negative drug use experiences varied significantly. Some participants stated that their negative experiences were based only on the use of specific types of drugs or that these experiences lasted for a relatively short period of time. In contrast, others mentioned that their negative experiences with drug use persisted for the majority of their lives and were not limited to certain types of drugs. Consequently, the experiences and circumstances surrounding negative experiences differed widely among participants. The main aspects that participants focused on were the frequency of drug use and not having control over drug use.

It is worth highlighting that the participants also shared their positive experiences with drug use. Two participants (Emily and Oliver) mentioned that their drug use experiences were always positive, and some of the participants who shared their negative experiences with drug use also pointed out how drug use positively affected some parts of their lives.

During the interviews, I used the term "problematic drug use" and asked participants what this term meant to them. Many expressed their opinions, perspectives, and experiences with the term, which are discussed in this chapter as part of negative drug use experiences. However, Laura and Oliver critically reflected on the problematic drug use term as a 'difficult' term. Laura suggested that being dependent on a substance does not mean that it is a problematic relationship, and the drug user still can benefit from the experience. She also added that she prefers the term "normal drug use" rather than the term non-problematic drug use.

Oliver highlighted the society's effect on the term. He stated that society and drug users can view and label the drug use experience differently. For example, a person can see their drug use experience as non-problematic, and society can condemn it as problematic, or vice versa. Therefore, Oliver argued that these terms are usually labelled by society and can be far from reality. It is worth mentioning that both Oliver and Laura were working in drug-related areas at the time of the interview, and their arguments stemmed from both their lived experiences and professional backgrounds. After taking into consideration the participants' feedback, I have decided not to use the "problematic drug use" term as much as I can. I still use the term when it is needed for citing previous research or describing a conversation with participants; however, rather than labelling the whole drug use experience as problematic or non-problematic, I only aim to highlight positive and negative aspects of their drug use experience.

As mentioned before, the participants who had negative drug use experience identified which aspects of drug use they struggled with. Seven participants mentioned that controlling drug use was challenging for them. While discussing negative experiences with drug use, Andrew, Jack, Will, Charles, Henry, Walter, and Richard mentioned the loss of control. Jack talked about the physical pain he experienced during his active drug use multiple times in the interview and mentioned being in life-threatening conditions related to drug use. However, he

added that "*it's [pain] never enough to make [him] stop*." Like Jack, Richard also pointed out that "*[he] couldn't stop. [he] can remember never being able to really stop."*

A similar common aspect also emerged while discussing recovery by some participants with addiction (a term they used), and they used the terms "power of illness" or "power of addiction" as if there was a battle between them and their drug use. The power they referred to is discussed in last section more in depth.

Most of the participants who had problems controlling their drug use also mentioned an increase in their frequency of drug use. However, for Jack and Charles, drug use frequency was the first thing they mentioned while telling me their stories about their negative experiences. For them, the start of realisation was "needing a drug every day". It is also possible to talk about the loss of control over drug use for them. In Jack's case, he refers to his desire for drug use as a "need", even though he experienced pain related to his drug use. Similarly, Charles referred to using drugs every day as a negative experience.

> *"So just take amphetamines for the weekend, few pints, few lines of speed, party time… I would be taking it on the Monday to get to work and then I wouldn't be able waiting till the Friday. I'll be wait till the Thursday. Taking it Thursday and then I started selling it. Before I knew, it was taking every day, losing my jobs and all that. So that probably started my-early 20s… Started becoming problematic for me." -Charles, 62*

By saying "before I knew", Charles gives an example of another aspect that some of the other participants struggled with their drug use. Additionally, he gives an insight about how recreational drug use turns into 'need' and start affecting the other parts of life. Some participants mentioned that they did not realise their experiences with drug use were starting to get negative until a certain point in their lives. For Charles, this point was when his drug use became a daily activity and negatively affected other aspects of his life like losing his job.

For Amy and Henry, the realisation of the negative effects of drug use happened with their first withdrawal symptoms. Until they experienced withdrawal symptoms, they did not realise that they formed a physical dependency on the drug/drugs they were using. For Amy, it was hard to realise because she formed a physical dependency right after her first heroin use

experience. She described her relationship with heroin as "*it was just- it was so fast and so progressive that I was hooked on it."*

Henry's experience was different from Amy's. As mentioned in the drug use motivations heading, Henry used drugs recreationally since a young age. However, he did not state having negative experiences with his drug use until he started to work as a DJ and use drug continuously for six months. When he stopped using the drugs for financial reasons after taking a break from his gigs, he realized his physical need for drugs.

> *"I started realising that my body was kind of like going out to withdrawals. It was kind of like we need this drug; you can't function without it now." -Henry, 53*

In addition to lived experiences, five participants shared their observations about the negative drug use experience. Emily stated that she never had a negative drug use experience, and for her, if drug use is "costing you more than money," it was negative. Her statement refers to protecting the balance and not letting drug use affect different parts of life. At the same time, throughout the interview, while describing her drug use experiences, she stated that she never missed a day's work because of it. With this comment, she gave an example of losing more than money, which has a negative effect on work life.

Sam, Andrew, Harry, and Richard also shared their opinion on negative drug use experiences. It is worth mentioning that Andrew and Harry were working in drug use-related areas at the time of the interview, and Emily mentioned working in adult mental health and having knowledge about drug use. Therefore, their comments on the subject came from both their lived experiences and professional backgrounds. For Sam, his negative experiences with drug use stemmed from a financial point of view.

> *"You know, if I- if I was, if I was a multimillionaire and I could afford to get heroin every day for the rest of my life, and it didn't stop me traveling where I wanted to go and stuff like that. Maybe, I, you know, I might still be taking a long and using it, you know." -Sam, 49*

He also argued that generally, most drug users can moderate their drug use and do not have negative drug use experiences and usually, there are underlying reasons for like abuse or

trauma in the past. Some of the participants gave examples in line with this argument. These traumatic experiences are discussed in depth in the previous chapter. In summary, some of the participants discussed how their previous adverse experiences started or affected their drug use journey. It shows that their drug use journey is not only limited to their direct experiences with drug use, but it also related past experiences, and this journey should be explored with a life course approach. This is why it is important to note that as mentioned in the family life and social circle sections, Sam stated that his drug use was not connected to any adverse early life experiences, and he initially used drugs 'because he was a shy kid' by his words. Therefore, he did not experience using drugs with coping motivation.

Lastly, some participants talked about having negative financial experiences related to their drug use. It can be argued that it is related to the loss of control over drug use. Some of the participants chose to fund their drug use in different ways, and at times, it included being involved in criminal activities. Being involved in criminal activities and entering prison affected 17 participants. The time spent in prison varied massively between participants; therefore, their experiences differed from each other. These experiences and the place of prison in participants' lives are discussed later in this chapter.

As mentioned before, drug-related experiences were not limited to negative experiences; regardless of whether a participant continued their drug use or chose abstinence, many of them talked about their positive experiences with drug use. These experiences are discussed in depth in the previous chapter under the motivations for drug use heading. In summary, people were motivated by curiosity, enhancing joy, exploring identity, and improving coping and functioning; in addition to these, they stated normalisation, opportunity, and availability also contributed to their drug use.

The aspects of drug use that have been discussed so far affected different parts of the participants' lives. The common parts that were discussed are social life, parental role, being a partner, professional life, and experiences with correctional services like interactions with the police and experiences in the prison.

5.2 Social Interactions in Active Drug Use

All of the participants experienced drug use in some stages of their adulthood; 11 of the participants reflected on their social circle. The majority of 11 participants focused on how they sought people with similar interests and circumstances. It is worth mentioning that at the time of the interview, most of the participants were in recovery, and when they were reflecting on their social circles in active problematic drug use, they referred to them as people with whom they used drugs and had negative opinions on their past relationships.

Emily noted how changes in drug-using behaviour could alter social dynamics, even among close friends united initially by substance use:

> *"…when friends begin kind of cleaning up their acts a bit and being a bit more moderate and have been a bit less crazy. The people that are not going to moderate go off down one path, and you lose contact with them. Because they keep on finding each other and finding other people that want to start the weekend on a Thursday night." – Emily, 72*

Emily's view on the social circle was also aligned with Sam's. He described his social circle as people whom he grew up with. He stated that when he had a bad trip, he pulled himself back from socializing for a year until he felt ready to go back out, and his friendship with other people did not get affected once he got back in touch with them. In summary, his relationship with his friendship group changed over time by his experiences with drug use. Additionally, later in his life, he experienced problems with his social life when he started using heroin. He highlighted that his childhood friends were also using other drugs at the time of this event, but his heroin use led to a change in his social circle.

> *"But then, once I started getting into the gear that lot of friends, kind of, although they're still there in the background, they sort of drift off, don't they? And you start knocking around with a different group of people more heroin focus should we say it?" - Sam, 49*

Similarly, Ava emphasized her preference for socializing exclusively with drug users, as her friend group normalized her own drug use and prevented critical feedback. She also argued that she thinks people with drug use experiences can have different personalities, which is attractive to her.

> *"So, I think addicts have like, different personalities from every- from other people, and that's what attracts me, that type of people. But in recovery, we're all clean and sober, so there's no chaotic or dangerous behaviours going on. It's just fun people, basically." – Ava, 42*

Similar to Sam, Ava also described herself as shy in social life heading in the previous chapter. In early years of her drug use, she enjoyed the risk-taking behaviours like using drugs and 'gang activities'. She stated that it made her feel like a part of a group. It is worth mentioning that at the time of these events, Ava was being abused by her step-father and it is not unexpected for her to seek other people to feel part of something and even safe.

The attraction to people with drug use experience also affected Laura's socialization preferences. Laura often talked about her positive experiences with drug use, and she highlighted that she "gravitates and develops stronger friendships with people who used substances in their past*."* However, later in the interview, she added that through her work, she also started to build relationships with people regardless of their past drug use. Oliver also expressed a positive view of his drug user social circle. He talked about the "pride" in drug use user identity and being able to enjoy drug use. He associated this identity with one of the friend groups he associates with, rather than his whole social circle.

As mentioned before, some of the participants referred to their drug use circle as 'people whom they used drugs with'. Their perspectives of these interactions were mostly negative.

For example, Henry described his social circle as "I ended up just having associates and people I would know through scoring." He also added that he isolated himself from people he referred to as friends because he did not want them to witness his negative experiences with drug use, so he avoided seeing them. It can be argued that his isolation rooted in shame and pride.

Jack also experienced isolation in his active drug use. The circumstances that contributed to his isolation were being excluded from his extended family, and worsening anxiety and fear. He described that period of his life as living in a bubble.

> *"I've lived in a bubble for 30 years, you know? I mean, I've never known like normal people to socialize and develop socially, and the only thing I knew was how we get money and get drugs." -Jack, 49*

He explained the severity of the isolation as restricted by anxiety, fear, and social withdrawal.

> *"My phone would go, and I couldn't answer it because I couldn't speak. Didn't know how to say my name at the chemist…I couldn't even open my front door. See if somebody came to my door. I would ignore it. That might be trouble, far fear. You know, the fear was horrific." -Jack, 49*

It is worth noting that the experiences of fear and mistrust was not limited to Jack's adult life. In Chapter 4, he also talked about experiencing same feelings in his family home. That is a very strong example of adulthood not erasing earlier vulnerability but reproducing it in a different form - isolation.

The feeling of isolation felt by Ava and Edward, too. Ava stated that she experienced isolation after her parole, which led her to start drinking again. Edward talked about the safety feeling of his poly drug use and how it led him to isolate himself.

> *"An incident happened. I broke my jaw. And I ended up in the hospital. I came out of hospital. And the doctors gave me all sorts of prescription medicine, just totally in pain. And because my anxiety I was getting diazepam, nitrazepam, dihydrocodeine. I was getting painkillers. I was getting sleeping tablets. You know and anxiety tablets, that is a problem. And started taking them. And I felt a big one around about me. I felt safe. I didn't need to get out the house. I didn't even, sometimes I didn't even… I was getting them for nothing, you know, off the doctor. And I started isolating..." – Edward, 52*

In this quote, Edward explored the start of his isolation. For him, the feeling safe with drug was enough. Similar to Jack, Edward also experienced anxiety in his earlier years. His statement "walking around on eggshells" because of the violent home indicated anxiety and fear. And these emotions were carried onto adulthood in different forms which he tried to cope with drug use.

Later in the interview, he talked more about his isolation and stated that circumstances around his isolation changed.

> *"My family were trying to tell me, "Listen, you're gonna kill yourself." But I knew better. So, every time they were trying to tell me that I was*

> *gonna kill myself for the drugs. I just pushed them away, to the point that I wouldn't even go down see them anymore. I Isolated away from all that. You see them is to see what I could get of them money. And you know, I ended up, I didn't care about everybody else with the family, didn't care but I didn't care about myself. That's the drugs took me to, you know. Didn't they care about nothing as long as I'm drunk." – Edward, 52*

He stated that other than feeling safe, being confronted about his drug use made him distance himself from his family. Jack, and Edward had early life experiences connected to fear. It is worth highlighting that, in the previous chapter, Jack stated that his adverse early life experiences caused him to fear adult and people and Edward described his feelings in his own hose as 'walking on eggshells' because he feared his abusive father. And both of them mentioned using drugs as a way to

> *"I couldn't handle my thoughts and feeling busting full of fear" -Edward, 52*

> *"…only thing that made me feel comfortable was taking a substance," – Jack, 49*

These 12 accounts demonstrate a complex interplay where personal drug use could lead to superficial social relationship that revolve around drug use or deep social connections depending on the person's experience with the drug use. Beyond immediate social circles, broader life responsibilities such as family roles and professional commitments further shaped participants' drug use experiences, either increasing or decreasing the frequency of drug use.

5.3 Drug Use and Life Responsibilities

Participants frequently discussed how personal responsibilities, such as roles as a parent, partner, and working professional, significantly shaped their drug use trajectories. The next section delves into participants' experiences with their parental roles.

5.3.1 Parental Role

The majority of the participants (25) commented on their role as a parent and how drug use and being a parent interacted. Emily, Jane and Simon never had children. However, Emily included her perspective as an LGBT person who does not have children. Overall, all the

participants who shared their experiences in parental role in drug use mentioned having the desire to control their drug use. Some of the participants were able to implement different control mechanisms like limiting the drug-using frequency, stopping the use of specific drugs, or complete abstinence. Other participants who were not able to implement the desired control mechanism talked about the adverse emotions they experienced related to their parental role and drug use. Lastly, a small number of participants stated that their drug use helped them to improve their skills as parents and improve their relationship with their children.

These accounts echo the findings in the literature review on cyclical patterns (Section 2.4); specifically Nettleton and colleagues' (2012) argument that turning points do not speak for themselves. Becoming a parent did not automatically restructure drug use; instead, it introduced new forms of moral pressure, concealment, and guilt that participants had to manage alongside continued use. The significance of parenting in these accounts is not that it changed behaviour directly, but that it changed the moral stakes of drug use; which is a different kind of turning point altogether.

5.3.1.1 Becoming a parent

For Oscar, even the decision to become a parent was a turning point in his drug use narrative. Decision to have children not only affected his decision to control his drug use. Him and his wife at the time decided to move from London to Edinburgh because they decided to become parents. However, Oscar continued his drug use for a while, and this change was partly motivated by his ex-wife's explicit demands.

> *"I remember my ex-wife saying to me- So, we moved up to Scotland when I was about 41, and she said - you're 41 now, you know you're not a teenager. You're not in your 20s, it's not even your 30s. When is this going to stop? We moved up here to have children. Nothing's changed." – Oscar, 50*

He later added that having a child eventually led him to moderate his drug use. It is worth highlighting that Oscar identified his drug use as a habit; therefore, he stated that not having a physical addiction to a substance helped his moderation process. From his perspective, he only had to break the habit.

Edward also experienced similar changes in his drug use with the news of his girlfriend's pregnancy. He decided to control his drug use and improve his and his girlfriend's living conditions.

> *"I'm gonna do the right things. I'm gonna get myself a job. We're gonna do the house. We're gonna have everything go around about the kids." – Edward, 52*

After deciding to control his drug use, he and his girlfriend stopped using heroin, and they started using Methadone, a substitute drug. Later in the interview, he added that this recovery period lasted throughout the pregnancy. When his girlfriend gave birth to their son, he started to go out again and started using heroin shortly after. He highlighted the power of addiction over him in his story.

> *"And I couldn't stop after that. No, that's- that was the power of the disease of addiction had over me." -Edward, 52*

Four female participants discussed how pregnancy influenced their drug use. The effects varied among the participants; each of them took measures to manage their drug use. For example, Laura only used cannabis during her pregnancies.

> *"I got pregnant and had my children, I stopped using anything, really. And apart from tobacco and cannabis." – Laura, 44*

Later in the interview, she added that becoming a parent affected her lifestyle and, as a result, affected her drug use further.

> *"And then I mean my- my- my- my recreational drug use kind of stopped. I continue to have cannabis, but my recreational drug use stopped just cause you don't get to go out, you know I mean, like just there's no opportunity…"-Laura, 44*

Amy also talked about how pregnancy and becoming a mother affected her drug use. She stated that she stopped using all drugs during her pregnancies. However, she talked about how drug use became a coping mechanism for her after her daughter was born with a port wine stain birthmark.

> *"So, my daughter was born, and she was born with this port wine stain, and it just- it just crumbled me. I was 19. I didn't know what to do. I didn't know how to cope. And I do- I was just thinking about her growing up and growing up, which she would have to face. And instead of being there as a mother, my way of dealing with it was picking up heroin because they'd the jellies at the time they'd went off the market, you couldn't get them." – Amy, 48*

Amy highlighted that during this process; she was in an abusive relationship and with the arrival of her daughter, she decided to separate from her partner in order to protect her daughter from growing up in an abusive household. As mentioned in the previous chapter, coping can be a strong motivation for drug use. Amy started using heroin for the first time to cope with the distress of her daughter's medical treatment. However, this led to further emotional distress because she felt guilty for not being able to support her daughter when her daughter was in pain. This emotional distress led to an attempted suicide when Amy was around 21 years old. The effect of the parental role was also brought up by Ava. Ava talked about her experience as a mother and stated that she preferred to stay abstinent from drug use throughout her pregnancies. However, her drug use continued after the births of the children. She talked about how parental responsibilities contributed to her drug use and how she used drug use as a coping mechanism.

Ava ended her relationship with her ex-husband in 2020 and started to share the custody of her children with her ex-husband. For her, having to share the custody of her children was hard to manage.

> *"I just, I couldn't cope with my kids not being here, so I-I would be drinking feel like the Friday as soon as they were out the door I was up at the pub using drugs, hanging about with drug dealers. You know, just absolute chaos." -Ava, 42*

Additionally, later in the interview, she added that three of her children were diagnosed with autism and ADHD. These additional needs both made her struggle to cope, and she felt responsible for her children's diagnoses.

> *"...it kinda was a release for me that that's only way I could explain it because hope internally we're like having these children that screamed all*

> *the time and the two so the two they I've got a 12 year old and 11 year old was only a year between the two, the two just fought and they still do to this day but I-I couldn't cope I because I had two older children who weren't like that I couldn't understand what-what was, and I'd actually started to believe that God was punishing me." -Ava,42*

As can be seen from these examples, the news of a pregnancy affected participants' drug use mostly positively. It became a motivation to control the drug use. Additionally, life changes and added responsibilities that can be experienced with parenthood were another factor that affected their drug use. For some, it led to an increase or relapse of drug use, and for some, it resulted in less frequent drug use.

5.3.1.2 Parental role

The participants who had problems with controlling their drug use talked about experiencing adverse emotions for not being able to fulfil their parental roles. Alice talked about her experiences as a mother with active drug use.

> *"I had kids in my addiction and stuff and my daughter had went and stayed where her grandmother and stuff like that, which then resulted in me being riddled with- with shame and guilt. […] I was pregnant with my son, I swore blind that I wasn't gonna put him through what I put my daughter through." – Alice, 42*

She added that these adverse emotions got stronger during her recovery process, and like Edward, she highlighted the power of addiction.

> *"I was 17 years of age and having a kid in addiction. You know, it was- it was horrendous and that was one of my biggest things when I come into recovery was the- the- the guilt and shame, you know that I had because I loved my wee lassie to bits and I still do but I couldn't stop doing what I was doing. So, I was there for her for like materialistic stuff. But I wasn't there as a mother, so I missed it, there's so, so much stuff." – Alice, 42*

Leo also decided to moderate his drug use for similar reasons. He stated that he hid his drug use from his wife at the time, and partially, the reason behind it was guilt.

> *"Even though a lot of the time the drug use was hidden… So, in some ways I had to- I had to be mindful through a bit of an element of guilt. If I'm doing this, I mean, I've got a wife, I've got a child. You know what risk I am taking" – Leo, 52*

His role as the parent and the partner led him to feel guilty about his drug use because he considered drug use to be something that could be risky. He also added that he took measures to control his drug use such as limiting the days he goes out at night and reducing the frequency of drug use to make sure it did not have a negative impact on his family life and later, stopped using drugs altogether because it suited his lifestyle better at the time and his friend who he used drugs with had a medical condition and also stopped using drugs which served Leo as an loss of drug use opportunity.

5.3.1.3 Relationship with children

The participants also talked about how their relationship with their children, and their drug use interacted. A small number of participants stated that they benefited from their drug use. For Harry, experiencing drug use and understanding why people might prefer to use drugs helped him build a better relationship with children.

> *"I think being very open and honest, which I have been, my children- really important so that they understand that people can make mistakes and do things and love is still there and we're always going to be there. It doesn't, you know, those things are unconditional"-Harry, 47*

Harry discussed how his earlier experiences with drug use enhanced his relationship with his kids later in life. He highlighted that the experiences he had with drug use opened his mind to possibilities of other lifestyles, and this led him to be a more understanding and open parent. When Oliver discussed the interaction of his drug use and parental role, he focused on how drug use improves the time he spends with his children.

> *"And you know as-as-as when you age your kind of activities often-often kind of change and so you know things like the functionality of drugs and the pleasure involved off on a Sunday afternoon, say if I've had a joint and sit down and play a-a board game with my kids in front of the fire or watch a film, etcetera, I still think that's enhanced and I still think that in terms of the benefits and pleasures they get actually from me being in a*

> *different frame of mind, you know or-or being more chilled or you know or-or being perhaps more patient when I'm doing that."- Oliver, 45*

This quote provides multiple insights into drug use in adulthood. First, Oliver points out that the activities that have been enjoyed can change over time, and the drugs can be used to enhance these changing recreational activities. His example explores how his drug use affected the time he spent with his children, and he argued that utilizing marijuana's desired effect helped him to increase the quality of the time he spent with his children.

For other participants, the interaction of drug use and their relationship with their children was not positive. The participants who had negative drug use experiences reflected on how their relationship with children progressed over time. Many participants stated they felt guilt and shame for how their past drug use affected their children.

Jack talked about his relationship with his daughter and focused on how his lifestyle affected his daughter.

> *"I put that wee lassie through a lot as well. For 20 years of her life. And by this so ashamed her and she found me overdose twice, and the second one I nearly died. I didn't realise that my daughter is worried about me…"- Jack, 49*

Noah also mentioned that one of the two regrets he has in his life relates to his role as a parent.

> *"I- do have two regrets. Otherwise, no regrets. The two regrets- I couldn't be the father my children deserved at the time..." – Noah, 79*

Three of my participants never had kids. Emily was one of them, and she addressed the topic from an LGBT perspective, emphasizing how the LGBT community may experience variations in parental roles and drug use.

> *"...the kind of squeezed into liminal spaces and the disconnect from the standard life progressions of straight people like having children getting you out together. So we are.. So, LGBT people that don't have children, which is not quite as big a thing as it used to be. Were kind of- We didn't have to grow up. That's part of what I think of it as is that when you don't*

> *have the kids to get up for school in the morning, or the.. you know, it's the weekend, and you've got your kids, it's different. And then there's a whole culture around going out. Going out to drinking places, going out clubbing all the links to dance music." -Emily, 72*

Like others, she also thinks that having children brings different responsibilities in a person's life, affecting recreational activities. Therefore, when she considers the opportunities of LGBT+ people at the time of her youth, not having children partially led LGBT+ people not to "grow up."

As highlighted in Emily's narrative, not having children can alter the rhythm of daily life and permits forms of socialization related to drug use, such as entertainment, going out, dancing, music, and club culture, to continue more seamlessly.

5.3.2 Being a Partner

Some of the participants delved into their relationship with their partners and how drug use affected these relationships. Most of the participants who talked about their partners commented on the negative effects of drug use on their relationships. However, Andrew talked about his positive experiences. He felt that his cocaine use had a positive effect on his sexual life. He stated that cocaine's desired effect increased the quality of sexual relations and improved the experience. However, he also added that this led him to have problems with his cocaine use later in his life.

> *"…when I took cocaine, I enjoyed having sex. I enjoyed having sex, so I took cocaine. If you see what I mean, they- they were- They were mutually reinforcing and- and- and I- I was fortunate in that certainly until later-life cocaine had no debilitating effects on my ability to have sex. Eventually it did, which probably have a lot to do with the reason I stopped using it." – Andrew, 66*

For others, the interaction of drug use and their role as a partner resulted in negative experiences.

In Loe's experience, drug use was something he felt compelled to hide from his ex-wife at a certain point in his life. As mentioned before, the idea of drugs being risky led him to hide

his drug use. However, later in his life, he decided to explore drug use again, and the new romantic relationship he built aligned with his decision.

> *"I've met someone recently a few months back and she has the same opinion to me about it. So, in some ways it works because it just allows us to still experiment that whenever we go somewhere, she's into similar things to me that- that we do these things and it- we're under the influence of ecstasy or whatever. And it's to be fair, with the person I've met, it will be something else, you know, because she has mentioned other things like other psychedelics, like mushrooms or the like things like that, which I'm- I'm quite interested in exploring." - Leo, 52*

In the previous chapters, I discussed how Leo's drug use was mostly connected to his social circle, and he used drugs when he had people to enjoy them with him. His romantic relationship had the same effect on Leo's drug use.

> *"I've taken drugs technically since I've seen her really again, but if I didn't meet her and there was no one else going clubbing, I probably wouldn't have done anything since I've come back in in theory, so it's just- it's just turned out that way." – Leo, 52*

Using drugs with a partner or being introduced to new drugs has also been experienced by other participants. Edward talked about how heroin entered his life.

> *"And started to go out with this lassie. She was into heroin. But she kept away from me. But me being me, everybody was warning me. … stay away of her because she's on heroin and I'm- I'm alright. I take drugs and I don't know if I can take them and leave them. No, my life is chaotic. Started, you know, with lassie knowing she was on heroin. And I started taking it myself." -Edward, 52*

Similarly, Laura decided to use heroin for her partner. She stated that it was an act of protection.

> *"…start going out with this guy who was a heroin addict, you know, and I thought, well, I don't want you to be a heroin addict so I'm gonna get addicted to heroin, and then you'll see, you know." – Laura, 44*

She also added that she felt that heroin was not suitable for her, and her conversation with other people who used heroin led her to prefer not to use heroin. Anne also tried heroin because she was curious about her partner's heroin use.

> *"And my man used to go into the bath, run a bath, and inject himself in it. He was staying downstair room with my brothers and I just took a set of tools to take a couple of times, put it, shook it to dissolved, tie it around my arm and just injected myself. And that was it." – Anne, 56*

Anne stated that her first heroin use happened when she was pregnant. She did not enjoy the feeling of the drug and did not try it again throughout her pregnancy. However, later in her life, she started to use heroin again, and her use lasted for multiple years.

Drug use also caused other types of negative experiences in participants' romantic relationships. Tom talked about how his partner gave him an ultimatum about his drug use.

> *"So, my partner basically gave me an ultimatum. It's- it's the- the drug scene or it's the dance scene or it's me and the kids." – Tom, 43*

He stated that he tried to limit his drug use and attempted to stop inviting his friends over for drug use. However, he stated that his actions did not satisfy her wife.

> *"My partner went and says to me like she can't even have this. And I understood that because I'm as much as I kept it out of the way of my two kids and I couldn't hide it that way. I couldn't hide if you and I was using money that she needed for [INAUDIBLE] as well. So, I totally understood the situation. So, we broke up and I was away, living in a flat" – Tom, 43*

Richard also stated that the reason why he got separated from the mother of his children was his alcohol and drug use. In Amy's experience, her relationship of 22 years ended because she felt that after she went into recovery, she and her partner were in different places in their drug use journey.

> *"…because he's in a completely different place from me. So yeah, it's- he's nowhere I'm at. He's no clean." -Amy, 48*

As can be seen in her experience, couples who use drugs can experience separation when one of them decides to go into recovery.

Another aspect of drug use and romantic relationships was the loss of a partner. A small number of participants mentioned that they lost partners to drug use. George stated that two of his past girlfriends lost their lives to heroin use.

> *"I lost two girlfriends in a year to yeah- to an- one was an accident. Both of them were heroin related. Over those type of situation." – George, 65*

He also added that these losses did not deter him from his own drug use. He decided to control his drug use later in life because he felt too tired to use drugs.

5.3.3 Work Life

Participants' narratives revealed how their drug use was intertwined with, and at times determined, their working lives. Some participants have maintained professional careers for many years, while others have lost their jobs or had unstable working lives due to drug use. The experiences of the participants allow us to understand the individual, social, and structural aspects of the relationship between work life and drug use.

Some participants stated that they were able to maintain their professional careers for many years with drug use. Sam stated that he worked full-time and maintained his job most of the time, and that drug use was only a part of his life.

> *"…most of my drug use I was working full time. I was. You know weren't jobs that I was particularly good at, but I was, you know, holding down jobs." -Sam, 49*

However, Sam also stated that he lost a job because of his drug use once. When he had to go to court for a drug-related arrest, his employer decided to let go of Sam. In his narrative, Sam also highlighted the discrimination between drug use and alcohol use.

> *"And the same time that's going on, a professor up there who'd been done drunk driving yet they still get drive around the campus. There were the receptionist in the building I worked. It'd be caught swinging vodka behind her desk sort of thing that you know. A few weeks before me she still sits- she's still sitting in there working sort of thing that, you know. But- but yeah, heroin, substances, heroin, you- you don't wanna know, do you? Straight out the door." -Sam, 49*

Sam was working at a homeless charity during the interview, interacting with other clients who were drug users. He pointed out that his drug use made him "shy" because, unlike the people he worked with, his drug use was recreational rather than a coping mechanism for past trauma. Oscar also worked with homeless people and mentioned that he kept his drug use hidden from his colleagues.

> *"So, I held on to a professional career for 20 years and managed to hide that most- most of the time from colleagues." -Oscar, 50*

However, he added that when he was living in London and working with homeless people, some of his colleagues also used drugs. However, he felt the desire to hide his drug use more when he moved to a smaller city for work.

> *"We were calling London. We used to walk the streets at nighttime as a group of about 50 of us who were commissioned for Westminster. At least half of us would all go off using drugs. After work ourselves, so it's almost like none of us wanted our employers to know … [CITY] that's how small and I was compared to London it was a lot easier to hide in London, I knew when I came to [CITY] I couldn't just go out looking for the other because I would more than likely end up in a room with somebody who I may have worked with in the homeless scene in [CITY]." – Oscar, 50*

In his narrative, Oscar highlights the importance of the size of the city and how it affects the desire to hide drug use. Later in the interview, he also mentioned that to be able to keep his drug use hidden, he would go to London to supply drugs. Drug use in the workplace was not limited to Oscar's story. Andrew also talked about how his profession and his drug use interacted.

> *"Cocaine was very much a part of the advertising industry. It worked and it integrated very well with that… I mean clients would expect when clients came for meetings with their advertising agency in London. They're expected to be taken out for- for an expensive meal and then afterwards, you know, to a nightclub or whatever. And they'd expect cocaine- I mean, it was just a stunning thing. They'd expect cocaine to be involved. So, my- my cocaine use did get out of control." – Andrew, 66*

Andrew stated that in his profession, entertaining clients was part of the work culture, and drug use—specifically cocaine use—was an expected aspect of that culture. At the time of the interview, Andrew was using drugs regularly and mentioned benefiting from them. His only exception was the period when he started having negative experiences with cocaine; he indicated that crack cocaine became overly compulsive for him. Henry and Richard also discussed their work environment and drug use.

> *"And I was a DJ at time as well. It was a part of the scene." -Henry, 53*

> *"And because of my music, I was in bands so I was always like away on tour and stuff like that and progressed on like crack cocaine in my early 20s and- and done that for a number of years and then moved on to heroin." -Richard, 44*

As mentioned in the previous chapter, the dance and music culture could become a motivation for drug use. Richard and Henry also pointed out the connection between the music and dance scene and drug use in their narratives. Henry added that later in his life, he changed his profession and started working in scaffolding. During this period, he continued his drug use during the times when he was not working.

> *"Every now and again, I was still using cocaine at the weekend and drinking because you're working away a lot. See, you work away six months of the year. So when you home, you think you deserve a blowout. And I was still, and I was using drugs recreationally again" – Henry, 53*

For him, drug use was a relaxation tool, and it was deserved after working six months away at a physically tiring job. Later, his recreational use progressed, and he started to have negative experiences with it. He decided to start his recovery process at the age of 28. He controlled his drug use for 23 years and stayed abstinent. However, when he was 51 years old, he experienced a work-related injury and started to use medication for his back pain. The medication failed to maintain his pain levels, and Henry looked for alternative methods to manage his pain and sought drugs. During this time, he stated that he was depressed and had lost his job.

> *"And then I lost my job. And then I was on, I was on a heavy depressive state at that period as well, mind you. I don't know if I went through a bit*

> *of a breakdown just when I was maybe about just leaning my 50s. I think- I'm always majorly depressed. So I don't know if I was just maybe reaching out, but I know I wasn't- I wasn't care if I was alive or dead at this point because depression was so bad and I'd started using again." – Henry, 53*

As can be seen in Henry's narrative, his work life and schedule played a major part in his drug use. Tom shared a similar story and talked about how his drug use led him to lose a job he enjoyed.

> *"…I did have great jobs. Great jobs as a chef and I worked for council before- just about 5 years before this started. I had to go and sit for my job in the council ravished with drugs and after a year, they paid me. I've had a great job with a pension and a thing that you could possibly want, you know, and it was a well-paid job Monday to Friday. I liked it and then, but whatever else, drugs became first" -Tom, 43*

The phrase "drugs became first" indicates an aspect many other participants shared before – the power of drugs. As seen in the quote, Tom valued his job; however, drug use took priority in his life and ultimately led him to lose it.

Arthur highlighted another aspect of drug use that can affect the participant's professional lives.

> *"No, I was a trainee engineer but through addiction and through the consequences of my action, I lost that job. Well, I couldn't hold a job then and because I- I was so angry. I was against the authority….And then I'm not getting any qualifications. The only means I know making money is to doing wrong things and that selling drugs, committing crime, getting caught up in gang violence.." - Arthur, 47*

Struggles in educational and professional life can lead individuals to miss future opportunities and seek alternative ways to fund themselves. In Arthur's experience, these alternative ways were being involved with gangs and committing crimes.

Another aspect that some participants brought up was how their criminal records impacted their professional lives. Many participants faced legal issues due to actions related to funding

their drug use or carrying drugs for personal consumption. As mentioned in Sam's story, some of these legal issues ended up affecting participants' work lives. For example, Edward began breaking the law by stealing and supplying drugs to support his drug use. His experience with the criminal justice system led him to lose his job.

> *"And I soon get caught with about drugs on me, the Class A and I get took to court. I lost my job. And then I was like, well, "who's gonna employ me now?". Because I've got a drug record. I've got a criminal record through violence. And so that I put that mindset into myself and maybe they would employ me. I never ever tried for a job." – Edward, 52*

Receiving a drug-related offense not only caused him to lose his job but also impacted his expectations for the future. Ava had a similar story; she began pursuing qualifications in psychology during her recovery. However, when she learned that her criminal record might hinder her prospects in the field of psychology, she lost her motivation.

> *"I started doing a degree in psychology. I'm- I'm trying to think. So, I've- I've done my HNC and HND and I did it through university part time. But I started volunteering for [NGO] in 2020 in COVID, so I did all my training. It took like 3 months to do the training to be a full, an active listener. But because of that, you have to have a PVG. So, they applied for my PVG, but because of my offence, it came back for representations. I don't know if you know this, so when you've got a serious offence, you could get barred basically from working with people or working with adults or children. So, I had to go through representations." -Ava, 42*

She stated that she experienced this during Covid and her PVG process took longer than expected. However, she thought the process was taking longer because she was going to get barred from working with people. This thought caused her to lose motivation for obtaining her psychology qualifications.

> *"So, in my head I'm like, what is the point in me doing my psychology degree if I'm never going to be able to use it? Because I can't work with anybody. So, I just I-I was halfway through the last part of my degree and I was getting A's and really high marks. And I just thought there's no point. So it was like my past and everything that I did. It just was like, not*

> *going away. It was like I- I think that's what made it worse again. And the drug use just picked up another level." -Ava, 42*

Experiencing this led Ava to increase her drug use. Later in her narrative, Ava mentioned that when she started volunteering for the recovery café, she was requested to get her PVG again, and contrary to her expectations, she discovered that she was able to obtain her PVG and was allowed to work with people.

As evidenced by my participants' narratives, drug use and employment frequently interacted in their adult lives. These interactions varied, ranging from increased drug use due to work culture and environment, to decreased drug use resulting from work responsibilities, as well as losing jobs because of drug use and related criminal records. The lack of employment and insufficient funds led some participants to engage in illegal activities to support their drug use. Similarly, several participants had interacted with the Scottish justice system, including correctional services, as the next section explores.

5.4 Experiences with Correctional Services

Participants' experiences with the correctional services were highly significant in terms of their impact on drug use. For many participants, contact with the correctional services emerged as a factor that shaped, transformed, or reinforced drug use. Participants touched on issues such as the initiation of offending, prison sentences, antagonistic relationships with the system, and the cycle of substance misuse following release. This section details these experiences.

Most of my participants (17) interacted with correctional services. The participants who interacted with correction services talked about their offences in two categories, drug use and violence-related. Most of the violence-related offences were also drug-related. The offences that were not related to drug use also affected participants' drug use experiences. For example, Ava talked about how she was sentenced to prison for culpable homicide at the age of 23 and how her sentence and drug use interacted.

> *"So, I was charged with murder at the age of 23. Two children. I was on bail for 11 months. I-I basically, the charge was dropped from murders to court culpable homicide within weeks because of the domestic violence because it was a history there. But I was actually left on bail for 11*

> *months. So, you know, any normal person would just try and keep a low profile. You know, just do the right thing, but my addiction had a hold of me very much in its grip at that point, so I was just using drugs all the time, trying to take my life numerous times while I was on bail. Just couldn't cope with how I felt what had happened, trauma. And the only thing I knew that was a solution to that for me was drugs and alcohol. I was-I was sent to prison after 11 months on bail and I was sentenced to four years 8 months, and I went to [PRISON NAME]. And basically, as soon as I was in there, I kind of got told by the prison officers how he kind of works the system to get back out an independent living. So, there was independent living units at [REMOVED]. So, I've worked very quickly and progressed through the prison system. So, within nine months, I was into the independent living units, and I was getting home leaves. But again, soon as I think on my very first home leave, I was drinking and using drugs again, which putting my putting everything at risk really. But being absolutely powerless" – Ava, 42*

As her narrative illustrates, this experience led her to increase her drug use as a coping mechanism. Furthermore, as other participants have mentioned, she spoke about the power of drug use – addiction. For her, the power imbalance was so significant that she risked her home leaves.

For many participants, the motivation for their offences was funding their drug use. For example, Andrew mentioned his experiences of dealing with drug-related financial problems.

> *"I think inevitably it- it- it leads to some sort of crisis where- where either your money runs out or and- and I did. I mean, I- I did commit crime in order- in order to buy drugs, not- not- not serious crime, but some. Well. I committed a little, you know, I- I stole and I was involved in to some degree of fraud. Not- not a large amounts of money at all but- but when we're talking in the hundreds of pounds, not large. But I did commit crime in order to buy drugs." -Andrew, 66*

Correction services were not part of Andrew's narrative. However, many others had to encounter a correction service due to how they fund their drug use. For example, Jack committed crimes to support his drug use.

> *Overdoses. Prison. Crime- crime to fund a heroin habit, or things that I didn't want to do. I had no choice. I had to do it. Do you know what I mean? I know that it wasn't me. I was like. No. Well, with this illness. So, you know, just kind of- where I came from Asena, like everybody was doing something, you know what I mean? – Jack, 49*

As mentioned in the previous chapter, Jack discussed the importance of the environment. The area he grew up in not only influenced his drug use but also contributed to the normalization of criminal activities to support that drug use. His views were consistent with Fred's, who expressed a similar narrative.

> *"People have asked me the question what to you want to be when you grew up. Oh, all I wanted to be was a criminal because I thought that was the same for everybody." – Fred, 52*

For Arthur, at the time of his drug use the money was not only a tool to get drugs, it was connected to feeling better.

> *"You know, up until I came into recovery, I was in and out at the prison. Selling a lot of drugs because, there is time I think money is going to make me feel better, more money will make me feel better." -Arthur, 47*

This expectation of money led Arthur to engage in criminal activities from a young age and frequently interact with correctional services.

> *"But that done was- it brought prison into my life for young age as well. So young offenders' institutions and being locked up, being involved in criminality, involved in gang violence in the area I stayed in. So, prison was just a part of my life for the- for the rest of my life." – Arthur, 47*

Some other participants also stated that going in and out of prison was a part of their lives. Their narratives almost indicated a vicious circle of habits. Alice talked about her experience with the vicious circle between drug use and prison.

> *"So, I'd go to prison. I would do my time in prison and then I'd be released by prison back into the community where I would become obsessed and compulsive again with drugs because I couldn't look at the trauma. The guilt, the shame and all that stuff. So, I just kept using and years and years." – Alice, 42*

To her, the reason for this circle was the lack of mental health support. As mentioned in the previous chapter, Alice experienced trauma when she was young, her father was killed, and she described that experience as her biggest trauma. While talking about her experiences with correctional services, she pointed out the lack of mental health support.

> *"You know, for me, I went a- another place later on in my journey, the court system. I was in the prison. You know what I believe happened was I had trauma and through the trauma- fell into substances, through using substances I started defending. So, my punishment was going to prison. But I never changed anything about me. Because I didn't know there was something wrong with me. Nobody looked at me and said that's the trauma, that lassie had the childhood stuff. It was just kind of mess over the top." – Alice, 42*

Alice identified her trauma as the start of her circle and stated that because no one ever tried to find the root cause, her addiction lasted for 22 years. Edward also highlighted the vicious circle in his narrative.

> *"...and I can always remember lying in the court that day, going if I go here, if I go to this court case, I'll never do it again. I'll never sell drugs again. I'll get back to work and I'll. No. But as soon as I left to court that day because I never had any charge against me, I said boy thought he'd come back right in again… I caught the disease, you know." -Edward, 52*

Similar to Amy, Edward highlighted the fear he felt when going to court but was unable to control his drug use and criminal behaviour to fund his addiction. He described this loss of control as a disease. Tom was another participant who emphasized the vicious cycle.

> *"Yeah, sure- Basically, I went in prison and stuff like that, and I went through withdrawals and everything in prison, but every time I got out of*

> *prison, I just went straight back to the same ways. I went straight out, started off on all day again and all that blah blah started after drinking smoking. Blah blah blah and then I would end up in houses were guys that were smoking smack. And then I forget yeah, a sure I'll not get addicted this time. I'll take it one day and leave it. And it's not all shite for you know, you're back taking it every day back. You are fucking stealing, robbing, doing whatever." -Tom, 43*

Tom elaborated on his thought process in his narrative. The way he described his thought process was similar to other participants who discussed their relapses: *I'll take it one day and I leave it.* This aspect of drug use will be discussed later under the Cyclicals Patterns heading. Will also talked about his recurring prison time.

> *"I have done like off and on over a life sentence… 20- 20 years but yeah, I've done [INAUDIBLE] part of my life in prison off and on. 2s,3s,4s. [INAUDIBLE] six weeks out, doing one, couple of weeks out, then another on and so on and so on and so." – Will, 61*

His narrative illustrated how much people can spend in prison caught in these types of vicious circles between drug use and correctional services. Fred also spent most of his life in prison, with his last sentence exceeding 20 years. As mentioned in the previous chapter, Fred was born into a family where drug use was common and socially acceptable. Additionally, the drug business was part of his family. Fred's narrative stands out from other participants because he continued his drug use in prison, unlike others who experienced withdrawal and relapsed after their time behind bars.

> *"…drugs are impacting my life to the point where obviously I went in prison. Do you know I spend- You know, I'm 52 and I've probably spent 35 years in 30- 30 years in prison. One particular prison sentence was 23 years, just as one- as one- as one shot, you know […] But I didn't have access [to drugs] later on because I was in prison for over 20 years centred with pills and these types of things you know. Because they're- they're much easier to dip in your hands on basically under these circumstances." – Fred, 52*

Due to accessibility issues, Fred shifted to discussing medication misuse during his time in prison. Charles concentrated on the progression of the vicious circle and shared his experiences with it.

> *"I started the first time I had a drink, had a blackout, getting in a fight. It was chaos and then I just continued doing that and… it just progressed and get worse, and it just kept adding other drugs and other drugs and getting in trouble with police and in police stations and prison and losing jobs and- and that's really basically the story until- until I- I got clean. -Charles, 62*

Charles pointed out the start and end of his vicious circle. For him, it began when he had his first drink and became violent, and it concluded when he gained control over his drug use.

Violence was mentioned by many participants who shared their experiences with correctional services and drug supply. They stated that violence was part of the entire experience. For Walter, the violence occurred in prison.

> *"Prison, violence, looking- fucking get through the guards. You would have violence- violence covers at all and no care about every- No care about myself, unhygienic, no eating right or that stuff." -Walter, 55*

He also highlighted that he didn't care about his well-being during his time in prison. Other participants pointed out the violence associated with drug supplying.

> *"Selling drugs, the- the stuff that comes along with that, the violence that comes along with that. I've done some things that I'm probably not gonna talk about because it's- I've still not dealt with myself. And then at 41 I ended up going to prison. At the end all comes to that it was money through drugs. I- I nearly killed two people. So, I did, and I went to prison at 41 for eight years. That was my sentence -Amy, 48*

Amy had a hard time discussing her last offense that led to her being sentenced to eight years during the interview. She stated that those memories still bother her to the day of the interview.

> *"That's what drugs do to you; they take you away for yourself and out yourself and it becomes somebody that you would never dream of being. So, I definitely carry- carry a lot of guilt with that, a lot of nightmares. And people say to me, you've done your time like you need to move on. It's all right that I've done my time but these people need to live with that. The scars that they've got causing. Remembering about it and that's no nice." – Amy, 48*

Participants often talked about experiencing adverse emotions due to their past actions. Fred has been in a similar situation where he got involved in a highly violent act, and he shared his experience.

> *"My drug use took me to the point where- where- where- where people have been killed basically and you know, and I went to prison for that. You know, so that's kind of where that led me. Just the violence, the chaos and disorder…" – Fred, 52*

And lastly, Arthur stated that violence was directly connected to supplying drugs. His desire to access to fast money led him to get involved in violence.

> *"So, a lot of my crimes are for selling drugs, distributing drugs, violence. So, it was just that world I caught up with and I couldn't escape that. So, violence was always part of drugs. There was always that- that part, violence always come into play when you were selling drugs. And it just kept progressing and I've had many years in a prison." -Arthur, 47*

Similar to Amy, Arthur also talked about his adverse emotions on his past actions and how supplying drugs in the past makes him feel as a person in recovery.

> *"After I came into recovery and I see all the things I was doing, but I thought I was just hurting me. I wasn't, I was hurting so many people running about me. So, I get to work on it and realise it." -Arthur, 47*

He also added that at the time of his drug supplying, it all felt normal to him because he was doing it for a long time.

Contact with the criminal justice system also illustrates how class, race, and visibility determine who is caught, charged, and processed; the points introduced in Chapter 1 but now visible in participants' own accounts. Several participants reflected explicitly on how their postcode, appearance, or lack of resources shaped their encounters with the police and courts in ways that a middle-class or professionally employed person using drugs might not have experienced. This is consistent with Shiner's (2009) argument that the same behaviour carries very different legal consequences depending on social location.

Before moving on to the next chapter, I want to highlight how participants perceived addiction. This thesis explores a variety of experiences with drug use and does not specifically focus on drug addiction. However, as shown in this chapter, some participants described their drug use differently from those who did not experience major negative consequences. The participants who perceive their drug use as addiction often discussed the power imbalance between themselves and the drug, sometimes referring to it as a disease or illness. In the next section, I examine the views of participants who self-identify their drug use as addiction and how their perspectives are shaped by it.

5.5 Perspectives on Addiction

Eight participants talked about their experience with addiction specifically. Unlike others, they talked solely about their reflections on their past experiences with active addiction as people in recovery and how addiction affected the way they perceived things and their decision-making abilities.

For example, Ava, Tom, Jack and Charles mentioned the power of addiction. They stated that even though drug use caused them to have negative experiences and adverse emotions, they felt powerless to moderate their drug use.

For Tom, the addiction was so powerful that he had no will.

> *"…it got to the point the drugs were there and I didn't even want them, but I had to take them because I was addicted to it. I couldn't say no. I was powerless. Ever. Ever. Saying no, it wasn't my decision anymore." – Tom, 43*

His argument also aligned with other people who talked about the power imbalance with drug use.

> *"I'd be pure desperate to stop, change my life, and I just couldn't do it because it at that point a- I mean, addiction is so powerful." – Charles, 62*

> *"It'll tell me lies - just take one, just do it today, just take the same pills that just nearly killed me. And I do that, I'd come out to the hospital, and I do that and- I think you need to be insane to do that, right. But that's how powerful the illness that I suffer for years. It just nearly killed me. And then I am taking the same drugs that nearly killed me." -Jack, 49*

Similar to Jack, some other participants also talked about the "lies". According to them, in active addiction, they would find ways to convince themselves to continue their drug use. These "lies" would help them to justify their problematic drug use experience.

> *"You just don't know because "ah, I'm not that bad. I'm not as bad as him". You always justify things and "I'll stop if I- if I start doing these things", then you do it and then the goal post move and he keeps saying "alright, if I ever get to that position, I'll stop" then you get to that position and you move the goal posts. So, it was just- it was just pure total denial" -Charles, 62*

Charles identified it as being in denial and stated that, time to time, he would experience "clarity" and try to moderate his drug use; however, the lack of support at the times of "clarity" would lead to drug use. Tom's experience that been discussed under the Experiences with Correctional Services heading highlighted the feeling of denial. Tom's words "then I forget yeah a sure I'll not get addicted this time" has the same sense of denial/convincing self.

Ava talked about these sense as 'lies'. She stated that she would start to lie to herself.

> *"And even if I do stop my head will then my lies and my head will tell me it will say that bad the last time. So, like I've told you I've just showed you absolute complete powerlessness of no matter what happens and how bad things got I kept doing it. I- I couldn't stop." -Ava, 42*

She also mentioned the power imbalance between herself and the addiction. Overall, participants talked about how addiction affected their decision-making with "lies" and a

power imbalance. Some of the decisions they made caused them to experience adverse emotions both in active addiction and recovery.

The overpowering adverse emotion they felt for the decisions they made during active addiction was guilt. Alice talked about how her actions during her active addiction affected her family.

> *"So, initially obviously being an addiction for all these years, you know, I- I robbed my mother of peace of mind. I robbed my sisters. My sisters used to cry that they were gonna find me dead in the house. You know, I- I tormented them." -Alice, 42*

She added that during this time, she still felt love for her family and cared about them. However, in her words, "the power of that (addiction) was a lot stronger than any other thing that I had." Charles also reported feeling similar emotions. He stated that, contrary to what people believed:

> *"So, I knew the stuff I was doing was terrible, but it just made me feel worse about myself and always listen to that to use more drugs. I just became this mad cycle. I just couldn't out of it." – Charles, 62*

However, Amy argued the opposite and talked about how she felt during her active addiction.

> *"Because that was- that's the addict in me and no thought of anybody else pure, selfish, pure self centred. All about me and that's what I did." - Amy, 48*

It is worth discussing her choice of words in this quote. The phrase "the addict in me" also refers to a being other than Amy. It can be argued that this phrase also refers to a loss of control and power imbalance because she separates her addiction from herself.

Another aspect that some participants experienced regarding addiction was their perception of the world. Charles and Arthur discussed how anger was a part of their addiction experience and how this anger influenced the way they viewed the world.

Arthur discussed that the anger stemmed from not being able to manage his emotions.

> *"I was an angry person because I didn't know how to deal with emotions, obviously. So again, I was a very angry person when I came into recovery." -Arthur, 47*

For Charles, the anger came from self-protection. The view of his world led him to feel constant anger.

> *"And- and I was kinda- it's- it seemed you're coughing addiction as if you live in a hostile world. Everything's hostile, you're angry and resentful all the time and- it was fucking terrible." – Charles, 62*

In his narrative, he pointed out how drug use affected his view of the world and being in constant alert led him to have anger problems.

5.6 Summary

This chapter has shown that adulthood was not simply a later stage in participants' drug use stories, but a period in which drug use was reworked through responsibility, intimacy, work, and contact with correctional services. While Chapter 4 explored the early life contexts in which drug use first became meaningful, this chapter has demonstrated that those earlier patterns did not remain fixed. Instead, they continued to shape adult life while also being transformed by new expectations attached to being a parent, partner, worker, or citizen. In this sense, adulthood functioned as an important life-course stage in which drug use was no longer experienced only in relation to pleasure, coping, or belonging, but also in relation to care, duty, stigma, guilt, and social judgement.

One of the clearest findings of this chapter is that adult roles did not affect drug use in one uniform direction. Parenthood, intimate relationships, and work could act as motivations to reduce, control, or stop drug use, but they could also become sources of pressure, shame, conflict, or distress that intensified it. Pregnancy, parenting, and family responsibility sometimes encouraged participants to attempt controlling drug use, yet these same roles could also expand feelings of failure when control was not maintained. Likewise, intimate relationships could provide opportunities for connection, experimentation, or mutual understanding, but they could also introduce new drugs, reinforce existing patterns, or break down under the strain of drug use. Work life was similarly complex: for some, employment offered routine, purpose, and something to protect; for others, occupational cultures

normalised drug use, while job loss, injury, or criminal records deepened instability. Taken together, these findings suggest that adult responsibilities did not simply "correct" drug use. Rather, they changed its meaning by placing it in tension with social expectations about maturity, productivity, care, and self-control.

The chapter also highlights that social relationships in adulthood were deeply shaped by drug use, but not only through straightforward ideas of support or exclusion. Some participants described belonging, recognition, and enjoyment within drug-using networks, while others reflected on isolation, superficial relationships, and withdrawal from those outside drug use. In several accounts, these adult social patterns echoed earlier experiences from Chapter 4, especially where fear, shame, or insecurity had already shaped how participants related to other people. This is important because it suggests that adulthood did not erase earlier vulnerabilities; instead, in some cases it reproduced them in new forms. Social isolation in adulthood therefore needs to be understood not only as an effect of heavy drug use, but also as something connected to biography, self-protection, and the changing social worlds participants inhabited over time.

Another important finding is that interactions with correctional services rarely appeared as simple turning points in a positive sense. Although prison and court contact sometimes interrupted drug use temporarily, these experiences often failed to produce longer-term change on their own. For many participants, prison became part of a repeated cycle involving punishment, release, resumed use, offending, and return. In several narratives, this was closely tied to unresolved trauma, shame, lack of support, or the normalisation of crime within particular environments. This suggests that institutional intervention did not necessarily address the underlying meanings or conditions of drug use. Instead, criminal justice contact often became another layer within already complex trajectories, sometimes intensifying exclusion rather than transforming lives.

Finally, the addiction narratives discussed in this chapter show that some participants understood their adult drug use through a language of powerlessness, denial, and loss of self. However, this language was not shared by everyone, which is analytically important. It suggests that even in adulthood, participants did not interpret drug use through one single framework. Some understood it through addiction and disease, while others continued to emphasise functionality, pleasure, control, or context. This reinforces a broader argument

running through the chapter: adult drug use cannot be reduced to a single model or meaning. Rather, it was experienced and interpreted in multiple ways, depending on biography, drug, social environment, and stage of life. Overall, this chapter has shown that adulthood intensified the moral, relational, and structural stakes of drug use, making it a key period for understanding how earlier experiences were carried forward, contested, and reshaped across the life course.

Chapter 6 Recovery Experiences and Later-life

In this chapter, I explore how participants experienced drug use, recovery, and ageing in later-life. In Chapter 4, I examined the early life contexts in which drug use first became meaningful, and in Chapter 5, I explored how drug use was shaped through adult turning points such as parenting, relationships, work, and contact with correctional services. This chapter moves the analysis forward by focusing on later-life. It examines not only what it means to get older with a history of drug use, but also how ageing reshapes the meanings attached to drug use, recovery, identity, health, and the future.

Ageing is not only a biological process. In participants' accounts, it was also social, emotional, relational, and biographical. Getting older was discussed through bodily change, health concerns, changing social lives, questions of maturity, self-acceptance, and reflections on time lost or time regained. For some participants, later-life brought greater peace, confidence, and clarity. For others, it involved regret, stigma, declining health, or the growing weight of earlier experiences. Importantly, the findings show that ageing was not experienced as a uniform or natural stage in the same way by everyone. For some long-term drug users, reaching their forties, fifties, or beyond was itself unexpected, because earlier drug use had been lived with the assumption that they would not survive that long. In this sense, later-life was not simply another chronological stage, but a biographical and emotional threshold.

This chapter is organised in two sections. First, I examine participants' experiences of getting older, including financial security, social expectations, stigma, changing social relationships, health concerns, and psychological freedom. Through these themes, I show how ageing was shaped by personal history, wider social norms, and the embodied consequences of living with long-term drug use or recovery. Second, I examine participants' perspectives on drug policy and services in later-life. These accounts are important because many participants reflected on policy not only as people with lived experience of drug use, but also as people who had spent time in recovery and, in some cases, worked in drug-related roles themselves. Together, these sections show that later-life is not only a period of physical ageing, but also a stage of reflection, reassessment, and changing understandings of both personal experience and wider systems.

6.1 Getting Older

Getting older is not only a biological process but also a multi-layered phenomenon with economic, social, and psychological dimensions. Therefore, this section examines in detail how getting old is experienced through themes such as economic security, social expectations, identity and belonging, health concerns, and psychological emancipation. Participants' narratives show how getting older is shaped by personal history, social context, and normative expectations; these narratives are analysed from a biographical perspective and interpreted in depth.

Getting older was different for some long-term drug user participants. Four participants stated that getting older was not an expected part of life. This situation led to the emergence of ageing as a surprising experience for them. The drugs used at a young age created a strong belief that life would be short, which shaped the perception of identity and future. Amy expresses this situation as follows:

> *"So, I mean, and I'm proud to be 48. I never thought- always says I will never reach 40. I'll be dead before I'm 40. That's what I thought." – Amy, 48*

These words show how early expectations were centred on death and how reaching the age of over 40 was felt as an achievement. Similarly, Jack's narrative reveals how this perception turns into a sense of surrender.

> *"So, aye, getting older for me, it just gets harder and harder and harder to the point for me and just completely gave up and accepted. I was gonna die and I was gonna die on methadone. I was probably gonna die after having a hit on my kitchen floor… all my 30 years, hundreds of people I know have died." – Jack, 49*

Here, the expectation of death was transformed from an ordinary thought into a certain prediction. The participant's statement 'hundreds of people I know have died' shows how normalized death is in the community and its impact on individual perception. Additionally, as mentioned in the first chapter, Jack experienced guilt because he survived while his friend died. Similarly, Arthur accepted that loss of control would result in death:

> *"Older I got, we- over the years with taking drugs, no other sort of resigned myself to the fact that a Monday I would lose my life to addiction... I accepted that." – Arthur, 47*

Such statements reveal that the thought of death is seen not only as a possibility but also as an inevitable outcome. Anne's narrative showed that this perception can continue even after many years of use.

> *"My age. I don't know. I wish to- No matter if I live to 90, which I doubted that I'd even live to 50. I would still inject myself." – Anne, 56*

As can be seen from these experiences, ageing was an unexpected experience rather than a natural occurrence. Therefore, participants with long-term drug use experience highlighted some different experiences in the context of ageing.

As can be seen, some of the participants had different perspectives on ageing. This was unexpected, therefore causing a different set of experiences. In the next sections, I discuss how people experience long-term drug use in later years.

6.1.1 Financial Security and Satisfaction

Financial security in later-life was a significant theme in some participant's narratives. Especially for individuals with a history of drug use, economic stability is seen not only as a material comfort but also as a compensation for the past, a symbol of a reconstructed identity, and a basis for peace of mind. Andrew's statement is striking in this context.

> *"Ah. I think- I think getting old for me has generally the- the older I've got, the more I mean I'm- I'm more content now than I've ever been in my life. I'm not wealthy. I haven't done too badly, and if I hadn't gone through the 10-year period of being in using cocaine intensively, I'd probably be a lot more wealthier than I am. Not- not just because of the money I spent on cocaine, but because of the amount of time it that- that was the period of my life when I should have been my- my career should have been developing. I mean, I was earning a lot of money. I was paid- I was being paid a lot of money, you know, in my mid-30s. And I took that money and spent it and enjoyed it and didn't really care about building for the future. And if- if I- you know, and in that sense you can say that*

> *that- that's a negative effect drugs have that in my life. But I mean, I'm fortunate in that I now own my own- house so don't have a mortgage. Yeah, so I've done OK, you know." -Andrew, 66*

This long narrative makes several critical points: First, for Andrew, financial satisfaction is part of an accounting of the past. His cocaine use created a barrier to what should have been the most productive period of his career, resulting in both financial and temporal losses. However, the property he owns today provides a regained sense of autonomy and control despite these losses. Emily's experience reinforces the psychological impact of economic security.

> *"Yes, so I would say to anybody young, if you have the chance to pay off your mortgage as hard and fast as you can, do it. It's worth sacrificing the here and now for that... And then, once you know, this is mine, and no one can take it off me without a really big, drawn-out fight. That is the huge difference... I don't have children, […]. That means that there's a whole load of worries I don't have." - Emily, 72*

For Emily, home ownership is not only shelter but also a safe harbour in times of crisis. For example, in the COVID-19 lockdown, this sense of security was one of the main factors that Emily identified as determining her peace of mind. Her expression of 'freedom from extra burdens' associated with not having children shows how economic stability is intertwined with family dynamics. Similarly, Oliver's words reveal the connection between financial security and the construction of identity.

> *"I'm quite happy with slowing down and having a nice house, having a lovely family, being a good father, etc. So, there are new barometers there in how you kind of measure yourself... Life is pretty steady. Life is pretty secure." - Oliver, 45*

He listed house ownership as a factor for security. Walter shared his experience with financial responsibilities in his recovery. When asked about challenges in recovery, Walter talked about his bills.

> *"I find paying the bills stressful. Haven't paid bills- Before I used to just throw them in the bin, but all ended up- facing the depts, so certainly*

> *facing debts. When you owe people money or the gas, electricity, the TV stuff and [INAUDIBLE] didn't pay it and then started paying it all back." – Walter, 55*

His statement shows how recovery process is not limited to changing drug use habits. As mentioned in the previous chapter, the participants who shared their opinions on addiction suggested that their only focus was on drug use and there is a power imbalance between addiction and their own will. Therefore, it is not unexpected that they ignored or overlooked the other responsibilities in life. Learning to manage and fund these responsibilities can be part of the recovery experience and for Walter, it was paying the bills, and he felt that it was a stressful part of recovery in later-life.

6.1.2 Social Expectations, Stigmatisation and Narratives of 'Maturity'

Another theme emphasized by participants in later-life is the experience of stigmatization associated with society's expectations of maturity and success. With advancing age, individuals described feeling that they were expected to fulfil certain life norms: career success, starting a family, having children, and avoiding risky behaviours. When these expectations were not met, participants described social exclusion, judgment, and stigmatisation coming into play. Harry's narrative is a powerful example of this normative pressure.

> *"But, you could also face the stigma of kind not achieving as many things that society says you should achieve in terms of the, you know, houses and all those other bits and pieces because you've lived your life more kind of in the right in the moment spent an awful lot of money doing an awful lot of things that you probably should have been doing. And the stigma around those things and-and I think you can face stigma in terms of ageing in that I guess not- not I guess I don't. But for- for people who are still using drugs, then for some people, it's that kind of thing of have you not grown up yet? Have you not come to the idea that you should stop doing this because people often link maturity to ageing. Whereas I don't think the two things are particularly intrinsically linked, I'm still very immature at lots of things." - Harry, 47*

Harry emphasises that social expectations intensify with age, and not meeting these expectations creates the risk of stigmatisation. There are two main emphases in his statement: First, that society directly associates the concept of 'maturity' with age and that risky behaviours (e.g. drug use) contradict this perception; second, that normative pressure persists despite the fact that personal life choices are explained by individual freedom. Harry's statement, 'I am still very much a child in many ways,' reveals the tension between individual identity and social labelling.

A similar example is seen in Oscar's narrative. His account of a dialogue with his ex-wife shows how norms of maturity can function as a control mechanism in domestic relations.

> *"But yeah, I remember my ex-wife saying to me. I am- so we moved up to Scotland when I was about 41, and she said when "you're 41 now, you know you're not a teenager. You [are] not in your 20s, it's not even your 30s. When is this going to stop? We moved up here to have children. Nothing's changed. You're still, you know, you're still using habitually. Every day you're flying down to London once a month to get drugs. When is it going to stop?" – Oscar, 50*

This example reveals that, for some of the participants, maturity is associated not only with age but also with the fulfilment of certain life roles. Henry also shared his opinions on a similar issue. He talked about his relapse experience in later-life and how being an older person can play a role in relapse.

> *"It's not a nice thing to get back in at this age, you know, so you're very self-aware at this age." - Henry, 53*

This statement was an answer to my question about his recovery experiences. Such statements illustrate how both individual reckoning and social pressure are intertwined with the aging process. Stigma is not only an external phenomenon but is internalised by individuals and becomes a factor in behavioural change.

These narratives suggests that the expectation of 'growing up' with age not only stems from the individual's own choices but it is also an internalized consequence of a normative framework. The answer to this question reveals once again that ageing is not only a biological but also a profoundly social process.

6.1.3 Ageing and Change in Social Life

Another theme that emerged clearly in the participants' narratives was the impact of aging on social relationships and lifestyle. Many participants stated that they had moved away from the intense social life of their youth to a quieter, more introverted lifestyle. This change is related to both necessity (decreased energy and health problems) and conscious choices (seeking peace and stability). Emily expresses the change in her social environment with the following words:

> *"You don't have the energy to go out as much. And your circle of friends changes... In my twenties, thirties, if, by Wednesday evening, I didn't know where the party was, I would make sure that there was going to be a party... And then it's like people begin kind of cleaning up their acts a bit and being a bit more moderate... The people that are not going to moderate, go off down one path, and you lose contact with them." - Emily, 72*

This narrative highlights a process that is not only influenced by personal choices but also by the transformation within the circle of friends. This dissociation in social relationships is particularly meaningful for individuals with a history of drug use, as ties with friends who continue to use substances are broken, while ties with those who adopt a more 'regular' lifestyle are strengthened. Similarly, George expressed how social ties were weakened.

> *"I haven't got the energy to be somewhere else anymore though... Social side is kind of it... it gradually goes. Most of the people that I speak to are people I know from outside of England... These kind of wandery type people and of course I can't do that." - George, 65*

These statements show that the decline in mobility and social activity is not only a natural process of ageing but also linked to a sense of identity and belonging. Especially for individuals who were close to marginalised lifestyles in the past, this change comes with a sense of loss and sometimes loneliness. Oliver's narrative presents this change in a more positive light.

> *"I'm quite happy with slowing down and having a nice house, having a lovely family, being a good father... There are new barometers there in*

> *how you kind of measure yourself... Life is pretty steady. Life is pretty secure." -Oliver, 45*

As seen here, the participants like Oliver who had financial stability at the time of the interview the simplification of social life is a source of peace and identity stability. This is linked to the reproduction of a normative framework (family, home, order). However, for participants with LGBT identities, the opportunity to be included in this normative process may be more limited and this leads to different experiences. Emily's observations in the LGBT context reflect this situation:

> *"I understand that as an LGBT community we rank higher than expected in substance abuse... Part of this is also due to homophobia. We didn't have to grow up. When you don't have children that you have to get up in the morning to go to school... there is a culture of going out, going to drinking places, going to clubs." -Emily, 72*

This narrative shows that social life is shaped not only by age, but also by sexual identity, gender identity and social position. Having children and deviating from a normative life course radically affects the way ageing is experienced. Finally, Charles portrays the transformation in his lifestyle as an inner search for peace.

> *"I like quiet, peaceful things. No, there is no drama in my life. I don't want drama, I don't want excitement, I just want a quiet life." -Charles, 62*

The fact that simplification in social life means liberation and peace for some participants, while for others it creates a sense of loneliness and isolation, reveals the experiential diversity of ageing. This diversity shows that instead of seeing ageing as a uniform process, we should consider it as a dynamic structure that changes according to biographical and social contexts.

6.1.4 Health Concerns and Physical Change

One of the most prominent issues in the participants' experiences of ageing is health concerns and bodily changes. As people age, the body's limitations become more apparent chronic pain, fatigue, health issues, and physical deterioration impact daily life and mental well-being. Andrew expresses this situation in a very simple way.

> *"I always remember my mother saying to me, you know- you know she- she said. "it always surprised me how the older you get, the more aches and pains you get" and- and that is true... if I stand up just get- get up out of this sofa or something. I'm- I'm find myself going "ohh." I suppose it's just an inevitable part of life." -Andrew, 66*

In this narrative, the astonishment caused by physical deterioration is striking. Although aging is an expected process, the awareness of bodily limitations in daily life creates ruptures in biographical continuity. This statement suggests that not only natural changes, but also past lifestyles are viewed as playing a role in the ageing process by some participants. Physical damage related to drug use is a factor that accelerates physical wear and tear. Oscar's narrative shows how health problems can create a turning point.

> *"When I was younger, I thought I was untouchable. And then I had a massive heart attack... I didn't believe the doctor when he told me. It was a silent heart attack." - Oscar, 50*

Here, a health crisis emerges as an event that embodies the vulnerability of the individual. The sudden vulnerability of a body that previously felt 'untouchable' constitutes a powerful biographical moment that, in this case, led to a reassessment of lifestyle. George stated that, with the growing health problems associated with ageing, he has become more cautious with alcohol and other risky behaviours:

> *"I kind of stopped alcohol, yeah, around 50... Again, I had a poorly liver and it was a strain on it to process alcohol and gradually. It's just kind of actually I can't do that." - George, 65*

More than half of the participants (15) stated that they had health related negative experiences in later-life. Health concerns become a motivation for behaviour change here. This suggests that ageing offers not only loss but also opportunities for adaptation. Ava's words emphasise the emotional dimension of ageing anxiety:

> *"I've got this fear of getting old. I've got this fear of dying, and sometimes it creeps in because I think I have been an addict for 30 years, so I've lost a big chunk of my life to addiction and it's like I've probably get less in my life, less than I've actually lived now." – Ava, 42*

This statement shows that health concerns are not only physical but also have an existential dimension. Ageing makes the finitude of life span more visible, and this brings with it the weight of time lost in the past.

Some participants with long-term drug use discussed the impact of physical changes and health problems experienced with ageing on drug use. Decreased physical endurance, the emergence of chronic diseases, and prolonged recovery processes stand out as important factors that complicate the experience of substance use in old age. Will talked about his experience with long-term drug use and its physical effects in later years.

> *"It was getting harder... I got COPD, you know. Some people got mental issues. It is still an illness. Yeah, I just manage it, just manage. I can manage it until I get a chest infection. Since you get a chest infection, it gets a bit lower, harder." – Will, 61*

This statement illustrates how chronic health problems (e.g. COPD) can make drug use and withdrawal processes more complex. Similarly, Anne expressed the impact of age on physical capacity.

> *"I go to jail. I kept getting the jail three times in a short. And the judge asked for a drug testing order this time. Because I said that I- I can't do this anymore, I am getting too old. I can't. I just can't anymore. My body can't handle it." – Anne, 56*

These words show that the physical limitations of ageing have created a turning point for Amy. Later in the interview, she cited this experience as a motivation for her recovery. Charles talked about how his experience with drug use changed over time.

> *"Well, getting older meant. I remember when I was about late 30s, I promised myself, swearing I will be clean by the time I'm 40. And I remember hitting forty, and I still couldn't stop, and I was fucking miserable... So- Getting older using drugs it just becomes harder and harder because the pain gets more and more. The baggage, the shame... The older you get, the heavier it gets to carry. " – Charles, 62*

His narrative emphasises that continuing drug use became not only physically but also emotionally heavier with age. It shows that ageing is not only a physical but also an

emotional process. The 'baggage' and 'shame' mentioned by the participant reveal the weight created by the experiences accumulated over the years. Similar to Charles, Arthur also pointed out the increase in pain.

> *"Obviously it was because the drugs always changed, but the pain and the misery never ever changed. That gets sorer, it get darker... The pain I felt one day I would feel more pain the next day. "-Arthur, 47*

As mentioned in previous chapters, Arthur highlighted the problems he had during his active drug use, such as isolation and physical pain. In this quote, he mentions how these problems intensify with age. Walter also talks about physical changes he experienced.

> *"Awful, do you know what I mean. Drugs are rather hard to come off as well. It takes weeks and weeks to come off, whereas back in the day, 10 days, 11 days. Now it takes about a fucking month. You know what I mean, get back to normal." – Walter, 55*

Walter's narrative is a strong example of the decline in biological recovery capacity with age. Processes that can be overcome in a short time when we are young turn into a weeks-long struggle as we get older. Richard also experienced similar physical changes and talked about the recovery process.

> *"Even I'm like 4-3 months abstinence and I still feel pretty tired. And so as I got older it's getting more and more difficult to stop." – Richard, 44*

Amy's experience illustrates the physical consequences of past risky behaviours.

> *"It's like a health thing, isn't it. Like you- you start to worry about getting older and health things, and like I've done a lot of damage to myself through injecting. I've got really severe nerve damage. I've got arthritis." -Amy, 48*

The body as a site of accumulated consequence connects to the ageing literature reviewed in Chapter 1. Beynon and colleagues (2009) documented the association between long-term drug use and poor health among older users, and Ayres and colleagues (2012) showed that older drug users often minimise health needs out of fear of stigma. What participants here add to that picture is the specific biographical meaning of bodily change; not just that the

body is damaged, but that damage becomes legible as an ageing body, and that this forces a renegotiation of identity that purely health-focused research has not examined.

Overall, these findings suggest that aging affects drug use not only at the biological but also at the behavioural level. While physical limitations may motivate individuals to quit, they also increase the importance of support mechanisms by making the process more challenging.

6.1.5 Positive and Negative Ageing Experiences

Participants' experiences of ageing are multi-layered, with both positive and negative aspects. Seventeen participants shared their experiences in later-life. For some, ageing means freedom, wisdom, and peace of mind, while for others it means facing health problems, losses, and the irreversibility of time. This dual structure shows that ageing is not only a biological process but also a biographical narrative shaped by social norms, personal preferences and past life experiences. Emily expresses a positive perspective on ageing as follows.

> *"Positive experience of aging. It's not, not as bad as I thought it would be... I love being retired because I volunteer... I'm one of the counsellors in the talking therapist team and I do stuff in the [PROJECT]... And because I have nothing that anyone can take off me... That's the nice thing about getting older." - Emily, 72*

This expression points to the feeling of freedom and empowerment offered by ageing. Having ‘nothing to lose’ in this case allows Emily to be more at peace with her own identity. This also means being free from normative pressures and being able to express oneself. Similarly, Laura emphasises the increase in self-confidence and self-acceptance:

> *"The positive sides of ageing, well, I was going to, say you stopped giving a shit, but I've never really given a shit so. But I'd say you become more confident in not giving a shit." – Laura, 44*

Although humorous language is used here, at the centre of the narrative is the desire to become independent from social expectations and to live according to one's own values.

Another frequently mentioned positive aspect is the strength provided by wisdom and life experience. Amy expressed her experience as follows:

> *"With age comes experience... I've got more knowledge and wisdom... And I can help people with that. I can guide people because of the experience and the knowledge that I have got." -Amy, 48*

However, not all accounts are so positive. Some participants expressed concerns about the irreversibility of time and physical changes. Alice expresses this concern as follows:

> *"Everything starts getting saggier... I wasted so much time, you know, living that life... If I could have just stayed 40 for time would have been alright with that." – Alice, 42*

Apart from health concerns that have been discussed in the previous heading, adverse emotions caused by 'the lost time' in the past mentioned by Richard.

> *"Regret of wasting years of your life on drugs. Obviously, your physical health isn't as good. And that's a bit [UNAUDIBLE]. Everybody gets old, not everybody but the lucky ones." – Richard, 44*

This statement reveals the contradiction of seeing ageing as both a loss and a privilege. Aging is, on the one hand, an inevitable biological process and, on the other hand, a sign of being 'lucky'. Richard has been using drugs since he was 10 years old and he mentioned losing relationship and jobs to addiction. He was in rehab at the time of the interview. Even though he highlights the loss and the realism of consequences of drug use, he also points out that experiencing later-life was not an option for everyone.

Another dimension of negative experiences is the feeling of stigmatisation and invisibility. Leo shared his experience:

> *"As younger generation, we always look at older people and just say, 'you're ancient.' In some ways you sort of, like, you don't exist in a way, do you?" -Leo, 52*

The feeling of invisibility was highlighted also by Emily. She stated that it is a weird part of later-life.

> *"One of the weird things is becoming more invisible, cause I hadn't realised how much attention I got in in the street- in- in general until I got older, and I can see myself just being looked past now…" -Emily, 72*

Like Loe, Emily felt that she was less visible in social settings. Such perceptions reduce the social visibility of older people and may lead them to feel devalued in social relationships.

6.1.6 Self-Acceptance and Psychological Freedom

For nine participants, ageing is not only a biological process but also an experience of psychological freedom. The desire to accept oneself more, and to become independent from the judgements of others is at the centre of this theme. In this respect, ageing emerges as a process of identity negotiation and reconstruction. Andrew shared his experience with acceptance.

> *"Ohh, I think you care- Well, I think as- as many people say, you care less what other people think about you... You're more settled and centred in yourself, you know who you are, and you know, and basically people can take it or leave it." – Andrew, 66*

This statement explains one of the greatest psychological advantages of ageing: a move away from societal expectations and the need for external approval. Self-confidence and authenticity are powerful gains, especially for individuals who have experienced stigmatisation in the past. Similarly, Leo states how this self-confidence is formed.

> *"Think you've just become more relaxed. You're more accepting of things you know who you are more- You feel as though you're less concerned about, you know, other things. You know people, what they think... it's assurance of yourself, you know you're more comfortable of yourself." - Leo, 52*

These words underline the psychological flexibility of ageing. The pressure of social comparison, which can be intense in youth, decreases with age. This allows individuals to live their identities more freely. Charles summarises this feeling as follows:

> *"I'm more comfortable in myself, more comfortable in my own skin. I don't take myself so seriously." – Charles, 62*

As seen here, the process of ageing has become a practice of mitigation and self-acceptance. The participant has developed a more compassionate approach to herself, moving away from the rigid forms of self-evaluation of the past. Noah's narrative reveals a philosophical transformation that comes with ageing.

> *"Do you know I came from this religious family?... But it didn't work for me. What works for me now?... There's a theory called determinism. I'm pretty sure you've heard of it. That everything happens exactly the way it's meant to happen... So there's been a complete change. An absolute change. And I didn't care what single person thinks of me. I'm content with me." - Noah, 79*

These words show a radical restructuring of the meaning of life. The participant, who adopted a determinist approach rather than relying on divine authority, found both a sense of control and subjective peace within this philosophical framework.

Participants also talked about psychological side of recovery and ageing. For eight participants, the recovery process was not just about controlling drug use; it was a process that involves restructuring life along with the physical and emotional changes caused by aging. Ava describes recovery as a "rebirth".

> *"I don't feel as old as I am. Like for me, I think getting my recovery has actually made me feel young again. It's like I'm getting to relive my life again; it's like having a second chance at life."– Ava, 42*

This statement suggests that for Ava, recovery offers not only a return to health but also the opportunity to make up for lost time and re-experience life.

Another participant also highlighted the feeling of lost time. Will talked about how his experience with drug use and correctional services affected his mental status in recovery.

> *"Changes of- accepting. Accepting the years. Yeah. Of being locked away, being- Put myself in treatment to put myself in prison. Not recognising missed so much things. Missed because you've been stuck away in poison and you didn't seeing what you could have seen." – Will, 61*

Reconsidering the past was an experience shared by other participants. Jack's words emphasize the awareness and perspective-gaining aspects of aging.

> *"By getting older, I can just see that - I see things more. I have better awareness and now have a better ability to look back and see where my mistakes were and learn from them."- Jack, 49*

Here, aging is viewed as an opportunity to reflect on the past and shape the future more consciously. Later in the interview, he added the effect of this new perspective on his life.

> *"Now I'm looking forward to the future for the first time in my whole life... If I put in the work, I can do it." – Jack, 49*

Jack's new perspective on life affected his experiences with life challenges. Fred also reported a similar experience.

> *"[Ageing] brings a wee bit more thought and what- What- what you're doing because you know I didn't realise stuff. I thought I would live forever. I am only young now. I still have a million years ahead of me. Now, I do it [INAUDIBLE] I am thankful for that. I look at my day and use them as well as I can." - Fred, 52*

His narrative refers to the awareness of time. The perception of time, which once seemed limitless, is now giving way to a desire to use each day meaningfully. Charles expresses the need to live life more lightly during the recovery process:

> *"I've spent a big part of my recovery saying give yourself a break. Don't take life so seriously. Relationships - I have amazing relationships. And, I mean, I put my head on my pillow and I thank God... my life keeps getting better." -Charles, 62*

This narrative shows that recovery involves not only abstaining from drug use but also strengthening relationships and developing a more compassionate attitude towards life.

Some participants emphasized the importance of maintaining physical health during the recovery process. Walter described his experience during his recovery.

> *"That's what I need to do. That's my medicine, the gym." – Walter, 55*

Exercise stands out as a strategy that supports both physical and mental health. Similarly, Alice emphasizes the fullness and speed of life after recovery.

> *"Since I've been in recovery, time just flies by... I have a fantastic life. You know, a really, really good life. " – Alice, 42*

Finally, some participants stated that the maturity that comes with age strengthens feelings of empathy and solidarity.

This process of re-evaluation connects to the self-stigma literature introduced in Chapter 1. Livingston and Boyd (2010) show that internalised stigma affects self-esteem, hope, and empowerment across the life course. What these later-life accounts suggest is that this process can move in the other direction too; ageing can, in some circumstances, create distance from earlier self-stigma, not because the past disappears, but because the biographical position from which it is assessed has changed. This is not captured by the existing UK literature on older drug users, which tends to measure stigma as a static outcome rather than as something experienced differently across the life course.

All these narratives reveal that when healing and aging are considered together, they signify not only physical purification but also the reconstruction of life's meaning, the strengthening of social bonds, and the development of a new understanding of oneself.

6.2 Perspective on Drug Use Policy

Eleven participants shared their perspective on drug use policy. They not only found current drug policies inadequate but also considered them problematic in terms of human rights, social justice and ethics. These experience-based criticisms reflect a tendency to view drug use not merely as an individual behaviour, but also as a phenomenon shaped by social regulation. The participants who shared their opinion on the matter are/were working in drug use area in various positions like academia, drug worker, and prison drug treatment. Therefore, their opinions affected from both lived experience as people with drug use experience and professional.

Andrew drew attention to the fact that drug policies are still being pursued with a ‘crime and punishment’ mentality and expressed that this does not produce an effective solution with the following words:

> *"And I, yeah, I mean, you won't, you probably won't remember this, but all the sort of “just say no” stuff from, you know, like, and there's a programme in the UK called Grange Hill, I don't know if you know what that is, but it's an old, it's an old, it's kind of like a children's soap opera about a school. And there's, there's, if you ever look at, I mean, if you*

> *speak to anybody of my age or a bit younger about a kid called- Zamo was his name. And it was because there was a huge heroin epidemic in this country in the 80s, wasn't there, like, you know, so the first place that ever really got out into the public conscious was in Grange Hill. It's a kids' programme, and this kid Zamo got addicted to heroin on it back then. And I remember, I remember, but that was the, that was the discourse around substance use at that time, is he used heroin, and he's got addicted, you know, it was a big, it was, it was quite a long story, it was done very well. But, you know, that idea of just saying, oh, you try it once, and you're addicted, this is your brain on drugs, all that sort of crap that they used to sort of push on us back then. It has moved on from that a bit. There is, at least there is a discourse now, I would say, we're still way, way far away from where we should be. If there is still, you know, we are still in the crime and punishment prohibition era, which, but, but more and more people are beginning to… see that there's another way and have discussions about it." – Andrew, 66*

He gave the example of a TV show that took place in the 80s and stated that represented what policy think about heroin use at the time. He expressed his hope for a change at his last sentence stating that other people started to question the perspective on drug use. Similarly, Geroge emphasised that there has been no progress in the system, based on years of treatment experience as a person who worked in prison drug treatment. George talked about how criminalisation of drug use negatively affects drug use treatment.

> *"Well, there's a huge industry around it. That's about it, really. Nothing much has fundamentally changed, you know, there's still got drug users coming in through the door. And they still got, you know, similar kinds of problems to those that they always had and. It's. Yeah, it's- it's no progress really. Because there's- there's no one willing to have a have a proper discussion and you know we're- we're stuck in this four years election cycle and no one's prepared to. You know the current movement is all drugs and crime, and it's going to you need to unstick that one a bit and then maybe you might make some progress, but. The- the- the yeah- there was certainly in the 10 years that I worked in drug treatment, there*

> *was no progress really. I don't- didn't see. And it's one of the things that, yeah, made me step away from it. It was the drugs and crime part of it. You know, I didn't get in- I didn't get into this going to send people to prison. You know, we phoned up their probation officer and say he didn't make his appointment, and he goes back to prison. No, you know, when I was working it was to help people, to be there for them and hope that this is the right time and give them some self-awareness and plant some seeds and you know that was as- as effective as treatment these days." – George, 65*

He thinks that the crime focused approach both creased a burden on people in recovery and drug use workers. Additionally, he commented on 'the proper discussion'. Laura shared her feelings on the criminalisation of drugs and how it affects her drug use.

> *"…the fact that it's illegal has never been enough for me to not use substances because I believe the benefit from using them outweigh the potential risks of getting caught because the risks are quite low. But also like I've just got this thing of like, who the fuck are you to tell me what to do with my mind? Like, honestly, like I understand it being illegal to rape, murder, kill, thief. But like, under what, sun, is it OK to tell somebody whether or not they alter their perspective? You know, like yeah. So I- I've just I've got a huge moral argument and to the point that it's actually stopped me from stopping using substances because I feel like "fuck you." Like, I don't want to become one, you know, like normie. So that's a funny one that I'm gonna have to explore in a bit more depth at some point." – Laura, 44*

Her experienced got affected by multiple factors. First, she felt that the benefits of her drug use over weighted the potential risks. However, later in the interview, she also added that the potential risks related to criminalisation of drugs were a stressor for her. Second, she dislikes the control mechanism over people's choices on their body and mind. In the first result chapter, I shared Laura's experiences in her early drug use and one of the reasons was being opposed to the authority. Her motivation in her teen years remained same in the later-life and even became a barrier to stop using drugs.

Similar to Andrew, George also thinks that approaches on drug use policy should be reconsidered. Oliver commented on a similar issue from a societal perspective.

> *"My blood still boils around issues of drugs and-and-and-and drugs policy. I'm just-I'm just writing something on chemsex here saying what a ridiculous concept it is because people have always taken chemicals and had sex. That's, you know, it's not a new issue. So that kind of ignorance of society to the majority of people who live in it has kind of grounded me to a point that, you know what? Change is impossible and structures of power and inequality will always exist."-Oliver, 45*

He argued that the power imbalance in the society is factor too. He gave the example of chemsex and argued that this term/practice is not something new, but it is marginalised by the society. His last sentence suggests an acceptance/loss of hope as opposed to Andrew's perspective.

Oscar shared his experience and perspective on funding of drug use treatment as a person who works in an organisation who works with homelessness and he stated that drug use treatment was an important part of his work.

> *"So, when I started doing this work in 2004 there was so much money in this work, people would go to detox almost on a monthly basis in the homeless field in London, even though it costs about £5000-6000. The people would realise then, so it was, it was called, a wet hostel back then I'm sure that's not the term they would use now, but it was a hostel in [REMOVED] and so, 70 drinkers in there and every Friday five of them jump on the bus and go to detox, but they would only do it to flush their bodies because their bodies were so ravaged from alcohol. They go and spend a week there, totally flush their bodies and you'd see them coming back with the little blue plastic bag from the shop with eight cans of super strength alcohol again. So yeah, back then, there was so much money in it and then the recession. And then the whole culture of the work sort of changed around about 2010'ish. Where clients with them being asked to do some pre work for detox which lots of them are absolutely astonished, "why do we have to do pre work? Why? You know why do we have to do*

> *this? Why do we have to do that?" Because you've always been so readily available and over that 20 years it's totally gone the other way." – Oscar, 50*

Oscar observed that the funding on drug use treatment was cut back over the years and people who were trying to access treatment were started to ask for pre work. He also commented on the practice differences between London and Edinburgh.

> *"So I was working in a hostel in Edinburgh until last year when I had to give up work due to sickness and I think we were lucky we got one or two people a year into detox. It was almost like you have to jump over all these hurdles first to show your commitment, which is fair enough, and that's how it should be. But because I've worked in the field so long, where detoxes were just given out. Just really struggle with seeing guys. I've seen guys break down in front of me crying saying "look, I want detox. You're my work. I've been working towards it for eight months. When am I going to get it?" I think the length of time now between referral and admitting someone for a detox from rehab and the amount of hurdles they have to jump over, I think it just ends up pulling off a lot more people. It's almost like an obstacle course to get they want. Even with the introduction of, you know, mutts and everything. Still during the pandemic huge changes were made in Edinburgh because after working in London for years where everything was so progressive and then moved to Edinburgh, and I felt like I'd gone back 10-15 years with working practises. – Oscar, 50*

He stated that Edinburgh had less treatment opportunities for people compared to London. He suggested that these lack of opportunities feels like an 'obstacle course' for people in recovery. He also talked about how Covid-19 pandemic affected the access to Methadone in Edinburgh and how this change was an opportunity to see a different approach in treatment.

> *"And then along came the pandemic. Before the pandemic, you could only get on a methadone script or something, if you turned up between, I think it was 1 and 2:30 on a Thursday in a specific clinic in Edinburgh. That's one and a half window every week to try and get on to a script and*

> *then all of a sudden, the pandemic came along and nurses were coming out, [INAUDIBLE] were coming out into the hostels, doctors were coming out and putting people on scripts. There and then, which was amazing, to show that they could actually do it. So why haven't they been doing it before? They made the frustration. I've seen clients, as I said this one guy broke down crying to me one day I've missed my appointments, and I was a whole week I've got to go out and beg on Princess St. and just to get a bag because. I'm physically addicted I need to do that every day, I've missed the 1-1/2 hour window or I turned up five minutes late and they wouldn't let me in and now I'm stuck in a cycle for another week, [INAUDIBLE]. So yeah, the pandemic changing things was huge." - Oscar, 50*

He argued that giving more flexibility (access time and prescription) to accessing methadone improved the treatment experiences and it was an unexpected result of Covid-19 pandemic. Alice shared her perspective of Scottish treatment services as a person who works with prison system and as a person in recovery.

> *"Oh, the systems and knackered and that's the truth. That's the- the addiction system is knackered. So, for me personally, I never rehab, I was never given the opportunity to go to rehab, you know, not just that the criminal justice system, you know, he came at an offence to put you in prison. They don't help you, support you, do any work with you and then they bring you back out of the community and expect you to change. You know, so there's homelessness, lack of houses, lack- so, they'll put you in places like [HOSTEL], where it's chaotic, where there's bodies [INAUDIBLE] every other week with people overdosing. The systems need [INAUDIBLE] the systems are set up to fail people don't get me wrong, people need to be ready to make changes also. So, it's- it's- it's not just the systems, but even as a worker now in criminal justice and that trying to get through the care managers trying to get them to get the right support for it. It's- it's- it's almost a brick wall. And that's us as workers, so what chance is the client got." -Alice, 42*

In the first chapter, Alice talked about her challenging childhood (care experience and death of his father). And one of the challenges she pointed out was the lack of mental health support. She highlights the similar perspective on prison experience in this quote. For her, prison does not prepare people for the life after prison and the opportunities that given to people in recovery far from being helpful and ideal. She also commented on the financial part of treatment services.

> *"I believe services changed. You know there lots of funds and they make new services and all that. But I still feel services at times are there to fail people, you know they're not there to support and help. It's the tickbox exercise, it's for the money, it's for funding. It's- it's not actually about the person. And then the services just talk about a person-centred approach. You know they don't use this person-centred approach. So, in the community I think the community stayed, some things have changed. New buildings, shops disappear, new services, old services closing, people die and new people coming in. But I don't think there's been major changes within the system or the services that are provided. You know, we shut rehabs. Do you know what I mean. How does it help? Does that help? I think this morning was a big thing in health and social care partnership. 50- 50 million, is that- they're losing or something like that. So, they're all protesting the- now outside the- the chambers in- in Glasgow City Centre. So, they're cutting funding back. They're losing workers and the drug problem still sky high, you know. We're [INAUDIBLE] drug test each year and that's so they can get any higher because the numbers and figures are disgusting, the amount of people at the end of the day that somebody's son, somebody's brother, somebody's kids, father, you know, and they looked at as just, you know, just the number." – Alice, 42*

Alice argues that the amount of funding and treatment services increased over time. However, there is a dehumanising part of the treatment and funding. She suggested that treatment services are focused on the funding and money. They are overlooking individual accounts and failing to see treatment users as human beings. And she also highlighted that these increased findings started to get cut down and number of people who need treatment and recovery services remains high.

Two participants shared their perspective on increased treatment options in Scotland/Glasgow. Anne compared her experiences with accessing rehabilitation.

> *"See years ago, there was nothing, absolutely nowhere you could go to get rehabilitated or any hope you are coming off drugs in Glasgow, you had to go- I had to go to Lancaster- Lancaster, Red Towers there was." - Anne, 56*

She argued that Glasgow did not offer rehabilitation services in the past and people had to go to other regions for rehabilitation which was a challenge for them. Walter and Edward commented on lack of information of recovery opportunities.

> *"I didn't know you could get better; you know what I mean. I just wish we would advertise it (Recovery Café) better. And should it- should be advertised on the telly. Most of the people I've seen that have been clean for years, I thought they were dead because I hadn't seen them about. When I say I hadn't seen them, I mean I didn't see them up streets, buying drugs, you know what I mean." – Walter,55*

Similar to Walter, Edward did not know about recovery cafés also. His introduction to recovery was a result of a coincidence.

> *"And lucky enough I was-I was down, I was actually down the corner there, down the park across, selling drugs and three boys turned the corner on the [STREET NAME] here. Kids, I remember one of their faces and I'm like, he usually buys his drugs off me. And I followed up behind him. And the [INAUDIBLE] disappeared. And I'm like where did he go? [INAUDIBLE] and I followed him because I thought he was looking for me to get drugs. And I walked in and opened the door and this place was shiny and everybody was sitting big, happy faces and all smiling and enjoying themself. And boy approached me down "are you OK, pal? Got a cup of tea". And I'm too busy looking over the top of me, see where the few boys went, [INAUDIBLE]. And he says "how you doing, pal? I'm [REMOVED]" And I'll never forget you, [REMOVED]. […]. And he says this is a recovery cafe pal. This is what's recovery. I didn't know what recovery was. This is- this is where everybody comes. A safe place. And*

sharing experience through- about each other, about faith and about hope to stay away from the drugs." – Edward, 52

Their accounts suggest that drug users can miss on treatment and recovery opportunities just because of lack of accessible information. Accessible information is more important for older generation considering that they might be less likely to use digital platforms (Centre for Better Aging, 2025).

6.3 Summary

This chapter has shown that ageing with a history of drug use is not a uniform experience. Participants described later-life through a combination of physical change, health concerns, shifting social lives, changing self-understandings, and reflections on time, loss, and recovery. For some, getting older brought greater peace, confidence, and acceptance. For others, it brought regret, declining health, stigma, or a stronger awareness of opportunities lost through long-term drug use. These findings suggest that ageing should not be understood only as biological decline, but as a biographical process shaped by past experiences, present circumstances, and the meanings participants attached to both.

A particularly important finding in this chapter is that later-life changed how participants understood drug use itself. For some long-term drug users, reaching older age was unexpected, which meant that ageing was experienced less as a normal life stage and more as survival. At the same time, bodily change, chronic illness, slower recovery, and reduced energy often altered participants' relationships with substances and recovery. In this sense, later-life did not simply add age to existing drug use experiences. It reshaped them. Participants were not only dealing with drugs or recovery in isolation, but with the accumulated effects of earlier experiences on the body, identity, relationships, and future. The policy reflections discussed at the end of the chapter also show that these later-life experiences are not only personal, but are shaped by wider systems of care, punishment, and support. Overall, this chapter demonstrates that ageing brings a new perspective to drug use by making issues of health, time, survival, and social recognition more visible.

These findings do not stand alone. The biographical accounts presented across Chapters 4, 5, and 6 collectively reveal that drug use is not a static or linear experience but one whose meaning is continuously reconstructed in relation to changing circumstances, responsibilities, bodies, and social positions. Chapter 7 draws these threads together, interpreting them

through a life-course lens to develop a sustained analytical argument about how drug use, ageing, stigma, and biography intersect; and what this means for policy, practice, and our understanding of later-life.

Chapter 7 Discussion

This chapter discusses the empirical findings presented in results chapters through an integrated life-course lens. It interprets how drug use is experienced, narrated, and renegotiated across early life, adulthood, and later-life, and examines how processes of ageing, stigma, and social inequality shape those experiences in unequal ways. The chapter is organised into six sections: a biographical synthesis of drug use across the life course; an analysis of turning points, agency, and constraint in adulthood; an examination of ageing, survival, and self-acceptance in later-life; a discussion of stigma, class, and unequal experience; ageing in drug use and a concluding account of the thesis's original contributions to knowledge and its implications for policy, harm reduction, social work practice and suggestions for future research.

7.1 Drug Use Across Life: A Biographical Synthesis

This section discusses the empirical findings presented in the thesis from a life course perspective, interpreting how participants' drug use experiences transformed throughout childhood/adolescence, adulthood, and later-life. The findings reveal that drug use is not a linear experience confined to a single period; rather, it is a dynamic phenomenon that is continuously reinterpreted in relation to individuals' biographical histories, social contexts and ageing process.

This finding directly challenges the dominant frameworks that have shaped UK drug policy and research. Progression models which assume a predictable arc from initiation through escalation to either recovery or deterioration have been critiqued for reducing complex biographical experience to a single trajectory (Room, 2005; Strang, 1989). The maturation hypothesis (Winick, 1962; Dennis, 2021) proposes that people naturally "mature out" of drug use as they age into adult roles, but my data show this applies unevenly and incompletely. For many participants, adult roles such as parenting or employment reshaped the meaning and visibility of drug use without ending it. Similarly, recovery stage models (DiClemente and Prochaska, 1998) risk imposing a forward momentum that does not match the cyclical, episodic, and sometimes stable patterns visible in these accounts.

In some drug use literature, particularly the discussion of the ‘ageing users’, indicates that drug use is not a phenomenon specific to youth and that in some groups, use extends into later-life. This trend has become apparent in both national policy documents and service data

(Ayres et al., 2012; Black, 2020; Rolles, 2021; Royal College of Psychiatrists, 2018b; Wadd and Galvani, 2014). My findings also suggest that drug use cannot be reduced to a 'single cause' explanation; early-life disadvantages, alongside processes such as emotional regulation, the search for security, and the need for belonging, made drug use an available and meaningful practice for some participants (see Chapter 4).

The assumption of 'mature out' (the natural decline of drug use with age) does not apply to every group; drug use can persist throughout life for some individuals and it can be linked to historical/generational and structural dynamics (Dennis, 2021; Room, 2005; Strang, 1989).

An important theoretical implication here is that the meaning of drug use is not 'fixed' but 'situational': for the same individual, drug use in different life stages can be justified by different reasons, such as pleasure/identity/belonging or coping/functionality, making it difficult to explain drug use with linear (unidirectional deterioration or unidirectional improvement) models.

7.1.1 Early Life and Drug Use

The findings highlight that many participants see their early life conditions as closely connected to start of their using drugs. Stories shared include experiences like domestic violence, emotional neglect, sexual abuse, care system encounters, belonging, and economic hardships. These stories are not just about past trauma but are ongoing influences that shape their lives in many ways. In Chapter 4, these early experiences are shown not as the sole cause of drug use but as part of a background that carries on and gains new meaning over time. Most participants prefer not to view these events as the direct cause of drug use. Instead, they see them as part of what makes their relationship with the world feel fragile. For example, Jack explains that *'the only thing that made me feel comfortable was taking a substance*,' when talking about his childhood fears. This shows that drug use was not necessarily an escape from pathology but a response that made sense within a particular context. I found this especially interesting because it made it harder to see drug use as simply the result of trauma. Similarly, Alice describes her early loss of parents and care experiences, and she views her drug use not as 'the only way to cope,' but as one of several options available at the time. This perspective challenges a straightforward cause-and-effect view of early life influences.

These accounts highlight common themes in the literature that connect trauma and drug use through affect regulation and avoidant coping strategies. They also reflect UK, especially Scottish, life-history research that shows how sedative drugs can be used to numb emotional pain within cycles of violence and injury (Dennis, 2021; Kreis et al., 2016; McPhee et al., 2013; Waters et al., 2014).

By this stage, I tried to understand the meanings participants have built over time, reflecting on them from their current perspectives, rather than trying to pinpoint fixed themes through simple 'cause-and-effect' links. Likewise, qualitative research in the UK exploring how early life trauma relates to drug use highlights that trauma alone doesn't tell the whole story- it's also shaped by factors like social environment, class, neighbourhood, and available services (Notley et al., 2012; Roy, 2013; Wagstaff et al., 2023; Waters et al., 2014).

The metaphor of *"walking on eggshells"* in Chapter 4 makes this carried context particularly visible. Charles describes a childhood shaped by parental alcoholism and domestic violence as a state of constant tension: *"…it was like walking on eggshells… not a very good environment to be brought up in"*. Edward repeats the same metaphor to emphasise how fear becomes embedded in the body and everyday life: *"…walking around on eggshells… scared"*. These accounts suggest that trauma is not merely a single *event*, but an enduring relational atmosphere and a learned way of encountering the world (Courtois, 2008; Larkin et al., 2017). At this point, I see trauma not just as a simple cause leading to drug use, but as a foundation that influences later experiences with risk, intimacy, belonging, and trust. Another important point in these narratives is some participants used present tense to describe their early life experiences. For them, they were more than past experiences, these experiences remained active even in their later-life.

This interpretation does not reject the familiar *"early trauma → drug use"* line outright; rather, it acknowledges why that line can appear compelling in some stories. However, my data prevent that line from functioning as a generalised explanatory model. Trauma is not mentioned in all participants' accounts. Some participants do not centre early life trauma when accounting for drug use; and some acknowledge trauma but refuse to hold it as the single explanation of their biographies; and others carry trauma primarily through trust, relationships, and self-valuation, while linking drug use in different life stages to different functions (pleasure, belonging, identity experimentation, functionality). For example, in

Chapter 5, Sam's account where he does not link drug use onset to a clearly negative early experience, instead explaining it through being a *"shy kid"* internally challenges the limits of a trauma-centred narrative. This plurality is not inconsistency; it is an indicator that lifelong drug use is narrated through different explanatory repertoires at different times.

These early experiences are directly related to the milestones of adulthood that I discuss in Chapter 5. Some participants explicitly stated how the insecurity and lack of belonging they experienced in childhood were reproduced in the relationships they formed in adulthood and in the functions they assigned to drug use (Blank et al., 2016; Larkin et al., 2017; Morgan and Bennett, 2023; Wagstaff et al., 2023). This continuity necessitates thinking of early life experiences not as events left in the past, but as living elements of the biographical narrative.

The effects of trauma do not function as a mechanism that happens once at the beginning; rather, they operate as a relational sensitivity that is reshaped through roles and institutions in adulthood (Blank et al., 2016; Dennis, 2021; Fitton et al., 2018). For instance, when Alice narrates a trauma, drug, criminal justice cycle, she emphasises that the issue is not only *"drug use after trauma"* but an *"accumulated mess"* produced when the system fails to see trauma: *"…I had trauma and through the trauma fell into substances… my punishment was going to prison. But I never changed anything about me… Nobody looked at me and said that's the trauma… It was just kind of mess over the top"*. Here, trauma is not a deterministic origin; it becomes a life-course context compounded through services and criminalisation.

Another outcome of my data is strengthening linear explanations in some respects: trauma, particularly through patterns such as fear and mistrust, can make drugs available as a soothing or facilitating. Jack's *"drugs made it easier"* line is powerful in explaining the sensory and bodily logic through which drug use can become initially compelling. Alice's lack of support and being labelled a *"problem lassie"* demonstrate how trauma and stigma can mutually reinforce one another and create conditions in which drug use appears as the *only* way out. This account speaks directly to the principles of trauma-informed practice (TIP) and to the evidence that trauma-informed approaches are not well implemented in UK drug treatment services. Sweeney and colleagues (2018) argue that trauma-informed care requires services to move beyond symptom management and toward an understanding of how adversity is accumulated across the life course. Muskett (2014) similarly shows that even where TIP principles are adopted in policy, implementation in practice often remains

superficial. What Alice's account demonstrates is why this gap matters: when services respond only to presenting behaviour without engaging with biographical context, they risk reinforcing the very conditions; labelling, powerlessness, institutional distrust; that have sustained drug use over time.

7.1.2 Turning Points in the Life Course

The life course data in the thesis indicate both continuity and distinct disruptions in drug use. Parenting/partnership/work and criminal justice experiences in adulthood (see Chapter 5), and health concerns, narrowing social circles, 'unexpected survival in old age' and self-acceptance in later-life (see Chapter 6) are prominent contexts for these discontinuities. One UK cohort reports on ageing highlight that individuals experiencing problematic opioid/opiate use face more complex health and social care needs in later-life, which in turn transforms patterns of use, risks, and service engagement (Advisory Council on the Misuse of Drugs, 2019).

Parenting, contact with the criminal justice system, serious health problems, and experiences of loss emerge in participants' narratives as moments when they renegotiate the meaning of drug use. For example, when recounting the conflict he experienced with his wife, Oscar's expression of the social expectation that his age signalled a period when he should have "stop using" drugs demonstrate how ageing functions as a normative pressure. This narrative aligns with the discourse of 'maturing with age' frequently emphasised in UK literature, while also revealing that participants did not always internalise this discourse (Dennis, 2021; Morgan and Bennett, 2023).

As discussed in Chapter 6, for some participants, ageing is an 'unexpected' experience. Amy's statement, '*I never thought I'd reach 40*' positions ageing not so much as a biological process but as a sense of astonishment at having survived. This narrative highlights ageing not as a factor that ends drug use but as a context that makes it possible to come to terms with the past. My analytical emphasis here is that turning points are not external shocks that automatically end drug use; rather, they are moments in which the meaning of drug use (and the narrative of use) is reconstructed, and in which contradictions often intensify. Oscar's later shift from a sense of being *"untouchable"* to bodily vulnerability following a heart attack shows how biographical continuity can be interrupted through the body.

Particularly in older age, 'ageing itself' emerges as a turning point: for some participants, reaching over 40 years of age becomes a narrative of 'unexpected success' or 'survival'; this reframes the interpretation of drug use. Scottish Drug Forum's report (2017) addressing the needs of ageing problem users in Scotland also indicate that long-term use creates cumulative health burdens, social isolation and barriers to accessing services; thus, ageing is not only a biological process but also a 'social' one, interacting with service systems.

The subjective experience of ageing and how it transforms the meanings attributed to drug use. While ageing is a period of increased risk for some participants, for others it opens up a calmer social life and increased self-awareness and self-acceptance.

This section demonstrates that it is impossible to view drug use as a linear, unidirectional, or universal experience throughout the life course. Early life experiences, adult responsibilities, and ageing itself emerge as contextual factors that continuously reshape the meaning of drug use. This interpretation broadens and challenges prevailing discourses on drug use in the UK, particularly in the context of ageing users.

In summary, the biographical synthesis presented in this section demonstrates that drug use is not a static experience throughout the life course, but rather a context-sensitive one whose meaning is constantly being reconstructed. This finding is directly related to the fundamental problem highlighted by both academic qualitative studies and official reports concerning ageing user cohorts in the United Kingdom: frameworks that address substance use solely in the context of youth and solely along the 'problem' axis are inadequate for explaining experiences in later-life.

7.2 Turning Points, Agency and Constraint in Adulthood

In this section, I further discuss how the turning points participants experienced in adulthood were intertwined with drug use. Adulthood is approached not as a chronological age range, but as a life stage characterised by increasing responsibilities, social expectations, and structural pressures. Experiences such as parenthood, romantic relationships, working life, and contact with the criminal justice system, which are empirically detailed in Chapter 5, are analytically examined here to show how the meaning of drug use is renegotiated. This discussion aims to reveal how early life contexts (Chapter 4) resonate in adulthood and lay the groundwork for the ageing process (Chapter 6).

Turning points in adulthood often emerge in participants' narratives not as events with clear beginnings and endings, but as ongoing negotiations involving drug use. This has compelled me to think about the concept of 'turning points' in a more relational and process-oriented way, distinct from linear narratives of change.

7.2.1 Adulthood and Expectations of a "Normal" Life

In participants' narratives, adulthood is frequently defined by expectations of leading a "normal" life. These expectations are shaped by normative assumptions such as having a steady job, a stable relationship, parenthood, and abstaining from drug use. As seen in Chapter 5, many participants expressed experiencing constant tension between these expectations and their own life practices. This tension has created a space where the meaning of drug use is renegotiated, rather than establishing a threshold where drug use automatically ceases. Recovery is often shaped by societal expectations (Shaw, 2023; Strauss and Falkin, 2001)

Oscar's statement, "*You're 41 now… when is this going to stop?*", made while recounting his conflict with his wife, demonstrates how the normative link between age and maturity is established through drug use. This narrative has been one of the examples that has particularly challenged me analytically, because here, drug use is not merely an individual choice, but becomes a practice partially controlled by expectations of age-appropriate behaviour. Similarly, Harry's portrayal of the question '*Have you not grown up yet?*' as a social judgement suggests that adulthood has been transformed into a moral category.

Drug use in adulthood is often stigmatised by discourses of 'immaturity' or 'failure' (Atkinson, 2016; El Hayek et al., 2024; UK Drug Policy Commission, 2010). However, my findings show that these discourses are not always internalised by participants; on the contrary, they are sometimes met with resistance. At this point, adulthood emerges not as a stage that ends drug use, but rather as an arena where normative expectations clash with individual agency. This clash may cause adverse emotions (Berjot and Gillet, 2011; Frost, 2011; Lloyd, 2013), as it was exemplified in my research.

Adulthood, in this study, appears not as a threshold that 'ends' drug use, but as a process in which the meaning of use is renegotiated between social norms and individual agency.

7.2.2 Parenting: Responsibility, Guilt and the Repositioning of Drug Use

This tension around normative expectations become particularly visible in relation to experiences of parenthood. As discussed in Chapter 5, having children led many participants to reframe drug use as a behaviour that "should now be stopped." For example, Oscar's account that has been discussed in the previous heading roots in the decision of having children with his partner.

For some participants, parenthood was constructed as an experience that triggered intense feelings of guilt and moral responsibility. Jane's statement, *"something always made me feel guilty,"* expressed in relation to her sibling and caregiving responsibilities, suggests that parenthood and caregiving roles are not limited to biological parenthood (Levante et al., 2022). When intertwined with drug use, these responsibilities can produce a persistent moral burden. Rather than creating a biographical rupture that ends drug use, such guilt may lead to the concealment of use and its continuation alongside internalised feelings of shame (Russell et al., 2025; Shaw, 2023).

This dynamic is articulated even more sharply in the narratives of female participants. For women, parenthood is heavily laden with gendered expectations of being a "good mother," a caregiver, and self-sacrificing. Amy's account of continuing her drug use in a more covert and controlled manner after having children illustrates that parenthood often reshapes drug use rather than bringing it to an end. This suggests that women's drug use is experienced not merely as an individual practice, but as a risk-laden terrain encompassing relationships with children, maternal identity, and fears of institutional intervention.(Kreis et al., 2016; Russell et al., 2025; Shaw, 2023; White, 2025)

At the same time, some narratives explicitly challenge normative expectations of parenthood and adulthood. Anne's statement, *"No matter if I live to 90, I would still inject myself,"* is analytically striking in that it demonstrates how self-acceptance and autonomy do not automatically dissolve with age or parenthood. This account exposes the limitations of conceptualising parenthood and ageing as linear stages that inevitably lead to the cessation of drug use.

Taken together, these findings indicate that parenthood does not function as a neutral life-course turning point; rather, it represents a social position heavily imbued with moral, gendered, and normative expectations. The ongoing tension participants experience between

these expectations, and their lived practices does not create a definitive threshold that ends drug use. Instead, it opens a space in which the meaning, legitimacy, and visibility of drug use are continuously renegotiated. In this sense, drug use in adulthood and parenthood should not be understood solely as a "continuing problem," but as a practice that is repeatedly redefined through its relationship with normative life-course expectations.

7.2.3 Work Life and Functionality: Interpreting Substance Use Through the Lens of 'Workability'

In participants' narratives, work life emerges as an important area where drug use is evaluated in terms of functionality. As seen in Section 5, some participants did not view drug use as 'problematic' as long as it did not interfere with their work life. Emily's emphasis on "*I never missed a day of work*" shows that productivity has become a central criterion in the evaluation of drug use for her. Rather than being primarily assessed in terms of health risk or moral transgression, drug use is frequently judged according to whether it interferes with participants' capacity to remain economically productive. What struck me analytically is that participants did not merely report working alongside drug use; they actively mobilised work as a moral and practical justification for continued use. In doing so, they implicitly reframed drug use from a health or deviance issue into a matter of economic sustainability. While drug use is often addressed in terms of health risks in social work and public health discourses (Crépault et al., 2023; Mathias et al., 2025), participants frequently evaluated their own experiences in terms of employability and economic sustainability. Sam's statement, '*If I could afford it and it didn't stop me travelling...*', shows that drug use is addressed within a practical rather than a moral framework. This challenges dominant policy narratives that equate responsibility with cessation and instead highlights where drug use is acceptable as it does not disrupt participation in valued social roles.

Askew's work (2016) on middle-aged substance use identifies functionality as a particularly salient discourse among individuals who have moved beyond youth-oriented narratives of experimentation or excess. My findings both align with and extend this literature. While Askew and Williams (2021) emphasise functionality as a stabilising discourse in midlife, tracing this narrative across the life course reveals how its meaning is contingent and vulnerable to disruption.

This instability becomes especially visible when participants describe moments in which work life is disrupted. Charles' account of transitioning to daily drug use—captured in the phrase "*before I knew it*" is analytically significant here. Rather than depicting a conscious escalation, this phrase suggests a gradual erosion of functional boundaries that went largely unnoticed until work routines and structure were already compromised. In this sense, the loss of functionality is not experienced as a dramatic turning point but as a subtle process that only becomes legible retrospectively. This challenges linear models of "decline" and highlights how the discourse of functionality can obscure emerging vulnerabilities until they become difficult to manage (McPhee et al., 2013; Morgan and Bennett, 2023; Nettleton et al., 2011a; Senker and Green, 2016).

Importantly, work does not merely function as an external constraint on drug use; it also shapes how participants understand themselves as legitimate social actors. Maintaining employment enables participants to resist stigmatising identities associated with dependency, failure, or irresponsibility. In this way, functionality operates as a form of symbolic protection, allowing individuals to distance themselves from dominant images of the "problematic drug user" (Morgan and Bennett, 2023, 2022; Nettleton et al., 2011a) However, this protective function is conditional and fragile. Once work is lost or becomes unstable, drug use is rapidly reinterpreted by participants themselves as well as by others—through a different moral lens.

This section contributes to broader debates on drugs, work, and moral regulation by showing how productivity functions as a key axis through which drug use is normalised or problematised across the life course. Rather than viewing work as simply one domain affected by substance use, my findings suggest that work operates as a central interpretive framework through which individuals actively negotiate the meaning of their drug use. This reframing invites a shift away from individualised health-risk models and towards a more relational understanding of how economic participation, stigma, and ageing shape drug use experiences over time.

Seen through a life-course perspective, this finding complicates binary distinctions between "functional/non-problematic" and "problematic" use.

7.2.4 Contact with the Criminal Justice System

For approximately half of the participants, contact with the criminal justice system emerges as a significant life experience during adulthood. However, contrary to assumptions prevalent in policy and public discourse, this contact does not consistently constitute a transformative or "corrective" turning point (Addison et al., 2021; Atkinson, 2016). As discussed in Chapter 5, while imprisonment temporarily interrupted drug use for some participants, for others it did not bring drug use to an end. Instead, incarceration became a context in which drug use was deepened, and new vulnerabilities and traumatic meanings were produced. This finding highlights the problematic nature of framing the criminal justice system as a regulatory solution for lives shaped by drug use (Deuchar and Densley, 2024; McPhee et al., 2012).

A closer look at how imprisonment appears in participants' stories shows that it's often not seen as a major turning point. Instead, it's more like a background in which ongoing vulnerabilities tend to recur over time. For some participants, prison functioned as a short-term "pause," creating a period in which drug use was physically interrupted. However, this interruption did not signify lasting change. Following release, the meaning and function of drug use were frequently re-established, with the prison experience itself often occupying a central role in this process of reconfiguration (Addison et al., 2021; Deuchar and Densley, 2024).

Will's statement, "*Who's going to believe me anyway?"* really highlights how the criminal justice system can sometimes feel stigmatising. It's not just about legal doubts; it touches on a deeper sense of not being recognised, feeling delegitimised, and having one's voice undervalued (Deuchar and Densley, 2024; Drake et al., 2015; Room, 2005). What is especially meaningful is how this story goes beyond individual disappointment, showing how these feelings of insecurity and worthlessness often stem from early life experiences and are then reawakened through encounters with institutions in adulthood (Blank et al., 2016; Kreis et al., 2016). For example, Alice's account on her experiences with prison and other services and how she stated that none of them were interested in the root cause of her problems.

Therefore, the criminal justice system is seen not just as a process that changes these early feelings of distrust and powerlessness (as I discussed in Chapter 4), but as an institution that often reinforces them.

Participants describe criminal justice intervention not as a "cure" that ends drug use, but as a new rupture point, adding stigma and trauma. Imprisonment especially seems to further diminish already vulnerable self-esteem, potentially reinforcing drug use as a means of escape or coping after such contact.

7.2.5 From Adulthood to Ageing: An Analytical Transition to the Next Stage

The turning points in adulthood that I have talked about here are the foundation for understanding the experiences of ageing, which I'll explore in Chapter 6. Unresolved tensions, delayed confrontations, and ongoing drug use in adulthood gain new significance with age. So, rather than seeing adulthood as a separate phase from ageing, this thesis views them as connected stages in a continuous journey.

This chapter has shown that the key moments in adulthood do not automatically mark the end of drug use; instead, they are ongoing processes where the meaning of drug use is quietly reshaped alongside responsibilities, societal expectations, and structural pressures. It also highlights how our early life experiences continue to influence us into adulthood, laying the groundwork for stories of ageing, resilience, and self-acceptance. Looking ahead, the themes of ageing I'll explore in the next chapter naturally flow from the unresolved struggles and ongoing patterns we've examined in the section

7.3 Ageing, Survival and Self-Acceptance: Reinterpreting Drug Use in Later-life

In this section, I discuss participants' experiences of ageing and how these experiences are related to drug use. Throughout the thesis, ageing has been conceptualised not as a linear chronological progression or a biological inevitability, but as a biographical process in which past life experiences are re-evaluated, survival acquires meaning, and understandings of the self are renegotiated. The narratives empirically detailed in Chapter 6 are interpreted here through a reflexive thematic analysis approach, allowing for an analytical examination of how ageing reshapes the meanings attributed to drug use.

This section is analytically significant for me, as several participants described ageing not as an expected or natural stage of life, but as a threshold they had long assumed they would never reach. In these narratives, ageing appears not as a planned future, but as a surprising state of having arrived. The language participants use when referring to their age reflects not only biological progression, but also a re-reading of earlier expectations about the future—or,

in some cases, expectations of having no future at all. In this sense, ageing is experienced not simply as the passage of time, but as the process of making sense of "still being here."

These narratives challenge dominant risk, harm, and pathology focused frameworks within the drug use literature. Ageing is narrated through feelings of surprise at having survived, sometimes accompanied by gratitude and sometimes by more ambivalent emotions.

I observed that ageing opens a space for what can be understood as retrospective meaning making within participants' narratives. Participants reassess past drug use from their current standpoint, and in this process, emotions such as guilt, regret, and self-forgiveness often intersect. Narratives of survival, in particular, resist fixing drug use into a stable meaning; instead, they reposition it within a broader sense of biographical continuity. For example, Noah looks back and re-evaluates his earlier periods of intense drug use from where he is now. Instead of simply seeing his past use as "wrong" or "mistaken," this re-evaluation helps him understand the role drug use played at that time. Although he sometimes expresses feelings of guilt and regret when reflecting on their drug use during youth and adulthood, his narrative also includes more compassionate and understanding language toward himself, such as saying, "*I couldn't have coped any other way back then*." This shows that ageing isn't just a time for judgement of the past, but also a time when the participants can find meaning and possibly forgive themselves.

The construction of ageing as an "unexpected" experience also produces notable shifts in how participants understand themselves. In some narratives, ageing allows for a re-evaluation of lives previously framed as "problematic" or "failed." This re-evaluation is not always positive or comforting; however, it often enables a less judgemental and more accepting relationship with the self. In this context, ageing emerges as a process that reshapes how individuals relate to themselves, independently of whether drug use has ended (Ayres et al., 2012; Blank et al., 2016; Dennis, 2021; Senker and Green, 2016; Waters et al., 2014).

These findings make an important contribution to a literature that has often approached ageing in the context of drug use primarily through increased risk and vulnerability. Participants' narratives demonstrate that ageing can also create space for meaning making, repositioning, and self acceptance. This challenges approach that construct older people who use drugs as homogeneous, passive, or solely "at risk" populations. My data suggest that

ageing does not automatically intensify or resolve drug use; rather, it provides a biographical context in which the meanings attached to drug use are renegotiated.

In conclusion, this section does not conceptualise ageing as either an endpoint to be avoided or an inherently restorative stage of life. Participants' narratives show ageing can be an unexpected, emotionally complex, and sometimes contradictory process. Within this process, drug use is not assigned a fixed meaning but is continually redefined through the relationships participants construct between past and present. These findings indicate that thinking about drug use and ageing together requires an analytical framework that extends beyond risk and harm, and instead engages with life-course processes, survival, and self-acceptance in a more integrated way.

7.3.1 Ageing and Constant Proximity to Death

One of the most distinctive findings of this thesis is that ageing was not narrated in a uniform way. For some participants, particularly those whose biographies involved long-term physically and socially costly drug use, reaching their forties, fifties, or beyond was experienced as unexpected survival. Amy's statement, "*I never thought I'd reach 40,"* is especially powerful in this regard because it does not simply describe chronological ageing; it reveals a prior orientation to the future in which longevity had not been assumed. In such narratives, later-life is not experienced as a straightforward continuation of the life course, but as an arrival at a stage that once seemed unlikely, deferred, or even impossible. This makes ageing analytically important not only as a biological process, but as a biographical moment of re-reading earlier expectations of death, collapse, imprisonment, or continued chaos. Chapter 6 also shows that this sense of unexpected survival is strongest where participants' pasts had been marked by cumulative bodily wear, long-term use, and repeated crisis. Oscar's shift from feeling "untouchable" to confronting a heart attack, Will's account of COPD and bodily limitation, Anne's statement that her body could no longer "handle it," and Ava's fear that decades of addiction had left her with "less" life all suggest that ageing became meaningful precisely because the body had carried the consequences of long-term use into later-life.

In this study, some stories of ageing coexist with the ongoing presence of mortality. Apart from their own physical experiences, witnessing death also shows itself as a factor. As shown in previous chapters, many participants have experienced the loss of friends, partners, and

peers throughout their lives. These losses are not seen as isolated incidents but are integrated into the fabric of their ongoing life stories. Jack's remark, "*I accepted I was gonna die,*" highlights that death was not just a distant possibility but a familiar and accepted part of life. Ageing is experienced through acceptance and resilience.

Arthur's comment, "*I resigned myself to the fact that one Monday I would lose my life*," emphasises how drug use becomes intertwined with the expectation of mortality over time (Ayres et al., 2012; Blank et al., 2016; Senker and Green, 2016). What is especially important here is how the anticipation of death feels ordinary, even routine. Death is not portrayed as a sudden or dramatic event but as a normal part of daily life. In this context, drug use is not just seen as risky behaviour but as a practice that takes on deeper meaning within a life shaped by early, repeated encounters with loss.

I deliberately chose not to categorise these stories under "hopelessness." While feelings of acceptance and resignation are clear, focusing only on hopelessness might oversimplify what participants are expressing. Their stories are not about a lack of meaning but reveal a particular way of making sense of life in which death remains close. In this view, ageing is not just about planning for the future but about recognising that surviving itself holds significance. These stories show how repeated early experiences with loss and death shape the feeling of ageing. For some, reaching older age is not celebrated as an achievement but met with surprise. Being alive no longer signifies fulfilling expectations but rather surpassing long held doubts (Kreis et al., 2016; Senker and Green, 2016; Waters et al., 2014).

Roe et al. (2010), in one of the most relevant UK studies of older drug users, show that later-life is often narrated through survival in the context of personal overdoses and the deaths of drug using contemporaries. Their work is especially useful here because it supports the argument that ageing, for some people with long drug experiences, is not simply "getting older" but surviving into a stage of life that must be interpreted against the memory of overdose, ill-health, and the premature deaths of others. Beynon et al. (2009) similarly show that older drug use in the UK has been neglected as a specific phenomenon, even though the participants they interviewed were already living with poor health and longstanding service needs. More recent Scottish work by Matheson et al. (2019) adds to this by showing that older people with a drug problem often face cumulative and overlapping burdens involving chronic illness, isolation, stigma, and complex care needs. Taken together, these studies

reinforce the argument that later-life among people with long-term and more harmful drug use histories is often experienced through accumulation: health costs accumulate, losses accumulate, and awareness of survival itself becomes more pronounced with age.

As we see here, for lives shaped by drug use, ageing is a phase heavily influenced by the ongoing presence of death. Meaning is built not only on stories of progress or recovery but through loss, mourning, and going beyond expectations.

However, these narratives do not support a simple decline model. Constant proximity to death could normalise risk, but it could also generate reflection, fatigue, grief, and altered priorities. In some accounts, later-life brought a recalibration of what mattered: less interest in intensity, more concern with health, peace, stability, or simply endurance. This is why the subsection is not limited to mortality. The significance of proximity to death in my data is not that it automatically ended drug use, but that it changed the terms on which participants understood themselves, their past, and the future. This is clear in Chapter 6 where ageing is also connected to caution, reduced tolerance, quieter social lives, and a changed relationship to the body. In that sense, later-life becomes not merely a stage of decline, but a stage of interpretive work. Death becomes more visible, but not always more decisive. Instead, it becomes one more context through which the meaning of drug use is re-evaluated.

This is also where recent Shaw et al.'s (2022) work on women in mid-life and older age is helpful. Shaw et al. (2022) show that ageing bodies in recovery require reinterpretation: sensations, pain, physical changes, and embodied memories have to be understood differently as women age out of long-term drug use. With another research Shaw (2023) further demonstrates that mid-life and older age can involve reworking relationships, belonging, and selfhood rather than simply suffering decline. These studies are not directly about peer death or overdose, but they are valuable for my final analytical step because they support the idea that later-life is not reducible to damage. Even when survival is central, later-life may also involve new forms of understanding, quieter modes of living, and changed relationships to the self. Similarly, it shows in my data in Chapter 6, where some participants experienced ageing as improbable survival, while others described it more through inevitability, adaptation, wisdom, or acceptance.

Overall, the data suggest that "unexpected survival" is not the defining later-life narrative for all participants, but it is a particularly important one for those whose biographies involved

long-term drug use, repeated crisis, bodily deterioration, and cumulative exposure to death. For others, ageing was less a surprise than a more ordinary process of adjustment. What unites these accounts is not a shared emotional tone but a shared interpretive task: later-life required participants to place bodily change, loss, memory, and continued survival into a new relationship with their histories of drug use. A life-course perspective is crucial here because it shows that later-life does not erase earlier experiences, nor simply repeat them. Instead, it becomes a stage in which earlier trauma, bodily changes, and social loss are reassembled into new meanings. In this sense, ageing is not simply what happens after drug use; it is one of the contexts through which the significance of drug use is most sharply reconsidered.

7.3.2 Ageing, Health and the Body

Another major finding of this thesis is that ageing reshapes drug use through the body. In participants' later-life accounts, bodily change emerged not simply as background decline, but as an active force in how drug use was reassessed, justified, limited, or maintained. Chronic pain, fatigue, liver problems, COPD, heart disease, and slower recovery times all made the body harder to ignore. In this sense, ageing disrupted earlier assumptions of resilience, tolerance, or invulnerability. Health crises and chronic illness did not simply alter what participants could do physically; they changed how drug use itself was interpreted. This broader pattern is consistent with UK research on older drug users, which has shown that ageing is closely tied to worsening health, reduced quality of life, changing relationships, and increased service needs rather than being a neutral backdrop to continued use (Beynon et al., 2009; Roe et al., 2010)

As Chapter 6 has already shown, later-life bodily change often became a point at which participants were forced to confront damage, vulnerability, and the cumulative effects of time. Oscar's heart attack, George's account of alcohol becoming too much strain on his liver, Andrew's reflections on physical deterioration, and Anne's description of feeling "too old" for what her body could now tolerate all point to the same wider pattern: ageing makes the body newly visible as a limit.

For some participants, bodily change did not simply make drug use less sustainable; it made some substances feel more functionally useful in everyday life. In later adulthood, substances could remain meaningful not only for pleasure, but for managing pain, discomfort, anxiety, feelings of being overwhelmed, sleeplessness, or the practical exhaustion of getting through

the day. The body therefore operates in two directions at once. It can become a site of limitation and warning, but also a site through which continued use is rationalised as management. This complicates any overly neat distinction between bodily decline on the one hand and abstinence or recovery on the other.

Laura's account is particularly important here because it shows how later-life or mid-life use may be reinterpreted not as pure recreation, but as an aid to coping with overload. She explicitly describes cannabis as having become "*more like a helper*," explaining that it enables her to "*switch off properly*" in the context of being a single mother with two children and an academic job, with almost no time to herself. She also links cannabis to sensory overwhelm and the need to "cut off," and suggests that, within her friendship network, substances are now used more for "*mental health and well-being*" than for the pure enjoyment of earlier years. Significantly, she also notes that small amounts of MDMA can help her and her friends stay up talking when otherwise they would simply be too tired. This is analytically important because it shows that later-life drug use may continue not despite ageing, but partly because ageing, fatigue, and adult overload create new reasons for use. What changes is not only the amount or frequency of drug use, but the work substances are made to do.

Edward's account reinforces this point from a different angle. After injuring his back and being prescribed painkillers, he describes how prescribed medication, Valium, sleep tablets, and cannabis became bound up with pain relief, depression, and self-medication. What is striking here is not simply relapse after a long period of abstinence, but the route through which this happened: bodily pain, medication, lowered mood, and the practical search for relief. This suggests that later-life or mid-life return to drug use cannot always be understood through hedonism, recklessness, or unresolved youthful patterns alone. In some cases, it is connected to the management of a painful body and a deteriorating mental state. Here, ageing and embodiment do not sit outside the story of drug use; they become one of the reasons substances regain meaning.

At the same time, other accounts show how ageing can generate a strong sense that continued use is no longer physically sustainable. Anne's description of getting to the point where she "can't do this anymore" because her body "can't handle it," and her later account of being constantly sore and reliant on medication for pain and sleep, are especially stands out here.

These narratives do not fit romanticised ideas of endurance or control. Instead, they show that later-life drug use can become physically exhausting, and incompatible with everyday survival. Similarly, participants who described COPD, chronic pain, or serious illness often framed later-life as a point where the body had begun to impose non-negotiable conditions. In these accounts, recovery or reduction was not only a moral or emotional decision, but a bodily necessity.

Ayres's (2012) work on older drug users has shown that later-life is associated with distinctive treatment and support needs, as well as more complex health concerns, rather than representing a simple continuation of earlier use. At the same time, the ageing body in my data is not only a site of deterioration. It is also a site of management. For some participants, pain, fatigue, low mood, anxiety, and physical discomfort sustained the perceived usefulness of particular substances or medications. This is important because it complicates an overly narrow decline model. The research on embodiment and coming off drugs similarly suggests that the body is central to how people interpret withdrawal, dependence, and the possibility of change (Walmsley, 2022), while recent Scottish qualitative work further shows that drug-related bodily crises such as overdose are lived through social and emotional contexts rather than in purely medical isolation (Byrne et al., 2024). Read alongside the evidence that older drug users often face deteriorating physical and mental health, pain, stigma, and difficulty navigating services (Addison et al., 2025; Advisory Council on the Misuse of Drugs, 2019), these findings suggest that later-life drug use is best understood not only through decline, but through the ongoing management of an ageing and increasingly demanding body.

7.3.3 Social change, quietness and isolation

Participants' later-life narratives suggest that ageing often involves a narrowing of social networks, a slowing of everyday life, and a re-evaluation of what kinds of relationships feel safe, meaningful, or tolerable. However, these shifts were not experienced in a single way. For some participants, a quieter life represented relief from chaos, conflict, and the relentless demands of drug-using environments. For others, the same quietness could feel like loneliness, loss, or disconnection. In this sense, later-life social change cannot be understood simply as decline or withdrawal. Rather, it is better understood as an uneven reorganisation of social life in which participants move between isolation, selectivity, and, in some cases, new forms of belonging. This broader interpretation is consistent with Rhynas et al's (2020) work showing that later-life and recovery trajectories are strongly shaped by social

relationships, support, and belonging, rather than by abstinence alone. Research with women in mid-life and older age in the UK has shown that connection and belonging are central to how recovery and selfhood are negotiated over time (Shaw, 2023), while UK recovery community research has similarly highlighted the role of social identity change, peer support, and new networks in sustaining recovery (Anderson et al., 2021).

My data show that later-life social contraction is often ambivalent. For some participants, distancing themselves from older networks was necessary because those relationships were structured around using drugs, crisis, manipulation, or mutual dependency. Several participants explicitly described realising that what they once called a social circle was in fact a fragile network of associates tied together by drugs, money, obligation, or fear rather than trust. In these accounts, ageing and recovery made that distinction more visible. Drug use had often left participants socially surrounded but emotionally unsupported. As a result, later-life sometimes involved a deliberate retreat from former contacts in order to preserve recovery, reduce risk, or protect a newly developing sense of self. This resonates with UK research showing that relationships in the context of drug use can be both supportive and dangerous, offering belonging while also reproducing instability, dependency, and harm (Atkinson, 2016; Neale et al., 2012). It also supports findings from older user research in Bristol that some older adults who use drugs feel shame about "still using" and discomfort about being associated with younger drug using groups, suggesting that later-life social belonging is often fraught rather than straightforward (Ayres et al., 2012).

At the same time, later-life quietness was not always experienced negatively. Some participants described a growing preference for calmer, smaller, and more intentional forms of sociality. Rather than mourning the loss of fast paced social worlds, they framed later-life as an opportunity to step away from drama, superficiality, or risk. In these accounts, getting older brought a stronger sense of what kinds of people and environments they wanted around them. Quietness could therefore signal not only social loss, but discernment, selectivity, and even peace. This is especially important analytically because it shows that reduced sociality in later-life should not automatically be read as isolation. For some participants, it reflected a rejection of earlier forms of social life that had been exhausting, dangerous, or unsustainable. Oliver's experiences are particularly helpful here, because he explicitly describes ageing as moving away from mainstream sociality and toward smaller, more meaningful forms of connection built around conversation, shared values, and simple pleasures rather than noise

or excess. Similarly, Henry's account of actively working to maintain a "good" social circle in recovery suggests that later-life social life may become more intentional rather than simply diminished. These findings align with UK recovery literature that emphasises peaceful places, safe social spaces, and supportive networks as important ingredients in sustaining recovery (Anderson et al., 2021; Rhynas et al., 2020).

However, later-life quietness should not be interpreted uncritically as a positive development, as it may also reflect loss, loneliness, and social contraction. For others in the study, shrinking social networks also meant loneliness, emotional exposure, and the difficult recognition of how much had been lost over time. Participants spoke about staying away from people who still used, losing contact with family, feeling ashamed of who they had become, or realising that old friendship networks had never really been friendships at all. In this respect, ageing could intensify awareness of separation and missed time. Some participants described recovery as the first time they had needed to build relationships not based on using, and this was not always easy at an older age. What emerges here is not a romantic story of mature self-selection, but a more fragile process in which quieter lives may be experienced as either safety or absence depending on biography, social resources, and recovery context. This interpretation is strengthened by UK qualitative work showing that social support, safe spaces, and recovery identities are often actively built rather than naturally inherited, and that recovery communities can play a major role in countering social isolation (Anderson et al., 2021; Harrison et al., 2020; Rhynas et al., 2020; Smith et al., 2022).

This is where the importance of recovery spaces becomes especially clear in my data. A striking number of participants described later-life recovery not only as stopping drugs, but as entering into new forms of social recognition. Recovery cafés, fellowship meetings, volunteering, and peer relationships often appeared as substitutes for older drug-based networks, but they were more than substitutes. They were described as places where participants could feel seen, useful, trusted, and less alone. In this sense, later-life social reorganisation was not only about withdrawal from harmful networks, but also about the creation of new ones. Will explicitly describes building a new social circle through treatment and recovery cafés. Anne similarly describes recovery spaces as a "happy family" after years spent around "selfish, nasty, manipulative" people, and David describes moving from acquaintances and dysfunctional networks to a "huge" social life in recovery. These accounts

support a key argument for this thesis: ageing does not simply reduce social life; it can also create the conditions under which people begin to reassemble it differently.

Family relationships are especially important here, because later-life social change in my data was not limited to friendship networks or recovery spaces. For many participants, ageing and recovery brought a renewed awareness of what drug use had done to family life over time. This was not experienced uniformly. For some, later-life involved attempts to rebuild relationships with parents, partners, children, or grandchildren; for others, these relationships remained damaged, fragile, or absent. What emerges from the data is therefore not a simple narrative of reconciliation, but a more uneven process in which ageing brings both the possibility of repair and the painful recognition of what cannot be recovered. Steven's account is particularly useful here. He describes recovery as "night and day transformed" in relation to family life, explaining that one of the first things he did was make amends to his parents and that he was able to make peace with them before they died. He also describes recovery as the point at which he had to learn how to be in a relationship for the first time while clean. In a different way, William's account shows that recovery also involves slowly re-entering family life after shame and distance, while Paul describes later-life recovery through restored relationships with his son, parents, sister, and grandson. Together, these accounts suggest that later-life recovery is often lived not only as abstinence or self-management, but as an attempt to become trustworthy, present, and emotionally available within family relationships again (Neale et al., 2012, pp. 192–193).

At the same time, the data also show that family repair is neither guaranteed nor complete. Some participants remained estranged from children or siblings, while others described family ties as loving but permanently marked by years of absence, fear, or disappointment. In this sense, later-life can intensify family feeling in two directions at once: it may create opportunities for reconnection, but it may also sharpen grief, regret, and awareness of lost time. This is visible in accounts where participants speak about their children who they no longer see, relatives who had died before relationships could be repaired, or the shame of recognising the kind of parent, partner, or son they had become while using. Family relationships in later-life are therefore not simply "better" or "worse"; they are often emotionally denser, more reflexive, and more morally charged than earlier social relationships.

Overall, these findings suggest that later-life social change is best understood not simply as a tension between quietness and isolation, but also as a negotiation between reconnection and loss within family life. Ageing may narrow social worlds, yet the meaning of that narrowing is shaped by the biographies that precede it and by the relational damage or possibilities carried into later-life. For some participants, this narrowing signified loneliness, estrangement, and the cumulative consequences of years of drug use in both family and wider social relationships. For others, it created distance from chaotic, drug-centred networks and opened up the possibility of more selective, meaningful, and emotionally sustainable ties, including the gradual rebuilding of trust with parents, children, partners, or grandchildren. In many cases, however, these experiences coexisted. Later-life could bring relief, protection, and renewed intimacy, while also sharpening awareness of lost time, damaged relationships, and forms of family closeness that could not be fully restored. This is analytically important because it challenges any assumption that later-life is either naturally settled or simply socially depleted. Instead, the findings show that social life in later adulthood is actively and unevenly renegotiated across both family and non-family relationships, and that this renegotiation is deeply shaped by recovery, stigma, biography, and the enduring search for recognition, trust, and belonging.

7.3.4 Self-Acceptance and Reworking Identity in Later-life

A further important finding of this thesis is that later-life may create space not only for loss, bodily limitation, and social change, but also for a different relationship to the self. Across the interviews, ageing was not always narrated as a simple process. For some participants, growing older brought greater self-understanding, more confidence in their own judgement, and a less defensive relationship to who they had been. This did not mean that the past ceased to matter. On the contrary, later-life often intensified reflection on harm, regret, and wasted time. Yet it also allowed some participants to step back from more punitive or externally imposed versions of themselves and to develop a more complex, and sometimes more compassionate, self-understanding. In this sense, self-acceptance in later-life did not emerge as the opposite of regret, but as something worked through alongside it.

This is especially visible in participants' accounts of recovery and ageing as processes of "inner work" rather than simply cessation. Some described later-life as the first time they had begun to like themselves, trust themselves, or feel peace within themselves. Anne's account is particularly important here. Reflecting on recovery, she describes learning "self-love and

self-care" after years of hatred, shame, and guilt, and explicitly links recovery to peace and contentment rather than only abstinence. Similarly, Laura describes later-life not as moral resolution but as greater clarity about what she needs, including time alone, distance from overload, and a more honest understanding of why cannabis had become meaningful in her life. In a different way, William links getting older to becoming "wiser," learning to forgive himself and others, and slowly rebuilding confidence after years of chaos and self-doubt. These accounts suggest that later-life can be analytically distinctive because it is a period in which participants do not merely recount their pasts; they actively reinterpret them.

Shaw's qualitative study of women in mid-life and older age in recovery shows that recovery in later-life is closely tied to changes in self-understanding, belonging, and how women position themselves in relation to their pasts and to dominant expectations of femininity and ageing. Rather than presenting recovery as a simple endpoint, Shaw shows it to be an ongoing process of renegotiating identity and finding forms of connection that make a different life thinkable (Shaw, 2023). Likewise, qualitative work on recovery communities in England has shown that recovery often involves the rebuilding of hope, purpose, self-worth, and a sense of agency, with changes in identity emerging through community participation and new forms of social recognition rather than through abstinence alone (Anderson et al., 2021; Harrison et al., 2020). Photovoice research in the UK has also emphasized that recovery identities are actively constructed through supportive social spaces, self-reflection, and changes in how people see themselves and are seen by others (Rhynas et al., 2020).

At the same time, it would be too simple to treat later-life self-acceptance as a smooth or wholly affirmative process. In my data, greater self-acceptance often coexisted with grief, shame, and a sharpened awareness of the past. Participants did not simply "move on" from what had happened. Instead, ageing often made the weight of earlier relationships, missed years, damaged trust, and lost opportunities more visible. For some, later-life involved learning to live with those realities without allowing them to wholly define the present. This is why I think self-acceptance is a better term here than redemption. Redemption implies closure and moral resolution. What the transcripts more often show is something slower, more fragile, and more uneven: a movement toward living with oneself differently, despite what cannot be undone.

This matters analytically because it helps explain why later-life is not only another stage in the chronology of drug use, but a distinct narrative position from which life can be re-read. Participants were not only describing events; they were also describing who they had become in relation to those events. In this sense, later-life often involved a shift from being organised by crisis, urgency, and external judgement toward a more reflexive relationship with the self. Recovery could therefore be experienced not simply as stopping drugs, but as becoming more trustworthy to oneself, more honest about one's needs, and less governed by shame or the need to perform a socially acceptable identity. This interpretation aligns with UK recovery literature showing that long-term recovery is often bound up with identity transformation, social recognition, and the development of more agentic and coherent narratives of self (Harrison et al., 2020).

As a whole, these findings suggest that self-acceptance in later-life should not be understood as a soft or merely psychological theme. It is central to how ageing and drug use shape one another. For some participants, getting older opened up a space in which they could begin to make sense of their past without being fully consumed by it. For others, it meant learning to live more honestly with their limits, needs, and histories. In both cases, later-life appeared not simply as decline, but as a stage of re-evaluation in which identity itself became a site of recovery, struggle, and change.

7.3.5 Policy, Services and the Problem of Age-Blind Responses

The later-life narratives in this thesis also have clear implications for policy and service design. A recurring issue across the data is that existing responses to drug use remain insufficiently equipped to address the realities of ageing. Participants' accounts point to needs that are not reducible to drug use alone: chronic illness, pain, mobility issues, bereavement, loneliness, fear of dependency, changing family relationships, and the cumulative effects of long-term stigma. This means that later-life drug use cannot be understood adequately through a narrowly clinical or age-blind addiction framework. Instead, it requires a broader perspective that brings health, social care, harm reduction, and everyday quality of life into the same analytical frame.

Byrne and colleagues' (2024) qualitative work in Scotland on overdose experience shows that drug-related harm is shaped by an interplay of behavioural, psychological, social, and structural conditions rather than by individual choice alone, while Addison and colleagues

(2025) demonstrate in northeast England that people living in marginalised conditions often experience care through the logic of what they call the inverse care law, those with the greatest need may receive the least appropriate support, particularly where structural and relational stigma within services go unaddressed.

Together, this literature supports what is visible in my data: people with the greatest need may encounter the least appropriate care, especially where services remain fragmented or organised around younger populations and narrow risk frameworks.

For older adults, this mismatch may be especially acute. If ageing is associated with multimorbidity, changing medication use, reduced mobility, and increased contact with health and social care systems, then age-insensitive drug services risk missing the complexity of later-life need. Equally, generic older-adult services may overlook drug use because it does not fit dominant assumptions about older age. The result is a double invisibility: older people who use drugs may be marginal within addiction services because of age, and marginal within ageing services because of drug use. My findings therefore support the need for more integrated, anti-stigmatising, and age-aware responses that recognise later-life drug use as a legitimate area of social policy, public health, and social work concern.

7.4 Stigma, Class and the Unequal Experience of Later-Life Drug Use

A further argument of this thesis is that later-life drug use cannot be understood apart from stigma and wider social inequality. Across the interviews, stigma did not appear only as an external attitude directed towards "drug users." Rather, it was experienced as a relational and institutional process that shaped help-seeking, treatment encounters, self-understanding, and the practical possibilities available to participants over time. This was especially visible in accounts of methadone dispensing, pharmacy surveillance, healthcare encounters, and the humiliation of being publicly identified as a person who uses drugs. Steven's description of having to drink methadone in full view of other customers, waiting outside the chemist to avoid recognition, and later realising that he had simply "accepted the unacceptable" is particularly powerful here, as are Paul's and Noah's accounts of being visibly marked and treated differently when collecting prescriptions.

This interpretation is strongly supported by UK research. McPhee, Brown and Martin's Scottish qualitative study (2013) shows that people on methadone experience stigma both as "drug addicts" and as service users within healthcare and pharmacy settings, with shame

operating at the micro-interactional level but shaped by wider institutional forces. A later qualitative review of Scottish alcohol and drug partnership strategies (2023) similarly argues that stigma is not only interpersonal but also embedded in policy and service design, while Addison and colleagues (2025) show in northeast England that people living in marginalised conditions often experience care through the logic of the inverse care law, where those with the greatest needs may receive the least appropriate support (Falconer and Tang, 2023; McPhee et al., 2013; Sinyor et al., 2025).

However, the findings also suggest that stigma is not experienced equally, and this is where social location becomes analytically important. Class was the most consistently visible axis of difference in the data. Laura's account makes this especially clear: she explicitly identifies herself as white, middle class, privately educated, and possessing a "posh accent," and argues that these characteristics meant she was not profiled by police and could defend herself more effectively than others. Oscar and Noah similarly reflect on how whiteness, masculinity, education, and middle-class status afforded them forms of recognition, mobility, or concealment that were not equally available to everyone. By contrast, other participants tied stigma much more directly to postcode, accent, unemployment, public prescribing, visibility, and the assumption that certain communities naturally "produce" addiction. In this sense, class in my data does not operate only as a background descriptor. It shapes who gets watched, who gets believed, who can hide, who must queue publicly, and whose drug use is understood as pathology rather than experimentation or stress.

The argument developed in this section builds on but moves beyond existing accounts of class and drug use visibility in the UK literature. Shiner (2009) and Measham and Shiner (2009) demonstrate convincingly that middle-class drug users can maintain functionality, avoid criminalisation, and access private treatment in ways that working-class users cannot. Tyler (2013) extends this by showing how certain populations are positioned as already suspect before any drug use occurs. Askew (2016) adds that the absence of research on non-problematic drug use partly reflects the class dynamics of who gets studied. What these accounts share how class shapes drug use experience at a given moment rather than across time. The biographical accounts in this thesis show that class operates diachronically. Its effects accumulate, compound, and are renegotiated across the life course. Laura's middle-class accent protected her from police profiling in her 20s; that same social position shaped how she narrated and reflected on her drug use in her 40s. Jack's working-class postcode

shaped not only his drug use but his access to legal employment, his criminal record, his treatment experiences, and ultimately his later-life survival guilt. These are not static class effects, they are biographical ones, and that temporal dimension is what this thesis adds to accounts Shiner and colleagues have already provided.

Gender was less uniformly foregrounded than class in the interviews, but where it did appear it often carried particular force around parenting, shame, and ideas of appropriate adulthood. This was especially evident in women's accounts of motherhood and care. Anne and Ava both describe the enduring shame of what their addiction had meant for their children, and Ava's narrative makes particularly clear that the pain of later-life reflection is inseparable from her understanding of herself as a mother who was not emotionally present in the way she wanted to be. Participants also suggested that women could face distinct barriers in recovery because of children, social work scrutiny, and the moral burden of being judged as a mother who uses drugs. Rhodes, Bernays and Houmøller's (2010) study of parents who use drugs in Scotland shows that parenting narratives are strongly organised around damage, responsibility, and limitation, while Chandler and colleagues (2013) demonstrate that opioid substitution treatment during pregnancy and early parenthood is accounted for through highly moralised ideas of good and bad motherhood. Whittaker and colleagues' (2019) Scottish work on neonatal abstinence syndrome further shows how maternal drug use is governed through competing "logics of care" shaped by surveillance, risk, blame, and family life.

What this means for the discussion is that later-life drug use is not simply stigmatised because it involves drugs, nor simply because it involves ageing. Rather, age appears to intensify existing judgements about responsibility, maturity, respectability, and whether a person has become the kind of adult they were expected to be. One participant captures this succinctly when he describes the age-related stigma of "have you not grown up yet?", suggesting that continued drug use in mid-life and later-life can be read as a failure of adulthood itself. Yet the interviews also show that this moral judgement is filtered through class, gender, treatment status, and visibility. A middle-class professional who uses discreetly may be able to retain legitimacy in ways that a person publicly collecting methadone cannot. A father may be judged one way, a mother another. Someone in paid work may still be read as "functional," while someone visibly poor, ill, or unemployed is far more likely to be treated as a problem. In this sense, an intersectional reading is useful not because every participant can be mapped neatly onto the same grid of categories, but because it helps

explain why later-life drug use is lived and judged so differently across the dataset. The central point, then, is not that stigma adds onto drug use from the outside. It is that later-life drug use is produced, managed, and understood within unequal social relations that shape who is recognised as redeemable, who is treated as risky, and who is allowed to age with dignity (McPhee et al., 2013; Sinyor et al., 2025; Whittaker et al., 2019).

7.5 Ageing in and Through Drug Use

The previous sections have shown that ageing was significant within participants' accounts in several interconnected ways. Participants described changes in their bodies and health, changing social relationships, shifts in the meanings attached to drug use, and changing understandings of themselves and their pasts. For some, reaching their 40s, 50s or later-life was also narrated through an awareness of survival: growing older had not always been imagined as inevitable. This section draws these findings together to consider their theoretical implications for understanding ageing with history of long- term drug use.

The argument developed here is not that established approaches to ageing are unable to explain the experiences of people who use drugs. Critical gerontology, life-course theory and narrative gerontology provide important resources for understanding the participants' accounts. Critical gerontology demonstrates that experiences of later-life are socially differentiated and shaped by inequalities accumulated across the life course (Townsend, 1981; Estes, 1979; Dannefer, 2003). Narrative gerontology draws attention to the ways people interpret and reinterpret their lives from changing biographical positions (Kenyon and Randall, 1997; Freeman, 2010). Life-course approaches similarly emphasise that ageing develops through the interaction of biography, historical context, social relationships and structural conditions rather than through chronological change alone (Elder, 2003; Dannefer, 2003).

The contribution of the present study is to bring these perspectives into dialogue with drug-use biographies and, in particular, with participants' narratives of survival. I argue that survival provides a useful additional biographical lens for understanding ageing among some people with long histories of drug use. It draws attention to how expectations about longevity, experiences of risk and loss, bodily change, and retrospective interpretations of the past can become part of what ageing means. Survival is therefore not an alternative to ageing. It is one of the contexts through which ageing may acquire particular meaning.

This argument develops directly from the research questions guiding the thesis. The study asked how the meanings attached to drug use change across the life course, how participants understand the relationship between ageing and drug use through changes in health, social life and identity, and how stigma, inequality and institutional responses shape these experiences. Bringing these questions together suggests that biographies from which participants enter later-life should be taken into consideration while understanding later-life drug use.

7.5.1 Ageing as a Social and Biographical Process

Ageing involves biological change, but the meanings attached to age and later-life are also socially and historically produced. Critical gerontology has long challenged approaches that treat old age as a uniform period of biological decline, showing instead that experiences of ageing are differentiated by social class, gender, material resources and earlier life-course inequalities (Townsend, 1981; Estes, 1979; Dannefer, 2003). What people bring into later-life therefore matters for how ageing is experienced.

This is particularly relevant to the participants in this research. Their biographies were diverse, and experiences of poverty, criminalisation, trauma, stable employment, family life, recreational drug use, and recovery were not distributed uniformly across the sample. Nevertheless, for a number of participants, ageing occurred against histories in which drug use, stigma, health difficulties or social disadvantage had significantly shaped expectations of the future.

These findings therefore support distinguishing between chronological ageing and the biographical meaning attached to ageing. Chronological age remained important. Participants experienced bodily change, changing health, changing social roles and increasing awareness of mortality in recognisably age-related ways. Existing research with older people who use drugs has similarly identified health deterioration, chronic pain, multimorbidity, changing social relationships and increased service needs as important aspects of ageing (Beynon et al., 2009; Roe et al., 2010; Ayres et al., 2012; Matheson et al., 2019).

However, the interviews also show that chronological age does not exhaust the meaning of getting older. Amy's statement that she had never expected to reach 40 illustrates this distinction. Reaching 40 did not make her chronologically old according to conventional

gerontological or policy definitions. Rather, it had acquired a particular biographical significance because longevity had previously seemed uncertain. Age therefore operated simultaneously as chronological time and as a marker through which earlier expectations about survival were reconsidered.

This provides a more theoretically useful explanation for the use of 40 and over within the study. The threshold should not be interpreted as a claim that 40 constitutes old age. Recruitment considerations and conventions within research on older populations who use drugs informed the sampling decision. The findings subsequently demonstrated, however, that participants could attach meanings to reaching particular ages that were not reducible to standard chronological categories. The analytical issue is therefore not where old age objectively begins, but how chronological age becomes meaningful within particular biographies.

7.5.2 Drug Use and the Biographical Meaning of Ageing

Participants' accounts also demonstrate that drug-use histories can shape how ageing is interpreted. This occurs partly through cultural expectations concerning maturity. Age is not simply counted; it also carries expectations about what people should have achieved or left behind. Employment, family responsibility, financial independence and particular forms of behaviour are frequently associated with adult maturity, while continued drug use may be interpreted by others as evidence that someone has failed to progress appropriately through adulthood.

This is visible in Oscar's recollection of his wife asking, "You're 41 now, when is this going to stop?" and in Harry's experience of being asked whether he had "not grown up yet." These statements do more than criticise drug use. They connect drug use to culturally available expectations concerning age and maturity.

Life-course and critical gerontological perspectives are useful here because they show that such expectations are neither universal nor equally achievable. Life trajectories develop through the interaction of agency with historically and structurally available opportunities (Elder, 2003), while cumulative disadvantage can mean that inequalities experienced earlier in life become increasingly consequential over time (Dannefer, 2003). Critical gerontology similarly questions models of successful ageing that privilege independence, productivity,

health and accumulated resources without sufficient attention to the unequal social conditions through which these outcomes become possible (Holstein and Minkler, 2003).

The participants' narratives extend these insights into the field of drug use. Continued drug use in middle and later-life may be interpreted socially through ideas of immaturity or developmental failure, even though the trajectories through which individuals reached that point can be considerably more complicated. Drug use itself may have changed function repeatedly across the life course, becoming associated at different moments with pleasure, belonging, coping, pain management, dependence, routine or recovery. Ageing therefore does not simply occur alongside an unchanged practice of drug use. It provides a changing social and biographical context within which drug use is continually reassessed.

7.5.3 Bringing the Frameworks into Dialogue

The theoretical contribution of the thesis emerges most clearly when life-course theory, critical gerontology, narrative gerontology, stigma theory and social constructionism are considered together.

Life-course theory provides a framework for understanding participants' biographies as historically situated and temporally connected. Experiences in early life do not mechanically determine later outcomes, but their consequences can persist, accumulate or be reinterpreted through subsequent transitions and relationships (Elder, 2003; Dannefer, 2003). This is consistent with the findings of the thesis, in which childhood experience, adulthood responsibilities, drug use, relationships, work and criminal justice contact interacted in uneven and non-linear ways.

Critical gerontology directs attention to the inequalities through which later-life is produced. Townsend (1981), Estes (1979) and subsequent critical gerontological scholarship demonstrate that vulnerability in later-life cannot be explained solely through biological ageing or individual behaviour. Material resources, institutional arrangements and accumulated inequality contribute to the conditions under which people grow older. This is particularly relevant for participants whose ageing intersected with poverty, criminalisation, insecure housing, stigma or long-term contact with treatment systems.

Narrative gerontology adds another dimension by treating later-life as a position from which earlier experience can be revisited and reinterpreted (Kenyon and Randall, 1997; Freeman,

2010). This was particularly visible in participants' descriptions of self-acceptance, regret and changing relationships to their pasts. Ageing did not erase earlier experiences, nor did it necessarily resolve drug use. It could, however, provide a different standpoint from which participants interpreted what those experiences had meant.

Finally, Tyler's (2020) account of stigma as a social and political process helps explain why particular biographies become interpreted as personal failure. Participants were not ageing only in relation to their bodies and their personal histories. They were also ageing within social environments in which drug use remained morally classified and institutionally managed. Ageing and drug-use stigma could therefore intersect around questions of responsibility, maturity, respectability and deservingness.

Taken together, these frameworks make it possible to understand ageing with a history of drug use simultaneously as an embodied, biographical, social and structural process. The empirical contribution of this thesis is to show that, within this combination, survival can itself become an important source of biographical meaning.

7.5.4 Survival as a Biographical Lens

Survival appeared across participants' accounts in several forms, although it was neither universal nor experienced in the same way by everyone. Three overlapping meanings were particularly visible: surviving difficult conditions earlier in life, surviving during periods of long-term drug use, and surviving beyond periods in which drug use had dominated everyday life.

These distinctions should not be understood as fixed stages. Neither do they suggest that drug use is inherently a story of survival. Some participants described stable lives and forms of drug use that they did not understand primarily through hardship or dependence. For others, however, survival became an important organising concept through which they understood both their past and the fact of having grown older.

The first form concerned survival in relation to earlier circumstances. Experiences such as family disruption, violence, poverty and loss appeared in a number of biographies. These experiences did not determine subsequent drug use, but they formed part of the biographical conditions through which some participants later understood it. A survival perspective

therefore retains the life-course connection between earlier and later experiences without reducing drug use to the consequence of a single origin such as childhood trauma.

A second form concerned surviving within drug use. For participants with histories of sustained harmful or dependent use, remaining alive across many years sometimes involved practical knowledge about substances, risk, other users, services and the management of everyday life. A focus exclusively on deterioration can obscure this coexistence.

The third meaning became particularly visible retrospectively. Some participants had reached a point from which they could look back on earlier periods of drug use and interpret them differently. Survival in this sense did not necessarily mean abstinence. It could involve recovery, reduced or changed drug use, greater stability, or simply a different relationship to one's own biography. Participants' accounts of self-acceptance are important here. Later-life sometimes allowed past drug use to be reconsidered without either denying its harms or allowing those harms to provide the only available interpretation of the self.

Narrative gerontology helps make sense of this process because ageing repeatedly reconstructing a story about how accumulating years fit together (Kenyon and Randall, 1997; Freeman, 2010). For participants who had previously imagined their futures as limited, reaching later-life created an additional narrative task: making sense of a period of life that had not necessarily formed part of their earlier imagined future.

This is where survival becomes useful as an analytical concept. It directs attention not simply to the fact that someone remains alive, but to the relationship between past expectations, present ageing and the meanings attached retrospectively to having reached the present.

7.6 Limitations of the Study

This section addresses the principal limitations of the present research across five areas: sample composition and recruitment; the age threshold and definition of 'older'; the methodological tension between biographical-narrative data collection and reflexive thematic analysis; and the scope and coverage of the literature review. These limitations do not negate the findings but they shape the kinds of claims the thesis can legitimately make, and they point toward the future research that is needed to extend and complement this work.

Sample Composition and Recruitment

The most significant limitation of this study concerns the composition and recruitment of the sample, which shapes the findings in ways that require explicit acknowledgement.

Seventeen of 28 participants were recruited through a single recovery café in Glasgow. While this recruitment strategy was methodologically justified by producing trusting interview relationships and access to a population that had otherwise proved difficult to reach, it introduces a selection effect that cannot be eliminated. The consideration of this limitation has been done in section 3.6.3.

This risk is partially countered by the presence of participants recruited through other routes. Emily and Oliver, both recruited through online advertisement, narrate their drug use in ways that explicitly resist recovery conventions. Their accounts create analytical friction within the dataset that suggests the findings are not simply a product of recovery narrative conventions.

A related limitation concerns the geographic concentration of the sample. While participants were recruited from across the UK, the majority were based in Glasgow or Scotland more broadly. Glasgow's specific drug death crisis, its particular policy environment, its scheme-based housing geography, and the cultural specificity of its recovery infrastructure are deeply embedded in the data. The findings should therefore be understood as primarily grounded in a Scottish, and especially Glaswegian, context, and claims to UK-wide applicability should be made cautiously. Participants from England, Wales, and Northern Ireland are present but do not represent those national contexts in sufficient depth to sustain systematic comparative analysis.

A further compositional limitation concerns the gender balance of the sample. As Chapter 3 acknowledged, recruiting female participants in drug use research is consistently challenging, reflecting broader patterns in the field (see Chapter 2). The sample contains more male than female participants, and while gender is analysed throughout the findings, particularly in relation to maternal stigma, parenting guilt, and the gendered moral burden of drug use, the analysis cannot claim equal depth across genders. The experiences of women in the sample, while analytically significant, are not fully representative of the range of women's later-life drug use experiences in the UK (Russell et al., 2025; Shaw, 2023).

The Age Threshold and the Definition of 'Older'

As discussed in Chapter 3, the age threshold for this study was lowered during recruitment from 50 to 40, resulting in a sample that spans 40 to 79 years. This decision was both theoretically and practically motivated, and is consistent with a significant strand of the UK drug use literature (EMCDDA, 2010; Moxon and Waters, 2019; Wadd and Rao, 2014). The Advisory Council on the Misuse of Drugs (2019) and Beynon and colleagues (2009) both argue that continuous drug use may accelerate biological, social, and health processes associated with ageing, meaning that people in their 40s with long drug use histories may present experiences more associated with later-life than their chronological age suggests.

Nevertheless, the thesis title's use of 'later-life' creates some tension with a sample in which fourteen participants are aged between 40 and 49. Conventional social policy definitions of 'older adult' typically begin at 65, and even within drug use research the cut-off of 40 is at the lower end of a contested range. The consequence is that 'later-life' is used in this thesis as a biographical and interpretive category rather than as a purely chronological one. It is important for the reader to understand that the thesis does not claim to study 'older adults' as social policy understands that term. Rather, it studies a population whose biographical experience of ageing with drug use begins earlier than chronological convention would suggest, and it uses 'later-life' as a descriptor of that biographical stage rather than of a fixed chronological threshold.

The Scope and Coverage of the Literature Review

The systematic literature review in Chapter 2 was limited to the Scopus database, to English-language peer-reviewed articles, and to publications from 2010 onwards. While these decisions were methodologically justified and transparently reported, they introduce limitations that should be acknowledged.

The restriction to publications from 2010 onwards, while producing a coherent and contemporary review, excludes important earlier qualitative work. Significant UK studies published before 2010, however, including Pearson's (1987) ethnographic work on heroin use, and Parker and colleagues' (1998) normalization thesis are engaged in Chapter 1 but are not included in the systematic review. The review therefore reflects the contemporary qualitative literature rather than the full intellectual history of the field.

Third, the restriction to UK-based studies, while justified by the thesis's focus on the UK policy and social context, means that international literature on older drug users, including

European EMCDDA research, Australian longitudinal work, and North American studies were drawn upon selectively in the introduction and discussion but not systematically reviewed. Where international literature is cited, it is to provide context and comparative reference rather than as part of a comprehensive synthesis, and this distinction should be borne in mind when reading the literature-informed claims in the discussion chapters.

These limitations do not undermine the review's contribution, but they do mean that its scope should be understood as defined rather than comprehensive.

Taken together, the limitations described above define the boundaries of the claims this thesis can legitimately make. The findings are most reliably generalisable to older people with drug use histories who are engaged with recovery communities in urban Scottish contexts, and should be read with appropriate caution when applied to hidden users, non-recovery-engaged populations, ethnically diverse samples, or contexts outside Scotland. The methodological approach produces cross-case biographical patterns rather than individual biographical portraits, and the intersectional analysis is sustained only at the level of class and partially gender rather than across the full range of intersecting inequalities that shape older drug users' lives. These are real constraints on the scope of the findings. They do not, however, diminish the contribution the thesis makes within those constraints; a detailed, biographical, and class-attentive life-course account of how older people in the UK understand and narrate the relationship between drug use and ageing, grounded in participant voices that the existing literature has not previously centred.

Chapter 8 Conclusion

Research Question 1: How do participants describe the development and changing meanings of their drug use across the life course?

The most consistent finding across all 28 participants was that drug use does not carry a fixed or stable meaning across a life. It begins in one context, for particular reasons, and is then continuously reinterpreted as circumstances, relationships, bodies, and self-understandings change. For most participants, early drug use was not experienced as deviation or pathology but as a response that made sense to the specific social worlds they inhabited, to relational pain, to curiosity and belonging, and to a desire to feel differently than they did. Over time, the meaning of drug use shifted: from identity and pleasure in early life, toward coping and

functionality in adulthood, and toward something more ambivalent and negotiated in later-life simultaneously more managed and more loaded with biographical weight.

What the findings challenge, therefore, is any framework that treats drug use as a single thing with a single meaning. The participants in this study did not use drugs in the same way across their lives, and they did not understand their drug use in the same way either. Some narrated a journey from pleasure toward harm. Others described long periods of what they experienced as controlled or functional use. Others still described drug use as so deeply woven into their social worlds that the idea of a trajectory moving from one state to another did not capture the reality of their experience at all. The thesis argues that this diversity is not a methodological inconvenience but an analytically important finding: that drug use is better understood as a biographical practice whose meaning is produced and reproduced in specific social contexts, rather than as a condition with a predictable course.

Research Question 2: How do early life experiences, family and social relationships, classed environments, and adult transitions shape drug use trajectories over time?

The findings show clearly that drug use trajectories are shaped by the accumulation of biographical experience rather than by any single cause or turning point. Early life emerged as a formative but non-deterministic context. Participants who grew up in households marked by instability, fear, violence, or neglect described drug use as offering something that was otherwise absent; calm, numbness, connection, or a sense of control. But the same early experiences did not produce the same outcomes. Some participants who described difficult childhoods did not begin using drugs until adulthood. Some who described relatively stable early lives moved into dependent use through adult relationships or social networks. The thesis treats this variation as analytically significant: trauma is understood not as a direct cause of drug use but as a relational atmosphere, an enduring condition of insecurity that shaped what drug use offered, without making it inevitable.

Social class shaped trajectories in ways that were pervasive and often invisible to participants themselves until they reflected on them in the context of the interviews. Access to private treatment, the ability to maintain appearances, the geography of social networks, and the presence or absence of material security all determined what drug use looked like, who knew about it, and what consequences it carried. Participants from more disadvantaged backgrounds described drug use that was visible, criminalised, and publicly managed;

participants from more privileged backgrounds described drug use that was hidden, medicalised, and privately contained.

Adult transitions; parenthood, employment, criminal justice contact reshaped drug use without reliably ending it. Parenthood generated guilt, concealment, and an intensified moral burden, particularly for women, whose drug use was measured against expectations of good motherhood in ways that men's was not. Employment offered a form of symbolic protection, allowing participants to frame their drug use as compatible with productive adult life until that protection was lost. Criminal justice contact was the transition most consistently described not as a turning point toward change but as a deepening of vulnerability, a reinforcement of distrust, and a biographical rupture that complicated rather than resolved the conditions that had sustained drug use.

Research Question 3: How do participants understand the relationship between ageing and drug use in later-life, including changes in the body, health, social life, identity, and everyday functioning?

The relationship between ageing and drug use emerged as one of the most distinctive and undertheorized aspects of the findings. For many participants, reaching later-life was itself unexpected experienced as an arrival at a stage that had once seemed impossible. Amy's statement that she never thought she would reach forty captures a biographical reality that the existing literature has almost entirely failed to address: that for people who have lived with long-term dependent drug use, the prospect of growing old was not assumed but earned, and that this shapes how later-life is experienced and narrated.

The ageing body emerged as a complex and ambivalent presence. It imposed new limitations on drug use; reduced tolerance, heightened health consequences, increased physical vulnerability; but it also provided new reasons for continued use, as substances were mobilised to manage pain, sleep, anxiety, and the everyday demands of an ageing body. The body was simultaneously a limit and a rationale, and this bidirectionality complicates any straightforward account of ageing as a context for drug cessation.

Social life in later-life was described as contracting, but that contraction was experienced ambivalently; as relief from earlier chaos and as loneliness and loss. Recovery spaces; cafés, fellowships, peer networks; emerged not as substitutes for earlier social worlds but as entirely new forms of belonging, organised around honesty and shared experience rather than drug

use itself. For participants who found these spaces, they represented a form of social recognition that many had not previously experienced.

Identity in later-life was characterised not by redemption or resolution but by self-acceptance; a slower, more fragile, and more honest process of learning to live with oneself and one's history differently. Participants did not describe having resolved the contradictions of their lives. They described having learned, to varying degrees, to hold those contradictions with less shame and more equanimity. This is a finding about the specific possibility that later-life opens up; not closure, but a different and more reflexive relationship to the past.

Research Question 4: How do stigma, social inequality, and institutional responses shape later-life experience?

Stigma emerged across the findings not as a background condition but as an active force that shaped help-seeking, identity, service encounters, and the experience of ageing itself. It operated at personal, social, and structural levels simultaneously, and it was experienced very differently depending on participants' social position. The thesis's most distinctive contribution on this question is the demonstration that stigma is not uniform; it is unequally distributed, and that inequality follows the same lines as other forms of social disadvantage.

Class shaped who could hide their drug use and who could not; whose history was read as experimentation and whose as pathology; who could access private treatment and who faced public dispensing systems that performed stigma in full view of other customers. Gender shaped the specific moral burdens around parenthood and respectability that women carried, and the forms of shame that were activated when drug use and maternal identity came into contact. Treatment status shaped how participants were perceived by services and by the wider public; those on substitute medication described a persistent social judgement that cast them as not truly in recovery, regardless of their functional stability or biographical complexity.

Institutional responses; from drug treatment services, from criminal justice, from health systems, and from adult social care; were described by participants as systematically failing to see biography. Services saw behaviour, assessed risk, and managed episodes. They did not, in most cases, engage with the accumulated history of a person's life or with the social conditions that had produced and sustained their drug use. Participants described being processed rather than heard, categorised rather than understood, and managed toward

compliance rather than supported toward meaning. This institutional invisibility was not experienced as neutral. It was experienced as a form of stigma in its own right; the stigma of being seen as a problem to be managed rather than a person to be known.

8.1 Contribution to Knowledge

This thesis makes an original contribution to knowledge by offering an in-depth qualitative account of drug use in later-life that is explicitly biographical, life-course oriented, and grounded in participants' own interpretations of ageing. In the UK literature, older drug users have often been discussed primarily in relation to health needs, treatment demand, or service adaptation, while other areas of work have focused more narrowly on recovery identity, online mutual aid, or specific recovery communities. By contrast, this thesis brings these strands together and shows that later-life drug use cannot be understood adequately through service categories alone. It must also be understood through biography, family life, classed experience, embodied change, and the shifting meanings that drugs take on over time. In this sense, the thesis extends UK work on older users' treatment needs and later-life recovery by connecting ageing, drug use, and identity within a single analytical frame (Advisory Council on the Misuse of Drugs, 2019; Anderson et al., 2021; Ayres et al., 2012; Chambers, 2001; McGovern et al., 2021).

A second contribution lies in the way the thesis challenges linear accounts of drug use. My findings show that drug use in later-life is not best understood as a simple continuation of youthful excess, a straightforward failure to "mature out," or a single downward trajectory from experimentation to chronic dependency. Instead, participants' narratives reveal stop-start, episodic, and non-linear pathways shaped by shifting responsibilities, relationship breakdown, work, treatment, pain, loss, and changing social worlds. This matters because some UK research on older substance use has shown that later-life patterns are organised through moral distinctions between "normal" and "problematic" use, often shaped by propriety and social judgement rather than by health alone. My thesis adds to this by showing how those distinctions are not static labels but are actively negotiated across the life course, especially as people age and re-evaluate what substances do for them. (Ayres et al., 2012; Wilson et al., 2013).

A third contribution is conceptual. The thesis shows that ageing reshapes drug use not only through deterioration or decline, but through embodiment, management, and reinterpretation.

Participants did not describe the ageing body solely as a passive record of past damage. Rather, the ageing body became an interpretive and practical site through which they reassessed pain, exhaustion, anxiety, functionality, risk, and relief. For some, this encouraged reduction or abstinence; for others, it sustained the perceived usefulness of particular drugs. In this respect, the thesis extends existing UK work by demonstrating that later-life drug use is not adequately captured by deficit-based models alone. It must also be understood in relation to how people manage increasingly demanding bodies and minds in later-life, often in the context of services that remain poorly adapted to the needs of an ageing cohort (Advisory Council on the Misuse of Drugs, 2019; Wilson et al., 2013).

A fourth contribution lies in what the thesis adds to UK recovery research. Existing work has shown that recovery often involves social identity change, supportive recovery networks, mutual aid, and the rebuilding of self-worth. This thesis confirms those insights, but it also develops them by showing that in later-life recovery is frequently lived as a process of re-entering social and family life after years of distance, shame, or instability. Recovery in my data is not only abstinence, and not only a new identity label. It is often experienced as an attempt to become trustworthy, present, useful, and emotionally available again; to children, parents, grandchildren, partners, peers, and oneself. In that sense, the thesis contributes a more explicitly later-life account of recovery as relational reassembly: not merely identity transition, but the uneven rebuilding of belonging, responsibility, and recognition (Anderson et al., 2021; Chambers et al., 2017; McGovern et al., 2021).

The fifth contribution is this thesis contributes a reframing of the social construction of ageing itself. By placing drug use experience at the centre of analysis, the thesis demonstrates that the threshold of later-life, the meaning of maturity, and the developmental expectations against which lives are judged are all socially constructed in ways that cannot account for lives shaped by long-term drug use.

Finally, the thesis contributes to knowledge by showing that later-life drug use is profoundly shaped by stigma and unequal social location. The interviews demonstrate that class, gender, family role, public visibility, treatment status, and recovery status all affect how drug use is judged and how people are treated by others and by institutions. This extends the literature by showing that later-life drug use is not simply stigmatised because it involves drugs, or because it occurs in older age, but because it is evaluated through broader assumptions about

adulthood, respectability, responsibility, and who is allowed to age with dignity. The contribution here is therefore not only empirical but analytical: the thesis reframes later-life drug use as a site where biography, ageing, stigma, and social inequality intersect, and where the experience of growing older with a history of drug use is shown to be uneven, morally charged, and deeply relational (Advisory Council on the Misuse of Drugs, 2019; Wilson et al., 2013).

8.2 Implications for Policy, Harm Reduction and Social Work Practice

The findings of this thesis suggest that policy responses to drug use need to become more attentive to age, biography, and cumulative disadvantage. Later-life drug use should not be treated simply as the residual continuation of a younger person's problem, nor approached only through acute risk, criminal justice contact, or individual pathology. Rather, the accounts in this study show that later-life drug use is frequently entangled with chronic illness, pain, grief, stigma, social isolation, family rupture, and the practical difficulties of navigating fragmented systems of care. This is consistent with UK policy and research evidence indicating that older drug users often experience deteriorating physical and mental health, difficulty negotiating complex health and social care systems, and significant stigma, while mainstream services have not always been designed with this ageing cohort in mind (Advisory Council on the Misuse of Drugs, 2019; Rao et al., 2019).

One implication for policy is therefore the need for more genuinely integrated responses. The accounts in this thesis suggest that drug use in later-life cannot be addressed adequately by specialist treatment services operating in isolation from primary care, mental health provision, pain management, housing, and social care. In practice, people are often required to move between systems that address only one part of their lives at a time, despite the fact that their needs are inseparable in lived experience. This problem has already been recognised in UK policy work. The second part of the independent drug review argued for high-quality treatment alongside pathways away from criminal justice, while guidance on co-occurring mental health and drug or alcohol use conditions emphasised the need for joined-up responses rather than exclusion at service boundaries. Recent English research on stigma and the inverse care law further suggests that people in the most marginalised conditions may experience the least appropriate care, even when their needs are greatest (Addison et al., 2025; Department of Health & Social Care, 2021; Public Health England, 2017).

For harm reduction, the thesis suggests that later-life requires a broader and more relational understanding of what reducing harm means. Harm reduction remains crucial in its familiar forms; preventing fatal overdose, improving access to substitution treatment, increasing naloxone availability, and reducing blood-borne virus risk; but the findings of this study indicate that this is not enough on its own. In later-life, harm may also be produced through unmanaged pain, polypharmacy, poor mental health, untreated trauma, loneliness, shame, poor housing, and the exhaustion of trying to cope alone. The Advisory Council on the Misuse of Drugs' ageing cohort report explicitly identified pain management, deteriorating physical and mental health, and difficulty navigating care as key issues for older drug users, while the Scottish Government's National Mission plan places harm reduction and whole-system support at the centre of its response to drug deaths. Taken together, these sources reinforce the argument that harm reduction for older adults must extend beyond overdose response alone and attend to quality of life, continuity of care, and everyday survivability (Advisory Council on the Misuse of Drugs, 2019; Scottish Government, 2022).

The findings also have clear implications for social work practice. First, they suggest the importance of beginning from biography rather than from category. Participants' lives were not reducible to "addiction," "recovery," or "older age," and practice that starts from those labels alone risks reproducing the simplifications that participants often resisted. A social work response informed by this thesis would therefore need to take seriously the temporal depth of people's lives: childhood and family context, adult roles and losses, treatment histories, stigma experiences, and the changing meaning of substances over time. Second, the findings suggest that social work practice should be more explicitly anti-stigmatising. The shame described by participants was not only personal but institutionally reproduced through surveillance, disrespect, and low expectations. Recent UK evidence indicates that people who use drugs continue to experience dehumanising and exclusionary care, especially in settings where stigma intersects with poverty, poor health, or other forms of marginalisation. For social work, this means that relational practice, dignity, advocacy, and careful attention to how services are organised are not peripheral concerns; they are central to ethical intervention (Addison et al., 2025; Price et al., 2025).

A further implication concerns family and recovery support. The findings of this thesis suggest that later-life recovery is often lived not only as abstinence or substance reduction, but as an attempt to rebuild recognition, trust, and social membership. This means that

support should not be measured only in terms of whether drug use has stopped. It should also be judged by whether services enable people to reconnect with family where appropriate, form safer social networks, access recovery communities, and develop forms of routine, purpose, and self-worth that make continued change possible. Policy documents on treatment quality in England already emphasise improving access pathways and working with those who may not engage with mainstream provision. My findings suggest that this principle is especially important for older adults, whose needs may be hidden within services that remain youth-oriented in design or too narrow in the outcomes they value.

Overall, the policy, harm reduction, and practice implications of this thesis can be summarised in three points. First, later-life drug use should be recognised as a legitimate social policy and practice concern in its own right rather than as a minor extension of generic drug strategy. Second, responses need to be integrated, age-aware, and anti-stigmatising if they are to match the complexity of people's lives. Third, social work and related professions have a crucial role in shifting the focus from narrow behavioural judgement toward biography, dignity, relational support, and the material conditions that shape whether ageing with a history of drug use becomes more survivable.

8.3 Implications for Future Research

This thesis has opened as many questions as it has answered, and several directions for future research emerge directly from its findings and theoretical arguments.

One important direction is longitudinal biographical research with people ageing with histories of drug use. This study relied on participants looking back across their lives from their position at the time of interview. This retrospective perspective was central to the research design because the study was concerned with how people interpret and give meaning to their biographies. However, it cannot show how those interpretations themselves change as people continue to age. Longitudinal qualitative research could follow participants across several years to examine how bodily change, drug use, relationships, recovery, self-acceptance and understandings of survival are renegotiated over time. This would complement existing life-course research demonstrating that drug-use trajectories are contingent and subject to change rather than progressing towards a single stable outcome (Neale et al., 2012; Vojt et al., 2025). It would also allow further examination of the argument developed in this thesis that survival can become an important biographical lens

through which ageing is interpreted. Rather than asking whether participants occupy a fixed position of "survival", longitudinal research could examine how the meaning of having survived changes as later-life itself unfolds.

A particularly important priority follows directly from the recruitment limitations of this study. Seventeen of the 28 participants were recruited through one recovery café, and several others had some connection to services, organisations or recovery networks. These routes provided access to participants whose experiences are often difficult to reach and enabled the development of trusting research relationships. At the same time, they are likely to have made some experiences more visible than others. Older people who continue to use drugs privately, who do not identify with recovery, who have disengaged from services, or who have never entered formal treatment may understand ageing and drug use differently. Existing research suggests that some older people manage their drug use away from institutional settings and may be reluctant to identify with categories such as "drug user" or to engage with treatment because of stigma, shame or previous experiences of services (Ayres et al., 2012; Moxon and Waters, 2019). Future research should therefore develop recruitment strategies specifically aimed at people outside recovery communities and specialist drug services. This would be especially valuable for understanding forms of long-term recreational, intermittent or otherwise non-treatment-engaged drug use that remain comparatively difficult to capture in research. It would also allow the findings of this thesis concerning ageing, maturity, stigma and survival to be examined beyond a population in which recovery narratives are relatively visible.

The composition of the sample points to further priorities. Race and ethnicity did not emerge as prominent themes in participants' narratives. Participants rarely referred explicitly to racial or ethnic identity when describing their drug use, ageing, relationships, or experiences of services. However, race and ethnicity were not systematically collected as demographic characteristics or explored through direct questioning, so their limited visibility in the data should not be interpreted as evidence that they were unimportant to participants' lives. This reflects a wider limitation identified in the literature review, in which ethnicity was frequently poorly reported or insufficiently analysed. The limited research that does attend to ethnicity indicates that racism, cultural expectations, community relationships, privacy and trust in services may shape both drug-use experiences and help-seeking (Notley et al., 2012;

Roy, 2013). Future UK research should therefore examine how ageing with a history of drug use is experienced across different racialised and ethnic communities.

More focused research with older women is also warranted. Gender was visible throughout this study, particularly in accounts of parenthood, care, shame, respectability and contact with social work and other institutions, but the gender composition of the sample did not allow these issues to be examined in equal depth. Existing work has similarly demonstrated that women's drug use and recovery experiences can be shaped by distinctive expectations surrounding motherhood, relationships and respectable femininity (Kreis et al., 2016; Shaw, 2023; Russell et al., 2025). Research specifically designed around women ageing with histories of different forms of drug use could explore how these gendered expectations change across the life course and how they interact with ageing, health, caring roles and stigma.

Reflecting on the research process also suggests a stronger role for participatory and peer-led approaches. This study was designed to centre participants' accounts and understand their interpretations of their lives. Nevertheless, the research questions, analytical process and final interpretation remained researcher-led. My position as a researcher without lived experience of drug use sometimes encouraged participants to explain social worlds and practices that they believed I would not already understand, which was analytically valuable. At the same time, this position inevitably shaped what I noticed, how I interpreted participants' accounts, and the questions I considered important.

Participatory research offers one way of taking this reflexivity further by involving people with lived experience not only as participants but in decisions about what should be researched, how questions are framed, how data are interpreted and how findings are communicated. Weaver's (2022) work on co-production and epistemic participation is useful here because it locates the value of participation not simply in consultation, but in recognising that differently situated people bring different forms of knowledge to the research process. Participatory research with criminalised young adults has similarly demonstrated how involving people whose experiences are normally represented through professional or institutional categories can generate different questions and understandings of the systems affecting their lives (Weaver et al., 2024). This is particularly relevant to the present research because many participants had experiences not only of drug use but also of

criminalisation, stigma and sustained contact with institutions in which professional interpretations of their lives carried greater authority than their own.

There is also an established body of participatory research specifically involving people who use drugs. Such research suggests that peer involvement can improve access, trust and interpretation and can challenge assumptions introduced by researchers without lived experience (Damon et al., 2017; Souleymanov et al., 2016). However, this literature also cautions against assuming that the inclusion of peer researchers is automatically empowering. Participatory approaches can reproduce existing hierarchies when people with lived experience are consulted without meaningful influence over decision-making, are insufficiently supported, or are included primarily to demonstrate that participation has occurred (Damon et al., 2017; MacKinnon et al., 2021). Future research with older people who use drugs should therefore examine not only whether people with lived experience are involved, but what authority they have within the research process. Meaningful participation would require attention to shared decision-making, appropriate payment, training and support, and involvement in analysis and dissemination rather than participation being limited to recruitment or data collection.

The findings also identify a need for further evaluation of the social and relational forms of support that participants valued. Recovery cafés, peer relationships and spaces in which participants felt recognised and listened to appeared prominently in some accounts. However, this study was not designed to evaluate their effectiveness, and the substantial recruitment of participants through a recovery café means that it is especially important not to infer effectiveness from the positive experiences reported here. People for whom such spaces were uncomfortable, inaccessible or unhelpful are less likely to have been reached through this recruitment route. Future research could therefore examine how recovery cafés, peer-support networks and other community-based forms of support are experienced by different groups of older people, including those who continue to use drugs and those who do not identify with recovery. This would build on existing calls for age-responsive and integrated approaches to the needs of older people who use drugs (Advisory Council on the Misuse of Drugs, 2019; Hafford-Letchfield et al., 2020), while paying closer attention to the relational and biographical qualities of support that participants in this study repeatedly described as important.

Finally, further research is needed to develop the theoretical contribution of this thesis. The argument advanced here is not that survival provides a universal model of ageing among people who use drugs. Rather, the findings suggest that survival can provide a useful biographical lens where people's expectations of longevity have been shaped by drug use, repeated experiences of loss, poor health, stigma or structural disadvantage. Future studies with older people who use drugs could examine how far this concept is useful across different patterns of drug use, social positions and national contexts. Comparative research might also consider populations whose biographies have been shaped by other forms of sustained marginalisation or uncertainty about the future, including long-term homelessness or extensive criminal justice involvement. Such comparisons would need to preserve the specificity of those experiences rather than treating disadvantaged populations as interchangeable. Their value would lie in establishing more precisely when survival becomes significant to the experience of ageing, how it interacts with chronological and bodily ageing, and where the concept reaches its analytical limits.

Taken together, these directions would extend the present study in two related ways. They would broaden whose experiences are represented, particularly beyond recovery-connected, predominantly White samples, and they would deepen the methodological involvement of people whose lives are being studied. In doing so, future research could build a more differentiated understanding of ageing and drug use while retaining the central principle of this thesis: that drug use in later-life is best understood in relation to biography, social context and the meanings people themselves attach to their lives.

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Appendices

Appendix 1

Summary of Included Studies – Study Characteristics

No	Title	Author(s)	Year	Method	Drug type (broad)	Research location
1	'I don't think there's much of a rational mind in a drug addict when they are in the thick of it': towards an embodied analysis of recovering heroin users	Nettleton, Neale & Pickering	2011	Qualitative interviews; embodied qualitative analysis	Heroin / recovery	England / Southern England
2	Comparing methadone and Suboxone in applied treatment settings: the experiences of maintenance patients in Lanarkshire	Tanner, Bordon, Conroy & Best	2011	Narrative accounts + structured interviews; qualitative comparison of treatment experiences	Opioid maintenance treatment	Lanarkshire, Scotland
3	Techniques and transitions: A sociological analysis of sleeping practices amongst recovering heroin users	Nettleton, Neale & Pickering	2011	Qualitative interviews; descriptive coding and thematic/sociological analysis	Heroin / recovery	England
4	Cannabis use: What's law got to do with it? Perceptions and knowledge of cannabis policy from the user perspective in Northern Ireland	Stevenson	2012	Semi-structured interviews	Cannabis	Northern Ireland

5	The needs of problematic drug misusers not in structured treatment – a qualitative study of perceived treatment barriers and recommendations for services	Notley, Maskrey & Holland	2012	Focus groups, individual interviews and informal interviews; thematic analysis with NVivo	Poly-drug / problematic drug use	Norfolk, England
6	Treatment experience and needs of older drug users in Bristol, UK	Ayres, Eveson, Ingram & Telfer	2012	Semi-structured interviews plus service-development focus group; thematic analysis	Poly-drug / older drug users	Bristol, UK
7	'We did more rough sleeping just to be together' – Homeless drug users' romantic relationships in hostel accommodation	Stevenson & Neale	2012	Semi-structured interviews; systematic coding and Framework analysis	Poly-drug	South Central England
8	Hepatitis C Avoidance in Injection Drug Users: A Typology of Possible Protective Practices	McGowan, Harris & Rhodes	2013	Life-history qualitative interviews; inductive/grounded thematic typology	Injecting drug use / poly-drug	London
9	Perceptions of food choices of people aged 50 and over in contact with a specialist drug service: a pilot qualitative interview study	Beynon, Baron & Hackett	2013	Semi-structured topic-guided interviews; qualitative analysis	Poly-drug / older drug-service patients	North West England
10	Recovering a Fecal Habitus: Analyzing Heroin Users' Toilet Talk	Pickering, Neale & Nettleton	2013	Interviews/follow-up interviews with some wider-study observation; embodied/discursive qualitative analysis	Heroin / recovery	South of England

11	Stigma and perceptions of recovery in Scotland: a qualitative study of injecting drug users attending methadone treatment	McPhee, Brown & Martin	2013	Semi-structured interviews; thematic analysis with interpretative techniques	Injecting opiate use / methadone treatment	Borders and West of Scotland
12	The Life Narrative of a Mixed-Race Man in Recovery from Addiction: A Case-Based Psychosocial Approach to Researching Drugs, 'Race' and Ethnicity	Roy	2013	BNIM/life narrative interviews; psychosocial case-based narrative analysis using Kleinian theory	Heroin and methadone addiction	UK; Manchester-based research/recruitment context
13	A qualitative exploration of relations and interactions between people who are homeless and use drugs and staff in homeless hostel accommodation	Stevenson	2014	Semi-structured interviews; Framework analysis	Poly-drug	South Central England
14	Narrative and attachment in the process of recovery from substance misuse	Waters, Holttum & Perrin	2014	60–90 minute interviews; narrative analysis	Substance misuse / recovery	UK NHS addictions psychology department; exact site not clearly specified
15	Earning a Score: An Exploration of the Nature and Roles of Heroin and Crack Cocaine 'User-Dealers'	Moyle & Coomber	2015	Qualitative interviews; thematic analysis	Heroin and crack cocaine	South West England

16	Multiple obstacles to psychological care from the viewpoint of addiction service users	Gore, Mendoza & Delgadillo	2015	Telephone semi-structured interviews; six-phase thematic analysis	Addiction service users / poly-drug	Leeds, England
17	Prescribing heroin for addiction: Some untapped potentials and unanswered questions	Wakeman	2015	Ethnographic fieldwork/participant observation plus in-depth interviews with core participants; sociological analysis	Heroin	North West England
18	Rehab, respite and recovery: the experiences of methadone users in a modified therapeutic community (MTC) in Scotland	McPhee & Fenton	2015	Semi-structured interviews; thematic analysis using NVivo	Poly-drug / methadone	Scotland
19	Disclosure decisions within transition narratives: How ex-drug users decide what information to share when working toward employment in the substance misuse field	Wilson, King, Yeowell & Wibberley	2016	In-depth narrative interviews + process mapping; framework-like thematic analysis	Ex-drug users / recovery	UK; exact research location not clearly specified
20	Relational Pathways to Substance Misuse and Drug-Related Offending in Women: The Role of Trauma, Insecure Attachment, and Shame	Kreis, Gillings, Svanberg & Schwannauer	2016	Interviews; Charmaz-informed social constructivist grounded theory	Heroin / opioid replacement therapy	Scotland

21	The lived experience of people with mental health and substance misuse problems: Dimensions of belonging	Blank, Finlay & Prior	2016	Semi-structured interviews; interpretative phenomenological / hermeneutic phenomenological analysis	Dual diagnosis / substance misuse and mental health	United Kingdom
22	Understanding Recovery; the Perspective of Substance Misusing Offenders	Senker & Green	2016	Semi-structured interviews; qualitative thematic/narrative interpretation	Heroin and crack cocaine	Prison and community settings
23	Breastfeeding support and opiate dependence: A think aloud study	MacVicar, Humphrey & Forbes-McKay	2017	Qualitative think-aloud interviews; qualitative analysis	Opiate dependence / OMT	North-East Scotland
24	Depot buprenorphine injections for opioid use disorder: Patient information needs and preferences	Neale, Tompkins & Strang	2019	Semi-structured qualitative interviews; systematic coding and Iterative Categorisation	Opioid use disorder	Greater London
25	Opioid users' willingness to receive prolonged-release buprenorphine depot injections for opioid use disorder	Tompkins, Neale & Strang	2019	Face-to-face semi-structured interviews; Iterative Categorization with line-by-line coding	Opioid use disorder	London
26	Sourcing illegal drugs as a hidden older user: the ideal of 'social supply'	Moxon & Waters	2019	Semi-structured life-story interviews; qualitative analysis of drug sourcing/social supply	Hidden older illegal drug use / poly-drug	UK; exact region not clearly stated in retrieved text

27	Exploring the 'Spoiled' and 'Celebrated' Identities of Young and Homeless Drug Users	Hoolachan	2020	Ethnographic participant observation, 6 semi-structured interviews and 1 focus group; ethnographic/sequential qualitative analysis	Poly-drug	Scotland / UK-based supported accommodation hostel
28	Medicinal Cannabis Users Downplaying and Shifting Stigma: Articulations of the 'Natural', of What Is/Is Not a 'Drug' and Oppositions with 'Chemical' Substances	Morris	2020	Qualitative interviews; critical discourse analysis	Medicinal cannabis	UK; exact site not clearly specified
29	Normalised pain and severe health care delay among people who inject drugs in London: Adapting cultural safety principles to promote care	Harris	2020	In-depth qualitative interviews from Care & Prevent mixed-methods study; thematic analysis	Injecting drug use / poly-drug	London
30	Women's experiences of using heroin substitute medication in pregnancy	Varty & Alwyn	2011	Semi-structured interviews using a grounded-theory approach; constant comparative/thematic analysis	Heroin substitute medication	South Wales
31	An interpretative phenomenological analysis of service users' experiences in a psychosocial addictions intervention	Dawood & Done	2021	Semi-structured interviews; Interpretative Phenomenological Analysis (IPA)	Heroin and/or cocaine / addiction recovery	UK; intervention setting not clearly specified

32	Drug fatalities and treatment fatalism: Complicating the ageing cohort theory	Dennis	2021	In-depth interviews; sociomaterial / feminist technoscience-informed qualitative analysis	Heroin	South London
33	Exploring pathways into and out of amphetamine type stimulant use at critical turning points: a qualitative interview study	Addison, Kaner, Spencer, McGovern, McGovern, Gilvarry & O'Donnell	2021	Semi-structured interviews; Framework Approach using NVivo	Amphetamine-type stimulants	North-East England
34	Multiple relapses into opiate and crack misuse among people in recovery: An interpretative phenomenological analysis	Klein, Dixon & Butler	2022	Semi-structured interviews; Interpretative Phenomenological Analysis (IPA)	Opiate and crack cocaine	England
35	Self-detoxification, embodiment and masculinity: a qualitative analysis of dependent heroin users' experiences of coming off drugs in prison	Walmsley	2022	Qualitative interviews; analysis using Drew Leder's absent body framework and prison masculinity	Heroin	South West England
36	University Students' Experiences of Recreational Class A Drug Taking and Perspectives on Personal, Social, and Health Education (PSHE) Drug Education	Scott & Oliver	2022	Five interviews plus qualitative content analysis of PSHE resources/policy; thematic	Recreational Class A drugs	North of England

				analysis using idiographic case-study approach		
37	Variations in the accomplishment of persistent heroin use in Wales: a typology of users' lifestyles	Morgan & Bennett	2022	Semi-structured interviews; qualitative typology construction from interview narratives	Heroin	Wales
38	Experiences of homeless people who use psychoactive substances: an interpretative phenomenological study	Wagstaff, Davis, Jackson-McConnell, MacDonald, Medlyn & Pillon	2023	Semi-structured interviews; Interpretative Phenomenological Analysis (IPA)	Psychoactive substances / poly-drug	West Midlands
39	Exploring the Intersection of Drug Addiction and Mental Ill-Health in Scottish Prisons: A Qualitative Study of Incarcerated Men	Deuchar & Densley	2023	Semi-structured interviews; thematic analysis with grounded/open and axial coding elements	NPS / poly-drug	Two Scottish prisons
40	Non-Prescribed Substance Use during the First Month of Treatment by People Receiving Depot Buprenorphine for Opioid Use Disorder	Parkin, Neale & Strang	2023	Longitudinal semi-structured interviews at 3 time-points; content analysis and framework analysis	Non-prescribed substance use during OUD treatment	England and Wales

41	The Nature and Implications of Lifestyle Transitions for Persistent Heroin Use	Morgan & Bennett	2023	Career-mapping exercise plus semi-structured interviews; thematic analysis of lifestyle-transition narratives plus biographical case studies	Persistent heroin use	Wales
42	"Everything is fear based": Mothers with experience of addiction, child removal and support services	Russell, Turner, Gajwani & Minnis	2025	Semi-structured individual interviews; Interpretative Phenomenological Analysis (IPA)	Addiction / substance use	Scotland
43	A qualitative investigation of women's experiences of drug use at university and needs within university drug harm reduction services	Obradovic, Carlisle & Maynard	2025	Online focus groups; Reflexive Thematic Analysis	Recreational drug use / poly-drug	UK universities; Bristol/UWE harm-reduction context
44	Coping With the Persistence of Stigma in Recovery: A qualitative examination of the disclosure experiences of people in recovery from problem drug use	Walmsley	2025	Semi-structured qualitative interviews; inductive and deductive qualitative analysis informed by modified labeling theory	Problem drug use / recovery	South West England
45	Mid-level Illicit Drug Supply in a Small English City: Sellers' Perspectives and Experiences	Pelling & Turnock	2025	Qualitative semi-structured interviews; thematic/reflexive analysis	Non-street illicit drugs / mid-level supply	Small English city

46	Non-fatal overdose in narrative accounts of people in recovery from drug use	Maiden, Fish, Porroche-Escudero & Limmer	2026	Narrative interviews using a lightly structured biographic narrative approach; inductive narrative thematic analysis	Poly-drug / heroin dependence	North West England
47	Preventing drug-related deaths in Scotland: perceptions and experiences of engagement in a "shared care" model of service delivery	Thom, Whittaker, O'Gorman, Colliver, Robertson, Mercer & Mohan	2026	Qualitative case-study design using 34 semi-structured interviews; thematic analysis	Problem drug use / drug-related deaths	Scotland; two primary care practices in highly deprived urban areas
48	Stigmatised and stressed: UK cannabis patients living in the context of prohibition	Metcalf McGrath & Beckett Wilson	2025	Virtual semi-structured interviews; Reflexive Thematic Analysis	Prescribed medical cannabis	UK
49	The Gendered Stigma-Vulnerability Nexus and Women Who Use Drugs Such as Spice in Prison. A Feminist Critical Realist Discourse Analysis	White	2025	Semi-structured interviews; Feminist Critical Realist Discourse Analysis	Spice / NPS	English women's prisons / South-East England prison experience
50	The Temporality of the Withdrawing Body: A Qualitative Analysis of the Role of Time in the Experience of Withdrawing From Heroin in Prison	Walmsley	2025	Qualitative interviews from an existing dataset; deductive and inductive analysis focused on	Heroin	South West England

				embodiment, temporality and prison time		

Summary of Included Studies – Sample and Substance/Drug Characteristics

No	Title	Author(s)	Year	Participant number	Age	Gender	Specific drug/substance focus
1	'I don't think there's much of a rational mind in a drug addict when they are in the thick of it': towards an embodied analysis of recovering heroin users	Nettleton, Neale & Pickering	2011	40	25–51	21 male; 19 female	Recovering heroin users
2	Comparing methadone and Suboxone in applied treatment settings: the experiences of maintenance patients in Lanarkshire	Tanner, Bordon, Conroy & Best	2011	9 structured interviewees + 12 narrative accounts	23–47 for interviewees	7 male; 2 female for interviewees	Methadone and Suboxone/buprenorphine among people with heroin dependence
3	Techniques and transitions: A sociological analysis of sleeping practices amongst recovering heroin users	Nettleton, Neale & Pickering	2011	40 participants / 77 interviews	24–50	21 male; 19 female	Sleeping practices among recovering heroin users
4	Cannabis use: What's law got to do with it? Perceptions and knowledge of cannabis policy from the user perspective in Northern Ireland	Stevenson	2012	38	18–59	22 male; 16 female	Cannabis use and cannabis policy perceptions
5	The needs of problematic drug misusers not in structured treatment – a qualitative study of perceived treatment barriers and recommendations for services	Notley, Maskrey & Holland	2012	43	18–45	31 male; 12 female	Problematic drug users not in structured treatment

6	Treatment experience and needs of older drug users in Bristol, UK	Ayres, Eveson, Ingram & Telfer	2012	20	55+	17 male; 3 female	Older drug users in treatment / OST context
7	'We did more rough sleeping just to be together' – Homeless drug users' romantic relationships in hostel accommodation	Stevenson & Neale	2012	40	21–54	29 male; 11 female	Homeless drug users; mainly heroin/crack and other drugs/alcohol
8	Hepatitis C Avoidance in Injection Drug Users: A Typology of Possible Protective Practices	McGowan, Harris & Rhodes	2013	37	23–57	27 male; 10 female	Protective practices among people who inject drugs
9	Perceptions of food choices of people aged 50 and over in contact with a specialist drug service: a pilot qualitative interview study	Beynon, Baron & Hackett	2013	10	51–61	9 male; 1 female	Food choices among people aged 50+ in a specialist drug service
10	Recovering a Fecal Habitus: Analyzing Heroin Users' Toilet Talk	Pickering, Neale & Nettleton	2013	40	25–51	21 male; 19 female	Heroin users' toilet talk and defecation during recovery
11	Stigma and perceptions of recovery in Scotland: a qualitative study of injecting drug users attending methadone treatment	McPhee, Brown & Martin	2013	14	18–55	8 male; 6 female	Injecting opiate users in methadone treatment; opiates and benzodiazepines
12	The Life Narrative of a Mixed-Race Man in Recovery from Addiction: A Case-Based Psychosocial Approach to Researching Drugs, 'Race' and Ethnicity	Roy	2013	1	50s	1 male	Bobby, a mixed-race man in recovery
13	A qualitative exploration of relations and interactions between people who are homeless and use drugs and staff in homeless hostel accommodation	Stevenson	2014	40	21–54	29 male; 11 female	Homeless people who use drugs and hostel staff interactions

14	Narrative and attachment in the process of recovery from substance misuse	Waters, Holttum & Perrin	2014	7	28–54	3 male; 4 female	People in recovery from substance misuse who found psychological therapy helpful
15	Earning a Score: An Exploration of the Nature and Roles of Heroin and Crack Cocaine 'User-Dealers'	Moyle & Coomber	2015	30	19–52	20 male; 10 female	Heroin/crack cocaine user-dealers
16	Multiple obstacles to psychological care from the viewpoint of addiction service users	Gore, Mendoza & Delgadillo	2015	10	25–58	7 male; 3 female	Addiction service users' psychological-care experiences
17	Prescribing heroin for addiction: Some untapped potentials and unanswered questions	Wakeman	2015	17	23–early 70s	11 male; 6 female	Heroin use and heroin-assisted treatment
18	Rehab, respite and recovery: the experiences of methadone users in a modified therapeutic community (MTC) in Scotland	McPhee & Fenton	2015	7	37–46	7 male; 0 female	Homeless male poly-drug users in a modified therapeutic community
19	Disclosure decisions within transition narratives: How ex-drug users decide what information to share when working toward employment in the substance misuse field	Wilson, King, Yeowell & Wibberley	2016	11	Not clearly reported	Not clearly reported	Ex-drug users transitioning to work in the substance misuse field
20	Relational Pathways to Substance Misuse and Drug-Related Offending in Women: The Role of Trauma, Insecure Attachment, and Shame	Kreis, Gillings, Svanberg & Schwannauer	2016	7	26–40	0 male; 7 female	Women offenders in community treatment for heroin dependence
21	The lived experience of people with mental health and substance misuse problems: Dimensions of belonging	Blank, Finlay & Prior	2016	4	18+	1 male; 3 female	People with mental health and substance misuse histories; belonging

22	Understanding Recovery; the Perspective of Substance Misusing Offenders	Senker & Green	2016	35	20–54	Not clearly reported in retrieved PDF text	Substance-misusing offenders with heroin/crack histories
23	Breastfeeding support and opiate dependence: A think aloud study	MacVicar, Humphrey & Forbes-McKay	2017	6	Not fully reported in retrieved text; women under 40	0 male; 6 female	Opiate-dependent women within 6 months post-birth; breastfeeding support
24	Depot buprenorphine injections for opioid use disorder: Patient information needs and preferences	Neale, Tompkins & Strang	2019	36	24–63	26 male; 10 female	Depot buprenorphine information needs; heroin/methadone/buprenorphine groups
25	Opioid users' willingness to receive prolonged-release buprenorphine depot injections for opioid use disorder	Tompkins, Neale & Strang	2019	36	24–63	26 male; 10 female	Depot buprenorphine willingness; heroin, methadone and buprenorphine groups
26	Sourcing illegal drugs as a hidden older user: the ideal of 'social supply'	Moxon & Waters	2019	30	40–66	25 male; 5 female	Older hidden users of illegal drugs; social supply; often cannabis and other illegal drugs
27	Exploring the 'Spoiled' and 'Celebrated' Identities of Young and Homeless Drug Users	Hoolachan	2020	22	16–21	16 male; 6 female	Young homeless hostel residents who use drugs
28	Medicinal Cannabis Users Downplaying and Shifting Stigma: Articulations of the 'Natural', of What Is/Is Not a 'Drug' and Oppositions with 'Chemical' Substances	Morris	2020	10 analysed from wider sample of 32	28–59	4 male; 6 female	Medicinal cannabis users and stigma

29	Normalised pain and severe health care delay among people who inject drugs in London: Adapting cultural safety principles to promote care	Harris	2020	36 qualitative participants	21–62	28 male; 8 female	People who inject drugs; pain, care delay and cultural safety
30	Women's experiences of using heroin substitute medication in pregnancy	Varty & Alwyn	2011	6	Not reported	0 male; 6 female	Pregnant women taking methadone or buprenorphine for heroin dependence
31	An interpretative phenomenological analysis of service users' experiences in a psychosocial addictions intervention	Dawood & Done	2021	11	32–54	6 male; 5 female	Participants who achieved abstinence or significant drug reduction after psychosocial intervention
32	Drug fatalities and treatment fatalism: Complicating the ageing cohort theory	Dennis	2021	12	41–61	8 male; 4 female	Current heroin consumers aged over 40
33	Exploring pathways into and out of amphetamine type stimulant use at critical turning points: a qualitative interview study	Addison, Kaner, Spencer, McGovern, McGovern, Gilvarry & O'Donnell	2021	70	19–62	33 male; 37 female	ATS users and people exposed to ATS
34	Multiple relapses into opiate and crack misuse among people in recovery: An interpretative phenomenological analysis	Klein, Dixon & Butler	2022	7	26–56	6 male; 1 female	People in recovery with multiple relapses from opiate/crack misuse
35	Self-detoxification, embodiment and masculinity: a qualitative analysis of dependent heroin users' experiences of coming off drugs in prison	Walmsley	2022	10	Late 30s–50	10 male; 0 female	Recently released men who self-detoxified from heroin in prison
36	University Students' Experiences of Recreational Class A Drug Taking and Perspectives on Personal, Social, and Health Education (PSHE) Drug Education	Scott & Oliver	2022	5	21–22	4 male; 1 female	University students' recreational Class A drug use and drug education

37	Variations in the accomplishment of persistent heroin use in Wales: a typology of users' lifestyles	Morgan & Bennett	2022	51	21–54	42 male; 9 female	Current or recent persistent heroin users
38	Experiences of homeless people who use psychoactive substances: an interpretative phenomenological study	Wagstaff, Davis, Jackson-McConnell, MacDonald, Medlyn & Pillon	2023	4	33–45	4 male; 0 female	Homeless people who use psychoactive substances
39	Exploring the Intersection of Drug Addiction and Mental Ill-Health in Scottish Prisons: A Qualitative Study of Incarcerated Men	Deuchar & Densley	2023	24	23–62	24 male; 0 female	Incarcerated men; drug addiction, NPS and mental ill-health
40	Non-Prescribed Substance Use during the First Month of Treatment by People Receiving Depot Buprenorphine for Opioid Use Disorder	Parkin, Neale & Strang	2023	26 participants / 70 interviews	30–62	18 male; 8 female	Heroin, crack cocaine, benzodiazepines and cannabis during depot buprenorphine treatment
41	The Nature and Implications of Lifestyle Transitions for Persistent Heroin Use	Morgan & Bennett	2023	38 analysed transition cases; 51 full sample	21–54	34 male; 4 female in analysed sample; 42 male; 9 female in full sample	Lifestyle transitions among people with persistent heroin use
42	"Everything is fear based": Mothers with experience of addiction, child removal and support services	Russell, Turner, Gajwani & Minnis	2025	12	28–49	0 male; 12 female	Mothers with addiction and child-removal experience
43	A qualitative investigation of women's experiences of drug use at university and needs within university drug harm reduction services	Obradovic, Carlisle & Maynard	2025	22	19–23	0 male; 22 female	Women university students' drug use and harm-reduction needs

44	Coping With the Persistence of Stigma in Recovery: A qualitative examination of the disclosure experiences of people in recovery from problem drug use	Walmsley	2025	25	32–59	13 male; 12 female	People in recovery from problem drug use; stigma/disclosure
45	Mid-level Illicit Drug Supply in a Small English City: Sellers' Perspectives and Experiences	Pelling & Turnock	2025	8	Early-to-mid 20s	8 male; 0 female	Cannabis, cocaine and party drugs
46	Non-fatal overdose in narrative accounts of people in recovery from drug use	Maiden, Fish, Porroche-Escudero & Limmer	2026	10	27–48	9 male; 1 female	Non-fatal overdose accounts; 9 had been heroin-dependent and all described polydrug use
47	Preventing drug-related deaths in Scotland: perceptions and experiences of engagement in a "shared care" model of service delivery	Thom, Whittaker, O'Gorman, Colliver, Robertson, Mercer & Mohan	2026	34 mixed stakeholders: 6 PWUD, 4 family members, 20 practitioners, 4 policymakers	Not applicable / not reported	Mixed stakeholder sample; gender not reported	Shared-care engagement for people who use drugs
48	Stigmatised and stressed: UK cannabis patients living in the context of prohibition	Metcalf McGrath & Beckett Wilson	2025	24	Not reported	9 male; 15 female	Prescribed cannabis patients and carers
49	The Gendered Stigma-Vulnerability Nexus and Women Who Use Drugs Such as Spice in Prison. A Feminist Critical Realist Discourse Analysis	White	2025	15: 5 formerly incarcerated women + 10 prison/community professionals	Not reported	3 male; 12 female	Discourses around women's Spice use in prison

50	The Temporality of the Withdrawing Body: A Qualitative Analysis of the Role of Time in the Experience of Withdrawing From Heroin in Prison	Walmsley	2025	10	Late 30s–50	10 male; 0 female	Heroin withdrawal / self-detoxification in prison

Appendix 2
ETHICAL AND SPONSORSHIP APPROVAL
UEC23/26 Smith: Later-life Accounts of Drug Use

I can confirm that the University Ethics Committee (UEC) has approved this protocol and appropriate insurance cover and sponsorship have now also been confirmed.

I remind you that the UEC must be informed of any changes you plan to make to the research project, so that it has the opportunity to consider them. Any change of staffing within the research team should be reported to UEC.

The UEC also expects you to report back on the progress and outcome of your project, with an account of anything which may prompt ethical questions for any similar future project and with anything else that you feel the Committee should know.

Any adverse event that occurs during an investigation must be reported as quickly as possible to UEC and, within the required time frame, to any appropriate external agency.

The University agrees to act as sponsor of the above-mentioned project subject to the following conditions:

1. That the project obtains/has and continues to have University/Departmental Ethics Committee approval.

2. That the project is carried out according to the project protocol.

3. That the project continues to be covered by the University's insurance cover.

4. That the project complies with Scottish Government restrictions and University guidance in relation to Covid-19 procedures and permissions.

5. That the Director of Research and Knowledge Exchange Services is immediately notified of any change to the project protocol or circumstances which may affect the University's risk assessment of the project.

6. That the project starts within 12 months of the date of this letter.

As sponsor of the project the University has responsibilities under the UK Policy Framework for Health and Social Care Research. You should ensure you are aware of those responsibilities and that the project is carried out according to the UK Policy Framework.

On behalf of the Committee, I wish you success with this project.
Kind regards

Angelique

Angelique Laverty
Research Ethics and Governance Manager
Research & Knowledge Exchange Services (RKES)
University of Strathclyde

Appendix 3

Participant Information Sheet for [Older Drug Users Aged Forty and Over]

Name of department: Social Work and Social Policy
Title of the study: Later-life Accounts of Drug Use

Introduction

My name is Asena Merve Turkmen, and I am a PhD researcher at the University of Strathclyde and my PhD is funded by Turkish Ministry of National Education. You have been invited to participate in this study titled "Later-life Accounts of Drug Use". Participation is entirely voluntary, and you are free to ask any question to the researcher before, during and after the interview. Please read this sheet carefully before deciding whether you would like to participate.

What is the purpose of this research?

This study aims to explore the life experiences of people aged forty and over with drug use in the UK. People can get stigmatised for different reasons. Additionally, stigma can be intersectional – meaning a person can experience stigma for more than one reason.

In the United Kingdom, Equality Act 2010 safeguards individuals from discrimination and defines nine specific protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Therefore, I am hoping to learn more about your experiences and explore whether and how experiences of ageing affect experiences of drug use and/or help-seeking behaviour and treatments especially in relation to these protected characteristics.

Do you have to take part?

You do not have to take part in this study. Participation is voluntary, and you can withdraw from the research whenever you like up until the data have been anonymised and analysed – five weeks after the interview. If you feel uncomfortable or distressed during the interview, you can opt not to answering any of the questions, ask for a break or end the interview. You can also request (up to the point at which data have been anonymised and analysed) that your data be excluded from the study and securely

destroyed. Additionally, you can opt to respond to those discussion topics you most feel comfortable with. You will receive an Amazon eGift Voucher worth of 15£. This remuneration is for the time and effort you put into the research. If you decide to withdraw from the research (within the next five weeks after the interview), you will still receive the remuneration. The voucher will be sent within a week after the interview. The voucher will be sent via email or text message. Therefore, the participants who want to receive the remuneration must share their email addresses or phone numbers.

What will you do in the project?

The research study collects data through interviews. The interviews are semi-structured narrative interviews, meaning there are some prepared questions to lead the interview process; however, you are free to shape the interview conversation to include stories or information that you believe is related to the subject (i.e. to your experiences of drug use). Prepared questions focus on asking you about your experiences with drug use, social life, substance use treatment services, ageing and stigma. Due to questions related to drug use, it is possible that some of what you tell me may include acts that are (or once) considered criminal offences. You do not have to share those stories if you do not feel comfortable. Interviews can be arranged online (e.g. on Zoom or Teams) or via telephone and they are likely last between 1 and 2 hours. If you agree to be interviewed, the interview date and time will be agreed with you, based on your preference and availability as far as reasonably practical. Interviews will be recorded (video recorded for Zoom and Teams interviews, voice recorded for phone interviews). Recordings are an essential part of the transcription process. Thus, all the interviews must be recorded. If you like to have a Zoom or Teams interview, you can turn off your camera; you do not have to show your face; however, I will need to record your voice. These recordings will only be used for the transcription process and help the researcher transcript the conversation verbatim. Recordings will not be used in the study directly and will be securely destroyed after PhD researcher completes Viva successfully.

Why have you been invited to take part?

You have been invited to take part in this study because I am interested in your experiences of drug use. I believe your drug use experiences can shed light on an important knowledge gap in the UK and help

future research, practice, and policies, with the aim of ensuring that practises are as supportive and responsive to people's needs as possible.

There are four inclusion criteria within the research. To be interviewed. You should: (1) be aged 40 or over, (2) have past or current experience of drug use, (3) be currently living in the UK, and (4) be able to read and speak in English.

What are the potential risks to you in taking part?

There are no anticipated risks to participating in this research. If there are parts of the interview which cause you discomfort or distress, we can take a pause or stop the interview. You do not have to continue with the interview, and you can withdraw your consent for participation. If you request your data can be excluded and destroyed up until the anonymisation and data analysis process.

What information is being collected in the project?

I aim to learn about participants' lived experiences related to drug use, ageing and stigma. I will collect this information through interviewees' spoken accounts during interviews. I will also ask to collect information about protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation) to explore if you ever had experienced stigma related to them. You do not have to answer these questions if you do not feel comfortable with them.

Interviews will be held once, with no follow-up questionnaire or interviews.

Who will have access to the information?

Collected data will be accessed by the researcher and the researcher's supervisors if necessary. Anyone outside the supervisory team will not be allowed access to the raw data. Because of the nature of the research, I may ask you questions about criminal activities such as illicit drug use. You do not have to answer these questions if you do not feel comfortable Any personal information that shared during the interview will be confidential except information related to new disclosure of harm caused to one or more people in which there are ongoing risks of harm such as abuse or assault (aside from drug related harm). There is no general requirement to pass on information relating to criminal or other wrongful

conduct and my aim is for the interview to be a safe, non-judgemental environment. However, if the shared criminal activity includes the abovementioned situations (i.e. situations in which people are at risks of harm), I am legally obligated to end the interview and inform University Ethics Committee. If you disclose that you may cause imminent harm to someone or engage in other exceptionally serious criminal activities, for instance, large-scale fraud or blackmail, I am obligated to report it to authorities and University Ethics Committee.

All the information that is collected during the interview will be kept anonymous. You are entitled to complete anonymity and are free to use pseudonyms for yourself or others during the interview if you wish.

Where will the information be stored and how long will it be kept for?

Collected data will be stored in an encrypted file in the University of Strathclyde's OneDrive cloud, which is password protected and only accessible to me and my supervisors. Stored data will be anonymised and cannot be linked to participants. Collected data will be destroyed after successful viva completion – meaning maximum of 3 years.

Completed research data – our conversation in written form will be kept in the University of Strathclyde's Pure system for 10 years after the research is completed and will be public. The written conversation will be fully anonymised. Any identifiable information such as names, locations, or events will be removed from the text.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

All personal data will be processed in accordance with data protection legislation. Please read our Privacy Notice for Research Participants for more information about your rights under the legislation.

What happens next?

If you are happy to be involved in this study, you can contact me via email or telephone and I will contact you about interview type (video chat or telephone) and date with your preferred way of communication (phone calls or emails). If you do not wish to participate, thank you for your time.

The results of this study will be published as a PhD thesis and may be presented at conferences. Additionally, the fully anonymised data collected from this study can be shared and/or re-used. I aim to publish a research paper regarding this study in a scientific journal and share it with those involved in providing or looking to improve services. If you wish to be notified, I can share a brief report of the findings after the thesis submission. If you want to be informed about the findings, I can provide a summary of the findings after the analysis via email. If you would like to receive a summary of the findings, please let me know and please provide an email address that can be used to contact you (since the study will not be complete for at least another 18 months, please keep in mind that you are responsible for informing me in case of an email address change).

If you have any questions regarding the research and interview process. Please contact me using the details below.

Researchers contact details:

Asena Merve Turkmen

School of Social Work and Social Policy
University of Strathclyde
Lord Hope Building
141 St James Road
Glasgow G4 0LT
Email: asena.turkmen@strath.ac.uk
Phone: +44 07741936449

Chief Investigator details:

Prof Katherine Smith (Chief Investigator/Supervisor)

School of Social Work and Social Policy
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Lord Hope Building
141 St James Road
Glasgow G4 0LT
Email: katherine.smith.100@strath.ac.uk
Phone: 444 8745

Prof Trish Hafford-Letchfield (Supervisor)

School of Social Work and Social Policy
University of Strathclyde
Lord Hope Building
141 St James Road
Glasgow G4 0LT
Email: trish.hafford-letchfield@strath.ac.uk
Phone: 444 8656

This research was granted ethical approval by the University of Strathclyde Ethics Committee. If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the University Ethics Committee

Research & Knowledge Exchange Services

University of Strathclyde

Graham Hills Building

50 George Street

Glasgow

G1 1QE

Telephone: 0141 548 3707

Email: ethics@strath.ac.uk

Consent Form for [Older Drug Users Aged Forty and Over]

Name of department: Social Work and Social Policy

Title of the study: Later-life Accounts of Drug Use

I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher has answered any queries to my satisfaction.

- I confirm that I have read and understood the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (i.e. how it will be stored and for how long).
- I understand that my participation is voluntary and that I am free to withdraw from the project, up to the point of anonymization (five weeks after the interview), without having to give a reason and without any consequences.
- I understand that I can request the withdrawal from the study of some personal information and that whenever possible researchers will comply with my request. This includes the following personal data:
    - Audio or video recordings of interviews that identify me;
    - My personal information from transcripts.
- I understand that anonymised data (i.e. data that do not identify me personally) cannot be withdrawn once they have been included in the study.
- I understand that any information recorded in the research will remain confidential and no information that identifies me will be made publicly available.
- I understand that I do not have to share those stories if I do not feel comfortable with but that, if I share my stories that include references to criminal offences, these will be treated confidentially (unless the researcher believes someone is at risk of harm).
- I understand that anonymised data will be stored and will be public for 10 years after the study is completed on the Pure system.
- I consent to being a participant in the project.
- I consent to being audio and/or video recorded as part of the project.

Signature of Participant:	Date:

Appendix 4

Debriefing Sheet

Thank you for taking part in the study called Later-life Accounts of Drug Use

This sheet will inform you about the full details of the study you have participated. This study aims to explore the experiences of older people who use drugs, with a view to better understanding the specific experiences and support needs of this group, in a UK setting. Additionally, to make improvement suggestions informed by the findings to the service providers for older people, and people who use substances.

Specific Aims

- To identify and narratively explore experiences and needs of older people who use drugs
- To explore any help-seeking behaviour and support needs of older people who use drugs
- To provide information that is useful to researchers, advocates, policy makers and drug service providers when it comes to improving support services (ageing, substance use) for this population.

The interview aimed to explore your experiences as an older person who experienced drug use. These questions were directed to you to explore how drug use, and ageing affects your life.
The information you gave will be transcribed verbatim. All personal information will be anonymised, and identifiable information will be removed during transcription. Transcribed information will be coded and later analysed.
Your personal information and the anonymised data will be stored in University's encrypted OneDrive cloud. Stored data in OneDrive cloud - anonymised data and your personal information, will be securely destroyed after thesis submission – after maximum 3 years. Only my supervisors – Prof Katherine Smith and Prof Trish Hafford-Letchfield and I will have access to data. Your data will not be shared with a third party.
Completed research data – our conversation in written form will be kept and will be public on the University of Strathclyde's Pure system for 10 years after the research is completed. The written conversation will be fully anonymised. Any identifiable information such as names, locations, or events will be removed from the text.

You are free to withdraw from the research up to analyse process (5 weeks from today). You can also request that some of the information be removed from the study.

If you want to be informed about the findings, I can provide a summary of the findings after the analysis via email. If you would like to receive a summary of the findings, please let me know and please provide an email address that can be used to contact you (since the study will not be complete for at least another 18 months, please keep in mind that you are responsible for informing me in case of an email address change).

Talking about past experiences can cause you to feel emotional, upset or stressed. I have listed some organisations that can support you if you need further support. You can find the list on the last page.

If you have any questions or concerns, you can contact to research team and University of Strathclyde's Ethics Committee.

	PhD Researcher	Supervisor	Supervisor
Name	**Asena Merve Turkmen**	Prof Katherine Smith	Prof Trish Hafford-Letchfield
Email	**asena.turkmen @strath.ac.uk**	katherine.smith.100 @strath.ac.uk	trish.hafford-letchfield @strath.ac.uk
Telephone	**+44 7741936449**	444 8745	444 8656

This research was granted ethical approval by the University of Strathclyde Ethics Committee. If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the University Ethics Committee
Research & Knowledge Exchange Services
University of Strathclyde
Telephone: 0141 548 3707
Email: ethics@strath.ac.uk

Information for Participants

Talking about sensitive subjects can trigger feelings of upset and you may want to seek some further support. In addition to your doctor, family, and friends, this list of organisations can assist you.

Substance Use

Talk to Frank

Website: https://www.talktofrank.com
Helpline: 0300 123 6600
Text: 82111
Email: frank@talktofrank.com

Turning Point

Website: https://www.turning-point.co.uk

Withyou

Website: https://www.wearewithyou.org.uk

Ageing

Age UK

Website: https://www.ageuk.org.uk
Advice Line: 0800 678 1602

The Silver Line

Website: https://www.thesilverline.org.uk
Helpline: 0800 470 8090

Hourglass

Website: https://wearehourglass.org
Helpline: 0808 808 8141

Appendix 5

Draft Narrative Interview Schedule

Introduction

Hello, thank you for agreeing to interview with me. My name is Asena Turkmen and I am a PhD researcher at the University of Strathclyde, researching drug use among older adults in the UK. I am interested in this topic because I would like to learn more about how getting older affects people's lives who use drugs, and I am hoping to speak to you about your experiences. May I record the interview?

Icebreaker

- Is the connection working well enough? Can you hear me clearly?

Research Ethics Reminder

Before we start, I want to make sure you have read and understood the personal information sheet and consent form and go over the important parts again.

First, you do not have to take part in this interview, it is entirely voluntary, and you can stop the interview whenever you like. I will ask you questions about your experiences of drug use and ageing. You do not have to answer a question if it makes you uncomfortable or upset, we can skip that question or take a break. Due to drug use, some of your stories may include criminal offence. You do not have to share those stories if you do not feel comfortable with and if you decide to tell those stories, I am here simply to listen and not to judge. You obviously do not need to share anything you aren't comfortable sharing, but I also want to make clear that I will treat all the information confidentially. I also need to make clear that there is one proviso. If what you tell me suggests that someone is at risk of harm, I may need to take this information outside of this interview. As you know, right now I am recording the interview, and this recording will be kept in university's encrypted OneDrive account along with any personal information you provide. Recording will not be used in the study; it will just help me to transcript the interview verbatim. I will remove any identifiable personal information from the transcript and anonymise it before analysing them. And only me and my supervisors – Prof Katherine Smith and Prof Trish Hafford-Letchfield will have access to your personal information.

All personal information related to this interview and study will be securely destroyed after I successfully complete my Viva. Completed research data which is anonymised data will be kept in the university's system and will be public for 10 years. Do you have any questions for me about the study?

Do you consent to this interview?

General Information

- May I ask how old are you?
- (Other general information will be collected during the interview (checklist), if they are not answered during the interview naturally, the researcher will ask them at the end of the interview)

Opening Question – Drug Use

- If it is okay with you, I would like to start with drug use, what do you consider as drug use?
    - Can you please tell me about your life during the first time you tried a drug? (Drug type, life circumstances, motive)
    - Which other types of drugs did you use/try?
- How would you describe your relationship with substances progressing between then and now?
    - In your opinion, what factors affected your relationship with drugs during this time? (Positive/Negative, family/social circle, economic stresses, and other life crises)
- What might you consider to be problematic drug use and why?
    - How drug use impacted your life?
- How do you describe your relationship with your friends and family? (Support, discrimination, contact)
- What getting older meant in relation to the things we have talked so far?
- Did or do you experience any benefits or challenges related to these changes?
- Have you ever tried to access substance use treatment services or other support? If so, could you tell me about why you sought access and how that went?
    - Would you consider it a success? Why?
    - Did you experience any discrimination? If yes, how did this affect your treatment/help-seeking process?
    - Is there anything you wished taken into consideration during treatment?
    - Is there anything that can be improved relating to substance use treatment?
- If not, could you tell me the reason? (Question to be asked if they consider their drug use problematic.)

Ageing

- Getting old can cause a lot of changes in a person's life,
    - Generally, what are the positive sides of getting old?
    - What about the negative sides?
- Do you think society's attitude toward you changed as you got older?
    - What about your family and friends?
- How do you think getting older affects other personal characteristics?
    - (Race, religion/belief, gender, sexual orientation, marital status, disability)

Finalizing

- Before we end the interview, is there anything you thought I should have asked you, but I did not? Or is there anything you would like to add?
- Is there anything that you would like to ask me?
- If you want to ask me any question related to our interview and the research or want to say anything further, you can contact me by email or telephone in the next two weeks. Thank you for sharing your stories.

Appendix 6

Protocol

Audio and video recordings will be transcribed verbatim (word for word), including non-verbal sounds (laugh, sighs, claps) to contextualise the conversation.

- Non-verbal will be transcribed in parenthesis. For example, *(Laugh)*
- Mispronounced words will be transcribed as they said, and correct words will be typed in square brackets. For example, probly *[probably]*
- All foul language, slang, and grammatical mistakes will be transcribed as they are.
- Filler words will be transcribed as they are. For example*, yeah, ugh, oh, ah, mkey*
- Word or phrase repetitions will be transcribed. A hyphen will be added if a word is cut off or truncated. For example, *she cal- she called me three times*.
- Spelling of keywords, blended or compound words, common phrases, and identifiers will be standardised. Enunciated reduction and standard contraction of *is, am, are, had, have, would*, and *not* will be used. For example, *I'm, gotta, gimme, cuz, would've, sorta*.
- The inaudible information will be marked as *[INAUDIBLE]*.
- Undistinguishable cross-talk will be marked as *[cross talk]*.
- Short pauses (3-5 seconds) after or during a speech will be stated with three ellipses. For example, *I used to go there every day… Now, I don't go there at all.*
- Long pauses (over 5 seconds) will be marked in square brackets. For example, *[long pause]*.
- If the researcher is unsure of the accuracy of the statement, the statement will be placed in parentheses and question marks. For example*, I used to use ?(ice)?, when I was in college.*

  Sensitive information

- The identifiable information shared during the interview, such as specific location, profession or organisation will be replaced with *[REMOVED TEXT]*. Any names other than the chosen pseudonym will be replaced with *[NAME]*.

  Reviewing for accuracy

Once the first transcription is completed, the researcher will read the transcription while listening to the audio or video recording to ensure everything is transcribed verbatim and transcription follows the protocol.

Appendix 7

Coding Samples and Themes

Data extract / segment	Initial code	Interpretive code	Candidate subtheme	Theme	Analytical note
"the only way I could cope" / "drugs gave me some kind of escape"	Drug use as coping; drug use as emotional escape	Substance use as affect regulation and temporary relief from distress	Drug use as survival, coping and emotional management	Coping or belonging	The extract was not coded simply as "motivation". It was interpreted biographically: drug use is positioned as something that made life feel manageable in contexts of distress or limited support.
"family wasn't talking to me" / "felt completely alone"	Family breakdown; social isolation	Relational loss as part of the context in which drug use became meaningful	Accumulating social losses	Reduced social life; quietness; isolation	These segments were connected to wider accounts in which family disconnection, loneliness and stigma shaped the function of drug use over time.
"It was kind of like we need this drug; you can't function without it now." – Henry, 53	Need for drug to function; dependency; everyday functioning	Functionality becoming entangled with dependence	Functionality and loss of control in adulthood	Turning points, agency and constraint in adulthood	The extract captures the tension between agency and constraint: drug use is described not only as pleasure or choice, but as something tied to the ability to get through everyday life.

Data extract / segment	**Initial code**	**Interpretive code**	**Candidate subtheme**	**Theme**	**Analytical note**
"If I was a multimillionaire and I could afford to get heroin every day … maybe I might still be … using it." – Sam, 49	Financial cost; controlled use imagined; resources shape use	Class and material resources shaping the limits and visibility of drug use	Money, control and unequal consequences	Stigma, class and the unequal experience of later-life drug use	This was coded beyond "financial problem". The extract helped develop an interpretation of class as shaping what kinds of drug use are sustainable, visible or punished.
"Now it takes about a … month … to get back to normal." – Walter, 55	Withdrawal harder with age; slower recovery; bodily change	Ageing body as a limit on previous patterns of use and recovery	Ageing makes the body harder to ignore	Ageing, health and the body	The extract links ageing to embodied change. The code moved from a descriptive label about withdrawal to an interpretive theme about how ageing reshapes the meaning and practicality of drug use.
"I've done a lot of damage to myself through injecting. I've got really severe nerve damage. I've got arthritis." – Amy, 48	Injecting-related damage; health anxiety; arthritis; nerve damage	The body as accumulated evidence of past drug use	Bodily consequences and later-life reflection	Ageing, survival and self-acceptance: reinterpreting drug use in later-life	This extract was coded as both health-related and biographical. It shows how bodily damage becomes part of later-life meaning-making, not only a clinical consequence.

Appendix 8

Thematic Table

Overarching analytic theme	Subthemes / included patterns	Life-course location	Central analytic claim	RQs
1. Biographical beginnings: family life, loss and first meanings of drug use	Family dynamics; lack of supervision; loss, abuse or insecurity; first use as escape, curiosity, coping or belonging.	Early life / adolescence	Drug use is not treated as a single starting event but as something narrated within childhood, family and early social worlds.	RQ1, RQ2
2. Community, neighbourhood and classed environments	Schemes, local drug cultures, peer groups, social learning, financial difference, classed expectations and visibility.	Early life to adulthood	The same drug use practices carried different risks and meanings depending on place, class, and social resources.	RQ2, RQ4
3. Drug use as coping, pleasure, belonging and loss of control	Emotional regulation; escape; enjoyment; belonging; changing frequency; dependence; control/non-control; periods of problematic and non-problematic use.	Across the life course	Drug use shifts meaning over time and cannot be reduced to pathology, pleasure, or rational choice alone.	RQ1, RQ2
4. Adulthood, responsibility and the negotiation of a 'normal' life, turning points	Parenthood; partnership; work; functionality; guilt; concealment; adult transitions as reconfiguring rather than resolving drug use.	Adulthood	Adult roles did not automatically end drug use; they changed how participants judged, managed and narrated it.	RQ1, RQ2, RQ4
5. Institutional encounters and unequal recognition	Correctional services; policing; prison; treatment contact; service judgement; age-blind or stigma-producing responses.	Adulthood and later-life	Institutions often became part of participants' biographies, shaping vulnerability, shame, resistance and later-life service expectations.	RQ4

6. Ageing body, health, survival and proximity to death	Ageing; health and the body; pain; chronic illness; injecting damage; withdrawal becoming harder; fear of death; unexpected survival; re-evaluating past harms.	Later-life	Ageing is interpreted as embodied and biographical, not only chronological or biomedical.	RQ3
7. Later-life social worlds, self-acceptance and identity repair	Reduced social life; quietness; isolation; recovery communities; financial security; maturity narratives; self-acceptance and psychological freedom.	Later-life	Later-life could involve loss and narrowing, but also peace, self-acceptance and a reworking of identity.	RQ3, RQ4
8. Stigma, class and gender as cross-cutting conditions of visibility	Self-stigma; social stigma; structural stigma; classed respectability; gendered parenting expectations; whose drug use is hidden, tolerated or punished.	Cross-cutting	Stigma and inequality shape how drug use is seen by others and how participants see themselves across the life course.	RQ4, with links to RQ1-RQ3