A Study on the Initiation, Continuation and Impact of Drug Use Among Females

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Executive Summary
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This study was undertaken in response to the growing public concern about the rise of drug use among females. The reasons for this rise are partly connected to the overall rise in psychotropic drug use and can be understood at two distinct levels. At one level, these drugs have become embedded in the global and local youth and music culture. In part, the global youth scene has greatly impacted and shaped the nature and problems associated with teen and young adult drug use in Hong Kong. Yet as we describe in this report, young people's use of these drugs is no longer solely confined to the dance scene, but has surfaced in other social arenas, and is linked to larger issues about the ways in which young people are coping with the strains and pressures in a society placing high expectations on educational attainment, and at the same time, offering limited opportunities for personal youth development and employment.

At the more personal or individual level and in the context of the wide availability of psychotropic drugs today in Hong Kong, peer pressure is often cited as one of the major factors related to the increase and raises important considerations for designing public education campaigns.

This report examines the initiation, continuation, and impact of drug use among female users, and their outreach and treatment experiences. The report addresses these issues and offers recommendations. Given the sensitive nature of the study, it is virtually impossible to obtain a representative sample of the drug using population. So although our study can provide a portrait of the nature of drug use, the findings must be interpreted with caution and can't be generalized to the larger female drug population. Another limitation of the study is our underestimation of the extent of poly-drug use. We found poly-drug use across all three data sets fairly extensive, and this introduced problems in trying to understand the single and combined effects of different drugs. With these limitations in mind, we offer the following highlights from the study:

Initiation into Drug Use

- Peer and partner influence, rebellion, curiosity, excitement and adventure, and a belief that drugs are not addictive are observed as overall reasons for females trying drugs. For ice and ecstasy, belief that the effects from the drugs – increased physical energy and appetite depressant - improve their appearance. For heroin users, traumatic life events and family and school pressures were also important factors for trying it. Ketamine and heroin seen as a potential source to effectively escape from pressures and boredom related to school and family life.

- Initial use was often in the context with partners or small groups of friends.

Continuation with Drug Use

- Importantly, these findings are from the point of view of users and represent their subjective experiences and understandings, however, it may not necessarily reflect the realities of using drugs. Moreover, their subjective understanding of the motivations, expectations, and effects of drugs derive from and perpetuated in the local drug culture which de-emphasizes the negative aspects of drug use. One common motivation across all user groups is an appreciation for the medicinal quality and effects of drugs. The "medicine" has a numbing effect to cope with teen and adult female problems. Additionally, for female heroin users, they report liking the feeling of comfort and well being brought on by heroin, which allows them to escape from ongoing problems, usually related to drug use. From the perspective of ice users, an important factor for continuing is the drug's slimming effect. Also, ice, from their point of view, is seen as a neutralizer and cure for heroin. It is appreciated for its ability to provide concentration and energy in getting various tasks and jobs accomplished. Some users also perceive that it provides them with increased confidence for communicating and socializing with others. Icer users also believe it is not addictive. Ecstasy and ketamine users are motivated to continue using these drugs because of its perceived non-addictive qualities, ability to give them "freedom" and pleasure, and its relative cheap cost. Some ketamine users also find the drug as a source to relieve the boredom and mundane qualities associated with school.

Consequences of Drug Use

- All user groups, but especially heroin and ice users experienced a number of negative health and relational consequences, particularly in relation to mental health, physical health, involvement in crime, violence and arrests and convictions.

- According to respondents, immediate and beneficial effects of drug use included the escape from problems and perceived improvements in appearance.

Outreach and Treatment Experiences

- Heroin and ice users tend to have tried to quit, access and experience treatment more so than ecstasy and ketamine users. The latter two groups do not perceive their use as problematic as the drug is seen as non-addictive. Moreover, these two groups believe that their use is controlled and occasional.
- For those experiencing treatment, most had tried several times to quit. Their entry into treatment was most often prompted by a court order, and therefore, their treatment process was involuntary.
- Parents are seen as the major and most important source of support before, during and after the treatment process.
- Obstacles impeding recovery include partner's use, poor controls over emotions, the myths associated with local drug culture, negative peers, and the belief that drugs can make one thin and beautiful.

Discussion and Recommendations

- Motivations to change vary among users such that less motivated users may impede the efforts of those who want to make changes. Two strategies are recommended to address this issue. One method would involve ways of integrating a treatment approach which channels the strong characters of the "big sisters" into a positive way and which helps build the confidence of those who want to make changes. Another strategy would entail developing a more coordinated diagnostic procedure at the time of sentencing such that different types of female users would be placed in settings designed specifically to deal with particularly types of users and their motivations to change.

- Develop education activities which take on the paradox of using drugs to attain beauty and it's reverse effects. In relation to this, physical and endurance training are an important vehicle for promoting a healthy "appearance," and are noted by our treatment respondents as worthwhile.

- Further examination and development of strategies targeting emotion management.

- Although female users report problems with family, it is parents who, female users identify, as the major source of support in trying to quit – from the point of making decisions to quit as well as during and after treatment. Parents can and do make the difference. Although they may perceive themselves as being helpless in helping their daughters, they are not. However, they need guidance by drug workers and in public education campaigns, such that they fully understand, like users themselves, that treatment is not a "quick fix" but is in fact an ongoing, lifetime recovery process.

Education

The findings from this study point to a number of important educational issues, particularly peer pressure, notions of beauty, and knowledge about drugs and their effects. In the U.K., the U.S. and Australia, the "just say no" approach in public education campaigns has been shown to be ineffective and unrealistic. Public media campaigns should move beyond the "just say no," approach as many young people see this as "naïve," particularly in light of peer pressure. A realistic educational strategy entails the following dimensions and are offered as part of our recommendations:

- As part of its education campaign, peer group education is an important and realistic component. Moreover, outreach workers could promote the use of a "peer watch" system in which users monitor and regulate each others' use to reduce the harms associated with drug use. As noted by the respondents in this study, many female users use in small groups together, and some of them report monitoring and controlling each other's use.

- Education should also focus particularly to notions about beauty and appearance. As has been well documented throughout the report, female drug users find drugs like ice and ecstasy as providing the means for "being beautiful," irrespective of its negative consequences. At present, girls and young women are heavily influenced by images of beauty that are associated with being thin. Unfortunately drugs are perceived as a "quick" method for achieving beauty. Educational campaigns must cultivate a healthy concept of "beauty, " and should emphasize the paradox of drugs in the attainment of beauty as the respondents in this study described how they initially perceived their use as enhancing their beauty, but eventually, the drugs made them feel "ugly."

- Educational campaigns should also target the reasons why drug users try to quit, including court orders, ties to family and tiring of one's addiction. Ex-users and their experiences would be an important and realistic part of the campaign.

- Drug education should be strengthened in prisons and treatment centers. Prisoners easily learn ideas from peers in these settings.

Research

- The relationship between drug use and suicide merits further research, as this study has shown that a significant proportion of female drug users, especially those using ice, had thoughts about and attempts to commit suicide. The precise nature of this relationship requires study and could provide useful information for developing outreach and intervention strategies.

- One important finding from this study was the extent and nature of female drug users' illegal income generating activities. From the survey and in-depth interview data, it was quite apparent that they rely on several types of illegal strategies to earn income for their drug use and lifestyle. Moreover, traditionally females have had a minor or non-existent role in selling, however, it was apparent from our data that some female users are also selling drugs and trafficking. Further investigation should focus on the relationship between drug use and illegal income generating activities.

- Another important finding from this study is that there are some psychotropic drug users who do not come to the attention of CRDA reporting agencies because they do not face or experience any immediate medical or enforcement consequences. From our survey data, 91% of 191 ecstasy users and 87% of ketamine users respectively have never been arrested. Approximately 60% and 72% of ecstasy and ketamine users respectively had not had contact with drug workers for counseling. Therefore, we recommend that studies targeting the "hidden" population are conducted on an ongoing basis to keep pace with the rapidly changing drug scene.

- As the findings of this study suggests, there is a complex relationship between users and their parents and families. On the one hand, some users have described family conflict and communication problems with their parents during their drug use initiation and continuation. Parents often, understandably, have limited understanding of how to cope with their child's drug use, and therefore may feel a sense of helplessness. On the other hand, users who have sought out help for their drug use problems have indicated that their parents are an important source of support in the recovery process. Further research on this complex relationship is needed and should include the development of skills based strategies for parents to assist their children in the drug recovery process.

Introduction

Public concern has grown in Hong Kong over the rise in psychotropic drug use among young people, particularly among females, who previously appeared to be fewer in number among the drug using population. Policymakers, law enforcement, health and drug workers have tried to gain a better understanding of the rapidly changing drug scene, estimating the prevalence, nature and problems associated contemporary drug use.

This study, commissioned by the Action Committee Against Narcotics (Research Subcommittee), provides an in-depth look at the initiation, continuation, and consequences of female drug use. The study's principal objectives are to:

a) identify the main characteristics of females using different types of drugs;
b) identify the determinants and factors related to initiation and continuation of use;
c) identify the risk behaviors and social and physical consequences associated with use:
d) identify the strengths and weaknesses of existing treatment programs for female drug abusers;
e) study the trends for various subcategories of female drug abusers and make comparisons with other relevant categories of drug abusers; and,
f) recommend suitable measures to tackle the female drug abuse problem.

The research team adopted multiple approaches to address the objectives and to ensure the validity and reliability of the data collected. The project used quantitative and qualitative research methods including:

1) analysis of CRDA data of female user trends and other official data (e.g., police, NGOs);
2) survey questionnaire, in-depth interviews and focus groups with female users in a variety of settings (e.g., street population, outreach clients, voluntary and compulsory treatment and aftercare);
3) focus groups and interviews with outreach workers and treatment staff; and
4) review of treatment and education strategies locally and abroad.

A full discussion of the research methods used in the study, along with the data instruments are contained in Appendices A and B respectively. We turn first to provide an overview of the female drug use situation in Hong Kong.

Overview of the Situation

One primary source for examining drug use trends has been the data supplied from the Central Registry of Drug Abuse (CRDA), which documents cases reported to the police and agencies working directly with drug users. CRDA has proven to be a valuable tool for monitoring overall trends in relation to heroin. It has, to some extent, been able to show general trends as well in the shift towards psychotropic drug use. However, the nature of psychotropic drug use is very different from that of heroin. For example, ecstasy, ketamine and even ice users believe that their drugs of choice are not addictive and can be used in a controlled manner. Therefore, unlike heroin users, these users would be less inclined to view their own use as problematic and seek help.

Moreover, the set and setting for psychotropic drug use is very different from heroin, and from what users tell us, they are less likely to be visible and detected by authorities. These examples suggest that while CRDA can capture overall drug use trends based on those who come to the attention of the police and drug workers, it may be under-estimating the extent of psychotropic drug use. Nevertheless, CRDA does provide important information on trends and change of drug use in Hong Kong.

There are several changes in Hong Kong's drug use trends, including an increase in poly-drug use. For example, among newly reported users, the percentage of poly-drug users under 21 rose from 19% in 1994 to 41% in 2002. This trend has occurred with those newly reported users 21 years of age and older, albeit at a slower increase than their younger counterparts. In 1994, the percentage of poly-drug users was 7%, but increased to 15% by 2002 (Narcotics Division 2003).

CRDA show another trend in drug consumption. Although there has been a slight decrease in the overall number of reported drug users in Hong Kong since 1994, this decline has been largely among males. Table I-1 shows that there has been an overall increase in the number of reported female users during the nine year period. The number of reported female users of all ages rose slowly from 2,188 in 1994 to 2,433 in 1996 but decreased over the next two years. The number of reported female users of all ages increased in from 2,154 in 1998 to 3,182 in 2002. Among reported female users under 21 years of age, there was a steady decline in the number reported from 931 in 1994 to 630 in 1999, followed by a peak of 1,211 in 2000, and since then, a gradual decline. Among older female users, the number of those reported has increased overall from 1,257 in 1994 to 2,228 in 2002, although there were annual fluctuations.

Table I-1
# of Reported Female Users By Age

	1994	1995	1996	1997	1998	1999	2000	2001	2002
Under 21	931	931	841	761	710	630	1211	1051	954
21 and Over	1257	1393	1592	1476	1444	1536	1770	1821	2228
Total	2188	2324	2433	2237	2154	2166	2981	2872	3182

Source: Information prepared for this study by Narcotics Division. February 2004.

Female drug use patterns have changed in other ways over the past nine years. Although historically heroin was the drug of choice among females (as well as males), this pattern has changed with the appearance of ice, ecstasy and ketamine (Joe Laidler et al. 2000). CRDA data indicate important changes in the drugs of choice among the younger population. As Table I-2 shows, for females, heroin consumption among newly reported users declined significantly over the nine year period from 419 in 1994 to 28 in 2002. Ice consumption among young female users rose steadily from 11 newly reported cases, peaking at 104 in 2000, and subsequently dropping to 66 newly reported cases. The number of newly reported young female ecstasy users grew from no reported users in 1994 to 474 in 2000, but has since tapered off to 248 reported users. These more recent declines in ecstasy use among newly reported female young users, however, have been

matched by an increase in ketamine use which grew from a few reported cases in 1997 to 458 reported cases in 2002. In our earlier report we observed that ketamine's popularity would surpass that of ecstasy and would become the drug of choice among young people (Joe Laidler, Day and Hodson 2001).

By comparison, the number of newly reported female heroin users 21 years of age or older fluctuated over the nine year period from 192 in 1994 to 127 in 1998 and 1999, but has increased to 189 in 2002. The number of newly reported older female ice users rose from 12 cases in 1995, peaking to 40 cases in 1999, but has since leveled off to 26 cases in 2002. Among older female users, newly reported use of ecstasy and ketamine is significantly lower than their younger counterparts.

Table I-2
# of Newly Reported Female Users By Selected Drug Type

	1994	1995	1996	1997	1998	1999	2000	2001	2002
Under 21									
Heroin	419	299	213	198	121	77	67	30	28
Ketamine	-	-	-	*	-	*	311	352	458
Ecstasy	-	-	*	11	*	57	474	314	248
Ice	n.a.	11	47	99	103	102	104	73	66
21 and Over									
Heroin	192	155	181	130	127	127	147	120	189
Ketamine	-	-	-	-	-	*	38	78	112
Ecstasy	-	-	*	*	*	*	56	77	61
Ice	n.a.	12	30	36	38	40	31	27	26
All Ages									
Heroin	611	454	394	328	248	204	214	150	217
Ketamine	-	-	-	*	-	*	349	430	570
Ecstasy	-	-	*	*	*	57	530	391	309
Ice	n.a.	23	77	135	141	142	135	100	92

Notes :
1) * data suppressed due to confidentiality reasons.
2) n.a. refers to not applicable
3) CRDA tabulates user information according to poly-drug use and multiple reporting events.

Source: Information prepared for this study by Narcotics Division, December 2003.

CRDA also reveals important information on the continuation of use among drug users. As Table I-3 indicates, the overall number of previously reported female users of heroin has increased over the nine year period, but this increase is largely among older female users. The number of previously reported young female users of heroin declined from 174 in 1994 to 34 in 2002, although there were a number of fluctuations during the nine year period. The number of previously reported ice users under 21 years of age grew from 7 cases in 1995 to 71 cases in 2001, but dropped in the last year to 24 cases. The

number of previously reported ecstasy and ketamine users under 21 years of age also grew in 2000 and 2001, but has also declined in 2002, and is significantly lower the number of newly reported users of these drugs.

The number of previously reported older female users of heroin has steadily increased from 831 in 1994 to 1,254 in 2002. There has also been an increase in the number of ice, ecstasy and ketamine use during the nine year period, albeit the numbers of these users is lower than their younger counterparts.

Table I-3
# of Previously Reported Female Users By Selected Drug Type

	1994	1995	1996	1997	1998	1999	2000	2001	2002
Under 21									
Heroin	174	276	317	246	252	201	128	67	34
Ketamine	-	-	-	*	-	*	90	156	122
Ecstasy	-	-	*	6	*	17	172	177	86
Ice	n.a.	7	38	50	66	59	61	71	24
21 and Over									
Heroin	831	942	1091	999	958	1063	1043	1047	1254
Ketamine	-	-	-	-	-	-	13	26	54
Ecstasy	-	-	-	-	*	*	18	28	26
Ice	13	18	31	26	28	29	31	25	36
All Ages									
Heroin	1005	1218	1408	1245	1210	1264	1171	1114	1288
Ketamine	-	-	-	*	-	*	103	182	176
Ecstasy	-	-	*	6	*	17	190	205	112
Ice	13	25	69	76	94	88	92	96	60

Notes :

4) * data suppressed due to confidentiality reasons.
5) n.a. refers to not applicable
6) CRDA tabulates user information according to poly-drug use and multiple reporting events.

Source: Information prepared for this study by Narcotics Division, December 2003.

The above trends suggests that overall reported female drug use has increased over the past nine years, particularly among those aged 21 or over. Among those females under 21, overall reported use increased, peaking in 2000, and has declined in the last two years. An examination of newly reported users indicates that while ecstasy quickly became popular, its' use has declined but matched by a rise in ketamine into 2002. Although the number of newly reported older users of ecstasy and ketamine has also increased, it has been significantly lower than younger users. Similarly, previously reported female users of all ages are indicating use of ecstasy and ketamine but at significantly lower levels than newly reported young users. Among previously reported older users, the consumption of heroin has steadily increased.

While CRDA show an overall decrease in reported use of younger female users, as noted above, it also shows an increase in the number of newly reported female younger users of ketamine and ecstasy (although it is noted that the number of reports has decreased in the last two years). Social workers confirm that there has been an increase in drug use among female teenagers.

> About three or four years ago, we used to see more males than females using drugs. However, now more female clients are referred to us these days and they are fairly young. Some of the clients are 14 to 15 years old when I first got to know them, and had already started to use when they were only 11 or 12 years old. They only take drugs occasionally. Actually the number of drug users is underreported. The true number is several times more than the official figures. I've talked to some young teenager students and they claim that half of their fellow schoolmates have taken drugs. It's far more than the estimate I've heard of 4%. We should not exaggerate the situation, however, the true picture is more serious than reported. (F2-2)[1]

The reasons for this rise in adolescent use of ecstasy and ketamine, particularly among females can be understood at two distinct levels. At one level, these drugs have become embedded in the global and local youth and music culture. We have reported on this elsewhere (Laidler, Day and Hodson 2001). In part, the global youth scene has greatly impacted and shaped the nature and problems associated with teen and young adult drug use in Hong Kong. Yet as we describe in this report, young people's use of these drugs is no longer solely confined to the dance scene, but has surfaced in other social arenas, and is linked to larger issues about the ways in which young people are coping with the strains and pressures in a society placing high expectations on educational attainment, and at the same time, offering limited opportunities for personal youth development and employment.

At the more personal or individual level and in the context of the wide availability of psychotropic drugs today in Hong Kong, peer pressure is often cited as one of the major factors related to the increase, and raise important considerations for developing public education campaigns. As one treatment worker tells us:

> It's simple. A group of young people, for example, all of the members in the group take it but you don't take it. Others may say, "it is not a problem, if you don't try, but under peer pressure, if you don't do what they do, you'll become less like them, so this is the peer pressure, that's is what pushes them to try. Why they try it? Actually everybody knows the bad effects of the drugs, and the media says, "don't take that drug, don't try it, but of course, the refusal techniques shown on t.v. commercials are unrealistic. Even my son says it is naive, just like,

[1] Internationally it is well established that although official reports of crime and drug use are a useful estimate measure, much crime and drug use does not come to the attention of authorities or reporting agencies (Muncie and McLaughlin 2001). This is commonly referred to as "hidden" crime or "hidden" drug use. Self-report studies show that crime and drug use is higher than that documented in official reports.

> Sometimes it is hard to say, they know what the consequences are, but the peer pressure is too powerful, if you don't do like them, you have nothing to talk about. It just depends on when you give your first try, of course they will try, they can't see a problem after taking just the first one. (F2-2)

Importantly, however, adolescent female drug users find ecstasy and ketamine as a source of "relief" and a strategy for "coping" with the pressures from their everyday life and encounters with school, family and peers. Their initiation, motivations and continuation, and the impact of their use is the subject of this report.

This report also examines female users' experiences with treatment in light of the views expressed by the working group of the three-year plan on Drug Treatment and Rehabilitation Services in Hong Kong. According to the working group, drug dependent females are a group warranting special attention in future planning of substance abuse treatment strategies given the upward trend over the past decade.

Presently there are two programs targeting female psychotropic drug abusers. PS33 has organized special therapeutic groups for females users. The goal is to help them handle their negative emotional problems and strengthen their relapse prevention skills. Cheer Luther Centre also conducts self-grooming groups for female users to promote their self-image and self-esteem.

There is a Compulsory Drug Treatment Program administered by Correctional Services at Chi Ma Wan Drug Addiction Treatment Centre. The clients are female drug addicts who are over 14 years old sentenced by the court for drug treatment and rehabilitation. The number of certified accommodation is 126 and by the end of 2002, the number of occupancy is 121.

Table I-3
Admissions to DATC from 2000 to 2002:

Year	Female offender aged under	Female offender aged 21 and above	Total
2000	29	158	187
2001	42	210	252
2002	24	206	230

For the Voluntary Residential Programs, there are seven NGOs in Hong Kong that provide residential treatment for female users. The capacity and individual drug treatment centre as the end of 2002 and the admission until these centres during 2000 to 2002 are as following:

Table I-4
Hong Kong Treatment Programs for Female Drug Users

Agency	Centre	Clientele	Duration	Capacity	No. of Admission		
					2000	2001	2002
Barnabas Charitable Service Association	Lamma Training Centre	Chinese Female drug dependent persons under 40	9 months	24	36	36	35
Operation Dawn	Girl Centre	Female drug dependent persons	18 months	12	7	7	6
Society for the Aid and Rehabilitation of drug Abusers	Sister Aquinas Memorial Women's Treatment Centre	Female drug dependent persons under 25, irrespective of race	6 to 12 months	42	96	79	118
	Adult Female Rehabilitation Centre (AFRC)	Female drug dependent persons above 25, irrespective of race	6 months	24	29	27	48
Mission Ark	Yuen Long Drug Treatment Centre	Female drug dependent persons	-	20	-	-	15
Wu Oi Christia Centre	Tai Mei Tuk Female Training Centre	Female drug dependent persons aged under 35	12 months	12	14	20	20
St. Stephen's Society	Tuen Mun Muti-purpose Rehabilitation Homes (Female)	Female drug dependent persons irrespective to race	Tailor made to the needs of individual client	13	-	-	15
Society of Rehabilitation and Crime Prevention, Hong Kong	Hong Kong Female Hostel	Female drug dependent persons	-	10	-	3	11
	Bradbury Wai Chi Hostel	Female drug dependent persons	-	16	20	23	21
Total				171	202	195	289

The treatment and rehabilitation programs are claimed to be tailor-made for the needs of women including drug detoxification, religious training, counseling services, therapeutic group, health education, life skill training, general education, vocational training, social recreational activities, voluntary services, adventure-based Camp, self-help group, home management and family work. SARDA's AFRC Centre and St. Stephens Society's female drug treatment centres also admit female drug dependent persons with children. Most of the centres adopt the Therapeutic Community Model which emphasizes psychological counseling and intensive group work. The main objectives are to help the female drug abusers to develop self-esteem, self-confidence, self-understanding, self-responsibility and problem solving skills.

For the Halfway Houses, the aims are to provide a therapeutic and temporary accommodation for those female rehabilitated drug abusers, to help them to re-integrate into the society and to restore their life.

Table I-5
Halfway House Programs in Hong Kong

Agency	Centre	Type of Activities Organized	Duration of stay	Capacity	No. of Admission		
					2000	2001	2002
Barnabas Charitable Service Association	Ma On Shan Halfway House	Counseling, group therapy, recreational activities, job skills training, fitness training, adventure training and musical training	6 months	25	19	20	14
Christian Zheng Sheng Association	Cheung Chau Female Training Centre	-	-	20	*	*	*
Society for the Aid and Rehabilitation of drug Abusers	Female Hostel	Individual and group counseling, social and recreational activities, health talks, self-help, and mutual help actives, employment service.	3 months	10	42	34	24
Total				55	61	54	38

* During this period, halfway house clients stayed in the residential treatment center due to building renovations.

The report is organized into eight main sections. Section Two reports on the background characteristics of female drug users. Section Three examines female drug users' initiation into use, looking particularly at the age at first use, set and setting of their first experiences, their motivations and expectations. Section Four focuses on their continued use, especially in relation to patterns of use, typical experiences, motivations to continue using, and obtaining and financing their continued use. Section Five describes the consequences of their use, including the perceived positive and negative impact of their drug use, perceptions of self image and relationships with others, and problems recognized and experienced. Section Six provides a discussion of their outreach and treatment experiences, focusing on turning points and accessing help, benefits and obstacles in dealing with their drug use, and issues related to the treatment process. Section Seven highlights the overseas treatment strategies developed to address female drug use. The final section concludes with a summary of our findings along with recommendations.

The report is based on three principal data sets collected during 2002-2003, including nine focus groups with frontline drug workers and drug users, 500 surveys with drug users from a variety of settings, and 60 in-depth interviews with drug users. It is important to note that these interviews with users reflect their perceptions of the drug using experience but may not be similarly interpreted by others with whom they interact with. While we were able to obtain the perspective of drug treatment workers' experiences with female drug users, thereby providing one method of affirming or seeing alternative views, we were not able to collect the views of parents, a group, as shown later in this report, to have an important role in female drug users' lives. Unfortunately this was beyond the scope of this research endeavor, but would be a relevant area for follow-up research. Throughout the study, we conducted follow-up interviews with five

frontline drug workers to confirm and verify the findings of this study. As noted above, Appendices A and B provide a fuller discussion of the research methodology and data instruments respectively. Appendix A also provides readers with some cautions regarding each data set, but we would like to point out a few of these here before the reader proceeds with the report. Given the sensitive nature of the study, it is virtually impossible to obtain a representative sample of the drug using population. So although our study can provide a portrait of the nature of drug use, the findings must be interpreted with caution and can't be generalized to the larger female drug population. Another limitation of the study is our underestimation of the extent of poly-drug use. We found poly-drug use across all three data sets fairly extensive, and this introduced problems in trying to understand the single and combined effects of different drugs. Appendix C includes a summary of the basic characteristics of the 60 women with whom we conducted in-depth interviews. In our proposal, we identified several preliminary research hypotheses, and some of these hypotheses are addressed in the report. However, for the readers' ease, we have provided, in Appendix D, a description of the hypotheses, our responses to those hypotheses, and noted where insufficient data prevented testing of those particular hypotheses. To the extent possible, we include a discussion of each of the data sets in relation to the areas of concern. Each of the data sets alone provide useful information about the female drug use situation, but when combined, provide a more comprehensive portrait from different perspectives. At the same time, the use of three data sets offers a way to verify the findings of each data set. To provide as comprehensive picture as possible, in each section of the report, we present the survey data first, followed by the interview data and then the focus group discussions.

Section Two: Background of Female Drug Users

This section provides an overview of the personal and social characteristics of the female drug users in this study. The first part presents the characteristics of the 500 surveyed female drug users and the second part provides an overview of the 60 women with whom we conducted in-depth interviews.

Survey with 500 Female Drug Users

Table 2-1*
Characteristics of Surveyed Female Drug Users

Characteristics	Heroin (n=155)	Ice (n=72)	Ecstasy (n=191)	Ketamine (n=176)
Age				
Under 21 yrs.	2.6	45.8	69.1	54.0
21 yrs or older	97.4	54.2	30.9	46.0
% Chinese ethnicity	98.1	98.6	100.0	100.0
Place of Birth				
Hong Kong	87.7	83.3	78.0	75.6
Mainland China	7.8	12.5	20.4	21.6
Other	4.5	4.2	1.6	2.8
Marital Status				
Single	38.1	65.3	78.0	77.8
Married/Living w/Partner	44.5	29.2	19.4	19.9
Separated/Divorced	11.6	5.5	2.1	2.3
Other	5.8	-	0.5	-
Current Housing Status				
Private owned flat	3.2	9.7	21.4	23.3
Private rented flat	3.2	22.2	17.3	18.7
Public housing	49.0	40.3	52.9	51.7
Hotel/Guest house	3.2	-	0.5	-
Group home	8.3	2.8	2.1	2.3
Residential treatment	19.3	19.4	5.8	4.0
CSD	13.5	5.6	-	-
% Currently in School	7.1	12.5	35.6	41.7
Yrs of Schooling Completed				
Primary	6.5	-	2.1	1.1
F1-3	62.6	58.3	44.5	39.2
F4-5	26.4	38.9	44.5	49.4
F6-7	1.3	2.8	8.9	8.5
Post Secondary	-	-	-	1.7
Unknown	3.2	-	-	-

Table 2-1 continued*
Characteristics of Surveyed Female Drug Users

Characteristics	Heroin	Ice	Ecstasy	Ketamine
% Currently Employed	44.5	29.2	30.9	36.0
Total	155	72	191	176
Type of Employment				
Service Industry	26.1	57.1	59.3	65.1
Transport	24.6	-	-	-
Finance/Business	4.3	-	5.1	7.9
Community/ Personal Services	31.9	19.0	22.0	23.8
Other	3.1	9.5	8.5	3.2
Unknown	10.0	14.3	5.1	0.0
Total	69	21	59	63
Average Monthly Wage of Those Employed				
$6,000 or less	21.7	47.6	33.9	41.3
$6,001-$10,000	52.2	19.0	49.1	38.1
$10,001+	20.3	19.0	11.9	20.6
Unknown	5.8	14.3	5.1	-
Total	69	21	59	63
Other Sources of Income In Last Yr.**				
Family	21.3	23.6	51.8	64.8
Partner/Boyfriend	36.8	22.2	13.6	18.8
Friends	4.5	9.7	9.4	11.9
CSSA	20.6	5.6	-	-
Illegal activities	20.6	15.3	11.0	9.6
Other	11.6	-	2.6	1.1
Source				
CSD	52.2	20.8	3.7	6.8
Halfway House	18.1	19.4	4.2	4.5
Outreach	-	41.7	47.1	39.8
Treatment	29.7	18.1	11.5	4.5
Street	-	-	33.5	44.3
Total	155	72	191	176

* Totals may not round to 100% due to rounding.
**Totals may not sum to 100% as this question allows for multiple answers.

As Table 2-1 shows, the majority of surveyed users are adolescents or young women in their twenties. Among heroin users, three quarters of them are in their twenties. Very few of them are in adolescence, although as we show later, many female heroin users initially try heroin in their teen years. Forty-six percent of ice users are under 21 years of age. Over half of ecstasy and ketamine users are under 21 years of age, and as described later, also start using in their early teens. Nearly all of those surveyed are Chinese and born in Hong Kong. While 45% of heroin users were married or living with a partner, two-thirds or more of ice, ecstasy and ketamine users were single.

Approximately one-half of all female users lived in public housing, although slightly fewer ice users reported living in public housing.

Given that a great proportion of ecstasy and ketamine users are younger than heroin and ice users, it is not surprising that the former two groups are more likely to be currently enrolled in school. Over one-third of ecstasy and ketamine users were currently enrolled in school whereas 7% and 13% of heroin and ice users respectively were going to school. The majority of ecstasy and ketamine users had completed either Forms 1-5, while approximately 60% of heroin and ice users had only completed up to Form 3. Forty-five percent of heroin users reported being employed, either in the service, transportation or community and personal services, and earning $10,000 or less. Among the 29% of ice users who worked, the majority were also working in the service sectors, principally in retail sales. Nearly one-half of those ice users working earned $6,000 or less. Thirty percent and 36% of ecstasy and ketamine users, respectively, were working, also in the service industry, earning $10,000 or less.

All of the surveyed female drug users report having tried other substances during their lifetime (data not shown). Given the poly-drug use nature of this population, we asked respondents to indicate whether they had another primary drug of choice.

Table 2-2*
Other Primary Drug of Choice By Type of Drug Used

Other Primary Drug of Choice	Type of Drug Used			
	Heroin (n=155)	Ice (n=72)	Ecstasy (n=191)	Ketamine (n=176)
Cough Mixture	-	2.8	3.1	4.0
Cannabis	3.2	15.3	11.5	9.6
Ecstasy	1.9	26.4	-	43.8
Ice	14.2	-	9.9	9.0
Other Stimulants	-	5.5	11.0	6.3
Ketamine	3.9	22.2	40.0	-
Heroin	-	30.6	1.6	3.4
Methadone	3.9	-	-	-
Other opiates	0.6	-	-	-
Midazolam	5.2	9.7	3.1	2.8
Diazepam	-	2.8	-	-
Flunitrazapam	-	2.8	2.1	1.1
Triazolam	-	6.9	3.1	2.2
Other tranquilizers	-	2.8	0.5	0.5

* Totals do not sum to 100% as this question allows for multiple answers.

As Table 2-2 shows, there are a number of users who have multiple drugs of choice, sometimes used in combination and, as shown later, used to counteract the effects of the other drug of choice. Fourteen percent of heroin users report ice as a second primary drug of choice. Among ice users, 30% of them reported heroin as their second drug of choice, 26% of them reported ecstasy as a second drug of choice and 22% of them reported ketamine as a second drug of preference. Forty percent of ecstasy users

reported ketamine as a second drug of choice and 11 percent of them also reported using other stimulants or cannabis. Ten percent of them reported ice as their second drug of choice. Among ketamine users, 44% of them reported ecstasy as their second drug of choice, and nine percent of them reported using cannabis or ice as a second drug of preference.

Table 2-3
Single or Multiple Drug Use By Drug Choice

Single or Multiple Drug Users

Drug Use	No of Drug User	Single Drug User	Multiple Drug Users
Ketamine	176	73	103
ECSTASY	191	73	118
Methamphetamine (ICE)	72	13	59
Heroin	155	34	121

Single Drug User: Use the drug alone
Multiple Drug User**:** Use current drug plus one or more other type of drug together

Table 2-3 provides details on single or multiple drug use by drug type. Among ketamine users, 41% of them use only this drug and the remaining 59% of them report using one or more other drugs. Similarly proportions are apparent with ecstasy. Thirty-eight percent of ecstasy users only use this drug while the remaining 62% of them use other drugs at least one other drug. The majority of ice users (82%) and heroin users (78%) report poly-drug use.

Age and Drug Use

While CRDA data show that reported heroin use has dropped among younger users which has been matched by a rise in psychotropic drug use, albeit this increase has recently tapered off. Moreover, reported heroin use is higher among older female users. As part of our analysis, we examined age and type of drug use.

Table 2-4
Psychotropic Drug Use * Age

Count

		Age Group		
		Younger female	Older female	Total
Psychotropic	No	5	130	135
	Yes	191	174	365
Total		196	304	500

Young user: Under 21 years of age
Older user: 21 years of age or older

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	97.766(b)	1	.000		
Continuity Correction(a)	95.736	1	.000		
Likelihood Ratio	121.658	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	97.570	1	.000		
N of Valid Cases	500				

a Computed only for a 2x2 table
b 0 cells (.0%) have expected count less than 5. The minimum expected count is 52.92.

As Table 2-4 shows, about 97% of younger females engage in psychotropic drug use, which is significantly higher than that of older female users (57%). This difference was statistically significant at the .001 level. This suggests that younger female users (under 21 years of age) are more likely to use psychotropic drugs than older female users (21 years of age and older).

Table 2-5
Opiates Consumer * Age Group

Count

		Age Group		
		Younger female	Older female	Total
Opiates Consumer	no	192	152	344
	yes	4	152	156
Total		196	304	500

Young user: Under 21 years of age
Older user: 21 years of age or older

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	127.691(b)	1	.000		
Continuity Correction(a)	125.467	1	.000		
Likelihood Ratio	160.206	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	127.436	1	.000		
N of Valid Cases	500				

a Computed only for a 2x2 table
b 0 cells (.0%) have expected count less than 5. The minimum expected count is 61.15.

Table 2-5 indicates that 50% of older females used opiates which is significantly higher than that of younger female users (2%). This difference was statistically significant at the .001 level. This suggests that older female users are more likely to use opiates than younger female users.

Table 2-6
Age by Single/Multiple Use By Drug Choice

Drug Use	Type of Drug Use	Young Female	Old Female	Significance
Ketamine	Single Drug User	37% (27)	**63% (46)**	
	Multiple Drug User	**66% (68)**	34% (35)	**0.000**
ECSTASY	Single Drug User	64% (47)	36% (26)	
	Multiple Drug User	72% (85)	28% (33)	0.334
Methamphetamine (ICE)	Single Drug User	**77% (10)**	23% (3)	
	Multiple Drug User	39% (23)	**61% (36)**	**0.016**
Heroin	Single Drug User	3% (1)	97% (33)	
	Multiple Drug User	2% (3)	98% (118)	1.000

Young Female: Under 21 years of age
Old Female: 21 years and above

Based on an analysis of age by drug use by single/multiple use, it appears that younger ketamine users are more likely than older female users to be multiple drug users. Also, older female ice users are more likely to be multiple drug users than younger female ice users. These finding were statistically significant at the .001 level.

In-depth Interviews with 60 Female Drug Users

Table 2-7 provides the basic characteristics of the 60 women drug users with whom we conducted in-depth interviews. Appendix D contains a summary table of the individual characteristics of each woman.

Table 2-7*
Characteristics of Interviewed Female Drug Users (n=60)

	Frequency	**Percentage**
Age		
Under 21	20	33.3
21 yrs or older	40	66.6
Education Level		
Primary	2	3.3
F1-F3	27	45.0
F4-F5	23	38.3
F6-F7	0	-
Vocational Education	3	5.0
Postsecondary	0	-
Not stated	5	8.3
Born in Hong Kong	59	98.3
Martial Status		
Single	34	56.7

Married/Living Together	20	33.3
Separated/Divorced	6	10.0
Occupation* *		
None	16	26.7
Sex Work	14	23.3
Sales/Cashier	8	13.3
Waitress	8	13.3
Clerk/Office	6	10.0
Drug Courier	5	8.3
Hair Dressing	4	6.7
Loan Shark	3	5.0
Housewife	3	5.0
Shop Owner	2	3.3
Other	3	5.0

* Totals may not sum to 100% due to rounding.
****** Total does not sum to 100% as multiple answers are possible for this question.

One third of the women interviewed for this study were young users, under 21 years of age. Of the older users, the majority were in their twenties. Just under one-half of them had completed the compulsory education of up to Form 3. Nearly all of them were born in Hong Kong. Over one-half of them were not married. Slightly over one-fourth of them did not have a job nor an occupation. Nearly one-fourth of them reported being engaged in sex work, although some referenced this as nightclub worker, public relations hostess. Eight percent of them reported being drug couriers, and five percent of them indicated loan sharking as their occupation. Thirteen percent of them reported working as sales ladies/cashiers or as waitresses. Eighteen percent of them stated that they had two or more jobs. The majority of them have also had some form of treatment during their drug period of using drugs.

Table 2-8*
Drug Use Among 60 Interviewed Female Users

	Frequency	Percentage
Primary Drugs of Choice		
Heroin only	17	28.3
Heroin & ice	10	16.7
Heroin & ecstasy	0	-
Heroin & ketamine	1	1.7
Heroin, ecstasy, & ketamine	3	5.0
Heroin, ice & ecstasy	3	5.0
Heroin, ice & ketamine	2	3.3
Ice only	0	-
Ice & ecstasy	0	-
Ice & ketamine	0	-
Ice, ecstasy & ketamine	10	16.7

Ecstasy only	0	-
Ketamine only	1	1.7
Ecstasy & ketamine	8	13.3
All Four Drugs	8	13.3
Has Been in Treatment	48	80.0

* Totals may not round to 100% due to rounding.

As Table 2-8 shows, 30% of them were single drug users, principally of heroin. The majority of them were multiple drug users. Seventeen percent of them identified heroin and ice as their drugs of choice. A similar percentage of them indicated ice, ecstasy and ketamine as their preferred drugs. Thirteen percent of the interviewed women reported all four drugs as their primary drugs of choice. Eighty percent of them had received some form of treatment during their period of drug use.

It is important to underscore that these 60 women represent the experiences of some female drug users in Hong Kong, but certainly not all. The discussion here and in the following chapters does not generalize to the entire female drug using population, but as is one of the benefits of qualitative interviews, to offer a more in-depth, detailed and subjective understanding of female drug use, from their point of view.

Summary

From the two sets of data above, the majority of female drug users included in this study effort are in their teens or twenties, locally born, single, have completed up to the compulsory Form 3 in schooling, and are multiple drug users. While the survey data indicate that between 10% and 20% of them are engaged in illegal activities as a way of generating income, between 5% and 23% of the 60 interviewed are involved in work activities such as sex work, moving and delivering drugs, and loan sharking.

Section Three: Initiation into Use

The first part of this section briefly examines the age of first use as documented by the quantitative survey with 500 female users. The second part of this section looks at the set and setting, age first used, expectations and reasons for trying drugs as described and experienced by the 60 women who participated in the in-depth interviews. Their accounts of drug use represent their subjective understanding of their feelings and experiences. However, their experiences may be understood differently from those with whom they interact.

Survey with 500 Female Drug Users

Table 3-1 presents the age at which the 500 surveyed female drug users first started to use their drug of choice.

Table 3-1*
Age of 1st Use of Drugs of Choice By Type of Drug

Age 1st Used	Heroin (n=155)	Ice (n=72)	Ecstasy (n=191)	Ketamine (n=176)
10-15 Years	23.2	45.8	63.8	62.0
16-20 Years	55.5	41.7	27.8	29.0
21-25 Years	5.8	6.9	1.6	0.5
25+ Years	9.0	2.8	-	4.5
Unknown	6.5	2.8	6.8	4.0

* Totals may not sum to 100% due to rounding.

Most surveyed female users first tried their drug of choice in adolescence. Importantly, while over one-half of heroin users first tried it between 16 and 20 years of age, over 60% of ecstasy and ketamine users first tried these drugs between the ages of 10 and 15. We now turn to examine the initial qualitative experiences of women in using their drugs of choice.

In-depth Interviews with 60 Female Drug Users

Table 3-2 shows the age of first use of the 60 interviewed female drug users. Similar to the findings above with the quantitative survey, the majority of interviewed women first tried their drug of choice in adolescence with 60% of them initiating in their early teens.

Table 3-2*
Age of First Drug Use of 60 Female Users

	Frequency	Percentage
Age First Used		
10-15 yrs old	36	60.0
16-19 yrs old	14	23.3
20-29 yrs old	8	13.3
30 yrs or older	2	3.3

* Total may not round to 100% due to rounding.
Note: As noted earlier, 70% of these women were poly-drug users, and hence we did not breakdown the information in this table by drugs of choice.

At a general level, there are a variety of reasons for why female drug users initially try drugs. These include peer and partner influence, rebellion, curiosity, belief that drugs are not addictive, and seeking excitement and adventure. In the following discussion, we examine the initial reasons, settings and expectations of the interviewed women looking at their particular drugs of choice.

Heroin

Given the findings in Table 3-2, it is not surprising that most heroin users first tried heroin during their early secondary school period. Forty-four of the 60 women interviewed, reported using heroin (includes both single and poly-drug users). They were introduced to some "outside" school friends who were typically older and more "mature" than them. The setting for their first use with heroin was usually with a small group of friends either at someone's flat or in a discrete area of a public estate or park. They did not have any specific expectations of heroin but were curious about its effects. Many interviewed heroin users stated that they were not aware that they were actually smoking heroin when they first tried it, as it is relatively common to smoke it like a cigarette. Therefore, they falsely believed that heroin was not harmful, but more similar to cigarettes or cannabis.

> My classmate's sister gave it to me the first time. We went to have lunch together. She took out a cigarette and smoked. The smell was different from tobacco. This method was also different. We thought that it was so special. We asked her what it is. She told us that it's heroin. But we didn't know what heroin was. I've never heard about it from TV or textbook. (C08)

> One day, my friends gave me a cigarette stick to smoke. I thought that it was just cannabis. But I could smelt the strange flavor. They told me frankly that it was a heroin stick. I still thought to myself that it was just something like cannabis and cigarette which are not very harmful. Then, I tried it. Later, every time we went out, they would give me one or two sticks. A month later, I found that I got addicted. (B04)

> In the first two months I took it in the form of a cigarette. I realized it was heroin when I tried it from the foil paper. (A16)

> I remember the first time I took heroin, I went to my friend's place. I didn't know…I just finished Form 4. I ran out of cigarettes and I didn't realize that their cigarettes had heroin. I took it for several days because I was staying at their place. I felt unwell and my boyfriend saw me. He said that there might be something in the cigarettes. (A06)

Some of the heroin users reported that their first time with heroin was stimulated by boredom and peer pressure.

> I used to be one of the better students but there were two types at the school. The baddies wanted to play and get noticed. I liked playing with them. They didn't look down on me. The goodies were always wanting me to study with them. Very boring. And both my parents worked so I always went out with my friends. I used to go the game center when I was in secondary school and I started skipping school more and more. We started playing at the housing estate, and some of my friends were laughing at me for not trying heroin. I noticed that they were always drowsy and I was the only sober one. So eventually, when they asked me to try it, I did. (A04)

Female heroin users also report that their initial use was a reaction to the stress associated with poor school performance and family problems. Compared to other drug user groups, heroin users were more likely to describe past severe family stress and personal trauma.

> My dad was a drug trafficker…I was a teenager when my parents divorced. I followed my mother, and my sister followed my father. It was the turning point of my life. I felt so depressed and extremely unhappy. I couldn't accept the fact that my family was broken. Worse still, my mom met a new boyfriend a few months later. Then, I had to move to my grandma's place. I knew some friends there. At that time, there're a lot of drug users hung around there. And I started to try taking drugs one month after I moved there." (B04)

> I was 26 when I first tried heroin. It was the darkest period of my life. At that time I was so irritated by the things related to divorce. The most annoying thing was that my ex-husband took away my son. The main reason (to take heroin) was that as I mentioned before, I felt extremely bored and irritated after divorce and losing my son. (B05)

> I was not happy during my childhood. I was abused by my mother and my mother's sister. They always beat me up and punished me when I was young. They used to beat me up with a clothes hanger. They only beat me up only, not my brother. It is quite frequent. I remember once I went faint when I was beaten up by my mother and I was bleeding. She didn't even take care of me…I kept

running away. When I turned 16, I started taking heroin with my boyfriend who sold it. Then when I went back, one of my relatives was a heroin addict so I started to get it from her. I think the main reason I took it was that I was around it since I was very young. (A14)

Some heroin users have similar reasons to initially try it such as belief that it is not harmful, boredom. As discussed below, this is similar to the descriptions provided by other user groups. However, heroin users are more likely than others to report experiencing significant pressures and trauma at an early age.

Ice

Fifty-five percent (or 33) of the women interviewed reported using ice (all poly-drug users). Among these 33 ice users, slightly over one-third of them were prompted to try ice out of curiosity, having heard about its' unique slimming and energizing qualities.

Taking ice would help me shed away the fat around my waist. My waist was only 23 inches! A friend called me one day and said she could slim down three pounds in two days. I was so curious about it. At that time, she gave me a little to try. I felt it was amazing. (C05)

I first tried it when I was 13 or 14 years old. I don't want to use it anymore, because it makes me look ugly. I want to lose some weight when I first tried it, but I became too skinny afterwards. People would call me a female heroin addict. But I don't use heroin. I still take ice when I feel I've gotten fat or when I don't want to sleep. (E01)

I tried ice in Form 3 because my legs were too fat. People used to bully me because of that. A friend of mine had bulky legs too. But since she started using ice, her legs got a lot thinner. So I tried it. I took it for this reason. Later I liked the feel of it. It made me feel good, energetic and I felt smarter. I took it at my friend's home, I was just curious in the beginning. I felt it was so amazing because we would become so energetic and talk endlessly. (A19).

About 60% of those who use ice reported that their boyfriends introduced them to ice:

My ex-boyfriend introduced me to it. I found him so talkative after taking it. People were using it like chasing the dragon. I found that very interesting. The first time, I only smoked a few doses, but I couldn't stop talking for two days. I used a small sweeper and cleaned the house. Wow! It was so cool. (I04)

Like the heroin users above, most female ice users falsely believe that ice is not addictive nor dangerous and consequently feel that it is acceptable to try it.

I didn't feel that it was very dangerous. I didn't have any sense that it was addictive or dangerous. I wanted to try different drugs. (A14)

Heroin users "learn" from their peers during treatment or through street interactions that ice is not addictive and can neutralize the sedative and addictive effects of heroin. In effect, they believe that ice is a "cure" for heroin. From our in-depth interviews, we have also learned that heroin users can be introduced to ice at heroin divans. It is important to underscore that although these drugs are addictive, these users are describing the beliefs of the local drug culture, as they understand it.

Ecstasy and Ketamine

Forty-eight percent (or 29) of the 60 interviewed users reported using ketamine and ecstasy. All twelve of those who have never been in treatment reported ecstasy and/or ketamine as their primary drugs of choice (see Appendix C for details). They first used these party drugs in discos. Ecstasy and ketamine female users also report that since the drugs are free, at least the first several times, providing another incentive for trying.

> I knew the security guards because they were like my big brothers. I got in for free and I got the drugs for free because they were drug dealers. (D06)

> I used ecstasy when I first went to a disco. I didn't know the guy but he gave me half of a tablet. I lost it on the floor! Then he gave me another half. He wouldn't let me give him the money. (F03).

Peer influence and acceptance in appearing trendy and fashionable are also reasons for initially trying ecstasy and ketamine. Using among friends is noted as a way of gaining recognition by peers. In addition, users report incredible feelings of freedom and happiness during their first time. These feelings are further enhanced when intimate others are there to share in the pleasure.

> My partner tried ecstasy a few weeks before. He told me that it's so free. He said that it's a very happy feeling after taking it. So I took one. Actually, I saw the girls taking ecstasy before. I found that they could really play and dance happily. I didn't take it before because I had already drunk a lot of beer. One night, by partner's family and friends came, and they gave me a tablet, and I swallowed it. I felt so free. I couldn't stop shaking my head for the whole night! (E06)

The need to "create" a family feeling in light of family conflict and adolescent rebellion was also another motivating factor for initial use.

> My relationship with my family was very bad. I hung out and I had been having lots of arguments with them. If it wasn't my parents who were arguing, it would be me who was arguing with them. My brothers seemed didn't even know me! I wondered why my family could not be like other warm families. I felt as if I had no family, even though I had one… I hung out in the disco because I wanted to play with a group of people. I was too upset at home. I hung out with them and played like a 'family'. I didn't like taking drugs that much. (G06)

Although ecstasy and ketamine users reported tension in their families, the severity of the conflict was not as intense as described by heroin users. Nevertheless, these women found their peers and their lifestyle a source for escaping what they perceived to be family pressures.

Summary

Both the survey data and the in-depth interviews indicate that these female drug users first tried their drugs of choice during their teen years. The in-depth interviews highlighted the circumstances of their initial use, usually with friends. Although the setting differs among the different female user groups, many of their initial expectations and reasons for trying their drug of choice were similar particularly curiosity, peer influence and rooted in the expectations associated with the local drug culture like the non-addictive qualities of ice, ecstasy, and ketamine, and the appearance enhancing effects of ice. Partner's influence was an important factor among ice users. Escape from traumatic events was also an important reason for initial use of heroin.

Section Four: Continuation of Use

This section examines the patterns and motivations of use among female users and their strategies for obtaining their drugs of choice. The section is divided into three main sections. First, it examines female users' patterns of drug use, the costs and strategies they adopt to finance their use based on the survey data. Second, we draw from the narratives of our in-depth interviews to look at drug users' perceived motivations for continuing use and the methods they use to obtain drugs, including sex work. The subjective experiences of heroin, ice and ecstasy and ketamine users reflect their beliefs and understandings about drugs but may not necessarily represent others' realities. In light of this, in the third section, we present drug treatment workers' observations and views on the reasons why women continue to use drugs and the ways in which they finance their use. Frontline workers' observations are an integral part of understanding female drug users' experiences and can also be used as a way to validate users' descriptions.

Patterns of Use Among 500 Female Drug Users

A number of trends related to continued use are discerned from the survey data. Table 4-1 documents the methods and incidence of use as reported by surveyed female users.

Table 4-1
Patterns of Use*

	Heroin (n=155)	Ice (n=72)	Ecstasy (n=191)	Ketamine (n=176)
Main Method of Use				
Mix in Drink	6.0	1.4	15.2	11.9
Oral	1.3	1.4	84.3	1.7
Smoke	9.0	-	-	-
Nasal	-	-	-	82.4
Injection	36.2	-	-	-
Chasing the Dragon	45.0	97.2	-	-
Not reported	2.5	-	0.5	4.0
Use Last Year				
10 x or less	11.0	23.6	50.8	19.9
11-50x	3.2	18.1	20.4	38.6
51-100x	2.6	16.7	12.0	20.4
101-250x	6.4	11.1	1.6	7.4
251-500x	5.8	8.3	2.1	3.4
501-1,000x	4.5	2.8	0.5	0.6
More than 1,000x	58.7	9.7	2.6	9.6
Not reported	7.7	9.7	9.9	-
Lifetime Use				
Less than 50x	4.5	18.1	37.7	26.1
51-100x	0.6	8.3	26.7	15.9
101-250x	0.6	13.9	16.8	14.8
251-500x	0.6	19.4	8.9	19.9
501-1,000x	5.8	18.1	4.2	10.2
More than 1,000x	87.8	22.2	5.7	13.1

Other drugs used with primary drug**				
Tobacco	79.4	68.1	64.9	67.0
Alcohol	12.9	25.0	63.9	68.2
Cannabis	3.2	4.2	11.5	10.8
Ice	4.5	-	5.2	3.4
Ecstasy	2.3	25.0	-	30.1
Ketamine	3.2	8.3	30.9	-
Heroin	-	-	-	-
Midazolam	10.3	-	-	-
Other	2.6	-	-	2.3

* Total may not sum to 100% due to rounding.
** Totals due not sum to 100% as this question allows for multiple answers.

Heroin

As described in the last section, female users first experience with heroin is often in the form of smoking it in a cigarette. When they continue to use, it typically starts with chasing the dragon. Forty-five percent of surveyed heroin users reported chasing the dragon as their main method. Thirty six percent reported injection use. Our earlier study (Joe Laidler, Hodson and Traver 2000) suggests that when the sensation from chasing the dragon begins to fade and fail to provide the previous experienced high, heroin users may move onto injection use. There are, however, a number of female users who continue to fear needles, and remain with the chasing method.

Sixty percent of heroin users report using, on average, .7 grams or less in a single session (data not shown due to different weight measures across different drugs). Nineteen percent stated that they used between 1 and 1.5 grams, on average, in a single session. The remaining 21% of them reported using, on average, between 1.6 and 3 grams in a single session. During the past year, over 60% of heroin users reported using 501 times or more. Among the surveyed heroin users, 88% of them reported a lifetime use of more than 1,000 times. While the majority of heroin users also report using tobacco while using heroin, far fewer report drinking alcohol (13%), midazolam (10%) and other drugs.

Ice

The main method for using ice is chasing the dragon. Ninety seven percent of the surveyed ice users reported this method. In an earlier study (Joe Laidler, Day and Hodson 2001), we learned that, for ice, chasing the dragon method is conducive to sharing in a small group. It is this prolonged sharing process which users describe as a pleasurable experience. Twenty-one percent of surveyed ice users report using, on average, between .5 and 1.5 grams in a session. Ten percent of them report using an average of 1.6 to 2.0 grams in a session. Sixty-nine percent of the surveyed ice users report using an average of between 2.1 and 3 grams in a single session. Importantly, it should be noted that 30% of ice users also indicated heroin as their other primary drug of choice. As noted earlier, these poly-drug users generally tend not to use the two drugs together, but ice is used to neutralize or counter the sedative and "addictive" effects of heroin. As Table 4-1 indicates, ice users do not report using heroin while using ice, but do use other drugs such as alcohol (25%), ecstasy (25%), ketamine (8%) and cannabis (4%). Nearly one-fourth

of ice users reported using ten times or less in the last year. Another 35% of them reported using between 11 and 100 times over the past year. Ten percent of surveyed ice users used more than 1,000 times over the past year. Another 18% of them had a lifetime use of between 501 to 1,000 times Twenty two percent of surveyed ice users had a lifetime use of over 1,000 times.

Ecstasy and Ketamine

The main methods for using ecstasy and ketamine are orally and nasally respectively. Our survey data indicate that 84% of orally consume ecstasy, and the remaining 15% mix it in drinks. Sixty four percent of ecstasy users report using ecstasy while also drinking. Similarly, 68% of ketamine users report consuming alcohol while using ketamine. About 30 percent of ecstasy and ketamine users report using both drugs at the same time.

According to our survey data, 53% of ecstasy users consume one tablet on average in a single session. Another 28% of them consume, on average, two tablets in a session. The remainder use three or more tablets in a single session. It must be underscored that 40% of these ecstasy users also consume ketamine, normally in the same evening, but not necessarily mixed together. Forty-eight percent of ketamine users report using, on average, between one and one half to two packets in a single event. Another 30% of them report using an average of one packet per session. Fifteen percent of them indicated using, on average, one-half or less of a packet in a single session.

While 50% of ecstasy users report using ten times or less in the past year, another 32% reporting using 11 to 100 times. By comparison, 20% of ketamine users report using it ten times or less, while 59% report using between 11 and 100 times during the past year. In terms of lifetime use, 38% of ecstasy users used 50 times or less, 27% of them used between 51-100 times, 17% of them used between 101-250 times, and the remaining 19% used more than 250 times. For ketamine lifetime use, 26% used it 50 times or less, 16% used it between 51-100 times, 15% used it between 101-250 times, and the remaining 43% used more than 250 times.

Obtaining and Financing

The amount of money required to continue using differs depending on the type of drugs consumed. Table 4-2 shows the reported cost for heroin and ice is higher, typically over 100 HK dollars (depending on amount consumed in a single session) than for ecstasy and ketamine which is usually $HK100 or less per tablet or packet (about .2 grams) respectively.

Table 4-2*
Cost of Drug in HK Dollars By Type of Drug

Cost in HK Dollars Per Session	**Type of Drug**			
	Heroin (n=155)	Ice (n=44)**	Ecstasy (n=191)	Ketamine (n=176)
$0	15.5	2.3	24.1	44.3
$1-100	1.9	6.8	70.1	44.9
$101-200	23.2	45.5	5.7	3.4
$201-300	30.3	31.8	-	2.8
$301-400	3.2	-	-	2.8
$401-500	13.5	6.8	-	1.7
$500+	12.3	6.8	-	-

* 28 ice users did not report cost.
**Totals may not sum to 100% due to rounding.

Table 4-3 presents the percentage of different drug users involvement in illegal activities and the amount of money generated from these activities.

Table 4-3*
Percentage Involved in Illegal Activities and Income Generated

	Heroin	Ice	Ecstasy	Ketamine
% Involved in Illegal Activities	53.8	34.7	20.4	20.5
Total	155	72	191	176
Type of Illegal Activities**				
Selling Drugs	34.2	60.0	84.6	69.4
Trafficking Drugs***	10.3	28.0	23.1	19.4
Sex Work	9.0	24.0	23.1	36.1
Stealing	13.6	36.0	30.1	22.2
Pickpocketing	3.8	8.0	5.1	5.5
Selling Pirated VCD or Cigarettes	8.4	24.0	23.1	25.0
Total	82	25	39	36
Average Monthly Income From Illegal Earnings				
Less than HK$5,000	28.0	48.0	56.4	52.8
HK$5,000-$9,999	13.4	20.0	15.4	13.9
HK$10,000-$14,999	23.3	8.0	17.9	19.4
HK$15,000-$19,999	7.3	-	-	8.3
HK$20,000 or more	28.0	24.0	10.3	5.5
Total	82	25	39	36

*Totals may not sum to 100% due to rounding.
** Totals do not sum to 100% as this question allows for multiple answers.
*** Trafficking drugs is defined here as transporting or wholesaling.

Heroin

As Table 4-2 indicates, over 50% of heroin users report the cost is between $101 and $300 per packet (about .2-.7 grams.) Given the cost, female heroin users rely on a number of strategies to obtain money for their continued use. Fifty three percent of the 155 surveyed heroin users reported being involved in illegal activities as a source for obtaining money. Among these 82 users, one-third of them reported selling drugs at the street level. Only ten percent stated that they had trafficked at a higher level. Heroin users also indicated stealing (14 percent), selling pirated VCD and cigarettes (eight percent), and pick-pocketing (four percent) as strategies for obtaining money. The average monthly income derived from illegal work varied with 42% of them earning less than $10,000, another 23% of them earning between $10,000 and $14,999, and the remaining 35% earning more than $15,000. Nine percent of the surveyed heroin users reporting involvement in illegal activities stated that sex work was another activity.

Ice

Among ice users surveyed, over three-quarters of them reported spending between $100 and $300 dollars per gram (note, however, 29 respondents did not provide this information). As we shall see in the next section, many of the ice and heroin users from our in-depth interviews, stated that they had held legitimate jobs, particularly in the service sector, but after time, with prolonged use, they were unable to stick with the routines of the job, and were either terminated or quit. Moreover, their family and friends gradually withdrew their support. Among the surveyed ice users, 35% of them reported resorting to illegal activities to generate income. Among these 25 ice users, 60% and 28% of them sold and trafficked drugs respectively. Other illegal income generating activities included stealing (36%) and selling pirated VCD or cigarettes (24%). Nearly one-fourth of them report engaging in sex work as an income earning strategy.

Ecstasy and Ketamine

The cost of obtaining ecstasy and ketamine is comparatively cheaper with most surveyed users reporting the price as being $100 or below per tablet or packet (about .2 grams) respectively. Unlike heroin or ice, some female ecstasy and ketamine users do not even pay for their drugs. In our user survey, 24% and 44% of ecstasy and ketamine users respectively report not having to pay for their drugs.

When ecstasy and ketamine users paid for their drugs, it was usually through money obtained from family and friends. However, 20% of ecstasy and ketamine users reported earning money through illegal activities. Of the 39 ecstasy users reporting illegal income, the majority reported selling at the street or retail level (84%) but fewer reported trafficking (transporting or wholesaling) (23%) drugs. Other illegal activities reported included stealing (30%), sex work (23%), and selling pirated VCDs or cigarettes (23%). Among the 36 ketamine users, 69% reported selling drugs, 19% reported trafficking drugs, 36% reported engaging in sex work, and 25% reported selling pirated VCDs or cigarettes.

Sex Work and Drug Use

We had anticipated that heroin and ice users were more likely to engage in sex work as their principal source of income than female users of ecstasy and/or ketamine users. Table 4-4 provides our analysis of this question. The first part of the table shows 5.8% of ice or heroin users and 3.5% of ecstasy or ketamine users were involved in sex work as a way of generating income in the last 12 months. Additionally, 24% of those who used ice or heroin and ecstasy or ketamine also said they were involved in sex work over the last year as a source of income.

Table 4-4
Sex Work * Type of Drug User

PART 1

Count

		Type of drug user			
		Ice or Heroin	Ecstasy or ketamine	both	Total
Sex Work	no	162	247	25	434
	yes	10	9	8	27
Total		172	256	33	461

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	22.776(a)	2	.000
Likelihood Ratio	14.812	2	.001
Linear-by-Linear Association	4.185	1	.041
N of Valid Cases	461		

a 1 cells (16.7%) have expected count less than 5. The minimum expected count is 1.93.

PART II

Count

		Type of drug user		
		Ice or Heroin	Ecstasy or ketamine	Total
Sex Work	no	162	247	409
	yes	10	9	19
Total		172	256	428

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.281(b)	1	.258		
Continuity Correction(a)	.797	1	.372		
Likelihood Ratio	1.254	1	.263		
Fisher's Exact Test				.339	.185
Linear-by-Linear Association	1.278	1	.258		
N of Valid Cases	428				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.64.

Part II of the table excludes those who use both heroin or ice and ecstasy and ketamine in order to conduct a test of significance. About 6% of female ice or heroin users engaged in sex work as a means to earn a living, and about 4% of ecstasy or ketamine users also did so. Only a small proportion of females either consume heroin/ice or ecstasy/ketamine earn their living via sex work engagement. No statistical difference was noted amongst these two groups of drug consumers.

Motivations to Continue Using Among The 60 Interviewed Female Drug Users

One common motivation running throughout these different groups of female users is an appreciation of the medicinal quality and effects of drugs generally. As a "medicine," drugs, whether heroin, ice, ecstasy or ketamine, have a "numbing" effect to cope with teen related problems like boredom, school and family and later, in adulthood, with problems like work and relationships. We turn now to examine the distinctive motivations associated with the continued use of particular drugs among female users.

Heroin

There are a number of motivations to continue using heroin. Female heroin users report liking and seeking the feeling of comfort, happiness and well-being brought on by the effects of heroin. Moreover, heroin is perceived as a vehicle for escaping from the accumulation of problems resulting from their habit, particularly in relation to money and relationships with parents and partners. It become a vicious cycle for them as they typically relapse when their relationships with partners or family members are bad.

> I started using heroin when I was 17. I was working at a restaurant and my colleague and I got addicted. We smoked every night. In the first few months, we just put the powder in the cigarette, but later, we changed to chasing the dragon because we were really addicted. We started taking it at work and eventually she got terminated. I changed to a different restaurant and there I met my first girlfriend. I really loved her so much. We lived together but eventually she complained about my use and didn't want to be with a drug addict. So I decided to go to treatment to quit. Then she would love me. But when I got out, I learned that she had met a boy, and that's why she left me. I was very upset and disappointed. I'm not sure whether she hated me because I was a girl or a drug addict. So I went back to using heroin and started shooting because I could save money…Eventually I met another girl, and decided to quit using so I could have a relationship with her. I locked myself into the flat for one week, and quit for three years. Before I took heroin because I was so bored. I had nothing to do. After I met this girl, I found that my life was much happier. I didn't need anything to make me high. But one day, I found out that she went out with a man and she told me that she loved him. I was shocked. I had quit using drugs and sacrificed so much. After I learned this, I went right back to shooting heroin. I don't know why, perhaps to escape from reality. (B08)

Alternatively they may be influenced by their partner's use, finding it easier to rationalize their own use.

> My boyfriend and I would buy and take the heroin together at our flat. I was not working then. Our habit was supported by his job. For about a year, we would have a friend deliver when we asked for it. Then we couldn't wait for the deliveries, our urge was getting stronger. And we thought why should we pay for this and suffer. We decided to quit and registered at the methadone clinic as husband and wife. For four months we went everyday to take the methadone. After 18 months, I eventually got a certificate for completing it. But he didn't because he had taken a hit once. I decided to move out, away from my boyfriend because I needed to do something for me. Always, I would just sit in the flat waiting for him to come home, doing nothing. I got a job as a sales clerk. After about six months, I went back to see my boyfriend at his flat, and got angry when I realized that he started taking heroin again. He promised to quit, but when I went back he was using and I told him to get me some, thinking that he would forbid this because I had quit for sometime. But he actually went to buy some heroin and let me have some. This is when I started using it again. (A19)

Because female users perceive heroin to have "medicinal" qualities, they continue to use it to alleviate withdrawal symptoms, other health related problems like asthma, and more generally, feelings of boredom. This 29 year old heroin user traces her initial and continued use to feelings of boredom brought on by the loss of custody of her two year old son.

> It was this period of time, after my divorce that I tried using heroin. I felt so bored at home. Before, all my time was spent with my son, but after I lost him, I felt so empty. I had nothing to do. Everyday, I would sit inside the clothing shop at work. I really felt so bored…I met some new friends at a bar, and later went back to their house and saw them chasing the dragon. They said they liked the feeling of freeness. I tried it and began to use it regularly. I treated it as normal. The main reason was I felt extremely bored and irritated after the divorce and losing my son… Two years later I got arrested and was locked up for one year. After that, when I got released, I felt bored after leading a "normal" life. I just sat at home and did nothing. So I went back to using heroin because I was bored. I wanted to have something to do at home. (B05)

While the immediate motivations may differ among these heroin users, they are all linked by a need to find relief from emotional or physical (e.g., withdrawals) pain and achieve, what they perceive to be a state of freeness and well-being, albeit for short periods of time.

Ice

From the users' perspective, there are several motivations to continue using ice. First, international studies have shown that methamphetamine acts as an appetite suppressant as well as a source for increased energy and physical activity for prolonged

periods (Freese, Miotto, Reback 2002; NIDA 1998). As such, the combination of these two effects, can, from the users' point of view, enable them to lose weight. Consistent with findings elsewhere (Joe 1995), the interviewed users in this study are attracted to using it to maintain a slender appearance. Two examples are provided to illustrate their subjective experience:

> I heard that ice was a very interesting drug. It could give you a special feeling so I tried it. After I tried it, I found that I could use it to help lose weight. Then I kept on using it. And it's not addictive. It's very good. (H06)

> I felt I was beautiful when I took it. I was slim and got to know quite a lot of people. When I went for an abortion, I had to stop taking drugs. I felt that I had gained a lot of weight. I was up to 110 to 120 pounds. I felt very fat and I wouldn't accept this. So I began taking it again. (A09)

Second, some users perceive ice is a way of not only getting off heroin, but as a way of neutralizing the sedative effects of heroin. Importantly, this is a myth that has become part of the local drug culture.

> My friend said that ice can help you to quit heroin. Yes it's true. Ice can neutralize heroin. After you take heroin, you become so sleepy. If you want to wake up, take some ice. (G03)

Third, users believe that ice is useful in concentrating and focusing on the various jobs at hand. For those who use heroin, ice provides the means for mobilizing oneself and combating the lazy feeling from heroin.

> You become very lazy, clumsy and tired after taking heroin. But ice neutralizes the effect of heroin. You can become very hard-working and concentrate on doing something. When I needed this feeling, I took both of them. (I02)

> My partner didn't know that I took ice. He discovered only later. He worked during the day. And I was very clever. I took ice only when he was at work. After he came home, I behaved very well. I cooked, tidied up everything, I was very 'normal.'

Fourth, given that ice is perceived as a way of neutralizing the addiction and effects of heroin, it is not surprising that they hold the false belief that ice is not addictive. Moreover, as noted above, ice has an energizing effect, and contributes to their perception of increased sociability.

> I do not think that I was addicted to ice. I only took it when I went to play with my friends. I would become full of energy after taking ice. I don't think I had any dependence, I could take ice once a week or wait and have it only once every three months. I am only addicted to heroin. (G02)

Given the drugs' perceived sociability effects, some female users felt that ice helped them to communicate and develop better relationships with their family members, particularly with their parents, although we do not know the parents' perceptions or understandings of these encounters. Users also describe ice as relieving boredom as the process of using is long and complicated (because it is chased and shared). But in general, motivations to continue using ice are related to notions of appearance, energy and confidence, and supported by a local drug culture which de-emphasizes its' negative effects. It is important to underscore that these motivations are part of the local drug culture and represent only a partial view of the drug using reality.

Ecstasy and Ketamine

From the respondents' point of view, the main motivations for continuing to use ecstasy and ketamine are feelings of freedom and dis-inhibition. Many of our in-depth interview respondents reported they liked using these two drugs to play freely without concern about the perceptions of others. Moreover, they enjoy the feeling of "being watched with appreciation" rather than evaluation by others in the dance setting. The combined effect of the dance setting and the drugs provided them with an unmatched pleasurable sensation of happiness.

> I don't know why I go to the discos or why I take drugs, but I like dancing. I get so sweaty and hot after dancing all night. When I take the drugs, I feel that people do not see me as being ugly. (E04)

> After taking ecstasy, I would talk about things from the bottom of my heat and I feel that we have no secrets among us. (E02)

> We dance and laugh [after taking ecstasy and ketamine]. Sometimes the girls would cry and tell me stories about their bad boyfriends. We would hug each other and cry the whole night…. People in the disco are very friendly and nice. I love the atmosphere. We are like a family. (E01)

> I get very sociable and talkative after taking ecstasy and ketamine. For example, I talk to strangers standing next to me continuously… (C05)

Another motivation, according to most ecstasy and ketamine users is that they can continue to use these drugs in a controlled and occasional manner, principally in dance settings. Their experiences lead them to believe that ecstasy and ketamine are unproblematic. From their point of view, these drugs are not addictive nor have any serious consequences.

> I started taking ketamine and ecstasy when I was in F2. I didn't take it so frequently at the time. I just played with my friends during the weekend and holidays. But I would feel tired on Monday mornings. It wasn't because of the drug but because we were playing too late at night. I feel fine after using. I am very normal, just tired. Half of the students in classes fall asleep during lessons anyway. (E02)

> I have to take ecstasy and ketamine when I go to the discos, but I am not addicted. (D02).

> I didn't use drugs in school. But sometimes, I get changed and go to school after I get back from the disco. Sometimes, the drugs are still having an effect on me when I get to school. I just sit there and am in a daze. I lay down and nobody notices, even when my saliva is all over the desk. I fall asleep…(D03)

Another motivation to continue using and going to discos is that it is relatively inexpensive, often times free. This form of entertainment is comparatively cheaper than most others in Hong Kong.

> I didn't need to pay for the entrance free nor the drugs. When girls go with the guys, it's the guy's who is suppose to pay. (E06)

Moreover, ecstasy and ketamine are perceived to be a "better" pleasurable substance than alcohol.

> It's better than the hangover that you get from drinking too much. At least I can sleep and eat afterwards. (E01)

> Ketamine is more mild than alcohol. And you can control the amount. You can just snort one or two doses. Moreover, it comes down very quickly. It's even faster than alcohol. You can wake up in 30 minutes. The feeling is more comfortable. (B04)

Although ecstasy and ketamine are associated with and perceived to be a drug connected with the dance setting, ketamine use has moved beyond the dance boundaries and this partially accounts for the surpassing popularity of ketamine over ecstasy. It has moved into the karaoke scene.

Strategies to Finance Continued Use Among The 60 Interviewed Female Drug Users

As described in Section 2, 68% of the 60 interviewed female drug users reported working in one or more occupations at some point in their life. We also noted that 23% of them reported being involved in sex work, eight and five percent of them reported being drug couriers or loan sharks, respectively. Although they may work, and draw on this income to pay for their drug use, as we show below, it becomes difficult for heroin and ice users to maintain a steady legitimate job, with some turning to illegitimate jobs to earn money.

<u>Heroin</u>

Given the cost, female heroin users rely on a number of strategies to obtain money for their continued use. According to our interview data, female heroin users rely on their families, partners and friends for money but these sources are gradually reluctant to do so after recognition of continued use. In addition, many of them tend to work in

legitimate jobs, typically in the service industry or requiring basic skills. However, with prolonged use, they find it increasingly difficult to keep their job. Moreover, the income derived from their legitimate jobs is unable to maintain their supply. One heroin user recalls the challenges of obtaining money for heroin, especially when she transitioned from chasing the dragon to injection.

> In the first year, when I was chasing, I felt quite all right with my life, although I was always short of money due to my use. I used $200 a day, and I only earned $6,500 a month. So I asked my mom for money and she refused to give me any thinking I had enough. Then I borrowed from friends and colleagues but I wouldn't ask for more than $100 otherwise they wouldn't lend it. Over the next year and a half, I became more and more addicted to heroin. I became very lazy and had no energy to work. I didn't go back to work everyday and my colleagues started suspecting that I was taking heroin. I was very lazy at work. I didn't want to move. Being a waitress, you need to stand and walk for the whole day. How could I have energy for such a demanding job? Moreover I needed to take more heroin than before. I had to take 1 big pill a day. It cost $300 to $400. My mind was occupied by "money." I was always asking my colleagues to borrow money and eventually I quit the job.
>
> Last year, a guy asked me to move some drugs since I didn't "look" like an addict. I thought why not? I could earn a lot of money. If I moved 30 pills, they would give me $2,000. I didn't need to worry about money. I started selling heroin with my friend. Sometimes we'd buy "ounce packs" from a big dealer and repack them into pills. Sometimes we didn't have to. Usually we could sell 10-20 pills a day for around $280. We earned several thousand dollars a day. (B01)

Her case illustrates a common experience female heroin users face in trying to maintain legal employment. As the above findings show, female heroin users tend to encounter difficulties in maintaining employment once they develop a sustained pattern of use, and therefore, employ multiple income generating strategies to maintain their use.

> Heroin users also report relying on their boyfriends or partners for their supply.
>
> Sometimes, my boyfriends would pay for me. I didn't need to worry about money. I had some boyfriends who worked in the drug stores. They had around $2,000 a day. So usually they would pay for me. We used about $700 a day for heroin. (B09)

In a few cases, they turn to dealing or carrying drugs or loan sharking, usually through an introduction by their partner and dealer friends. As we'll see below, some of them may turn to sex work as a means to generate income.

Ice

As indicated earlier, all of ice users from our in-depth interviews were polydrug users, with 17% of them also using heroin and another 17% of them using ecstasy and

ketamine. Therefore, we found that they adopt strategies used by heroin users or ecstasy and ketamine users, and rely on their families, friends and boyfriends for money to purchase their drugs. Somewhat differently from other groups, however, ice users generally tend to use with a small circle of friends, and consequently, the supply and cost of ice is shared. One 26-year old woman, who uses ice and heroin described the changes in the ways she generated income and obtained drugs.

> My husband is a loan shark so we'd have money to buy. After I divorced him, I had a job in a restaurant but I quit because I wanted to play more. So I worked as a loan shark and also helped dealers to distribute drugs. I was an old friend of the dealer so it was easy for me to work in distributing and also to get some ice for me. I wouldn't take too much though because I had to reserve most of it to sell. When I use ice, I usually take it together with four or five others. It's normal to share with others if you have it. (T18).

So while women who use ice may share the cost of using it together, they must still rely on other sources for obtaining their other drugs of choice.

Ecstasy and Ketamine

The cost of ecstasy and ketamine are relatively cheaper than for ice or heroin. Users perceive that ecstasy and ketamine's minimal cost is one of its attractive features, and can rely on pocket money from their families or friends. In some cases, users report that they do not have to pay anything for their supply. According to a 21 year old, poly-drug user of ecstasy, ketamine and cannabis:

> I took drugs for seven days consecutively a week. I did it everyday and met guys everyday. I didn't need to pay when I went to the disco. The drugs are also free. I thought that we, as girls, were accompanying the guys. It would be their responsibility to pay and supply those things for us. I would avoid partying where I needed to pay for my own. Outreach and treatment workers observe that ecstasy and ketamine are not only readily available in dance settings, but are often free for females. (A01)

As apparent from the above discussion, the interviewed female users indicate that they all rely on their families, friends and partners to obtain money for their drug use, and on legitimate jobs. However, in the case of heroin, and some ice users, because of the inability to maintain a steady job, must resort to other strategies for generating income. By comparison, the cost of ecstasy and ketamine are less, and in some cases, free.

Sex Work and Drug Use

As noted in the previous section, some female drug users engage in sex work as an income generating strategy. From the survey data, seven percent of the 500 female drug users reported involvement in sex work. As part of the study's objectives, the research team initially proposed to conduct focus groups with sex workers to estimate the prevalence of drug use among this population and to gain a better understanding of the relationship between sex work and drug use. Despite the team's persistence in working

with non-governmental agencies, outreach workers, and street contacts throughout the study period, we were unable to access this group. However, we were able to obtain information on sex work and drug use from our in-depth interviews and from our focus groups with women in treatment and with treatment workers.

Twenty-three percent (or 14) of the 60 women interviewed report being public relations girls or working girls. Among the 14, 13 report heroin use, 8 report ice use, 6 report ecstasy use and 5 report ketamine use. Most of them are poly-drug users. Nine of them report being PR girls and 5 identify as "working girls." Although nearly all of them used heroin, few reported using heroin in entertainment settings like nightclubs and karaoke settings. From their descriptions, the use of heroin is a violation of the "house" rules although we can not confirm this from our other data sources.

> We aren't supposed to use heroin. I can't let my manager at the karaoke know I'm taking it. Actually I haven't seen any of the other women using heroin. I am not sure if anyone knows that I'm using it. But I don't do anything stupid at work so no one cares. (B04).

> I don't let my heroin use affect my work or work performance. My use has never caused any problems at work because I don't use it work. I just don't get high at work. I don't use heroin at work anyway because if I have to drink, if a customer forces me to drink, I would become really sick. (B02)

All nine of the PR girls report that ketamine, unlike heroin, is acceptable to use in the nightclub and karaoke settings. In fact, the respondents indicate that some clients expect them to use ketamine to enhance the immediate experience.

> In the last two years, I have to take ketamine at work. Our clients ask us to snort some with them. It's very common in karaoke and nightclubs now. Before we just needed to drink with them but now they also want us to take ketamine. Rarely, they would ask us to take ecstasy but we refuse to take it. Why? Because you can't control your head and body movement after taking ecstasy. We are in a karaoke room, not a disco. We can't shake crazily in "company." (B05)

> Before I worked in the nightclub, I used drugs occasionally, say a few times a week, but when I started working there, I took it nearly everyday. You have to do that. The clients ask you to take it with them. (A09)

Some female heroin users, disliking the stigma associated with prostitution, and develop "relationships" with men to obtain money and drugs for their addiction, but are fully cognizant of the transactional nature of their "relationship." For example, one woman describes her failed attempts at a job and her alternative strategy to obtain money to get heroin.

> C: I had about five or six jobs doing sales in a year. But I didn't stay long in any of them, one month was about the longest.

I: Why?

C: Drugs. Working hours for a sales lady is over ten hours. It was so boring, I went to the toilet frequently to have drugs. So my co-workers complained about my frequent absences from duty. As a result, I was either fired or simply quit the job.

I: How did you pay for drugs?

C: I depended on my men to provide me with heroin. Before I became addicted, I sought out boyfriends for fun and security. Since I'm addicted, I did it really for drugs. I didn't have any money to buy drugs, so I have to depend on some guys to help me. I calculated how to cheat men for drugs and was cautious about people… I cheated them for money. When I know someone feels good towards me, I pretend to like him and coax him to have drugs together so that I don't need to pay for the drugs. (A19)

Based on our analysis of these interviews, it is important to note that the use of heroin preceded their involvement in nightclubs or on the streets while the use of ketamine began after they had worked in this occupation. All of them indicated that ketamine was used in nightclubs. The six women who reported using ecstasy indicated that they used this drug only during non-working hours when they go to discos with their friends. Six of the eight women who used ice started using ice after working in nightclubs.

Frontline Workers' Perceptions of Female Users' Patterns, Motivations, and Involvement in Sex Work

Outreach and treatment workers confirm the view that while female users' may express a preference for a particular drug, they like the medicinal qualities of the drug. This observation is aptly described in a focus group with treatment workers:

No matter what kinds of drugs they take, the main reason is that they want to use drugs is to anaesthetize themselves and avoid their problems. Although the reactions of different drugs are different, the result for them is the same – they don't need to think. After taking ice, they become very energetic but actually, their mind and behavior are not under their control. They think that they can escape from reality during the high period. Taking heroin is the same. It makes them feel sleepy but again, they know they don't need to think during that "cloudy" period…(F2-3)

They can't face the frustration – families with parents divorced, poverty, school and poor academic results…(F2-5)

Usually after their family has developed problems, they will try using drugs. Females feel it more than guys. They are more attached and affected by their

> family. They are more dependent. If they lose the thing that they can rely on, they will easily go in the wrong direction. (F2-1)

Outreach and treatment staff agree with the views expressed by users that one of the important reasons for using ecstasy and ketamine is the relatively low cost.

> Drugs like ecstasy and ketamine are easily accessible because some discos distribute those drugs free of charge to girls. When we ask the girls, "do you have to buy those drugs, they tell us, 'no!" (F3-1)

> They don't need to pay for the drugs. The psychotropic drugs are free for girls. If the boy wants to catch the girl, he will give her free drugs. It's very common in the discos. (F5-3)

> I think it's one of the reasons why so many girls take drugs in the discos. They can get free drugs. It sounds good to them…Most of my clients like to play in the discos, rave parties aren't as popular now, the ticket is quite expensive. So they like to play in the cheap discos more. Most of the discos they go to have ladies night, and don't have to pay for the tickets. They may even get a free drink. (F5-2)

However, frontline workers also believe that the motivations to use ketamine extends beyond partying in discos. They have witnessed a growing use in other venues like nightclubs and karaoke bars.

> My colleagues and I find that ecstasy is becoming less popular these days. The boys and the girls both like ketamine more in general. They take ketamine more because it is not very convenient from them to go to discos nowadays. They categorize drugs with the occasion. They think that ecstasy is to be taken in discos only. It makes them wild and exciting. Ketamine can be taken in many occasions such as schools during lunch. Ecstasy is too strong for school but ketamine makes one settled. They would take some ketamine in restaurants. They can take it in karaoke because they can be there anytime. And the chances of getting caught in those places are lower. If they go to discos, they are more likely to get caught because they are underage. From their point of view, they are using drugs in a 'rational' way. (F1-3)

Frontline workers point to the perceived calming effect of ketamine as a primary reason for using in the school context. An outreach worker offers this telling example of one girl's strategy for coping with the discipline-oriented environment of school:

> They feel that they can control themselves better. The education system is very hard for some teenagers. They can't manage student-teacher relationships and some teachers are inexperienced in handling the students. They don't understand what students think and have other administrative work to attend to. One girl said she quarreled with the teacher in class, and when the school social worker asked to see her, the teacher would not permit it. When the student argued with the

> teacher, she was scolded about her bad attitude and was punished. So she would take ketamine so it would give her a feeling of peace. When she takes it, nothing matters. She listens to the teacher and stays still. I don't think taking drugs is a good way to solve problems, but she thought it worked for her. (F1-1)

So while most young female users continue to use ecstasy and ketamine in the dance scene as a form of youth expression and culture, some perceive these drugs as having a medicinal effect, much in the same fashion that older female users describe in connection with heroin and ice. For them, drugs act as a medicine, solving the immediate problems resulting from the stress of school and family relationships but do little for self-empowerment. These frontline workers captures this feeling among young users:

> They are only school-aged girls, but they can't do anything to change their current relationships. They can't handle it. They have no self-esteem and have little value for themselves. Taking drugs makes time pass quicker, but can't solve their real problems. The drugs can 'help them to ventilate their unhappiness because, like ketamine, it is noted as the "happiness drug." It's very hard for them to cope with those family problems. (F2-2)

> Those girls with lots of troubles, many worries and unhappiness, they take large doses, sometimes even overdosing. They can't control themselves. They take enough until they feel it. Some have taken 6 to 7 pills each time. Their tolerance seems to be quite high. (F1-3)

Clearly then, ecstasy and ketamine remain popular in the dance settings, but as frontline workers observe, female users also report other motivations for using these drugs in different settings.

Sex Work

According to frontline workers' observations and experiences, it is difficult to estimate the number of female drug users who engage in sex work given the "hidden" nature of both drug use and sex work. Moreover, they note that the variety of "occupational titles" associated with the sex work industry such as hostess, PR girls, private hour girls, "working ladies" are "loose terms" for what they perceive to be, as sex work. Nevertheless, among female drug users who do engage in sex work, frontline workers have observed differences between heroin, ice, and ecstasy and ketamine users. For female heroin users, sex work is an outcome rather than a precursor to drug use and is stigmatized even within the sex worker community.

> Most of the heroin prostitutes use heroin before they join the "profession." They do it because of their use. They are totally controlled by heroin. They may not be willing to do this kind of thing but they have to because they think that they can't live without heroin. They need money to buy and sustain their use. (F2-3)

> Most of the heroin users are streetwalking prostitutes. The price for their services is relatively cheap since their appearances are not that attractive. But the PR girls are more pretty and therefore more expensive. These heroin users who are

> prostitutes are looked down upon. The public relations [PR] girls see themselves as more high class, and think they are even different from prostitutes. (F2-4)

According to frontline workers, the main motivation for heroin users to engage in sex work is to obtain money to purchase heroin. By comparison, they have observed that ice users, who tend to share their supply of drugs have fewer financial anxieties compared to heroin users.

> I find that ice users don't worry much about not having money to take ice. Heroin users are thinking of how to get money to buy heroin all the time. But ice users seldom mention money problems…I think it's because they take ice with a group of friends and share. So they can have free ice during the ice gathering. (F4-2)

It is difficult to determine the extent of ice users who engage in sex work. For example, frontline workers note:

> Most of the ice users main source of money is from so-called boyfriends, who also give them drugs. I find that ice users tend to be prostitutes, they think it's a fast way to earn money. It's the most common job among ice users. (F4-1)

Unlike older heroin users who are streetwalking prostitutes, female ice users who do get involved in the entertainment industry, tend to work as PR girls and hostesses and may not necessarily perceive themselves as prostitutes or sex workers. Moreover, for this particular group, involvement in the entertainment industry typically precedes the use of ice. Frontline workers observe:

> I think drugs like ice help them to reduce the shameful feeling. They know that it's not good to do this kind of thing, but drugs can help them to cover this feeling. For example, they can play wilding with a guy they've never met before. She can talk a lot to him and not feel shameful. She becomes very enthusiastic. I think ice really helps them to work in the nightclubs and karaoke environment. (F1-2)

> I think sex workers use ice because they want to numb their feelings. When they get involved in this kind of occupation, there is a myth, that the drug will help you to lose your feelings. (F3-3)

Frontline workers further note that PR girls and hostesses sometimes use ketamine while they are working to help them "play" and "sing" with their clients, but refrain from using ecstasy at the nightclubs and karaoke settings. Ecstasy is reserved for "after hours" work to "shake out all the unhappy feelings" (F2-2).

Summary

From the survey data, a number of patterns of female drug use are discernable. Each type of user group has a distinctive method of using with heroin users chasing the dragon or injecting with a needle, ice users relying on chasing the dragon, ecstasy users

ingesting tablets, and ketamine users snorting. Data from the in-depth interviews confirm that these are the preferred methods of use.

The survey data also indicates that heroin users reporting using more frequently in the last year, and over their lifetime, than ice, ecstasy and ketamine users. This pattern may be due to the fact that the women using in this study are older than those who use ecstasy and ketamine, and therefore, have a longer drug using history. From our in-depth interviews with female users, 73% (or 44) of them were heroin users, and of these, 16% (7) were under 21 years of age. By contrast, those women who used only ice, ecstasy or ketamine tended to be under 21 (13 out of 16).

Users (from our in-depth interviews) and frontline workers (from our focus groups) share the perception that drug use generally has a medicinal quality, relieving the strain from conflict with family members and partners or pressures from school or work. In relieving this stress, drugs can, from the point of view of users, strengthen their self-esteem, albeit only temporarily while under the influence. From our interviews with users, it has also become clear that there are a number of myths that have emerged as part of a local drug culture, such as the belief that ice is a way of neutralizing the effects of heroin, and that ice, ecstasy and ketamine is not addictive.

The cost and strategies for obtaining drugs varied depending on the type of drug. From the survey data, we found that heroin and ice tends to cost between $100 and $300 whereas ecstasy and ketamine tends to cost less than $100. Yet as our in-depth interviews indicate, ice users share their supply and experience the drug together, thereby reducing the cost. Ecstasy and ketamine are less expensive to buy than the other two drugs and our in-depth interviews with users and focus groups with treatment workers confirm this, indicating that the use of these two drugs in discos is minimal, and sometimes free.

According to the survey data, female users are engaging in illegal activities to generate income. About 55% of heroin users, 35% of ice users, and 20% of ecstasy and ketamine users report involvement in illegal activities with selling drugs being the most often reported. Trafficking (e.g., carrying or wholesaling) drugs was also reported but to a lesser extent than selling. Our in-depth interviews indicates that there is some involvement in illegal activities like selling and carrying drugs but this was not a common experience among the interviewed female users.

In relation to sex work, important issues emerge from the observations and experiences of frontline workers and drug users. Frontline workers indicate that the relationship between drug use and sex work differ depending on the users' drug of choice such that heroin users find themselves engaged in sex work due to financial reasons. By contrast, sex workers may turn to using ice and ketamine to cope with and manage their work environment. However, the respondents' poly-drug use suggests a slightly more complex relationship between sex work and drug use. Although heroin use is generally unacceptable in the nightclub and karaoke setting, it does sometimes occur. The use of ice and, more recently, ketamine, however, appear to be more acceptable and in the case of the latter, encouraged in these settings.

Section Five: Impact and Consequences of Use

This section of the report discusses the consequences associated with the different types of drugs used including relationships, children, work and school, mental and physical health, self-image, sexual behavior and legal status. In light of the perceived impact of drug use on their lives, we then turn to look at problem recognition. In each section, we first present the survey findings and then offer insights gained from the qualitative data, principally the in-depth interviews.

Survey with 500 Female Drug Users

Risks and Consequences

Table 5-1 reports on the risks and mental health characteristics of the surveyed female drug users. The risks reported may have occurred prior to or during their drug use. As noted in the table, 40% or more of ice, ecstasy, and ketamine users reported being emotionally hurt by family and non-family members when under 18 years of age. Similarly, 48% or more of these three user groups reported being physically hurt by a family member when they were under 18 years of age. Across all drug-using groups, the proportion reporting sexually abuse is relatively low.

Table 5-1*
Characteristics of Surveyed Female Drug Users

	Heroin (n=155)	Ice (n=72)	Ecstasy (n=191)	Ketamine (n=176)
Risks				
Family member emotionally hurt you?				
When under 18 yrs old	26.4	45.8	44.0	40.3
When 18 yrs old or above	20.6	12.5	5.8	8.0
Non family member emotionally hurt you?				
When under 18 yrs old	26.4	38.9	47.1	50.0
When 18 yrs old or above	28.4	18.1	12.0	48.3
Family member physically hurt you?				
When under 18 yrs old	38.7	62.5	52.4	48.3
When 18 yrs old or above	10.3	4.2	2.6	2.2
Non family member physically hurt you?				
When under 18 yrs old	14.8	20.8	21.5	16.5
When 18 yrs old or above	12.3	15.3	11.0	8.0
Family member sexually touch you against wishes?				
When under 18 yrs old	5.8	4.2	3.1	2.3
When 18 yrs old or above	1.9	0.0	0.0	0.0
Non family member sexually touch you against wishes?				
When under 18 yrs old	9.0	8.3	12.0	9.7
When 18 yrs old or above	5.8	4.2	7.8	9.0

Family member had sex with you against wishes?				
When under 18 yrs old	0.0	1.4	0.0	0.0
When 18 yrs old or above	0.0	0.0	0.0	0.0
Non family member had sex with you against wishes?				
When under 18 yrs old	3.2	1.4	11.0	8.0
When 18 yrs old or above	2.6	1.4	3.7	5.7
Mental Health:				
Have you ever experienced one week or more of:				
Feelings of sadness, depression, or loss of interest in something you cared about?				
When under 18 yrs old	33.5	58.3	49.7	47.2
When 18 yrs old or above	46.5	33.3	17.8	26.1
Feelings of emotional disturbances?				
When under 18 yrs old	31.6	55.6	38.2	36.4
When 18 yrs old or above	46.5	32.0	10.5	13.6
Hearing voices/having hallucinations?				
When under 18 yrs old	14.2	36.1	40.3	33.0
When 18 yrs old or above	23.9	22.2	11.0	11.9

* Totals may not sum to 100% as some questions allowed multiple answers.

In relation to mental health, at least one-third or more of all users reported feeling sad and had emotional disturbances for at least one week when they were under 18 years of age. Just under 50% of heroin users reported similar experiences as adults. Over one third of ice, ecstasy and ketamine users report having had hallucinations or hearing voices when they were under 18 years of age for one week or more.

As Table 5-2 shows, the majority of female drug users surveyed for this study have been affected by their drug use in some way. The nature of this impact, however, varies by the type of drug used.

Table 5-2*
Types of Consequences By Type of Drug

In the past year, Has Your Use Created Problems With:	Heroin (n=155)	Ice (n=72)	Ecstasy (n=191)	Ketamine (n=176)
Relationships?	89.6	83.3	65.9	56.8
Partner	51.6	40.3	17.3	15.3
Friends	50.3	14.2	25.6	23.3
Parents	79.4	66.7	48.7	38.6
Siblings	51.6	38.9	23.6	19.8
Other relatives	28.3	22.2	4.7	9.6
Drug Sellers	4.5	4.2	1.0	0.5

Children?	40.6	19.4	6.3	6.3
Loss custody of child(ren)	1.3	2.3	0.5	0.5
Can't care for child(ren)	17.4	6.9	1.0	1.1
Insufficient money to care For your child(ren)	11.6	4.2	2.6	2.3
Work/School?	70.3	81.9	60.2	62.5
Poor work performance	38.7	27.8	17.8	33.0
Loss job	39.4	37.5	30.4	13.0
Poor school performance	7.7	25.0	37.1	35.8
Dropped out of school	7.7	25.0	37.1	35.8
Mental Health	85.2	90.3	79.6	77.3
Depression	30.3	50.0	29.3	28.4
Hallucinations	30.3	63.9	36.6	36.9
Paranoia	5.2	23.6	18.3	18.8
Isolation	37.4	36.1	17.8	12.5
Anxiety	38.7	52.8	22.0	21.6
Irritability	23.9	51.4	25.1	16.5
Aggression	7.1	19.4	12.6	10.8
Violence	11.0	29.2	14.6	10.2
Increased Confidence	49.7	44.4	31.4	30.1
Decreased Confidence	49.7	29.2	7.8	8.5
Physical Health	94.2	94.4	75.4	71.0
Appetite loss	68.4	86.1	55.0	42.0
Weight loss	77.4	75.0	42.4	32.4
Memory loss	64.5	79.2	59.7	60.2
Vision Impairment	12.3	19.4	10.0	7.9
Chills	31.6	29.2	15.7	15.9
Sweats	31.6	41.7	28.3	25.0
Accidents	-	5.6	7.3	10.8
Injuries	3.2	23.6	20.9	18.8
Disruption of menstruation	57.4	36.1	20.4	19.9
STD	1.3	2.8	0.5	-
Sexual Behavior				
Increased sexual activity	10.3	37.5	20.9	18.8
Decreased sexual activity	20.0	4.2	1.6	2.3
Easier to reach orgasm	1.9	4.2	6.8	8.5
Difficult to reach orgasm	72.9	26.4	6.3	8.5
Change in sexual activity	5.2	4.2	2.6	3.4
Criminal Record				
% drug related arrests	87.1	36.1	8.9	13.1
% convicted drug offenses	85.2	37.5	7.9	12.5
% arrested other offenses	36.0	19.4	4.2	5.1
% convicted other offenses	31.6	20.8	3.1	1.7
% placed on probation	65.2	37.5	8.4	9.0
% placed at DATC	80.6	39.0	8.4	12.5
% other institutions	53.0	27.8	6.3	9.1

* Percentages do not total 100% as questions allow for multiple answers.

Among the surveyed heroin users, the majority of them (90%) report having problems in with their relationships in the past year due to their use, particularly with parents (79%), siblings (52%), partners (52%) and friends (50%). Ice users report similar interpersonal problems, mostly with parents (67%), partners (40%) and siblings (40%). As Table 5-2 shows, heroin users were more likely than any of the other groups to have had problems with their children, being unable to care for their children because of their use (17%) and lack of money to care for their child(ren) (11%). This finding is related to the fact that fewer ice, ecstasy and ketamine users have had children.

As noted earlier, heroin and ice users, although at the start of their drug use, tend to have legitimate jobs, their use and the ways in which they use, create difficulties at work and eventually results in their termination or quitting their job. Over 70% of heroin and ice users report having work or school related problems during the past year due to their use. Over 37% of both user groups report having lost at least one job in the last year.

The majority of surveyed users experience some form of mental health problems as a result of their use. Eighty-five percent of heroin users reported having mental health related problems, particularly, anxiety (39%), isolation (37%), depression (30%) and hallucinations (30%). Ninety percent of ice users reported mental health problems, especially hallucinations (64%), anxiety (53%), irritability (51%), and depression (50%). Fewer surveyed ice users reported paranoia (24%). Over three quarters of surveyed ecstasy and ketamine users report having mental health problems as a result of their use. It is important to underscore that 77 of these respondents reported these two as their primary drugs of choice, and consequently, these findings reflect the combined effect of the two drugs. Ice, ecstasy, and ketamine users were more likely to report increased levels of confidence than heroin users (where equal number of heroin users felt their confidence was increased or decreased).

The survey data further suggests that female users across all the drug user groups have thoughts of wanting to die and attempting suicide, particularly in their adolescent years.

Table 5-3
Suicide Thoughts and Attempts By Type of Drug Used

	Heroin (n=155)	Ice (n=72)	Ecstasy (n=191)	Ketamine (n=176)
Before 18 years old				
% Wanted to die*	14.8	44.0	28.3	20.0
% attempted suicide	20.6	33.3	26.0	17.6
18 year until present				
% Wanted to die	10.3	13.9	10.5	11.9
% attempted suicide	16.1	13.9	5.2	5.7

* Had thoughts about wanting to die for a one week period or more.

As Table 5-3 shows, female drug users have had thoughts or attempted suicide during adolescence. Fifteen percent of heroin users had a period of one week or more during which they wanted to die prior to 18 years of age, and 21% of them had attempted suicide. Among female heroin users, for both periods (before 18 years of age and 18 until present), the percentage attempting suicide is greater than the percentage of those who reported having thoughts of wanting to die. This difference is related to the fact that the respondents were specifically asked if they had thoughts about wanting to die for a one week period or more. Therefore, it is possible that a respondent could attempt suicide in a rather spontaneous manner without having had thoughts about dying for one week or longer. As we discuss in the next section, some users may attempt suicide with more immediacy and without periods of thinking about dying. Comparatively, the largest proportion of users who have had suicide thoughts and attempts during adolescence was among ice users with over 40% of them having had thoughts in adolescence and one-third of them tried to commit suicide. The proportion of ice users who thought or attempted suicide after adolescence continues to be the highest compared to other groups. Importantly, 14% of ice users both thought and attempted suicide during their adult years. Given that most users started in adolescence, suicide ideation and attempts are very likely interconnected to use. However, the ways in which they are linked are not clear and beyond the scope of this research endeavor.

In terms of physical health (refer to Table 5-2), over three-fourths of all groups reported that their drug use resulted in such problems. Much of the perceived increase in confidence is related to users notions that their drug use helps to improve their physical appearance. From the users' point of view, one of the most immediate and beneficial effects of use is the loss of appetite and weight. Among the surveyed users, 86% of ice users, 68% of heroin users, 55% of ecstasy users and 42% of ketamine users reported a loss of appetite. About three quarters of heroin and ice users report weight loss. Importantly, it should be noted that interviewed heroin users report losing weight from lack of interest in eating regularly because of the drowsy effects of the drug whereas ice users find that the appetite suppressant quality of ice resulted in weight loss. Forty two percent of ecstasy users and 32% of ketamine users also report weight loss, and as noted earlier, this may be related to both the drug and the environment in which these drugs are consumed (e.g., physical energy and dance).

There are a number of less desirable effects reported from drug use. Across all groups, 60% or more of them reported having memory loss. Heroin and ice users were more likely to report suffering from chills than ecstasy and ketamine users. Sweats were reported by 25% of ecstasy users, 28% of ketamine users, 32% of heroin users and over 40% of ice users. Although few heroin users reported experiencing injuries, about 20% of ecstasy and ketamine users and 24% of ice users were injured as a result of their use. Disruption of menstruation was reported by 57% of heroin users, 36% of ice users and 20% of ecstasy and ketamine users.

Another consequence for ice users bears our discussion. International studies have shown that there is a connection between methamphetamine use and violent behavior.

While some laboratory studies indicate that amphetamines may result in amphetamine induced psychosis," case studies, qualitative research and animal studies suggest that the link between violence and ice is mediated by situational influences, particularly social isolation (See Parker 1998 for full discussion on studies). From the survey data shown in Table 5-2, 30% of ice users reported that their use resulted in violence related problems compared to 11% of heroin users, 15% of ecstasy users and 11% of ketamine users. A higher proportion of ice users also report their use being associated with aggression compared to heroin, ecstasy and ketamine users.

In relation to sexual activity, Table 5-2 shows, heroin users found their sexual activity diminishing (20%) and had difficulties in reaching orgasms (73%). Although 37% of ice users reported an increase in sexual activity, 26% of them also report difficulties in reaching orgasm. About 20% of ecstasy and ketamine users report an increase in their sexual activity. In terms of safe sex practices, as Table 5-4 shows, the proportion of surveyed female users across all groups who use condoms all the time is relatively small and as noted below, may be related to lack of awareness while under the influence.

Table 5-4*
% of Times in Last Year Used Condom By Type of Drug

% Times Used Condom	Heroin (n=155)	Ice (n=72)	Ecstasy (n=191)	Ketamine (n=176)
None	61.3	58.3	52.9	56.3
1-20%	4.5	4.2	11.5	11.3
21-40%	3.9	6.9	10.5	10.8
41-60%	9.0	18.0	20.4	15.9
61-80%	5.2	6.9	2.6	4.0
81-100%	16.1	5.6	2.0	1.7

* Totals may not sum to 100% due to rounding.

When users do use condoms, the principle reason cited is to protect against pregnancy. Across all user groups, over 60 percent of those reporting condom use indicated that they wanted to avoid pregnancy. Table 5-5 provides an overview of the pregnancy history of surveyed female users across all drug types. While nearly 70% of heroin users have been pregnant at least once, just under 40% of ice users have been pregnant. By comparison, far fewer ecstasy and ketamine users have been pregnant. Among those who have been pregnant, Table 5-5 suggests that the majority of users, irrespective of type of drug, continue to consume during pregnancy. Miscarriages are lower for heroin users and highest ice and ecstasy users. While over 70% of ecstasy users also report having an abortion, 67% and 56% of ice and heroin users respectively have had an abortion.

Table 5-5*
Pregnancy History

	Heroin	Ice	Ecstasy	Ketamine
% pregnant at least once	69.0	38.9	20.9	10.2
Total	155	72	191	176
% using alcohol or drugs during pregnancy	85.0	85.7	77.5	68.2
% miscarriage	11.2	29.2	32.2	23.3
% abortion	56.0	66.7	71.0	30.0
Total	107	28	40	44

* Totals do not sum to 100% as this question allows for multiple answers.

Among the surveyed heroin users, over 85% of them had been arrested and convicted on heroin charges, and gone to DATC. Over one-half of them had been placed in other institutions. Over 30% of them had been arrested and convicted for other offenses as well. Among ice users, over one-third of them had been arrested and convicted on drug related offenses. Nearly 40% of them had been on probation and sent to DATC for treatment. The higher proportion of heroin users being arrested and convicted on drug charges compared to ice users may be related to the former groups higher public visibility in purchasing and consuming heroin.

The survey data suggest that female drug users across all groups, but at varying levels, experience a number of problems as a result of their use, in relation to significant others, with work and school, and in terms of the mental and physical well health.

Impact of Occasional Versus Frequent Use

An important dimension in assessing the impact of drug use is the frequency of use. We hypothesized that occasional users are more likely to have a positive attitude towards drug use than frequent chronic users. Moreover, we hypothesized that occasional users are more likely to have limited cognition towards drug use than frequent chronic users. Table 5-6 presents the results of our chi square tests of drug use by frequency by consequences and controls for whether the user had children, parents or partners/spouse. The value in the column refers to the proportion of yes response of respondents towards the corresponding issue concerned. Occasional use is defined here as 50 times or less in the past year. Frequent use is defined as 51 times or more in the past year. The difference of their significance is listed on the right column and those being highlighted show whether there is a great difference between occasional and frequent drug users statistically.

Table 5-6
Drugs of Choice By Frequency of Drug Use By Consequences

Type of Drug	Occasional	Frequent	Significance
Heroin			
1) relationship	0.72 (60)	0.92 (132)	**0.000**
2) children	0.79 (14)	0.91 (57)	0.186
3) work/school	0.58 (26)	0.77 (66)	0.075
4) sexual behavior	0.50 (60)	0.89 (132)	**0.000**
5) mental health	0.88 (60)	0.86 (132)	0.819
6) health affecting	0.90 (60)	0.95 (132)	0.232
ICE	Insufficient Data		
Ecstasy			
1) relationship	0.65 (234)	0.75 (60)	0.167
2) children	0.78 (23)	0.58 (12)	0.258
3) work/school	0.68 (138)	0.58 (38)	0.252
4) sexual behavior	0.30 (234)	0.52 (60)	**0.004**
5) mental health	0.80 (234)	0.88 (60)	0.190
6) health affecting	0.75 (234)	0.93 (60)	**0.001**
Ketamine			
1) relationship	0.64 (211)	0.68 (97)	0.606
2) children	0.80 (25)	0.47 (17)	**0.045**
3) work/school	0.70 (122)	0.62 (69)	0.263
4) sexual behavior	0.34 (211)	0.42 (97)	0.203
5) mental health	0.82 (211)	0.80 (97)	0.754
6) health affecting	0.75 (211)	0.84 (97)	0.106

Occasional : 50 times or less in the last year
Frequent : 51 times or more in the last year

Several findings are noted. First, frequent heroin users are more likely than occasional heroin users to report having problems in their relationships and altered their sexual behavior during the past year as a result of their use. Second, occasional ecstasy users are more likely than frequent ecstasy users to report that their use in the past year has affected their sexual behavior and physical health. Third, occasional ketamine users are more likely than frequent ketamine users to report that their use in the past year has affected their relationship with their children. As highlighted in the table, these findings are statistically significant. The majority of ice users were occasional users, and therefore, there was insufficient data to conduct a statistical comparison.

Table 5-7
Drug Type By Consequences

Type of Drug	Ice or/and Heroin	Ecstasy or/and Ketamine	Significance
1) relationship	0.90 (172)	0.60 (256)	**0.000**
2) children	0.84 (25)	0.44 (16)	**0.014**
3) work/school	0.75 (77)	0.62 (170)	0.058
4) sexual behavior	0.77 (172)	0.20 (256)	**0.000**
5) mental health	0.84 (172)	0.77 (256)	0.111
6) health affecting	0.94 (172)	0.71 (256)	**0.000**

Note: Two groups are mutually exclusive from each other and those with both drugs consumption have been excluded from our analysis due to the limited figures.

We had hypothesized that female users of ice and/or heroin were more likely to experience negative consequences from their use than female users of ecstasy and/or ketamine. We conducted the following analysis to examine this issue. Generally female users of ice and/or heroin are more likely to experience negative consequences from their use than female users of ecstasy and/or ketamine in terms of their family relationship, their child, at work or schooling, mental and physical health as well. Also, a significant difference was reported in their relationship amongst family member and it is noted that ice and/or heroin users are involved in more problems with sexual consequences and health problems as a result of their use**.**

In-depth Interviews with 60 Female Drug Users

In this section, we provide a qualitative discussion of the problems and consequences associated with use from the perspective of the female drug users with whom we conducted in-depth interviews.

Relationships

Among the interviewed female heroin users, the majority of them are involved in personal relationships with other heroin users, finding it difficult to stay in a relationship with a "normal" partner. Most few "normal" men would tolerate having a partner who used heroin. One heroin user recounted the demise of her last "normal" relationship:

> One day, my partner complained about my use. We had been together for two years already and I didn't keep heroin at home, only at work. He said that he hated me because I was a heroin addict. We had a fight and he said that he would never have a drug addict partner. I was hurt. I don't know why he changed. He knew that I took heroin. But we seldom talked about it. (D08)

Heroin and ice users also report that their use created problems and tension with their families. One 30 year old woman, who uses heroin and ice described the deterioration of her relationship with her father and sisters when they discovered that she started injecting heroin:

> After I started injecting, I dared not to go home to see my parents. I remember, one day, when I was having tea with my sisters' families, my brother-in-law asked me what happened to my arms. I was so embarrassed. I told them that I got a disease, was bitten by mosquitoes. I'm sure they knew I was injecting. My dependence got deeper and deeper. I had to go home to ask for money. I told them that I needed the money because I was in debt. If I didn't return the money, someone would come to chop me. My mother was easily convinced and gave me some money. But my father was very angry with me and said he couldn't care less if I was killed. My sisters also hated me very much and wouldn't come to see me. They thought I brought too much trouble to the family. They wouldn't allow me to see their children. (B12)

Over one-half of ecstasy and ketamine users also report having problems with relationships, especially with parents and siblings. From our in-depth interviews,

problems tend to develop with family members upon discovery of their use. An 18-year old ecstasy and ketamine user, recalls her father's negative reaction:

> My relationship with my family was bad when I took drugs. I ran away from home for some time…I ran because my father read my diary and learned of things. My father called me many times. He said if I didn't come back now, I shouldn't ever return. He could be very difficult if he is angry. He beat me so hard that I had to go to the emergency room. I didn't return home, packed up my clothes and went away the next day…He once slapped me for ten times very hard. My mother held me and my brother stopped him. (D03)

This father's reaction was more extreme than those reported by others. Among those interviewed who used ecstasy and ketamine, approximately one-half of their family members did not know of their child's use. Among those who did know, their parents typically scolded or punished their daughter, and refused to give her money, believing it would be spent on drugs.

Children

As noted in the survey data, few ice, ecstasy and ketamine users have children, however, 41% of heroin users had children. Approximately 30% of the heroin users who we interviewed reported having children. One heroin user believes that the drowsy effects of heroin are problematic in looking after her children:

> In the first few years, I liked the comfortable feeling it gave me. But now I have no feeling even after taking a big dosage. I liked the 'sleepy' feeling when I was young. But now I can't let my daughter and son find me in that 'sleepy' condition. So I have to try hard to control myself. The feeling is bad. I feel that I suffer everyday. I felt that I was suffering from great and unbearable pressure. (D10)

From our in-depth interviews, women who had children tended to rely on their parents and in-laws for child-care. One woman recalls her experience when she gave birth to her daughter:

> After I gave birth, we moved to a flat owned by my in-laws. They knew that my husband and I took heroin but they still treated us well. I knew that deep down they didn't like me since I had introduced my husband to heroin. But they love their granddaughter so much. They hoped that if we moved, we would change. But unfortunately, we didn't. My father in law helped to find a job for both of us, and at first we worked very hard, but we quit after a year. My in-laws were very disappointed. They thought we had quit. I think we quit because heroin was making us lazy and we lacked energy to work. It's impossible for us to do some regular routine work. We borrowed money from his parents, at first they didn't want to lend it, but later they worried that we would do illegal things to get money, so they sent us money every month. My husband's family was so angry because we were unproductive. We felt so bad. I went back to work in the karaoke and my

husband went to work in the drug store so we wouldn't have to ask for money. (B04)

As her experience demonstrates, there is a distinctive paradox as family members try to help with child-care and finances, but at the same time, this support enables them to continue using. This paradox has been noted in female drug research among Asian Americans in the U.S. (Joe 1995).

Work and School

As we described in Section 4, heroin users, and to a lesser extent, ice users find it difficult to maintain a legitimate job with continued use - failing to show up for work, falling behind in their duties, and being discovered by colleagues. Several ice users reported either being terminated from their jobs or quitting because they disappeared into the bathrooms too often and annoying their colleagues. As legitimate job opportunities become increasingly restricted, some turn to alternative forms of work like working in nighclubs.

> I worked in a factory doing packing for a year. Then I also worked for a company doing accounting. Then, one of my estate friends introduced me to work as a PR in a night-club. I could earn more than before. I started using heroin again. I was 17 or 18 years old. At that time, many PR girls liked taking drugs. We didn't need to think and couldn't remember anything. It helped us to sleep. It's very common in the night-club. However, the unconsciousness feeling was not good. (B09)

Although over 60% of ecstasy and ketamine users also report having problems in this area, it is principally in relation to school with over one-third of them reporting poor performance or dropping out of school. This finding is further illustrated by this 17–year old girl's use in school:

> I used ketamine at the disco, but also at school. My teachers knew it too. I fell down on the floor after eating ketamine several times in Form 2. My teacher told me that there were many teachers who were 'afraid' of me then. She said that I sometimes looked at the window, smiling at myself. But when they looked out the window, there was nothing there. Sometimes I scolded the junior students. My conduct mark at the time was very negative. The school wouldn't kick me out, but the teachers wouldn't let me attend the lessons. That's why I didn't go to school so often. In Form 3, I challenged myself, and dressed tidily and got to class on time. They were surprised by my change, and thought I had changed to be a good student, I tried to behave because I didn't want to get kicked out, but I still used ketamine, and played with my friends in the park. I just controlled myself. I sold it in school too. (E03)

This finding is particularly important given that some users, as described earlier, have started using ketamine to cope with their perceived boredom and pressures at school.

Mental Health

As one woman recalls, she took heroin to get away from her problems, which helped build her self-confidence and self-esteem. But after prolonged use, she ironically felt the opposite, that her confidence and self-esteem were diminishing. This became a vicious cycle.

> I: you said you took heroin to get away from some problems. What problems do you want to avoid the most?
>
> R: The worst thing is that I always think I'm a looser. I have nothing good. I don't have a good boyfriend. I have no career. I can't go home. I don't have genuine friendship. All my friends are bad guys. There are the worst things that I avoided to think of. (A19)

Ice data from our in-depth interviews suggest that this "suspicious" feeling becomes very apparent with prolonged use. The most typical example cited by ice users was the feeling that someone was watching and following them, usually other drug users or the police. A 23-year old woman recounts her experience with hallucinations and her growing obsession with it:

> There was always a sound around me and I asked my mother but she said she did not hear. That time, I began to think that even she betrayed me…my mother sent me to hospital for mentally disorder people. I began to be more conscious and listen more clearly. I wanted to find the origin of the voice inside me. And I found that it made me very annoyed and depressed because that voice has disturbed my life and made me feel totally exhausted… The doctor told me that I had mental disorder which is a side-effect of ice. Some people will have that for the rest of their life. (A17)

Another young woman had a similar experience, and sought a doctor's help:

> At the time, I expected that if I took ice, it would help me to cure my addiction with heroin. I had seen someone else taking it and it didn't seem like a big deal. But I found that I could not handle it since the illusions became very serious. After a year of using it, I was having very serious illusions. I kept illusioning that somebody was calling me, asking me to die. I felt that everyone besides me was not being good to me. My husband asked me to see the doctor after knowing I had the illusions. The doctor gave me some medicine to stop the illusions, and to help repair the damage from taking drugs for so long. (A17)

The ecstasy users in our in-depth interviews all used ketamine, pointing to the inseparability of these two drugs. Hallucinations, depression and anxiety are among the most often reported problems. As these users describe, the feelings are discomforting, but do not prevent them from continuing to use the drugs.

> My heart would beat faster and harder. When I had got too much, my eye would be twice as big as now but I would not be able to talk. My hands would shake. There was a time when I saw my vein was green and became a lot bigger. I was

> so afraid that the drugs had got into my bones. I stared to feel worried and scared. I needed to hug my friends and hid before I could gain a sense of security again. (D03)

> I started using ketamine a few weeks after I started using ecstasy. I remember that I took it in a disco in Tseun Wan. I still had hallucinations after eating it for a few hours. I was chatting with my friends on the phone and I talked with another 'person' at home. I asked the person to dry his hair. My friend asked me if there's anyone in my home. I told her that there's no one there except me. She was so confused. (E02)

> I have seen some illusions. Once I saw some elderly people walking in the corridor. And there was another time when I crossed the road and 'saw' a car crashing into me. I hurried to pull my friend back, but I found out later that there was no car at all. And there was always someone calling my name. (D01)

Self-image and appearance is a major preoccupation for all female drug users, and for ice and some ecstasy users as we described earlier, is an important motivation for continuing to use. However, they tend to recognize that while their use helps maintain their "beauty," it also has negative consequences on both their physical and mental health, and ultimately has a negative effect on their appearance. Some heroin users describe similar feelings as this woman, who has used heroin for the past 20 years:

> I am the kind of person who is very aware of my appearance. However, heroin has bad effect on my skin. I need to use much extra money to buy Chinese herbs to rescue the situation. I drink many soups to keep my appearance. I can't let myself get ugly. Heroin helps cover my health problems. However, when you stop taking it, all the illness appeared again. Although I seldom suffered from withdrawal, I have terrible emotional problems. I always want to die. I am so disappointed in myself. I lost all my enthusiasm in life. I don't want to bring any trouble to my family. (B10)

Another mental health issue requires our focus. Based on our in-depth interviews, some female users have wanted to die, with some attempting suicide.. One woman who has used heroin for ten years and ice for four years, describes her feelings:

> Last year, I tried to commit suicide with my friend. We took over 100 tablets of triazolam. She was my best friend. We were trafficking together. We thought that we had no future, no hope. We knew that we might get caught one day so we decided to die together. We took ice before we made the decision… I tried to commit suicide many times before. I liked to cut my arms. But I don't think that I really wanted to die before. I just wanted to experience the feeling of pain. But that time last year, we really had the clear aim, we were going to die. Later, when we were in the hospital, we gave up the idea and ran away. We went off to take heroin immediately. So I think heroin is better, ice hurts your brain cells. The hallucinations are bad. (B11)

Another young woman, who also used heroin and ice, described her attempt to commit suicide after seeking help for her drug problem.

> At my husband's urging, I went to the Hospital to get help with my drug problem. But I didn't have the determination. I couldn't get rid of the feeling of wanting to use. I left the hospital, bought some pills, and attempted to commit suicide. Luckily I failed and my husband rescued me. After that, I went back to the hospital for medical treatment, and stopped taking it for several months. I got a job, but I lost it when I started using drugs again. (A17)

For some users, like these two women who have been using heroin or ice for sometime, view the negative impact of their use as the reason for wanting to die. Their decision to attempt ending their life seemed to take on an immediacy with recognition that their life was being controlled by their drug use.

Physical Health

Among the interviewed female drug users, heroin and ice users report appetite and weight loss. Some heroin users indicated that this was due to a lack of interest in eating while feeling sedated from heroin. Similarly ice users all reported losing weight, and as noted earlier, this is likely due to the combined effects of the drug in depressing appetite and stimulating physical activity. While some ecstasy and ketamine users attribute the weight loss to the drug itself (perceived direct effect of the drug), others believed it was due to the physical activity (e.g., dancing) related to using. From our in-depth interviews, this weekend ecstasy and ketamine user tells us:

> When I started using ecstasy, I lost 20 pounds in three months. At that time, I was only 125 pounds. I got very thin. And all the girls said that I was very fit. I didn't change my eating habits, but maybe I lost weight because I danced for the whole night and it helps me to burn the fat. It's really very effective. (E01)

It is beyond the scope of this study to determine whether the weight loss is due to the drug itself or the activities associated with the use of these drugs. International studies show that stimulant drugs result in decreased appetite and increased physical energy and it is likely that weight loss may be related to a combination of these two effects (Freese, Miotto and Reback 2002).

Violence

From our in-depth interviews, with only a few exceptions, the female ice users whom we interviewed, had witnessed violence among their drug using peers. Fifty four percent of them reported being directly involved in violence. For example, one woman who is in her 20s, and used heroin and ice for over ten years describes this violence:

> When I was unhappy, I would use ice…Later, I found my personality change dramatically. After I took ice, I would walk down the street, I didn't know where to go. I just walked for many hours…Sometimes I would go to the rooftop and cry

> loudly. I would beat myself and hope to get a painful feeling. Actually, at that time, my ex-boyfriend also took ice. His personality also changed a lot. He became very selfish. He would beat me up when he got high. It's very interesting. I would let him hit me. Sometimes, I was badly beaten and my eyes were black and swollen. Sometimes, he would push my head to the wall. I didn't know why I let him do that. (B9)

From our in-depth interviews, we have also found other forms of violence involving ice use. In the case of an 18-year old user, she had been using ice for the first time along with her regular drug of choice ketamine:

> I: Have you faced any danger after taking drugs?
> R: I think the last time I had drugs was the most dangerous. I mixed ketamine and ice together. The effects were so strong that I felt dizzy and I could not even move my finger. I lay on the ground and vomited. I was not able to walk.
>
> I: Was that the first time you had ice?
> R: Yes. The first and the last time…I felt nothing after I took ice at first, so I took ketamine. I didn't know they couldn't be mixed. The effects came so fast and I fell on the ground then. I was frightened. I thought of death. It seemed I was in the other world. It seemed I was controlled, but I could still speak. I still want to vomit after I woke up the next morning. I promise myself to get rid of drugs and discos since then… I was sexually abused by my friend that night. I was scared to death… I don't want to talk about it… (E03)

Although it is impossible to disentangle the effects of their ice use with heroin and ketamine use, as noted above, other studies have documented a link between ice and violence. Importantly, the users' quoted above recognized the differential effects of ice compared to heroin or ketamine on their own subjective experiences.

Sexual Behavior

From our in-depth interviews, heroin users reported that their interest in sex declined as they became more dependent on heroin. This was due, according to their descriptions, to their constant and overwhelming feeling of sedation from heroin.

Based on our qualitative data, users observe that while under the influence, they tend to have a "blind faith" towards sex generally and safe sex in particular. Because her heroin use had disrupted her menstruation, this woman found her pregnancy to be unexpected:

> When I was 20, I was pregnant. It was an accident. We didn't plan it. Both of us took heroin, we assumed that the chance for me to get pregnant would be very low. So, we never used condoms or other measures to avoid pregnancy. My period only came once every few months. So none of us expected it to happen. (B04).

Although few surveyed users reported contracting sexually transmitted diseases, our in-depth interviews suggest that users tend not to recognize the symptoms until they are required to see a doctor because of treatment. One woman describes how, as a heroin addict, she felt she had little choice in using a condom.

> The doctor here said that I had sex disease. You can't insist to use a condom when you need money. When I suffered from cold turkey and I really needed money to buy heroin, I was not allowed to choose the clients. I had to have sex with them even if they rejected to use a condom. (B12)

So although users want to protect themselves, their options are shaped and constrained by their customers and by their drug dependency.

Among ecstasy and ketamine users, our in-depth interviews suggest that what might be interpreted as promiscuity may actually be a decrease in the level of awareness while under the influence. According to this young woman, the combined effects of the dance drug scene lessens male's and female's inhibitions:

> Over 95% of people in discos are using drugs. The boys like to take advantage of the girls. They come and dance with you, hugging and groping. They touch girls' bottoms. But the girls don't mind because everyone, boys and girls are high in the disco. (E06)

None of the ecstasy and ketamine users, however, reported an increase, decrease or change in their sexual activity. From the discussion above, what may appear to others as a "relaxed" attitude toward sex is, from the users' perspective, is a reflection of the effects of the drug, drug cultural perceptions about the inability to become pregnant in the absence of menstruation, and the need to earn money..

Criminal Record

The majority of heroin users in our in-depth interviews had been arrested and convicted on drug related charges. Our in-depth interviews with ice and heroin users indicates that ice use is typically purchased and consumed in very private settings whereas heroin tends to be bought in public settings, making detection easier. Only one of the five users who used only ecstasy and ketamine had been arrested on drug charges.

Frontline Workers Perceptions of Problem Recognition Among Female Drug Users

This section describes problem recognition by users from the point of view of frontline workers who have first hand and comparative experience in working with users at different stages of use and associated problems. For female heroin users, the recognition of a problem with their use becomes readily apparent when they suffer from withdrawal symptoms. However, this contrast with ice users, who although they become increasingly edgy, do not present such transparent physical symptoms. Frontline workers observe the differences between heroin and ice users, finding the latter to be more likely to view their use as unproblematic.

> With heroin, the withdrawal symptom is shivering. But they know what is happening, they are totally conscious of their surroundings. But ice users are totally unconscious about what they are doing. (F5-1)

> Ice can harm your mental health very quickly. But unlike heroin users, ice users don't know they have problems. The chances of them being caught for ice is less as well because they "appear" more normal than heroin users. So there are many potential "bombs" on the street. They become psychotic. We've seen some suicide cases, including a couple who jumped after taking ice. (F4-2)

Moreover, when ice users report symptoms like paranoia and hallucinations, they may disregard or downplay these symptoms if others are not aware of a drug use problem. As one treatment worker notes, general cultural expectations of female behavior like gossiping may ironically be used by ice users to deny the existence of a problem:

> I think female ice users are less aware about the problems of using ice. Perhaps, it is because of the personality and experiences of women in general. You know, like, when they feel that some people are talking bad about them, they may think it is normal. Because in normal times, women are usually very sensitive to what others say about them. So when they get symptoms, they may reinterpret that as they are being overly sensitive about nothing. (F4-1)

This treatment worker recalls one of her client's experiences:

> She heard that other people were saying bad things about her (paranoia), she saw ghosts and she thought that many police were chasing her. However, other people couldn't see that she had taken ice since she still went to work, her face was still pretty and she could do all her social activities. Ice users aren't as pale and weak as heroin users. You know, a heroin user's face is very dark and yellow. Some of the ice users get "ice pimples" but if she is a clean and tidy lady, she can use make-up to cover it. No one can see anything strange. In this situation, her friends, family and colleagues didn't know she had a problem and she continued to use, and persuaded herself that it wasn't a problem. (F4-2)

Ecstasy and ketamine users tend to not recognize problems with their use, principally because they believe these two drugs are not addictive and that their use is controlled. Treatment workers observe:

> Among female users, heroin users know they have serious problems. However those using ecstasy and ketamine don't think it's a problem. They think that they just play and take occasionally. And the fact is that they really only take those kind of drugs occasionally. So I think 90% of my clients think that they will take ecstasy and ketamine again after being released. (F5-1)

Treatment workers confirm the view of users who believe that ecstasy and ketamine are not addictive, and can therefore be used in a controlled and unproblematic manner.

Summary

The survey data and the in-depth interviews confirm that female drug users experience a number of problems in their relationships with others, particularly with their parents and siblings, and at work or school because of their use.

In terms of criminal justice action, heroin users were more likely to be arrested on drug offenses than ice, ecstasy and ketamine users. This may be related to the fact that heroin is typically purchased in highly visible public locales, making users easier to detect. Because ice is bought and consumed in private settings, police detection is less likely to occur. Although ecstasy and ketamine are typically bought and consumed in public settings, the public nature of users' activity does not seem to result in criminal justice action, as both of our data confirm, only a small proportion of ecstasy and ketamine users have been arrested for any offense.

Both sets of data also confirm that female drug users experience weight loss, and as such, they perceive this to be beneficial to their appearance and self-confidence. However, this is countered by a number of consequences mental and physical health problems as a consequence of their use, most of which, they perceive as negative.

Section 6: Outreach and Treatment Experiences

In this section, we first examine female users attempts to quit using, focusing on the motivations, obstacles and ways of accessing help. We then turn to the treatment experiences, examining the number of times and likes and dislikes. In the final section, we focus on the perceived successes and difficulties in the treatment experience for female users. The survey data are presented first, followed by a discussion from our in-depth interviews and focus groups with treatment workers where relevant.

Survey with 500 Female Drug Users

Trying to Quit

Table 6-1 reports on the number of times the surveyed female users tried to quit using drugs.

Table 6-1*
Number of Times Tried to Quit

# of Times Tried to Quit	Heroin (n=155)	Ice (n=72)	Ecstasy (n=191)	Ketamine (n=176)
None	4.5	13.9	49.7	55.7
1-2	11.6	29.2	24.1	13.1
3-4	9.0	23.6	11.0	13.6
5-6	14.2	12.5	11.0	9.6
7+	60.6	20.8	4.2	8.0

* Totals may not sum to 100% due to rounding.

As shown, nearly all heroin users have tried to quit, with 60 percent of them having tried to quit seven or more times. Among ice users, slightly over 50% have tried to quit between one and four times, but another 20% have tried seven or more times. By comparison, about one-half of ecstasy and ketamine users have not tried to quit at all. This difference is largely due to the perception among ecstasy and ketamine users, noted earlier, that their use is unproblematic and controlled.

Motivations to quit

Table 6-2 shows the main reasons for the different types of drug users to try quitting.

Table 6-2*
Main Reason Tried to Quit By Drug Type

1st Main Reason Tried to Quit	Heroin (n=148)	Ice (n=62)	Ecstasy (n=191)	Ketamine (n=176)
Family	31.8	19.4	15.6	20.5
Financial	1.4	1.6	-	-
Health	4.7	14.5	20.8	18.0
Social Worker Support	-	-	5.2	6.4
Work/Study	-	11.2	16.7	11.5
Court Order	43.2	30.6	18.8	18.0
Tired of Habit	18.9	22.6	22.9	25.6

* Totals may not sum to 100% due to rounding.

The most significant reason for heroin and ice users to obtain help is the imposition of a court order requiring treatment. Far fewer ecstasy and ketamine users have not tried to quit. Among those who have tried, however, the two most frequently reported motivating factors include being tired of the habit, health considerations, court orders and family.

Obstacles to Getting Help

As evidenced in prior sections, ecstasy and ketamine users tend to perceive that their use is not problematic and controlled. Moreover they feel that they can quit on their own without outside intervention. Therefore, they are unlikely to identify obstacles or barriers to getting help. According to the survey data, about 90% of ecstasy and ketamine users did not identify a barrier in getting treatment (Table 6-3). Among ice users, 60% of them did not identify any barriers.

Table 6-3
Most Important Barriers to Getting Treatment by Drug Type*

Most Important Barriers To Getting Treatment	Heroin (n=133)	Ice (n=29)	Ecstasy (n=16)	Ketamine (n=19)
Lack knowledge of services	16.5	24.1	-	5.2
No openings/Long Wait	13.5	10.3	6.2	10.5
No appropriate treatment	12.0	3.4	-	5.2
Fear withdrawal	29.3	31.0	25.0	52.6
Don't want addict methadone	28.6	24.1	-	5.2
Drug lifestyle interferes	11.3	24.1	13.0	10.5
Partner's addiction	24.1	27.5	68.8	31.6
Don't want family to know	33.8	27.5	37.5	47.4
Work schedule conflict	29.3	6.8	-	26.3
Lack transportation	1.5	6.9	-	5.2
Financial	18.0	13.8	-	-

* Respondent may answer more than one category.

There were some similarities and differences among those female users who felt there was a barrier to their treatment. For heroin users, the main obstacles included not wanting family to know about their drug problems (34%), fear of withdrawal (29%) or methadone addiction (29%), work schedule conflicts (29%) and partner's addiction (24%). Among ice users, fear of withdrawal (31%), partner's addiction (28%) and not wanting family to know (28%) were among the three most important barriers to accessing treatment. As noted earlier, many ecstasy and ketamine users do not perceive or recognize their use as a problem, and only 8% and 11% of ecstasy and ketamine users respectively saw obstacles to getting treatment. Although few ecstasy users did not perceive any problems nor barriers, those who did report their partner's addiction (69%) and not wanting family to know as the most significant obstacles (38%). For ketamine users, fear of withdrawal (53%), not wanting family to know (47%) and partner's addiction (32%) were among the most important barriers.

Accessing Help

Table 6-4 reports on the number of surveyed female drug users who had contact with a frontline worker about information regarding drugs, accessing services or counseling.

Table 6-4
Contact with Drug Workers for Services by Drug Type

	Heroin (n=155)	Ice (n=72)	Ecstasy (n=191)	Ketamine (n=176)
#ever contact drug worker for information	69 (55.0%)	33 (45.8%)	43 (22.5%)	39 (22.2%)
# found useful	31 (44.9%)	21 (63.6%)	22 (51.2%)	19 (56.4%)
# ever contact drug worker for counseling	65 (41.9%)	43 (59.7%)	76 (39.8%)	49 (27.8%)
# found useful	31 (47.7%)	27 (37.5%)	51 (67.1%)	25 (51.0%)
# ever contact drug worker to access outpatient	37 (23.8%)	10 (13.9%)	5 (9.8%)	1 (0.6%)
# found useful	20 (54.1%)	5 (50.0%)	3 (60.0%)	1 (100.0%)
# ever contact drug worker to access inpatient	45 (29.0%)	9 (12.5%)	7 (3.7%)	6 (3.4%)
# found useful	30 (66.7%)	5 (55.5%)	7 (100.0)	6 (100.0%)

A higher percentage of heroin and ice users have been in contact with drug workers to obtain information, counseling, access in-patient and out-patient services than ecstasy and ketamine users. Fifty-five percent and 46% of heroin and ice users respectively have obtained information about drugs and services compared to 22% of ecstasy and ketamine users. Contact with drug workers for counseling shows a similar pattern, with over 42% and 60% of heroin and ice users respectively obtaining counseling. However, a slightly higher percentage of ecstasy and ketamine users (40% and 28% respectively) have received counseling compared to solely receiving information about drugs and services. Twenty-four percent and 14% of heroin and ice users had contact with a frontline worker to access out-patient services compared to 10% and 0.6% of ecstasy and ketamine users respectively. Similarly, 29% and 13% of heroin and ice users contacted a drug worker to obtain in-patient care compared to 4% and 3% of ecstasy and ketamine users. Among this group of drug users who had contact with a frontline worker for information or assistance with services, a relatively high proportion found the services useful. With only a few exceptions, about 50% or more of the different user groups found the various services useful. Just under 40% of ice and ecstasy users found drug counseling useful.

Treatment

As Table 6-5 shows, there are significant differences in getting treatment among different female drug user groups. Surveyed heroin users appear to have the most extensive experience with treatment. The majority of them have gone to DATC at least

once (81%) or been to a non-DATC (53%). Over 40% of them have been through methadone detox (48%) and methadone maintenance (41%). For those heroin users who have been to DATC, over 80% of them have spent between two to three months at the facility (data not shown). For those who have been to a non-DATC, slightly under one-half have stayed for the same period of time. Approximately 30% of them have stayed less than 60 days in the non-DATC.

Table 6-5*
Percentage of Those Experiencing Different Treatment By Type of Drug

	Heroin (n=155)	Ice (n=72)	Ecstasy (n=191)	Ketamine (n=176)
% DATC	80.6	39.0	8.9	12.5
% Non-DATC	53.0	35.0	6.3	8.5
% Methadone Detox	47.8	8.3	1.0	3.4
% Methadone	41.2	16.7	0.5	3.4
% Outpatient Counseling	23.0	12.5	0.5	0.5
% 12 Step Program	1.9	1.4	0.5	0.6
% Private Doctor	17.0	5.5	0.5	2.2

* Respondents may answer more than one category.

Compared to heroin users, fewer surveyed ice users have been to treatment with 39% and 35% of them having gone to DATC and non-DATC respectively. For ice users who have been to the DATC, 55% of them have stayed between two to three months (data not shown). Twenty three percent stayed more than three months. For those who spent time at a non-DATC, 36% stayed between two and three months and 44% stayed for more than three months. As noted earlier, most ecstasy and ketamine users do not perceive themselves as having problems with their use, and consequently, it is not surprising that few have been through any treatment program.

Table 6-6
Received Treatment By Drug Use

Count

		type		
		heroin	psychotropic	Total
treatment	no	84	253	337
	yes	71	112	183
Total		155	365	520

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	10.908(b)	1	.001		
Continuity Correction(a)	10.255	1	.001		
Likelihood Ratio	10.704	1	.001		
Fisher's Exact Test				.001	.001
Linear-by-Linear Association	10.887	1	.001		
N of Valid Cases	520				

a Computed only for a 2x2 table
b 0 cells (.0%) have expected count less than 5. The minimum expected count is 54.55.

Table 6-6 provides the analysis on the majority experience (30 poly-drug users were excluded from the analysis). About 46% of heroin users reported receiving treatment which is comparatively higher than psychotropic drug users (31%). This finding was statistically significant at the .001 level. This suggests that female heroin users are more likely to access treatment than female psychotropic drug users.

Table 6-7
Factors Related to Getting Treatment

Table: Adjusted odd ratios estimated from logistic logit regression model, risk factors for treatment assessment

Factor		Odd Ratio	95% CI		P-value
Child	Yes	0.549	0.324	0.932	0.026
	No	1	-		-
Sex Work Engagement	Yes	2.337	1.096	4.985	0.028
	No	1	-		-
Ice Consumer	Yes	2.962	1.693	5.181	0.000
	No	1	-		-
Sexual Difficult due to Drug Use	Yes	5.186	3.323	8.094	0.000
	No	1	-		-

A backward selection method was employed to determine the significant risk factors that may affect those drug users in treatment assessment in the presence of the other variables. Table 6-7 provides the logistic regression with forward selection procedure to analyze factors related to obtaining treatment. The following factors were considered:

1) Demographic factors
Age Group, Child, Current Martial Status, Self-Living, Partner, Education, Sex Work

2) Drug type considered
Alcohol, Tobacco, Ice, Ecstasy, Ketamine, Heroin

3) Difficulties due to the drug consumption
Family relations, Sexual behavior, Mental health, Physical health

Four factors were found to be statistically significant in distinguishing those active help seeking group from others. Our analysis presents that female users who don't have children have a greater probability of obtaining treatment than those who do. Users who engaged in sex work during the past 12 months are more likely to obtain treatment than non-sex workers. Ice is an important factor in distinguishing between those who obtain treatment and those who do not. Users who report that their drug use has affected their sexual behavior are more likely to seek treatment than those who do not. Other factors, listed above, but do not appear in the table were reported to be insignificant in selection procedure.

As Table 6-8 shows, the majority of female drug users surveyed, regardless of primary drugs of choice, found their parents to be the major source of support during the treatment process. Other significant sources of support included siblings and partners.

Table 6-8
Persons Supporting During Treatment By Drug Type*

Persons Supporting **During** Treatment	Heroin (n=144)	Ice (n=39)	Ecstasy (n=26)	Ketamine (n=27)
Parents	84.0	76.9	76.9	96.3
Siblings	52.1	53.8	50.0	44.4
Partner	50.7	58.9	61.5	37.0
Friends	33.3	43.6	26.9	51.9
Treatment Worker	20.6	43.6	26.9	18.5
Church	6.3	2.3	19.0	3.7

* Respondent may answer more than one.

This finding bears emphasis as we shall see below, treatment workers have also noted above, that female users are motivated to seek help, not solely because of court orders, but because of their parents.

After Treatment

Users continue to identify parents as the major person supporting them after treatment across all groups.

Table 6-9
Persons Supporting After Treatment By Drug Type*

Persons Supporting **After** Treatment	Heroin (n=144)	Ice (n=39)	Ecstasy (n=26)	Ketamine (n=27)
Parents	75.7	69.2	95.5	79.2
Siblings	41.7	41.0	54.5	20.8
Partner	48.6	10.3	50.0	33.3
Friends	36.1	38.5	59.0	45.8
Treatment Worker	20.4	48.7	54.5	25.0
Church	8.3	15.4	-	12.5
Not answered	-	10.3	18.2	12.5

* Respondent may answer more than one.

As Table 6-9 shows, about 70% or more of all user groups found their parents supportive after the treatment. Over 40% of heroin users also found siblings and their partners being supportive, although as discussed earlier, many female heroin users are involved in relationships with other users. Among ice users who've been in treatment, over 40% of them reported siblings and treatment workers as sources of support. For ecstasy users, about 50% or more of them found friends, siblings, treatment workers and partners as being supportive after treatment. For ketamine users, 46% of them found support from friends.

Table 6-10*
Experiences After Treatment

	Heroin (n=144)	Ice (n=39)	Ecstasy N=26)	Ketamine (n=27)
% Able to Obtain Employment After Treatment	61.0	46.2	53.8	59.2
Most Important Problem After Treatment				
None	38.9	53.8	69.2	63.0
Financial	4.8	2.6	-	-
Family	3.5	-	-	-
Social Relationships	9.7	12.8	11.5	11.1
Employment/study	11.8	7.7	3.8	7.4
Mental Health	26.4	20.5	15.4	18.5
Relationship w/partner	4.8	2.6	-	-

* Totals may not sum to 100% due to rounding.

Upon leaving treatment, a relatively high percentage of them are able to find work after treatment. Over 50% of heroin, ecstasy and ketamine users reported obtaining employment after treatment. Slightly fewer ice users (46%) found a job after completing treatment. Fewer users across all groups reported employment or studies as their most important problem after treatment. Aside from employment and studies, mental health issues continue to concern some users. About 26% of heroin users, 21% of ice users, 19% of ketamine users and 15% of ecstasy users indicated that mental health issues was the most important problem they faced after treatment. It should be noted, however, that 39% of heroin users, 54% of ice users, and over 60% of ecstasy and ice users reported that they did not have any major problems after treatment.

Table 6-11*
Views of Users Experiencing Treatment on Programs

	Heroin (n=144)	Ice (n=39)	Ecstasy (n=26)	Ketamine (n=27)
Program Best Suited For Your Needs				
None	6.9	28.2	15.4	18.5
DATC	25.0	10.3	7.7	3.7
Non-DATC	43.1	41.0	34.6	51.9
Methadone	9.7	2.6	-	-
Outpatient Counseling	-	-	-	-
Private	8.3	5.1	3.8	7.4
Other	6.9	12.8	38.5	18.5
Most Helpful Program?				
None	6.2	28.2	42.3	11.1
DATC	23.6	12.8	34.6	7.4
Non-DATC	49.3	43.6	-	48.2

Methadone	6.9	-	-	-
Private Doctor	10.4	5.1	-	14.8
Other	3.5	10.3	23.1	18.5

* Totals may not sum to 100% due to rounding

Users who have experienced some form of treatment were asked about the program that best suited their needs. Forty-three percent of heroin users found the non-DATC program suited for their needs compared to 25% of them who said the DATC program best suited them. Similarly, 41% of ice users found non-DATC programs suited for their needs whereas 10% of them reported the DATC as suitable for their needs. Over 50% of ketamine users also reported non-DATC programs as best suited for their needs and four percent reported DATC as the most suitable for them. Slightly over one-third of ecstasy users found non-DATC programs and other treatment like acupuncture and Chinese medicine as most suitable for them.

A similar pattern is found in response to which program has been most helpful. Over 40% of heroin, ice and ketamine users who have experienced treatment report non-DATC programs as most helpful. Among ecstasy users, 42% of them did not identify any program as helpful and 35% of them reported DATC as helpful. As we shall see in the next section, users from our in-depth interviews report that while non-DATC programs are disciplined and regimented, they are less restrictive than at the DATC which they equate with prison. Given that most ecstasy and ketamine users do not go to DATC, the few who go to non-DATC favor this type of program. However, as shown later, these users tend to view treatment as overly restrictive and a curtailment of their freedom, especially in light of their perceived lack of drug problems.

Table 6-12*
All Surveyed Users' Views on Unmet Needs

	Heroin (n=155)	Ice (n=72)	Ecstasy (n=191)	Ketamine (n=176)
Most Important Unmet Need				
None	35.5	33.3	31.4	36.4
Financial	20.0	6.9	26.2	21.0
Family relations	24.5	19.4	8.4	5.6
Social relations	2.6	-	-	0.6
Relations w/child(ren)	1.3	1.4	1.0	0.6
Employment/study	6.5	16.7	19.9	27.3
Accomodation	0.6	-	0.5	-
Mental health problems	4.5	15.3	2.1	3.4
Physical health problems	3.2	4.2	5.2	5.1
Other	1.2	2.8	5.2	-

* Totals may not sum to 100% due to rounding.

All surveyed users were asked about whether they had any unmet needs. One third of heroin and ice users reported having no unmet needs. However, 25% and 19% of heroin and ice users respectively, state that family relationships are the most important unmet need they are facing. Although 31% and 36% of ecstasy and ketamine users, respectively, believe they do not have any unmet needs, another 26% of them report financial needs as a problem area and another 27% of them identify employment or schooling as their most pressing issue.

In-depth Interviews with 60 Female Users' Perceptions of Treatment Programs

As noted from the survey data, among those who have been in an in-patient treatment program, a higher percentage of them find non-DATC programs more suited to their needs and more helpful than DATC programs. We turn now to examine users' accounts of these experiences based on our in-depth interviews with users.

DATC Experiences

Within the local drug culture, female users liken the DATC as the same as prison as it is restrictive, and actually situated next to a prison facility. As noted above, many female users have been to the DATC at some time during their life. Among those who have been there, several themes emerged. Some female users have stated that, although the DATC is more "prison-like," they express a preference for it rather than the residential treatment center in the community because the length of the DATC program is perceived as being shorter than those designed by community based treatment plans. Users report that the former takes several months. CSD reports an average of about six months for young and adult females in DATC for the year 2003 while the latter involves, on average, about one year (see range of length of stays by facility in Tables I-4 and I-5). It is important to underscore that while they do not have the power to make this decision during sentencing, the court conducts a pre-sentence assessment in which the user is allowed to express her views to the probation officer. Ultimately the judge or magistrate makes the decision as to whether to impose a mandatory stay in the DATC or a community facility. These former residents reflect on their discussions with probation officers prior to sentencing:

> Last time, they asked whether I wanted to go to the DATC or to a drug treatment center. I chose the DATC because it's shorter [in duration] than a non-DATC. I didn't think DATC was any different from prison. I didn't think I learned anything. I chose DATC just because the time I had to stay there was shorter. I didn't expect to get anything out of it, I wouldn't change after release. (G01)

> The main reason I wanted to go to the DATC was that it was faster to complete. It was better than going to the drug treatment center since I wouldn't have to spend one to two years. I didn't think whether DATC would be good for me. At the time, I just considered the shorter period of time. (G02)

Although past residents found the staff helpful, they felt the peer environment made it difficult to think or make any changes in their life. For example:

> The good thing about that place was the staff were nice. They listened and talked with me. The bad thing was the other inmates. They were in groups and gossiping all the time. It was hard to live with all those strangers. (G03)

In addition, former heroin residents recalled learning about "ice" and other psychotropic drugs in prison. Despite the peer pressure within the DATC, some users find the separation from their former lifestyle a vehicle for reflection and change, but also reinforced and supported by family members:

> Being locked up helped me. At least I had time to think about my daughter and mother. Before being locked up, I seldom took care of them, but after the DATC experience, I had time to think and realized that I was controlled by heroin and it resulted in my loss of freedom. I made my mother disappointed for so many years. When I was at the DATC, the staff asked my mother to come and visit. It was very touching. Although I had not seen her in many years, I felt that she still loved me. So I think prison helped me. (B01)

Non-DATC

By contrast, female users learn from others in the local drug culture that non-DATC treatment is too long and, although not like prison, is still very much disciplined and restrictive. The majority of female users who go to a non-DATC agency for residential treatment are placed there by court order. In a few cases, parents have "forced" their daughter to go for treatment. Consequently, initially they dislike the ideas of having to "be there" involuntarily. Moreover, the relatively restricted lifestyle (compared to the freedom of their prior lifestyle) and separation from intimate others proves to be exceptionally challenging in the first two months. The separation from others and the isolated locale of many of the treatment settings, however, ironically helps them to appreciate and reflect on their experiences.

> I like it here. It's very quiet and gives me space and time to think of my problems. Yes it's very difficult to quit outside as there are too many temptations. (G11)

> In the first month, I wanted to leave. But then I got use to life. The girls get close and become friendly. I started to think of the effects the drugs were having on my family. I really hurt them. I need to do something to compensate them for all I've done to them. For them, I will try not to use again. (G08)

> I didn't like the religion part of it, but I like it here otherwise. I have also gotten used to the discipline. (G14)

> In the beginning, I felt the religion was annoying but after awhile, I found it very useful. The philosophies apply to my life experiences. (G12)

> I've been able to think about my past and my problems. When I first arrived, I really hated it. I was so angry and wanted to leave. I was very emotionally

unstable. But I think I changed a bit. I don't know if I have the will to say no to all drugs, but I can say no to heroin. (G07)

Users felt that the treatment process could be strengthened in a few areas including teaching them better management of emotions to avoid emotional problems. One woman says, "I think they need to pay attention to our emotional problems. I lose my temper easily. I started playing a musical instrument and this helps me to keep my temper balance."(A17) Other areas included vocational training and job assistance upon release and physical training and endurance programs.

Frontline Workers Perceptions of the Perceived Successes and Obstacles of Treatment

From the above discussion, female users who have been in a non-DATC program may initially have problems in adjusting to the treatment environment, but gradually accommodate to a routine lifestyle and reflect on their drug use and its impact on themselves and their families. In this section, we present frontline workers' views on their perceptions of the successes and obstacles in treating female drug users.

Perceived Successes

An important dimension of treatment is support from others. As seen with the survey data, parents are one of the key support groups among female users who have been in treatment. Frontline workers support this view. While frontline workers find that mandatory treatment represents the primary factor for getting help, accounting for an estimated 90 percent of the cases they see, they also believe that female users are also motivated to make some changes in their drug use for their parents.

> If you ask them, 90% of them will tell you that their parents asked them to come and they don't want to disappoint their parents. None of them say that they want to come by themselves. They give you the impression that they love their parents very much. (F2-3).

Despite having past problems with their parents either as children or as a result of their use, female users, especially those using heroin and ice, find family as an important motivation source for trying to quit.

Given that female users are motivated to seek help, not solely because of court orders, but because of their parents, frontline workers actively encourage family members, particularly parents to be part of the treatment and recovery process. Most residential programs offer family visitations once a month and encourage telephone class and letters when they can't have face-to-face interaction:

> They have to know that quitting drugs is not easy, it takes a long time, changing their value system and life are the most important, if the family members don't understand, and ask them to go home to help with family duties, past experience tells us that they will go back to using drugs again. (F4-1)

> We have family visits, and let family members know how to support clients, and that the client needs to stay here for a while, not just a short period. Their family has to support us to finish the whole course, because family influence is very powerful. (F4-3)

Treatment workers uniformly agreed that parental support is one of the key factors throughout and after the treatment process. However, as noted below, there are a number of obstacles female users face during treatment.

Perceived Obstacles

Treatment workers note that users often times have little understanding of the non-residential treatment setting, viewing these environments as the same as the DATC or prison with many restrictions and little freedom. This suggests that misperceptions about the options and nature of treatment is an obstacle to getting help.

> Most of our voluntary cases here are heroin users, they get bored of taking heroin. They lost all their possessions and can't live out on their own. These ones consider quitting and come to us. Most of the ice and psychotropic drug users are forced to come by probation order. The reason they don't seek help earlier from treatment centers is that I think they really worry that the environment of the treatment center will be similar to prison. They worry that they will be beaten by others. They also don't want to lose their freedom. They think that the period of treatment is too long and they can't see their boyfriends. (F1-3)

Because many users find themselves in treatment due to a mandatory court order, treatment workers believe that some of them may, not be committed to the recovery process. Some find it difficult to conform to the regime and discipline of residential settings. Moreover, given users' perceptions of drugs like ecstasy and ketamine as being "soft" drugs, feel it is acceptable to return using these drugs upon release.

> Some of them give up, especially when they think they are forced to come, and it is not of their own free will. We require them to have a very disciplined lifestyle here. They have to wake up at 7:00 a.m. every day. But for them, it is very difficult because they went to sleep at 7:00 a.m. when they were outside…(F2-3)

> I think half of them didn't come to seek help whole-heartedly. They said, 'I was only forced to come here by the judge.' Some of them tell me that they won't use heroin later but they will still use psychotropic drugs. They tell me firmly that they will definitely smoke cigarettes after release. Their concept is that psychotropic drugs are the same as alcohol or cigarettes. (F2-2).

Treatment workers also point to the "emotional" dimensions of working with female drug users as being a distinct difficulty, especially in comparison to male users.

> They don't know how to get along with other people. They will get angry easily for some minor things. They are very sensitive. They may feel that we are prejudiced against them. They will be unhappy if they see other girls getting a bigger piece of the snack. (F3-1)
>
> Psychologically they rely heavily on others. They will be jealous if we pay more attention to somebody else. Some will start acting like the "big sister." If we see this situation, we will suppress her immediately. They are very bad because they will bully newcomers. They won't let others watch television, give them pressure, say bad things behind their back." (F3-2)
>
> I have worked with males and females. Males are easier to work with because a male's will power is stronger, if they understand they do it, and boys will not easily get angry, unless there's a "big issue." Their self-control is better. But comparatively females are more emotional. This is the most difficult part to deal with, sometimes she may seem very well, but suddenly because of one thing that causes her unhappiness, she may give up. We hold more emotional management groups to teach them how to deal with their unhappiness. (F4-2)
>
> In terms of physical addiction, males and females are almost the same, but in terms of psychological issues, females look at things from an emotional point of view… because I think females have multi-dimensions of emotions, they are more dependent and their traumatic experiences are different from males, so it is easier from their point of view to give up. (F4-3)
>
> For females, we mainly help them with their psychological dependence. We need to deal with their emotional problems. They are very emotionally unstable. They didn't know how to face themselves when they encounter emotional irritations. If they can't solve their problem or difficulties, they think it's the end of the world, no hope, then they use drugs to help them escape. (F5-3)
>
> Poor relationships with their boyfriends also lead them to be emotionally unstable. Most of their boyfriends are drug users, so it's very important for them to leave them. They know it's true, that they have to leave, however they feel down and upset when they think about it. We don't force them to leave their boyfriend, but we encourage them to face their own problem bravely. We try to have more sharing time for females, let them share their feelings. (F5-5)

Another obstacle warrants our focus. One of the most attractive features of drugs like ice and ecstasy for females is its slimming effect. For them, being thin is equated with being beautiful, and therefore, the slendering effects of these drugs can help raise their self-esteem. Unfortunately their obsession with being thin is a reflection of the primacy of this cultural value both locally and internationally. Treatment workers uniformly agree that the problem of "beauty" female drug users is one of the major difficulties in getting female users to stop:

> I think the concept of "beauty" for them is very strange. They think that extremely thin is beautiful. Some of them are already very bonny when they enter here. But they still say they have to lose weight outside. Now, in Hong Kong, thousands of these kind of weight control medicines are used by girls. (F2-2)

> I think the main reason for them to get slim is to attract the boys. When they get here, their bodies expand. They eat a lot. They finish everything. They blame the food and water makes them fat. But actually they can't control their diet. They aren't aware of their health. One of the girls told me that she eats very little on the outside, only water and an apple. They always say that they were extremely beautiful before. They don't like their present fat look so I worry that they will use some not very good methods to lose weight after they leave. (F2-5)

Users have noted their dissatisfaction and unhappiness with their weight gain during periods of quitting, thereby decreasing their self-esteem and confidence. They appear to have little understanding of alternative ways to maintain a healthy body weight. One social worker criticizes her colleagues saying:

> Those female users who are sentenced by the court for drug treatment and rehabilitation in the center get fat after they enter and start the program. I think service providers should help them maintain good body shape. They have nothing but their bodies. But other social workers are not taking this seriously. (F1-3)

One residential treatment center recognizes the issues of health and beauty and organizes seminars and courses for their residents.

> We provide some personal hygiene seminars as they didn't know how to take care of themselves before. We also teach them about safe sexual behavior. Moreover we organize some beauty courses for them. It's main aim is to increase their self confidence. You know, their self image is very low, If they can make themselves look better, they will be more confident. (F5-2)

At a broader level, these obstacles are a reflection of the drug culture in Hong Kong. Notions about "soft drugs," the "slimming effects of drugs," and counteracting the addiction of some drugs with other drugs (e.g., heroin with ice) are part of the prevailing local drug culture. This culture is apparent both on the "outside" as well as within treatment settings as noted by treatment workers:

> There is a myth among the female users that they can use ice to quit heroin. Most of them believe that ice is not addictive. I'm very surprised they still believe this. In prison, for example, they chat with each other about their experiences. They can learn this kind of thing, like ice is not addictive in the prison. All the information they get is from their conversation with peers. So they learn some "information" like ice can help you loose weight. And they believe that ice won't harm their physical health and isn't addictive. They come to believe that they can

> control their use, and use it once a week or once every two weeks. We can see that prisoners have little knowledge. The drug education in prisons is an urgent issue. (F4-1)

The importance of moving away from the drug culture has been recognized by some non-residential treatment programs. One religion based program shapes the program such that clients, upon nearing their re-entry into the community, engage with regular members of the church.

> We don't refer our residents as clients, I don't like calling them my client. We call them brothers and sisters. The most successful point of our religious program is that we have brothers and sisters in other churches to receive our brothers and sisters in the treatment program, and they help them to "grow up" there. They help them to jump out from the "culture" and know a new group of people. (F4-1)

From the above discussion, frontline workers perceive family support as an important success in the treatment process. It is through family support that users can work through their addiction and make lifestyle changes during and after treatment. Frontline workers have observed a number of obstacles in working with female drug users including users' misperceptions about various treatment options and the nature of treatment, difficulties in adjusting to the discipline of residential treatment and addressing users' emotional issues. In addition, frontline workers find that many of the myths and beliefs of local drug culture – ecstasy, ketamine and ice are not addictive, ice can be used to cure heroin, the slimming effects of ice and ecstasy can enhance one's appearance – are obstacles in the treatment process.

Perceived Treatment Effectiveness – Strengths and Weaknesses

The views of the users from our in-depth interviews and of the treatment workers from the focus groups are summarized in the following summary. The focus of the strengths and weaknesses are on general treatment strategies, and does not examine the effectiveness of individual programs as the latter is beyond the scope of this study and to abide by issues of confidentiality.

Strengths of Treatment from Users' Perspective

- Counseling – Individual and group counseling in the residential community setting is seen as beneficial in recognizing that drugs are used as a way to escape problems, in confronting and addressing reality, in developing problem solving skills, in expressing and controlling emotions and anger.

- Peer group activities – These peer activities develop communication skills. Through these activities, there is also recognition that cooperation is necessary to living and sharing with others. It helps to build sense of belonging.

- Family involvement – Confidence and communication skills strengthened through family's participation and visits. Improved family relationships.

- Physical training – The physical training activities help develop body and are seen as a positive challenge.

- Job counseling – Strategies on how to find jobs and how to interview for employment are seen as a critical next step.

Weaknesses of Treatment from Users' Perspective

- Disciplined environment – Although one-half of users report liking the structure and routine imposed by treatment programs (both DATC and community residential settings), the other one-half dislike the rigidity and disciplined environment.

- Negative peer influence – A number of negative peer influences perceived as disruptive of the treatment process including gossip, learning more about drugs from peers, and peer ridicule towards wanting to change.

Strengths of Treatment from Treatment Workers' Perspective

- Religion – For those treatment providers working in a religious setting, they believe that a religious approach enables clients to develop a philosophy that values life and in this way, facilitates self-empowerment and confidence.

- Counseling – Several forms of counseling services from individual, group to family are offered. Workers point to emotion management in the counseling process as an important and effective part of the treatment process with emphasis on showing clients where emotions come from and how to control and respond to emotion.

- Family involvement – Through family visits, treatment workers encourage family members to support the client and teach them ways to be supportive (e.g., encouraging their child to complete the program, being positive and patient, and recognizing that the recovery process continues after release).

- Peer group activities – Through sharing and exchange of experiences, users develop cooperation and communication skills.

- Beauty courses – One program offers beauty courses. The objectives are to address misconceptions about drug use (especially ice) and weight loss and to increase self-esteem and confidence through balanced diet and physical fitness.

- Physical training – One program offers physical and endurance training with the goal of developing self-confidence and a healthy body and lifestyle.

- Educational training – Programs offer a range of activities to develop language and technical skills.

Weaknesses of Treatment from Treatment Workers' Perspective

- Difficulties in dealing with different types of users. While some users are motivated to change, others are not. The latter group views their stay in the program as a temporary break from drug use and its associated lifestyle. According to treatment workers, those who are not motivated to change tend to negatively influence those who do want to change, thereby making the treatment process and environment a difficult one.

From the above comparison of interviewed users' and treatment workers' views on the strengths and weaknesses, it appears that they agree on many of the same issues. For example, both users and treatment workers agree that the major strengths of residential treatment include individual and group counseling, peer group activities, family involvement and physical training. Interviewed users also believe that job counseling is an important strength as it helps them in the re-integration process. Treatment workers also believe that their education training is a major strength as it prepares users' for future employment. Treatment staff perceive that beauty courses are useful for altering users' perceptions about appearance and beauty. Finally, frontline workers add that a religious or spiritual orientation is a strength of the treatment process.

While interviewed users perceive the influence of negative peers as a weakness of treatment programs, treatment workers make a relatively similar observation. According to treatment workers, some users can have a negative influence on others, especially in terms of motivation to make change. Interviewed users also identified the disciplined environment as a weakness of treatment programs, yet as treatment workers have noted, the discipline and regime are one of the difficulties users' face in trying to change their drug using lifestyle.

Summary

This section has examined users' experiences in trying to quit and in treatment. The survey data shows that heroin and ice users are more likely to try quitting and have been in some form of treatment than ecstasy and ketamine users. While the majority of them obtain treatment because of court orders, users are also motivated by their families.

From our survey data, users identify parents as an important source of support during and after the treatment process. Frontline workers agree that despite problems in the past between the user and her family, families are a critical part of recovery, and as such, take steps to facilitate parental involvement. This is perceived as an important strength of treatment programs as described by our interviewed users and frontline workers.

From the survey, users also report that obstacles to getting treatment include not wanting their family to know of their addiction and problems, fear of withdrawal, problems with work or school schedules, and partner's addiction. Frontline workers have also observed that heroin users are more likely to obtain treatment and are motivated to make changes not solely because of court orders, but because of their families. From frontline workers perspective, the perceived obstacles in treatment include misperceptions about the options and nature of treatment and the myths or beliefs about the effects of particular drugs like ecstasy and ketamine.

The survey data and in-depth interviews indicate that users find that non-DATC treatment is more useful and better suited towards their needs. Interviewed users and treatment workers agree that counseling, peer group activities, physical training, and family involvement are among the major strengths of treatment in the non-DATC setting.

Section 7: Treatment Abroad

This section provides a summary of our review of the treatment experiences abroad.

Child Care

- One of the major barriers for addicted women who are mothers and want to seek help is the concern of childcare. MacGregor (2001) suggested that women's self-image and the image of others that they are incapable of being good mothers hindered the addicted women to seek treatment. They fear that that their children will be taken away. So if it is possible to keep children with the women during treatment, this can improve their motivation to recover. McCaul (1990, 1999) found that residential services that allowed children live with their mothers in the treatment settings appeared to have higher retention rates. According to a clinical trial, Hughes and associates (1995) found that women who lived with their children in the residential therapeutic community treatment programs remained in treatment significantly longer than women whose children were placed with relatives or friends during treatment. Moreover, the level of depression was reportedly lower while self-esteem was higher for women with their infants. Steven's (1998) study also showed similar results; women assigned to live with their children were more likely to report abstinence from drugs and alcohol, involvement in aftercare or support groups, employment, custody of children, and no arrests or incarceration. Therefore on-site childcare services of the outpatient treatment programs and specialized residential programs for pregnant and parenting women are important and the useful services to increase attendance rates.

Prenatal Care

- Substance use during pregnancy may have serious physiological and emotional health consequences for mother and fetus. Therefore enrollment and compliance with substance treatment for the pregnant women is crucial. Many pregnant women however are reluctant to seek help since they may feel guilty about the harm they may be causing to their baby and the fear that their children might be taken into care (MacGregor, 2001; Clarke, 2001). So Clarke suggested that interventions for this population should consider including activities that promote understanding of treatment which is beneficial to the well-being of their babies. Svikis (1997) also found that pregnant women who received addiction treatment had better clinical outcome at delivery.

Partners' involvement

- The Caron Report indicates that women's use of drugs and alcohol are always influenced by 'an old man' in their lives (Gordon 2002). According to McCaul (1999), since intimate relationships are shown to be very important to women, treatment programs that are effective in engaging the women's substance-abusing partner into addiction treatment may have better retention and recovery rates. Therefore, treatment programs for women can also offer family education section to teach their partner about issues concerning addiction and recovery.

Counseling sections about couples therapy addressing underlying psychological and family issues of the couples can also be included.

Mental Health Component

- Research studies (Blume, 1998; Volpicelli, 2000; Gordon, 2002) point out that psychiatric services are one of the important component of treatment for women addicts. The Caron report found that there is a direct relationship between a diagnosis of Post Traumatic Stress Disorder (PTSD) and later substance abuse (Gordon 2002). Women with histories of violence and sexual abuse are more likely to suffer from flashbacks of trauma. Therefore, treatment for women's psychiatric problems is a crucial component of the women specific services. Early assessment and diagnosis of psychiatric illness, such as depression and anxiety can be added as a treatment module for women.

Gender-Separated Program

- Gordon (2002) found that single-gender treatment programs provide more effective care to women addicts than the mixed-gender programs. In Sweden, Dahlgren and Willander (1989) also noted that female patients showed a more successful rehabilitation both in terms of alcohol consumption and social adjustment in the specialized female unit of the alcoholism treatment centre. Women in such gender-separate programs experience a higher recovery rate and are more likely to complete treatment. Ashely (2003) suggested that women are more willing to discuss sensitive and painful issues in the women-only treatment environment where they may feel more comfortable. A similar finding also showed in Caron report, Gordon found that women tend to express themselves more frequently in the female-only groups where interruptions are far more less frequent (2002). Discussion on sensitive topics, such as physical and sexual abuse can be promoted in the gender-separate program and therefore facilitate the therapeutic treatment.

Non-judgmental and non-punitive approach

- The Caron Report points out that addicted women are more likely to condemn themselves as they are put on a higher moral pedestal as wives, caregivers, and mother, and therefore are stigmatized more negatively by society (Gordon 2002). These women fear to face the moral judgment and refuse to seek treatment. MacGregor (2001) therefore suggested that if the services aim to attract more chaotic women to participant, a non-judgmental and non-punitive style have to be adapted. Such approach requires a shift in attitude among the treatment workers and the law enforcers. A more friendly, informal and flexible services can lead to improved success rates. The women's treatment at the Caron Foundation is also aware of this problem (Gordon 2002). They found that the stigma attached to women's addiction produces a barrier to self-awareness of the problem. Their main objective is to educate women that addiction is a disease so as to reduce their feelings of shame and isolation. Therefore the treatment approach and environment have to be therapeutic and serve to strengthen a woman's identity and worth as an individual.

Family participation and support

- Grilla and Joshi (1999) found that women are less likely than men to report that their family encouraged them to abstain from drug use. However, many studies found that addiction is a family issue and therefore the family's support and communication during treatment is very essential for women's recovery (Gordon, 2002). To promote family trust and healing, programs designed to improve communication skills between family members are important. Moreover, a series of home visits which aim to help patients to reintegrate into the their family are also encouraged to include in the treatment process.

Nurturing and supportive environment and Relational Models of treatment

- Treatment services which provide a warm and supportive environment for women contribute to successful outcome. Staff characteristics are also one of the important factors for determining the effectiveness of the programs (Gordon, 2002). Gordon (2000) found that many female addiction patients preferred having female therapist since they thought that staff in the same sex would be more sensitive and responsive to their needs. According to McCollum (1995), female addiction patients reported that helpful therapists were supportive, caring and concern. A NIDA report (1991) also suggested that a continuing relationship with the treatment provider is an essential component of treatment, especially for women. Based on the sensitivity to the importance of relationships in female development Dr. Covington developed a relational model of addiction treatment for women (Covington, 2000). The philosophy behind this is that women recover in environments that are characterized by interpersonal safety and connection to one' treatment provider.

Self-help groups

- MacGregor (2001) suggests that the stabilization of the women's abusing situation should be the first aim of the treatment strategies for women. He states that "once trust and contact have been encouraged then further steps back can be made"(p.20). Studies (Schober, 1996; Allen, 1995) have found that many addicted females feel shame towards their addictive behaviors and avoid treatment as a way of hiding the shame. MacGregor (2001) therefore suggests setting-up self-help groups which are composed of people with personal experience of drug use, who are aware of the needs of addicted women to help overcome the isolation of female drug users. The self-help groups can be a key first contact for the addicted women since it is believed to be easier for the women to trust and accept advice and information from those who have had similar experience as them.

Education

- Skill enhancement in areas such as stress management, assertiveness, communications, establishing and maintaining healthy boundaries, intimacy, developing a spiritual practice, and building a recovery network are part of the curriculum in treatment at the Caron foundation (Gordon 2002).

- Health education: Programs for women should address reproductive health issues and concerns. Hilter (1996) evaluated a standard substance abuse treatment program supplemented with psychosocial workshops. It consisted of weekly sessions on topics such as breast health and breast self-examination; sexual and reproductive anatomy; sexually transmitted diseases, including HIV and acquired immune deficiency syndrome prevention. This approach resulted in positive attitudes toward practicing safer sex and increased self-esteem.

Vocational Training

- Female addicts tend to be unemployed and have lower vocational skills than their male counterparts (MaCaul, 1999). It is important to add classes in vocational training, high school education, and independent living skills. In treatment at Caron addicted women are encouraged to seek employment, do volunteer work and take classes at the local facilities (Gordon, 2002).

In 1991, The National Institute on Drug Abuse identified services shown to be successful in addressing major risk factors, consequences of addiction, and barriers to care for women drug addicts. The treatment methods for women include:

- Food, clothing and shelter
- Transportation to treatment
- Child care during treatment
- Job counseling and training
- Legal assistance
- Literacy training and other educational skills
- Parenting skills training
- Family and couples therapy
- Medical care and family planning services
- Psychiatric assessment and mental health services
- Assertiveness training

According to the IREFREA (2003) report concluded that

> "In the encounters with the health services structures it should be emphasized how this group of users feel more the need for psychological rather medical support with needs which often involve not only the sanitary structures but also family members and the partner, needs which are often not met." (p.66)

In light of these overseas experiences, we now turn to the conclusion and recommendations emerging from this study.

Section 8: Discussion and Recommendations

In light of the findings from the previous section, we offer the follow discussion and recommendations in relation to outreach and treatment, education and research.

Outreach and Treatment: Strengthening Recovery Process

As described earlier, the vast majority of female drug users who do seek help are prompted by court order. Consequently, some, but not all, of the clients will see this mandatory treatment as a vehicle for recovery while others may see it as a temporary break from their drug use. As noted earlier, some of them admit to treatment workers, that they will return to using upon release, albeit at less harmful levels, initially. Given this situation in residential settings, frontline workers have observed that there are difficulties in trying to balance and manage those female users who are willing to try and those who see this as a break from using. As such, one task at hand is to consider ways in which to work these two types of groups in a more effective manner.

> The difficulty in the treatment process is that the abilities of clients are different… I think the government should weigh more on the quality rather than the quantity. Some girls referred by the court are really bad. They think that they are just forced by the court to come. Their bad attitude can influence other girls. Other girls may easily internalize their ideas and think in the same way as them. So we want to serve those people who really want us to help them. (F2-3).

Moreover appearance and beauty issues are important dimensions of female drug use. As female users who have gone to treatment indicate, treatment itself is a paradoxical battle for them as they try to quit, they acquire a different diet and lifestyle, and as a result, perceive the healthy weight gain as "ugly" and incentive for returning to drug use. The following recommendations are offered:

- Motivations to change vary among users such that less motivated users may impede the efforts of those who want to make changes. Consideration should be given to ways in which different types of users in treatment can work more effectively together. There are at least two ways to address this issue. One method would involve ways of integrating a treatment approach which channels the strong characters of the "big sisters" into a positive way and which helps build the confidence of those who want to make changes. Another strategy would entail developing a more coordinated diagnostic procedure at the time of sentencing such that different types of female users would be placed in settings designed specifically to deal with particularly types of users.

- Develop education activities which take on the paradox of using drugs to attain beauty and it's reverse effects. In relation to this, physical and endurance training are an important vehicle for promoting a healthy "appearance," and are noted by our treatment respondents as worthwhile.

- Further examination and development of strategies targeting emotion management.

- Although female users report problems with family, it is parents who, female users identify, as the major source of support in trying to quit – from the point of making decisions to quit as well as during and after treatment. Parents can

and do make the difference. Although they may perceive themselves as being helpless in helping their daughters, they are not. However, they need guidance by drug workers and in public education campaigns, such that they fully understand, like users themselves, that treatment is not a "quick fix" but is in fact an ongoing, lifetime recovery process.

Education

The findings from this study point to a number of important educational issues, particularly peer pressure, notions of beauty, and knowledge about drugs and their effects. This study has shown that drug users have bought into a local drug culture which is embedded in a number of myths about the effects of particular drugs, such as ice is not addictive or has a neutralizing effect from heroin use. In the U.K., the U.S. and Australia, the "just say no" approach in public education campaigns has been shown to be ineffective and unrealistic. Public media campaigns should move beyond the "just say no," approach as many young people see this as "naïve," particularly in light of peer pressure. As noted by one outreach worker, it's especially important to reach girls at an early age and educate them as they are seeking an identity and rely very much on the support of their peers" (F52). A realistic educational strategy entails the following dimensions and are offered as part of our recommendations:

- As part of its education campaign, peer group education is an important and realistic component. Moreover, outreach workers could promote the use of a "peer watch" system in which users monitor and regulate each others' use to reduce the harms associated with drug use. As noted by the respondents in this study, many female users use in small groups together, and some of them report monitoring and controlling each other's use.

- Education should also focus particularly to notions about beauty and appearance. As has been well documented throughout the report, female drug users find drugs like ice and ecstasy as providing the means for enhancing their appearance irrespective of its negative consequences. At present, girls and young women are heavily influenced by images of beauty that are associated with being thin. Unfortunately drugs are perceived as a "quick" method for achieving beauty. Educational campaigns must cultivate a healthy concept of "beauty, " and should emphasize the paradox of drugs in the attainment of beauty as the respondents in this study described how they initially perceived their use as enhancing their beauty, but eventually, the drugs made them feel "ugly."

- Educational campaigns should also target the reasons why drug users try to quit, including court orders, ties to family and tiring of one's addiction. Ex-users and their experiences would be an important and realistic part of the campaign.

- Drug education should be strengthened in prisons and treatment centers. Prisoners easily learn ideas from peers in these settings. So the government should give more drug education lessons in these settings. It's not really enough at all now. I still hear comments about ice in the drug treatment centers. Drug addicts seldom

read newspapers nor watch television. They are just concerned with getting drugs. The government shouldn't spend more money on leaflets or posters. They won't see them. When drug addicts enter prison, the government should use this opportunity to group them together and teach them about drugs. (F4-1)

Research

A number of pressing themes emerge from this report and require further investigation.

- The relationship between drug use and suicide merits further research, as this study has shown that a significant proportion of female drug users, especially those using ice, had thoughts about and attempts to commit suicide. The precise nature of this relationship requires study and could provide useful information for developing outreach and intervention strategies.

- One important finding from this study was the extent and nature of female drug users' illegal income generating activities. From the survey and in-depth interview data, it was quite apparent that they rely on several types of illegal strategies to earn income for their drug use and lifestyle. Moreover, traditionally females have had a minor or non-existent role in selling, however, it was apparent from our data that female users are also selling drugs and trafficking. Further investigation should focus on the relationship between drug use and illegal income generating activities.

- Another important finding from this study is that many ecstasy and ketamine users may not come to the attention of CRDA reporting agencies because they do not face or experience any immediate medical or enforcement consequences. From our survey data, 91% of 191 ecstasy users and 87% of ketamine users have never been arrested. Approximately 60% and 72% of ecstasy and ketamine users respectively had not had contact with drug workers for counseling. Therefore, we recommend that studies targeting the "hidden" population are conducted on an ongoing basis to keep pace with the rapidly changing drug scene.

- As the findings of this study suggests, there is a complex relationship between users and their parents and families. On the one hand, some users have described family conflict and communication problems with their parents during their drug use initiation and continuation. Parents often, understandably, have limited understanding of how to cope with their child's drug use, and therefore may feel a sense of helplessness. On the other hand, users who have sought out help for their drug use problems have indicated that their parents are an important source of support in the recovery process. Further research on this complex relationship is needed and should include the development of skills based strategies for parents to assist their children in the drug recovery process.

Appendix A
Research Methodology

The study objectives, as noted in the introduction of the report, included:

a) identify the main characteristics of females using different types of drugs;
b) identify the determinants and factors related to initiation and continuation of use;
c) identify the risk behaviors and social and physical consequences associated with use:
d) identify the strengths and weaknesses of existing treatment programs for female drug abusers;
e) study the trends for various subcategories of female drug abusers and make comparisons with other relevant categories of drug abusers; and,
f) recommend suitable measures to tackle the female drug abuse problem.

Our research team adopted multiple approaches including quantitative and qualitative research methods to address these objectives. As described below, the use of multiple approaches provides a more comprehensive portrait of the situation as compared to a single method. Also, the use of several methods provides multiple perspectives of the situation, and is an important means of supplementing and complementing any one form of data. Also, the use of multiple methods is a source of triangulating the data to ensure the validity and reliability of any single method (Babbie 2004).

Three sets of data were collected during the two-year study period from October 2001 to October 2003. Because of the unforeseen events related to SARS, we were delayed in the completion of the study by about four months. During the SARS, the participating agencies understandably postponed our data collection for health prevention reasons. In addition, we postponed collecting data from non-agency referrals for the same reason.

Focus Groups. The first set of qualitative data collected were 8 focus groups with female users in treatment and rehabilitation, female users who successfully quit, and outreach workers and treatment staff in the first six months of the research. All of the participants did so voluntarily. There were no rejections to our requests for participation in the focus groups. All of the focus groups were conducted in Cantonese at the treatment agencies with the exception of one focus group with treatment workers done at a coffee shop. The focus groups lasted between 60 and 90 minutes. The research assistant took extensive notes during the focus groups, and transcribed the notes into a transcription shortly after the event. Due to confidentiality reasons, we can not provide the name of the participating agencies. A copy of the data instruments for the focus groups are contained in Appendix B.

Two focus groups with females users in treatment and rehabilitation were held in two voluntary female residential treatment centre. Each focus group included four participants who were all poly-drug users of heroin, ice, ecstasy and ketamine. The focus groups discussion provided us with information about the range and general characteristics of female users and their patterns and problems with use. The questions were designed to elicit these users' general observations rather than individual experiences. In addition, it was felt that participants would be more revealing about female drug use trends when asked general rather than individually oriented questions. To our surprise, participants were forthcoming about both their general impressions and individual experiences. Perhaps, given that the participants were living with each other, were involved in group activities, and had shared experiences, their willingness to speak openly should not be so surprising. A third focus group was conducted with six females users who had quit using drugs. The participants were those living in and had just left a halfway house and started reintegrating into the community and family. This focus group included additional questions on their experiences in treatment. Similarly, they offered their views on general trends and individual experiences. The data provided us with a general impression about the treatment process and services, and their perceptions of the benefits and problems with specific treatment strategies and post treatment experiences.

Five focus groups with 15 treatment staff and outreach workers from five NGOs providing in-patient and out-patient services were conducted to obtain information on the trends of female drug use and to identify outreach and treatment strategies that work and don't work with female users populations. These discussions helped us to gather more detailed information on female user trends, specific problems female users face, issues in accessing and engaging female users, outreach and treatment strategies employed, methods or maintaining female users as clients, and obstacles encountered in addressing the specific problems of the female users. All of the respondents were candid in their descriptions of general drug use trends among females, the obstacles female drug users face in getting help, and the strengths and problems associated with treatment. However, it should be noted that because treatment workers, working together, may be reluctant to be too forthcoming in discussing the weaknesses in treatment, lest it be misinterpreted as a criticism of their own agency. Nevertheless, their insights were useful in providing a different perspective of the problems female drug users experience, albeit it is important to note, that many of their observations confirmed trends and problems described by users themselves. Frontline workers' views then provided a way of verifying users' claims in the in-depth interviews.

We used the results from these focus group discussions to establish our targeted sample groups. Moreover, based on these findings, we drafted the qualitative in-depth interviews

schedule and quantitative survey questionnaire for women drug abusers. The focus groups were also advantageous as they were done in a relatively expedient manner, offered the views and experiences of multiple participants (users and frontline workers), and had high face validity. However, the selection of the participants was achieved through non-probability sampling, and therefore, the participants can't statistically represent the drug using or frontline worker population. The focus group data then yields important descriptive and exploratory information but can't be over-generalized to the larger population.

In-depth Interviews. The second qualitative set of data was collected from in-depth interviews with 60 female users. Twenty-one female users were from three voluntary residential treatment centres. Three NGOs' halfway houses provided 11 referrals. Fifteen were residents at the DATC, Chi Ma Wan. Seven were introduced by outreach workers and six were identified through the interviewers' personal contacts. One of the reasons for the relatively fewer number of interviews in the street and outreach samples is that many arranged interviews of these two groups were cancelled due to the SARS incident, therefore we had to rely more on the sources which could provide us with available respondents without too long of a delay. Given this convenience sampling procedure, it is important to note that the data and analysis derived from the in-depth interviews can't be generalized to the larger drug using population.

All of the in-depth interviews with the users from DATC, treatment and halfway house were conducted at the agencies as requested by the agencies. We were provided individual room for the interviews. The formal setting may not be the ideal interview location, but at the very least, the separate room ensured complete privacy. Most of the interviews of street and outreach sample were done in the quiet corners of public places, like small parks, McDonald's or the respondents' own shops; sites of familarity. These locations were chosen as the respondents claimed that they felt at ease and comfortable in.

The interview was designed as a semi-structured interview. The interviewer read and memorized the interview questions carefully before the interviews. She seldom referred to the interview schedule during the interviews. The interviewer was free to phrase the questions and adjusted the focus of the discussion according to the respondents' characteristics. In addition, the interviewer rephrased questions when there appeared to be gaps or contradictions in the interviewees' responses as a way of verifying and ensuring reliability and validity. It encouraged a friendly rapport to develop between the interviewer and respondents. As some respondents from treatment or prison setting were quite cautious, it's very important to make them feel relax and comfortable by establishing good rapport.

The interviewer was aware of the problem reactivity and interviewer bias. So she avoided using leading questions and making any form of judgments during the interview. More 'why', 'how', and 'what' questions were asked to encourage them to express more about their own point of view. The interviewer also encouraged the respondents to discuss ideas and concepts in their own words and terminology. She avoided using English or terms that the respondents may not understand during the interview.

The interviews started with some general personal questions to make the respondent 'warm-up' and feel at ease. Usually, the female respondents welcomed the discussion on their family or relations. After the warm-up section, they would volunteer the information to the interviewer. Then, the discussion would shift to some sensitive questions like their drug use habit and sex/pregnant experiences. When the interviewer found that the respondents felt uneasy to talk about an issue, she would leave it for a while and tried to come back to it at a later time.

The interviewer declared at the very beginning of the interview that all the information the respondents provided us was confidential and would not be revealed to their agencies nor anyone else. The interviewer also emphasized that the study was a University research project and emphasized that we were not making judgments about them, their experiences nor their responses. In doing so and based on their responses, we believe that the respondents did not provide the "answers" they thought we wanted to hear (e.g., 'socially acceptable responses'). Granted, drug users, given the illegal nature of their activities and behavior, may minimize or exaggerate their experiences, however, we rephrased questions to confirm their answers. Importantly, it should also be noted that qualitative drug research has shown that drug users are generally truthful in their reports of drug use and problems (Waldorf, Reinarman and Murphy 1991).

The duration of these in-depth interviews was around 60 to 90 minutes. All of the interviews in the treatment, aftercare, outreach and street sample groups were agreed to be tape-recorded. However, owing to the security reason of the DATC and their regulations, no tape recording was allowed in the DATC setting. So the interviewer took notes during the interviews and wrote up the detailed interview report right after each interview. The in-depth interviews examined more closely on female users' process of initiation into use and the setting, the motivations, rationales, support and context for continued, lifestyles and risk behaviors, methods for obtaining drugs, physical and social consequences of use, experiences with outreach and treatment, and problems associated with recovery. Demographic, drug use and treatment characteristics are in Appendix C.

These in-depth interviews allowed us to obtain an in-depth, descriptive, and exploratory look at the different stages and issues in women's drug use, and as noted by others (Babbie 2004), are generally of high validity, but may have lower reliability as compared with quantitative approaches. Also, as noted above, the interview data does not represent the larger drug using population given the sampling procedure and the relatively small sample size of 60. The reader should keep this in mind when reading the report.

Survey. The third data set is a quantitative one, and aimed at providing a larger portrait of drug use among females. The project aimed at a purposive sampling strategy since it's the most appropriate way to select members from a difficult-to-reach and relatively hidden population. It is impossible to know the extent and types of drug users in the general population, and therefore, probability sampling is not appropriate. Therefore, we used subjective information and experts (e.g. treatment workers, outreach social workers and other drug users) to identify a 'sample' of female drug users for inclusion in our project. Originally, we targeted the survey for 500 female users, with 100 coming from five different sources including DATC, non-DATC residential facilities, halfway houses, outreach workers, and street contacts. However, due to the health crisis of SARS, we had to modify our original sampling strategy as some agencies declined our requests to conduct interviews for health safety reasons. In the end, we had to adjust our targets, and consequently, our respondents were selected through convenience sampling. We conducted 500 surveys with females users in which 100 was from Chi Ma Wan DATC, 58 from halfway house, 140 were clients of the outreach workers, 88 from treatment centre and 114 were females users who have never been in treatment introduced to the project through snowballing methods.

Two rounds of letter requests for conducting the survey in all the treatment and rehabilitation centres and halfway houses for women were sent. However, only three treatment centres and four halfway houses permitted us to access potential respondents for the survey. In order to meet the target number of the original plan of the research, we asked assistance from the outreaching social work team, integrated services for young people and counseling service for substance abusers. Fifteen teams agreed to help. The surveys were administrated by our research assistants and outreach workers. Due to the concern of time, all surveys conducted in the DATC, treatment centre, halfway house and outreach samples were done by face-to-face interview with 5-10 female inmates at a time. Although the research assistants and outreach workers answered questions when respondents had problems filling in parts of the survey, we recognize that some respondents may have left some questions unanswered, and therefore, limits the analysis. Moreover, it should be noted that some frequent users may have recall difficulties in answering questions related to past drug use. Most of surveys in the street sample were done by individual interview. The survey

took 15 to 20 minutes to complete depending on how many types of drug the users had been using and how many times they had contact with drug workers or services.

The response rate for DATC was 100%. The treatment centres' response rate was 93%. The non-response for this group was due to illness during the survey time or lack of interest in completing the survey. The response rate of halfway house was 90%. Among those who did not participate, the main reasons were related to lack of time due to other house duties or employment. In anticipation of a lower response rate among the outreach sample, 450 survey questionnaires were sent to 18 teams of outreaching social work team, integrated services for young people and counseling service for substance abusers, and 140 were collected. The response rate was 31%. All the respondents recruited through snowballing agreed to do the survey. However, a group of students of community college rejected our requests since the survey had to be done during their term-break, resulting in the response rate of this sample group to be 85%. The research team recognizes that the differences in sample sizes may contribute to differences in the findings, and readers should exercise caution in examining the findings. Although we believe that we have provided a good cross section of the different types of users in the general population for a descriptive analysis, we note that the findings, given the sample, can't be generalized to the larger general population, and is a limitation of this data set. The research team also notes that while ideally we would be able to sample distinct groups of drug users (e.g., heroin, ice, ecstasy or ketamine), to be able to point to the effects of any single drug, it has proved impossible to do as most drug users in this study, and as reflected in the CRDA data, are poly-drug users. This finding in itself is important to understanding drug use and for developing appropriate interventions. Still, readers should exercise caution in reading the report, noting that the effects they experience may be related to multiple drugs of choice rather than one.

A team of student research assistants was responsible for the data entry right after the questionnaires were collected. They were trained and supervised by a PhD candidate of the university of Hong Kong to ensure the coding was used consistently by all data entry helpers. After 100 cases were entered, the supervisor verified them by using possible code cleaning method (wild code checking) first. He checked the categories of all variables for impossible coding and cleaned it immediately. Then, contingency cleaning was also employed in the verifying process. The supervisor checked for coding error by cross-classifying two variables and looking for illogic combinations. The results provided a quantitative portrait of the socio-demography and drug use patterns of females, risk behaviour, consequences of use and contacts with service and health workers. SPSSX was used for all statistical analysis. Chi square tests were performed to tests for statistical significance and a logistic regression

with backward selection procedure was used to examine the significant risk factors that may affect whether female drug users obtain treatment or not, in the presence of the other factors.

While these data offer a more quantitative portrait of female drug use than the focus groups and in-depth interviews, readers should note the limitations of this survey including its' inability to generalize to the larger drug using population, possible difficulties in users' recall of drug use history or users' non-response to some questions, and difficulties in disentangling the effects of poly-drug use. As also noted by Babbie (2004), while quantitative approaches like surveys have greater reliability than qualitative methods, they tend to have lower validity compared to in-depth interviews and focus groups.

女性吸毒問題問卷調查

訪問編號:#_____ 訪問日期_____ 訪問員_____

背景資料

1. 出生日期: 年_____月_____日_____

2. 國籍: 1=中國 2 其他_____

3. 出生地點: 1=香港 2=中國 3=其他_____

4. 在香港居留了多少年?_____

5. 婚姻狀況: 1=單身獨居 2=同居 3=已婚 4=分居
5=離婚 6=寡婦 7=其他_____

6. 過去 12 個月居住在那種類型房屋:
1=私人(自置)房屋 2=私人(租住)房屋 3=公共房屋
4=酒店 5=公寓 6=懲教署戒毒所
7=分租屋 8=自願戒毒所 9=其他_____

7. 你和誰人同住: 1=自己 2=伴侶/丈夫 3=伴侶及子女
4=子女 5=父母 6=父母及子女 7=兄弟姊妹
8=親戚 9=朋友 10=同房朋友 11=其他_____

8. 你和你固定伴侶一起有多久: _____(月)

9. 你伴侶有沒有吸食毒品: 1=有 2=沒有

家庭

10. 誰人負責養大你: 1=父及母 2=母親 3=父親
4=母親及繼父 5=父親及繼母 6=祖父母 7=兄弟姊妹
8=親戚 9=寄養服務 1 0=自己 11=其他_____

11. 你有多少個兄弟姊妹: _____

12. 你認爲誰是你最親密的人: 1=母親 2=父親
3=繼父母 4=兄弟 5=姊妹 6=祖父母
7=姨丈/姨母/叔父/叔母/舅父/舅母 8=表/堂兄弟姊妹
9=伴侶 10=子女 11=女性朋友
12=男性朋友 13=沒有人 14=其他_____
第一親密:_____
第二親密:_____
第三親密:_____

13. 父親主要職業:_____

14. 母親主要職業:_____

教育

15. 你現在有沒有上學: 1=有 2=沒有 (如果沒有):

16. 你之前最高讀到邊一級: _____

子女

17.你有多少個子女: _____

18.你的子女年齡: _____,_____,_____

19.你子女最常和誰人同住: 1=你 2 =你伴侶
3=你和你伴侶 4=你父母 5=你和你父母
6=你祖父母 7=你兄弟姊妹 8=親戚
9=朋友 10=托兒所 11=其他_____

20.你的家庭成員有沒有幫你照顧子女:
1=經常 2=只在日間 3=只在晚間
4=有時 5=很少 6=沒有

21. 有幾多個子女與你住:_____

職業及收入

22.職業:_____

23.你做這份工, 平均每小時賺到幾多錢:_____

24.你做這份工, 平均每月賺到幾多錢:_____

25.你做這份工, 令你去年賺到幾多錢:_____

26.過去 12 個月, 你從事過的非法工作:
1=賣毒品 2=運毒 3=性工作 4=盜竊 5=搶劫
6=售賣翻版 VCD/私煙 7=恐嚇/勒索 8=爆竊 9=其他_

27.你從事這些工作平均每月賺到多少錢:_____

28.過去 12 個月, 你的主要收入來源是:
1=家庭 2=朋友 3=男朋友 4=政府社會福利
5=其他志願機構資助 6=其他非法工作 7=其他____

29.你全年收入多少:_____
你每月平均收入多少:_____

吸毒情況 過去十二個月(或在未接受治療前)吸毒情況

30.你最主要經常吸食哪種毒品:_____

31.你吸食這種毒品時, 會混和酒或其他毒品一起用嗎?
如果有, 請註明哪些酒或毒品:_____

Focus Group with Female Users In Treatment and Rehabilitation

Thank you for your assistance in helping us with this focus group. Please be assured that your participation and identity is anonymous and confidential. Our session is intended to get a better overall understanding of female drug use, problems and service needs. Our discussion can be based on your observation of female users generally as well as your experiences.

General drug knowledge

1. Main drugs currently used in Hong Kong.
2. The purity and price. The Location of use.
3. What are the percentages for female drug users? Increasing?

What are the general characteristics of female users (Opiate/psychotropic)?

1. Age
2. Occupation
3. Education
4. Family – parents/children
5. Relationship with partner
6. Social groups affiliated
7. New immigrant?
8. How was drug used in female users family/partners and friends?
9. Living situation
10. Economic situation
11. Legal history
12. Health history (mental and physical) – Eating disorder? Depression? Physical problems? Diet?
13. Risk behaviours – Sex and drugs

Initiation and Continuation of use (Opiate/psychotropic)

1. What are the reasons for female using drugs initially?
2. At what age and under what circumstances did you take your first drug?
3. Why do they/you continue using the drugs?
4. Describe what you like and dislike about the drugs.
5. What sorts of stress are they/you under that might be related to using? Are they/you experiencing relationship problems (with partners, family or children), problems with money or work, or law? How do they/you typically manage or cope with these stresses?

What is the pattern of use among female users? (Opiate/psychotropic)

1. What kind of drugs they/you are consuming?
2. What are the main drugs they/you are using?
3. Are they/you polydrug users? (Which drugs and mixtures?)
4. Where do they/you buy and use the drugs?
5. Who do they/you use with?
6. How do they/you use the drugs?
7. How frequent do they/you use the drugs?
8. What is the amount of use?
9. Do the frequency, type of drugs, method and amount of use change over time? Why and how?
10. From your observation, how do women users get their drugs? That is, how do they finance their supply for drugs?
11. What are similarities and differences between men's use?

Consequences (Opiate/psychotropic)

1. At what point does use become a problem for female users?
2. What problems do women face in using?
    a. Health – physical and mental
    b. Finances
    c. Sex life
    d. Social life
    e. Legal
    f. Family life
    g. Children
3. What are the similarities & differences in consequences between women and men?
4. What sorts of things do women users do to take of themselves to protect their health (e.g. use of condoms, clean needles, etc.)?

Experiences in treatment (Opiate/psychotropic)

1. In the past, is there anything preventing you from going to treatment?
2. Where do you decide to quit or receive the treatment?
3. Where/who do you go to when you are in need of help?
4. Who do you usually talk to when you are in trouble?
5. Who have you talk to about seeking services? How was it?
6. What kind of treatment are you in?
7. What did you expect to happen when you first receiving treatment services?

8. What did you want to happen?
9. What things about the treatments do you like most or found helpful?
10. What things about treatment do you dislike most or do not found helpful?
11. What fears do you have about receiving services?
12. What life problems do you face when coming for services/treatment?
13. What do you think need to happen for you to continue receiving services?
14. Who do you consider to be a part of your support system?
15. Could you suggest something to make the treatment for female users better?

Closing

1. Do you or other females you know, need help with housing, health care, mental health or violence? Have you or they sought help for any of the above, and how was the experience?
2. What do you think the future trend of drug use in Hong Kong will be like and why?
3. What do you think your future drug use will be like and why?
4. Any additional areas/comments you'd like to make.

Focus Group with Female Users Who Have Successfully Quit

Thank you for your assistance in helping us with this focus group. Please be assured that your participation and identity is anonymous and confidential. Our session is intended to get a better overall understanding of female drug use, problems and service needs. Our discussion can be based on your observation of female users generally as well as your experiences.

General drug knowledge

1. Main drugs currently used in Hong Kong.
2. The purity and price. The Location of use.
3. What are the percentages for female drug users? Increasing?

What are the general characteristics of female users (Opiate/psychotropic)?

1. Age
2. Occupation
3. Education
4. Family – parents/children
5. Relationship with partner
6. Social groups affiliated
7. New immigrant?
8. How was drug used in female users family/partners and friends?
9. Living situation
10. Economic situation
11. Legal history
12. Health history (mental and physical) – Eating disorder? Depression? Physical problems? Diet?
13. Risk behaviours – Sex and drugs

Initiation and Continuation of use (Opiate/psychotropic)

1. What are the reasons for female using drugs initially?
2. At what age and under what circumstances did you take your first drug?
3. Why do they/you continue using the drugs?
4. Describe what you like and dislike about the drugs.
5. What sorts of stress were you facing when you started using? Were you experiencing problems in relationships (with partner, family or children), problems with money, work or law? What were the typical ways of managing or coping?

What is the pattern of use among female users? (Opiate/psychotropic)

1. What kind of drugs they/you are consuming?
2. What are the main drugs were they/you using?
3. Are they/you polydrug users? (Which drugs and mixtures?)
4. Where do they/you buy and use the drugs?
5. Who do they/you use with?
6. How do they/you use the drugs?
7. How frequent do they/you use the drugs?
8. What is the amount of use?
9. Do the frequency, type of drugs, method and amount of use change over time? Why and how?
10. From your observation, how do women users get their drugs? That is, how do they finance their supply for drugs?
11. What are similarities and differences between men's use?

Consequences (Opiate/psychotropic)

1. At what point does use become a problem for female users?
2. What problems do women face in using? And how do they cope?
    a. Health – physical and mental
    b. Finances
    c. Sex life
    d. Social life
    e. Legal
    f. Family life
    g. Children
3. What are the similarities & differences in consequences between women and men?
4. What sorts of things do women users do to take care of themselves to protect their health (e.g. use of condoms, clean needles, etc.)?

Experiences in treatment (Opiate/psychotropic)

1. In the past, is there anything preventing you from going to treatment?
2. Where do you decide to quit or receive the treatment?
3. Where/who do you go to when you are in need of help?
4. Who do you usually talk to when you are in trouble?
5. Who have you talk to about seeking services? How was it?
6. What kind of treatment are you in?
7. What did you expect to happen when you first receiving treatment services?

8. What did you want to happen?
9. What things about the treatments do you like most or found helpful?
10. What things about treatment do you dislike most or do not find helpful?
11. What fears do you have about receiving services?
12. What life problems do you face when coming for services/treatment?
13. What do you think need to happen for you to continue receiving services?
14. Who do you consider to be a part of your support system?
15. Could you suggest something to make the treatment for female users better?

Post-treatment

1. What kind of post-treatment do you receive?
2. What are the social supports and social services need for the drug rehab women? How does this compare for men?
3. In your observation and experiences, are these supports and services being met?
4. Do you think these factors affect the chance for relapse? How?
    - Family support
    - Vocational training
    - Employment
    - Community support

Closing

1. Do you or other females you know, need help with housing, health care, mental health or violence? Have you or they sought help for any of the above, and how was the experience?
2. What do you think the future trend of drug use in Hong Kong will be like and why?
3. What do you think your future drug use will be like and why?
4. Any additional areas/comments you'd like to make.

Focus Group with Treatment/Outreach Workers

General Questions

1. What are the main drugs currently used in Hong Kong now? Which drugs are most available now? The purity and price. The location of use.
2. What are the trends for female users? What are the reasons for this trend?
3. What percentage of your clients is female?

What are the general characteristics/Typology of your female clients (Opiate/ psychotropic)?-(break out by type – heroin, ice, X, K and polydrug use)

1. Age
2. Occupation
3. Education
4. Family – parents/children-support systems
5. Relationship with partner
6. Social groups affiliated
7. How was drug used in your female clients' family/partners/friends?
8. New immigrant?
9. Living situation
10. Economic situation
11. Legal history
12. Health situation (mental and physical) – Eating disorder? Depression? Physical problems? Diet?
13. What are the stresses in their life? And how do they typically cope or manage these stresses?
14. Which groups of users are rising?
15. Risk behaviours – Sex and drugs

Initiation and Continuation of use (Opiate/psychotropic)

1. What are the reasons for your female clients using drugs at the first time?
2. At what age and under what circumstances did your female clients take the first drugs?
3. How do your female clients get introduced to using?
4. Why do they continue using the drugs?
5. What sorts of stress are they under that might be related to using? Are they experiencing problems (with their partner, family or children), problems with money, work or the law? How to they typically manage or cope with these stresses?

What is the pattern of use among your female clients? (Opiate/psychotropic)

1. What kind of drugs they are consuming?
2. What are the main drugs they are using?
3. Are they polydrug users? (Which drugs and mixtures?)
4. Where do they buy and use the drugs?
5. Who do they use with?
6. How do they use the drugs?
7. How frequent do they use the drugs?
8. What is the amount of use?
9. How long been using?
10. How use is financed? What do they get for drugs (sex work, sell drugs, boyfriend)?
11. Do the frequency, type of drugs, method and amount of use change over time? Why and how?
12. How's this pattern compared to male?

What are the specific problems your female clients face? (Opiate/psychotropic)

1. Health – physical and mental
2. Finances
3. Sex life/disease
4. Social life
5. Work
6. Legal
7. Family life
8. Violence
9. The role of drug use in
    a. domestic violence
    b. child abuse and neglect
    c. problem parenting
10. How do they think of the "problem" (drug use)?
11. What do they define as the "problem"?
12. What do they think caused the "problem"?

Treatment/Outreach Issues (Opiate/psychotropic, Occasional Users/Frequent chronic users)

1. Where do you receive your female clients?
2. What caused your female clients to seek services?
3. At what point in their drug use? Personal life?

4. Who do they usually talk to when they are in trouble?
5. What do they expect to happen and what they want the result to be when they first start receiving services?
6. What fears do they have about receiving services?
7. Do they underuse the drug treatment services (compare to male)? How and Why?
8. What life problems do clients presents when coming for services/treatment?
9. What difficulties/obstacles do clients perceive about treatment?
10. What are the specific treatment strategies used for the female users?
11. What are the outreach strategies which can attract female users into recovery?
12. What do you think need to happen for your clients to continue receiving services?
13. Is there any special treatment for female users with children/pregnant female users?
14. Are they effective? Why or why not?
15. What are the specific access, engagement and treatment problems that you have to deal with female users?
16. How effective is the prevention strategies to reduce drug problem among women?
17. Are there any cultural factors that protect or encourage drug use? How do these factors protective or facilitating factors dealt with in your treatment efforts?
18. What methods do you use to maintain female users as client?
19. What kind of post-treatment do you provide for the female users?
20. Do you think that the social support for the drug rehab patients is enough?
21. Is there any community education trying to increase public awareness of the female drug use problem?
22. How these factors affect the chance for relapse?
    - Family support
    - Vocational Training
    - Employment
    - Community support
23. What's the relapse rate for your clients?
24. What types of clients/users are more likely to succeed or benefit from the treatment services? Why?
25. Who are the one with difficulties? Why?

Closing

1. What do you think the future trend of female drug use in Hong Kong will be like and why?
2. What efforts can be taken to make the treatment for female users more effective?

Appendix C
Demographic Characteristics of Interviewees in the In-depth Interviewers

Ref. No.	Age	Ed Level	Occupation	Drug Use				Age Start using drug	Marital status (Single, Married/Coha Divorced	Ever in Treatment
				Heroin	Ice	X	K			
A01	21	F.4	Junior Hair-dresser	-	-	Y	Y	18	S	Y
A02	20	F.5	Office Assistant	Y	Y	Y	Y	17	C	Y
A03	47	F.3	Housewife	Y	-	-	-	26	M	Y
A04	24	F.2	Night-club PR	Y	Y	-	-	13	S	Y
A05	23	P.6	Night-club PR, Waitress	Y	Y	Y	Y	12	S	Y
A06	28	F.4	Cashier	Y	Y	-	-	11	M	Y
A07	23	F.5	Saleslady, clerk	Y	-	Y	Y	15	S	Y
A08	16	F.3	-	-	Y	Y	Y	12	S	Y
A09	23	F.5	Night-club PR, Waitress	-	Y	Y	Y	21	C	Y
A10	19	F.2	Prostitute	Y	Y	Y	-	13	S	Y
A11	23	F.3	-	Y	Y	-	Y	19	S	Y
A12	23	F.5	Assistant Manager	Y	-	-	-	13	S	Y
A13	19	F.3	DJ	Y	Y	-	Y	15	C	Y
A14	23	F.1	Night-club PR	Y	Y	-	-	16	M	Y
A15	45	-	Prostitute	Y	-	-	-	15	S	Y
A16	28	F.4	Saleslady, Waitress	Y	Y	-	-	17	S	Y
A17	23	F.4	Usher	Y	Y	Y	Y	12	S	Y
A18	26	F.3	Drug courier, Shark loaner	Y	Y	Y	Y	15	M	Y
A19	19	VE	Saleslady	Y	Y	Y	-	14	S	Y
A20	25	F.3	Clerk, Junior hair-dresser	Y	Y	-	-	15	S	Y
A21	17	F.2	-	Y	-	-	-	14	C	Y
B01	20	F.3	Drug courier, Waitress	Y	-	-	-	13	S	Y
B02	22	F.2	Night-club PR	Y	-	-	-	14	C	Y
B03	25	F.3	Waitress, Junior hair-dresser	Y	-	-	-	18	D	Y
B04	28	F.4	Night-club PR	Y	-	Y	Y	16	D	Y
B05	29	-	Saleslady	Y	-	-	-	26	D	Y
B06	28	F.4	Drug courier, Shark loaner	Y	-	-	-	16	C	Y
B07	36	F.2	Prostitute, Property agent	Y	-	-	-	26	C	Y
B08	26	F.1	Waitress	Y	-	-	-	17	S	Y
B09	26	F.2	Night-club PR	Y	Y	-	-	13	D	Y
B10	40	-	Housewife	Y	-	-	-	17	M	Y

B11	23	F.2	Drug courier	Y	Y	Y	Y	12	S	Y
B12	30	F.3	Prostitute	Y	Y	-	-	21	C	Y
B13	23	F.4	Housewife	Y	-	-	-	12	M	Y
B14	30	F.5	Clerk	Y	Y	-	-	21	C	Y
B15	28	-	-	Y	-	-	-	22	D	Y
C01	35	F.2	Shop owner	Y	-	-	-	30	S	Y
C02	18	F.4	-	-	Y	Y	Y	12	S	Y
C03	24	F.4	Waitress, cashier, saleslady	Y	Y	Y	-	12	S	Y
C04	22	F.5	-	-	Y	Y	Y	16	S	Y
C05	18	F.3	Saleslady	-	-	-	Y	14	S	Y
C06	25	F.3	Cashier	Y	-	-	-	15	C	Y
C07	20	F.4	-	Y	Y	Y	Y	13	S	Y
C08	23	F.4	Night-club PR	Y	-	Y	Y	15	D	Y
C09	24	F.2	Office assistant	Y	Y	-	-	12	M	Y
C10	20	F.5	Night-club PR	Y	Y	Y	Y	16	S	Y
C11	22	F.3	Junior hair-dresser	Y	Y	-	-	17	C	Y
D01	16	F.2	-	-	Y	Y	Y	12	S	-
D02	16	VE	-	-	Y	Y	Y	14	S	-
D03	18	F.4	-	-	Y	Y	Y	13	S	-
D04	40	-	Prostitute	Y	-	-	-	30	S	Y
D05	22	F.5	Waitress	Y	-	-	Y	17	C	-
D06	15	F.2	-	-	-	Y	Y	12	S	-
D07	25	F.4	-	Y	Y	Y	Y	15	S	-
E01	30	P.6	Shop owner	-	-	Y	Y	27	M	-
E02	16	VE	-	-	-	Y	Y	14	S	-
E03	17	F.4	-	-	-	Y	Y	13	S	-
E04	16	F.4	-	-	Y	Y	Y	13	S	-
E05	14	F.1	-	-	Y	Y	Y	12	S	-
E06	18	F.3	Drug courier, data entry clerk	-	Y	Y	Y	13	S	-

* VE - Vocational Education

Appendix D
Preliminary Research Hypotheses

The following preliminary research hypotheses were included as part of this study. Although we included a discussion of some of these hypotheses in the text of the report, we specifically discuss them in this appendix. It should be noted that we were unable to address due to insufficient data.

1. Younger female users (under 21 years of age) are more likely to use psychotropic drugs than older female users (21 years of age and older).

   About 97% of younger females engage in psychotropic drug use, which is significantly higher than that of older female users (57%). This difference was statistically significant at the .001 level. This suggests that younger female users (under 21 years of age) are more likely to use psychotropic drugs than older female users (21 years of age and older). (See Table 2-4).

2. Older female users are more likely to use opiates than younger female users.

   Fifty percent of older females used opiates, which is significantly higher than that of younger female users (2%). This difference was statistically significant at the .001 level. This suggests that older female users are more likely to use opiates than younger female users. (See Table 2-5)

3. Female opiate users are more likely to initiate use with one other user (e.g., partner, significant other) than female psychotropic users.

   We did not have quantitative data to look at this hypothesis, but from our in-depth interviews, we did not find support for this hypothesis. In fact, we found that opiate users tended to initiate with a small group of friends.

4. Female psychotropic users are more likely to initiate and continue use in a peer group setting than female opiate users.

   We did not have quantitative data to look at this hypothesis, and from our in-depth interviews, we did not find support for this hypothesis.

5. Female opiate users are more likely to perceive their continued use as a form of medicine for coping with daily life than female psychotropic drug users.

   We did not have quantitative data to look at this hypothesis, but from our in-depth interviews, we found that female users who use heroin, ice, ecstasy and/or ketamine find drug use as a form of medicine for coping with their problems.

6. Female psychotropic users (except ice) are more likely to perceive their continued use as a form of recreation for stimulating their daily lives than female opiate users.

We did not have quantitative data to look at this hypothesis, but from our in-depth interviews, we found that ecstasy and ketamine users liked to consume these drugs in discos as a form of entertainment.

7. Female ice users are more likely to perceive their continued use as a method for managing their daily lives than female users of opiates or other psychotropic drugs.

   We did not have quantitative data to look at this hypothesis, and did not find support for this hypothesis from our in-depth interviews.

8. Female opiate users are more likely to continue use in isolation than female psychotropic users.

   We did not have quantitative data to look at this hypothesis, and from our in-depth interviews, we did not find support for this hypothesis. We did find that ice users tend to use in small group. Also, ecstasy and ketamine users tend to use in the presence of others when attending discos, however, some ketamine users also consume in other settings like school and karaoke bars.

9. Female users of ecstasy and ketamine are less likely to perceive adverse effects from their use than female users of ice and heroin.

   We had insufficient data to address this question.

10. Female users of ice and heroin are more likely to experience negative consequences (i.e., mental and physical health, legal, work, social and family) from their use than female users of ecstasy and ketamine.

    We had hypothesized that female users of ice and/or heroin were more likely to experience negative consequences from their use than female users of ecstasy and/or ketamine. We conducted the following analysis to examine this issue. Generally female users of ice and/or heroin are more likely to experience negative consequences from their use than female users of ecstasy and/or ketamine in terms of their family relationship, their child, at work or schooling, mental and physical health as well. Also, a significant difference was reported in their relationship amongst family member and it is noted that ice and/or heroin users are involved in more problems with sexual consequences and health problems as a result of their use**.**

11. Female users of ice and/or heroin are more likely to engage in sex work as their principal source of income than female users of ecstasy and/or ketamine users.

    About six percent of female ice or heroin users engaged in sex work as a means to earn a living, and about four percent of ecstasy and ketamine users also did so. Only a small proportion of females either consume heroin/ice or ecstasy/ketamine earn their living through sex work. No statistical difference was noted amongst these two groups of drug consumers. (See Table 4-4)

12. Occasional users are more likely to have a positive attitude towards drug use than frequent chronic users.
13. Occasional users are more likely to have limited cognition towards drug use than frequent chronic users.

    In Table 5-6, we attempted to look at hypotheses 12 and 13. The statistical analysis yield several findings, but we did not find support for these two hypotheses. First, frequent heroin users are more likely than occasional heroin users to report having problems in their relationships and altered their sexual behavior during the past year as a result of their use. Second, occasional ecstasy users are more likely than frequent ecstasy users to report that their use in the past year has affected their sexual behavior and physical health. Third, occasional ketamine users are more likely than frequent ketamine users to report that their use in the past year has affected their relationship with their children. As highlighted in the table, these findings are statistically significant. The majority of ice users were occasional users, and therefore, there was insufficient data to conduct a statistical comparison.

14. Female heroin users are more likely to access treatment than female psychotropic drug users.

    About 46% of heroin users reported receiving treatment which is comparatively higher than psychotropic drug users (31%). This finding was statistically significant at the .001 level. This suggests that female heroin users are more likely to access treatment than female psychotropic drug users. (See Table 6-6)

15. Female users with children are less likely to enter treatment compared to those who do not have children.

    Female users who don't have children have a greater probability of obtaining treatment than those who do (See Table 6-7).

16. Female users with social support are more likely to experience a longer relapse time than those female users with limited social support.

    We were unable to test this hypothesis with the available data.

17. Female users with family cohesion are more likely to experience a longer relapse time than those female users with limited family cohesion.

    We were unable to test this hypothesis with the available data.