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# Sinning and Sinned Against: The Stigmatisation of Problem Drug Users

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August 2010

Published by:
The UK Drug Policy Commission (UKDPC)
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Web: www.ukdpc.org.uk

This publication is available online at www.ukdpc.org.uk/reports.shtml

ISBN 978-1-906246-24-2



The UK Drug Policy Commission (UKDPC) is an independent body providing objective analysis of evidence related to UK drug policy. It aims to improve political, media and public understanding of drug policy issues and the options for achieving an effective, evidence-led response to the problems caused by illegal drugs.

UKDPC is a company limited by guarantee registered in England and Wales No. 5823583 and is a charity registered in England No. 1118203. The UKDPC is grateful to the Esmée Fairbairn Foundation for its support.

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# Acknowledgements

I am grateful to the UK Drug Policy Commission for giving me the opportunity to undertake this review and to Roger Howard and Nicola Singleton, in particular, for their helpful comments throughout the process. I would also like to thank Ross Coomber (University of Plymouth), Neil McKeganey (University of Glasgow), Sharon Grace and Christine Godfrey (University of York) and William (Bill) White (Chestnut Health Systems, Philadelphia) for their many valuable thoughts and comments on the report.

The UK Drug Policy Commission is very grateful to the Paul Hamlyn Foundation, the Scottish Drug Recovery Consortium and the Esmée Fairbairn Foundation for their financial support for the stigma research project, of which this report is the first part.

# Summary

This report aims to summarise what the research evidence has to tell us about the stigmatisation of problem drug users; to explore the nature of this stigmatisation, its impacts and why it happens. These considerations raise some fundamental issues about the nature of addiction and the extent to which it is seen as a moral, medical or social issue. They also raise important questions about autonomy and the blame attached to addiction.

As the title suggests, the central focus of this report is on the stigmatisation of **problem** drug users. However, this is not a self-evident term that comes with a common understanding. A pragmatic approach has been to define problem drug use in terms of combinations of particular drugs and modes of use: the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) defines it as *"injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines".*[1] It is this latter type of definition that has informed this report, but, to the degree that it is dependent on other studies and reports, this report has had to adopt the definitions used in these studies.

### WHAT IS STIGMATISATION?

Stigmatisation occurs when a person possesses an attribute or status (a 'stigma') that makes that person less desirable or acceptable in other people's eyes and which thereby affects their interactions with others. While at one level, we have all been stigmatised and all been stigmatisers at some point in the past, this phenomenon becomes much more serious when the stigma takes centre stage, to the obscuration of the rest of a person's identity: when it becomes a 'master status'. Problem drug use is one such master status.

It has been suggested that stigmatisation can only take place when there is a power imbalance between stigmatised and stigmatiser. People who are seen to be responsible for their own stigma tend to be more greatly stigmatised, as are those that are perceived to be dangerous.

Stigmatisation seems to stem from the normal way in which people make sense of the world, categorising and stereotyping people in order to simplify the great complexity of the social world. It may be functional in some respects, enhancing the self-esteem and group identity of the stigmatiser. It may also be hard-wired into our genetic make-up as a social animal, whereby the stigmatisation and exclusion of certain individuals may have helped survival of the group.

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[1] See: www.emcdda.europa.eu/themes/key-indicators/pdu

The groups most frequently referred to in the research literature and other publications on the problems associated with stigma are groups such as those with mental illness, the disabled, minority ethnic groups and also those with drug and alcohol problems. However, there is universal agreement that the objects of stigmatisation change over time and place: for all stigmatised groups, there is therefore the prospect of change for the better.

There is a large body of research demonstrating that people with mental illness are heavily stigmatised and that stigma may be a major stumbling block to successful rehabilitation. This has led to a number of initiatives in the mental health field which explicitly target stigmatisation and which may provide models or learning points for similar initiatives in the addictions field.

## RESEARCH ON PROBLEM DRUG USERS

### Public attitudes

The general public perceives problem drug users to be dangerous, deceitful, unreliable, unpredictable, hard to talk with and to blame for their predicament. Young people may have more negative views in this respect than adults. The families of users are also stigmatised, being seen as partly responsible for their relative's addiction.

### Health professionals

Hospital staff can be distrustful and judgmental in dealing with problem drug users but drug users can themselves be aggressive and manipulative. In the United States staff who choose to work in hospitals serving the most deprived, inner-city populations appear to be more compassionate and patient.

### Users' accounts

Users report that the stigmatising attitudes of others can have a profound impact on their lives, leading to feelings of low self-worth and the avoidance of contact with non-users.

The supervised consumption of methadone in pharmacies provides a unique context in which users' status as problem drug users can be made public. Many feel stigmatised by the attitudes of pharmacy staff and other customers.

Attending a drug treatment agency may also increase stigmatisation. Some users feel that the very act of seeking treatment serves to cement an 'addict' or 'junkie' identity, which can lead to further rejection from family and friends. This can prevent users from seeking treatment.

Users in methadone maintenance treatment can feel particularly stigmatised, in comparison to other treatment types.

### Policing

Street policing of problem drug users can be publicly humiliating and add to feelings of injustice, alienation and stigmatisation. This may be particularly damaging for recovering users trying to make a fresh start.

### Recovering users

A lifetime stigma appears to be attached to the use of heroin and crack cocaine. Stigma continues to haunt such ex-users, preventing access to good housing and employment.

The structured and regulated nature of employment in the UK may preclude more flexible, informal types of employment that might be suitable for the most chaotic, excluded group of problem drug users.

### Multiple stigmas

Problem drug users frequently report suffering from other stigmas: being black, female, Hepatitis C or HIV positive, disabled or suffering from a mental disorder. However, research shows the problem drug user status to be the most stigmatising.

## KEY ISSUES

### Medicalisation vs criminalisation

Viewing problem drug use as a health issue rather than a crime is likely to lead to less stigmatisation, although some health conditions are also stigmatised. The illegal status of heroin, cocaine and other drugs undoubtedly plays an important role in the strong stigma attached to problem drug users. 'War on drugs' and 'tough on drugs' rhetoric from politicians may also play a role.

### Language matters

The media are a crucial influence in how the general public forms an understanding of addiction and problem drug users. The pejorative term 'junkie' is frequently used in the bestselling newspapers in the UK and there is a strong note of invective in many of their articles.

The language that is used to denote problem drug use and problem drug users is important. One study showed that even mental health professionals are influenced by language and that describing someone as 'a substance abuser' rather than as having 'a substance use disorder' is more likely to elicit responses identifying the person as responsible for their condition and suggesting that punitive measures should be taken against them.

### Blame

Blame lies at the heart of the particular stigma associated with problem drug users. Users are blamed for taking drugs in the first place and are also perceived to have a choice whether or not to take drugs in the future.

### Is stigmatisation all bad?

Some have argued that the stigma attached to problem drug users prevents others from taking drugs by example and that the shame of stigma pushes users into treatment. However, attempts to scare young people away from drug use have not proved effective. The evidence reviewed here suggests that stigma keeps users away from treatment.

The argument has been put forward that we should continue to stigmatise drugs but not the users of those drugs. However, there are clearly strong associations between the two: the image of a drug reflects on the user of that drug and *vice-versa*. Nevertheless, the extreme nature of the stigmatisation of problem drug users argues for there being plenty of scope to stigmatise users less, without rendering heroin or crack-cocaine significantly more attractive.

## WHAT CAN BE DONE?

### Language

- The use of pejorative language in the media could be challenged by user groups, celebrities and/or advocacy groups. For example, a specific campaign could be initiated to stop the use of the word 'junkie' in the British press.

- The use of terms like 'abuse' and 'misuse' are increasingly being challenged. More thought needs to be given to terminology in the addictions field.

### Education

- Drugs education in schools could include a stronger focus on the nature, causes and consequences of addiction.

- Training for health care and pharmacy staff should include a greater focus on drugs and addiction.

- Treatment agencies need to maintain their focus on the whole person and not see problem drug users as solely problem drug users. Some drug addicts are also bird-watchers.

- Users and the families of users may also benefit from a greater understanding of the nature of addiction, which in the latter case may help to reduce the self-blame felt by many drug user's parents.

### Contact

- More imaginative ways of increasing contact between problem drug users and the general public are needed. Volunteering may be one fertile area.

- The police need to reflect on their practice in policing problem drug users at street level. Users should always be treated with respect.

### Campaigns

- Campaigns in the US have focused on the need to educate the public about addiction, treatment and recovery. These have been embraced by the likes of Arnold Schwarzenegger. Why not here?

### The law

- The law has an important symbolic role but may have limited practical value in that laws do not, of themselves, change attitudes.

### Managing stigma

- Approaches that allow users to manage their (ex-) drug user status through removing needle track marks and tackling dental problems may yield benefits in terms of social reintegration.

## RESEARCH

This is a comparatively unexplored area, especially in the UK. Among other things, we need studies on:

- Media reporting on problem drug users, including a focus on the language used.
- Experiments in the UK employing vignettes to explore stigmatisation, including the impact of language.
- The nature of the blame attached to addiction and how this can be changed.
- The role of stigma in preventing access to drug treatment.
- Users' experiences of stigma in primary and acute care settings.
- The stigma experienced by problem drug users in pharmacies.
- Trends in the attitudes of the general public through regular survey.
- Discrimination and stigmatisation experienced by recovering users seeking employment, housing and other services.
- The actual dangers posed by problem drug users, compared with public perceptions.

## CONCLUSION

Stigmatisation matters. We feel stigma exquisitely because we are fundamentally social in our make-up. Problem drug users are a very strongly stigmatised group and this has a profound effect on their lives, including their ability to escape addiction.

Blame lies at the heart of this stigmatisation and yet it is this blame that makes it hard for problem drug users to be adopted as an unfairly treated group, alongside clearly blameless groups such as the mentally ill and the disabled.

Those seeking to reduce the stigmatisation of problem drug users therefore need to challenge the entrenched and widespread assumption that users are solely culpable for their condition by educating people, including health professionals and the media, about the causes and nature of addiction. While some aspects of the state of drug addiction are disease-like, others are inherently social and psychological. The root

causes of addiction are perhaps best understood as a complex nexus of genetic and environmental risk factors that develop over time. This interacts with the social, psychological and physiological impacts of the addiction itself to produce individuals who are frequently socially excluded, with precarious or non-existent employment, housing and relationships. Such a model of addiction leaves little room for simplistic blame: how can an individual be blamed for his/her genetic and early family background?

A further conclusion is that there needs to be a consideration of the role of stigmatisation in preventing the social reintegration of problem drug users. If recovery really is to be the ambitious 'new' goal of drug treatment, then politicians and policy-makers will have to look carefully at the question of stigma and how they and others can shift society towards a more compassionate approach to this deeply stigmatised group.

# 1. Introduction

On one level, stigma is a universal phenomenon. Nearly all of us will have felt stigmatised and or have stigmatised others at some point in our lives. The stigma might consist of wearing glasses or certain clothes, having a regional accent or a particular music preference or one's employment (or lack of employment). Depending on the context, all of these examples might have serious consequences for the stigmatised, but it is where the stigma overrides all other aspects of a person's identity and where it hangs over and affects their interactions with others that the impact can be very great.

The focus of this report is on the stigmatisation of problem drug users, a group for whom the 'addict' identity tends to take centre stage, to the obscuration of all other facets of identity and personality, and a group that is very near the top of the nation's list of pet hates. Negative views are common throughout society, including among some of the professionals that work with drug users. Some of the most extreme views are expressed within national newspapers, which frequently adopt a vilifying tone and abusive language in reporting on 'junkies'. On the other side of the equation, problem drug users frequently create a lot of trouble for those close to them, those working with them, communities and wider society. They also seem to bring their problems on themselves: many will feel that they 'chose' to take drugs in the first place, and that all they need to do now is to stop taking them.

This report aims to summarise what the research evidence has to tell us about the stigmatisation of problem drug users; to explore the nature of this stigmatisation, its impacts and why it happens. These considerations raise some fundamental issues about the nature of addiction and the extent to which it is seen as a moral, medical or social issue. They also raise important questions about autonomy and the blame attached to addiction.

### OUTLINE OF REPORT

The final section of this chapter provides a brief commentary on the methods used to review the literature on which this report is based. Chapter 2 provides a brief introduction to the general literature on stigma. Chapter 3 addresses the question of who gets stigmatised and which stigmatised groups are the focus of concern. Chapter 4, the largest section of the report, focuses on the research literature on the stigmatisation of drug users, including the attitudes of professionals and the general public and the views and experiences of problem drug users. The final chapter, Chapter 5, offers a discussion of some of the key issues that come out of the literature review and a consideration of what could be done to counteract the stigmatisation of problem drug users.

## METHODS

Different strategies were adopted for reviewing the literature on the stigmatisation of drug users and for reviewing the general literature on stigma. Given limited time, a highly selective approach was taken to the latter. From initial reading of a number of articles and papers, it was realised that four of the key texts were Goffman's *Stigma: Notes on the Management of Spoiled Identity* (1963), Jones et al.'s *Social Stigma: The Psychology of Marked Relationships* (1984), Link and Phelan's paper 'Conceptualising stigma' (2001) and Heatherton and colleagues' edited book *The Social Psychology of Stigma* (2000). As a starting point, these were read and notes taken. Other chapters, books and papers on the general subject of stigma were then accessed and read as they arose in the context of reading these texts and in the review of the drug literature.

To identify relevant papers for the more thorough review of research on the stigmatisation of problem drug users, searches were conducted of the following databases: DrugScope's DrugData, PubMed, PsycINFO and the Social Sciences Citation Index. Multiple search terms were used, including 'drug', 'substance abuse', 'stigma' and 'discrimination'. Only English language papers published in peer-reviewed journals and book chapters were included. Large lists of papers were identified in each search and abstracts were read to assess relevance. By this method, 90 papers were identified and accessed. Each was then read and notes taken. This led to the identification of further relevant references, and a further 70 relevant papers were identified and read. Many of these papers proved not to be of central relevance to the study, but all were read, which helped to give the author a wider perspective on the issue.

In reporting on the literature, the aim has been to include all the relevant references. However, the amount of attention given to each source has varied according to its centrality to the issue under scrutiny and also according to the nature of the study. While quantitative studies have been extensively referenced and described, probably been more text has been devoted to qualitative studies. This was not a conscious strategy adopted by the author, but rather arose because of the nature of stigmatisation (as conceived by Goffman, see Chapter 2). Stigmatisation involves a complex set of attitudes and behaviours, which play out in the interaction between people in a variety of settings. While quantitative research has very usefully identified and measured aspects of this process ('social distance' being a commonly used metric), qualitative research seems better able to capture this complex and dynamic process in its entirety.

In reporting on qualitative studies, there is the danger that quotations from individuals interviewed in these studies can be used out of context to make a particular point, regardless of their role within the original text. An effort was made to ensure that quotations are used in a balanced way, to exemplify the key points made in the original studies.

This report has a UK-bias, in that an attempt has been made to cover any relevant research from the UK first and then other English-language studies from around the world.

Finally, the themes that were identified for discussion came out of the reading and analysis of the literature in an inductive manner: there was not a predefined set of issues to cover.

## LANGUAGE

As the title suggests, the central focus of this report is on the stigmatisation of **problem** drug users. However, this is not a self-evident term that comes with a common understanding (National Audit Office, 2010). Some have used the term in a literal sense, to mean drug use which causes problems (be they medical, legal or social problems). However, there is then a question of the severity of these problems – does a heavy caffeine habit constitute problem drug use? A pragmatic approach has been to define problem drug use in terms of combinations of particular drugs and modes of use: the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) defines it as *"injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines".*[2] It is this latter type of definition that has informed this report, but, to the degree that it is dependent on other studies and reports, this report has had to adopt the definitions used in these studies. An attempt has therefore been made to identify clearly how the term has been use in these referenced studies. The author's use of the term in the discussion in Chapter 5 corresponds with the EMCDDA definition (although excluding the type of long-duration, regular, controlled use of heroin studied by Warburton et al., 2005).[3]

This issue is important for a number of reasons, but perhaps most crucially because the issues relating to the stigmatisation (and stereotyping) of users of 'recreational' cannabis, alcohol, ecstasy and other drugs are very different from those relating to problem drug users. They are certainly worthy of study but are not covered here.

Writing about stigma makes one painfully aware of the potentially stigmatising nature of the language that one uses. It has been pointed out by colleagues that the term 'problem drug user' could be seen as potentially stigmatising in that it seems to label a person as a problem. However, employing the EMCDDA definition, it is hopefully clear that it is the drugs that are the problem – i.e. the definition relates to the mode of use of particular drugs. Problem drug users are people who use these (frequently) problematic drugs in problematic ways.

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[2] See: www.emcdda.europa.eu/themes/key-indicators/pdu

[3] Rather than rendering the text tedious by endlessly referring to problem drug use, the terms 'drug addiction' and 'drug dependence' have also been used in places.

# 2. What is stigma?

The word 'stigma' has an interesting and revealing history. The word originates from an ancient Greek word meaning tattoo or puncture mark made with a sharp object. This stems from a practice in ancient Greece of branding slaves with a pointed stick to ensure universal recognition of their status and to prevent them from absconding. From this origin, the English word has taken on a variety of meanings, including blemishes on the body, such as birthmarks, and marks said to appear spontaneously on people's wrists and feet signifying Jesus Christ's crucifixion wounds. However, in this report, the focus will be on stigma's central modern meaning, as *"a mark of disgrace or infamy; a sign of severe censure or condemnation, regarded as impressed on a person or thing; a 'brand'"* (Oxford English Dictionary, compact edition). It is this meaning that has been used in the substantial sociological and psychological literature to describe the ways in which visible or symbolic 'marks' can lead to the discounting and discrediting of an individual or group.

The ideas of stigma and stigmatisation are closely identified with the North American sociologist Erving Goffman, who wrote the widely referenced *Stigma: Notes on the Management of Spoiled Identity* (Goffman, 1963). However, other relevant streams of thought from a slightly earlier period include Edwin Lemert's social construction of deviance (Lemert, 1951), which described the way in which an individual behaving in a certain way can then be given a negative label by authority figures ('primary deviance'). If the 'deviant' person then accepts this label, it becomes part of his or her identity – Lemert's 'secondary deviance'. Thus, deviance was seen by sociologists like Lemert as being socially constructed and therefore something that varied across time and between cultures, rather than being something intrinsic to the act itself. Deviance was seen as resulting from social **interaction** between people, with both deviant and authority figures playing key roles in its creation.

### GOFFMAN

The idea of interaction also lies at the heart of Goffman's fascinating and rather modestly titled *Notes on the Management of Spoiled Identity*, in which Goffman provides a detailed account of the ways in which stigmatised individuals interact with others and how this interaction is shaped by their mutual awareness of the presence of stigma. Goffman describes how stigma arises when a person possesses an attribute that makes him/her different from others *"and of a less desirable kind – in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma"* (Goffman, 1963: p.12). He goes on to describe three type of stigma: first, there are 'abominations of the body', such as physical deformities. Second, there are the *"blemishes of individual character perceived as weak will, domineering or unnatural passions, treacherous and rigid beliefs, and dishonesty"*

(p.14) – blemishes which come from the knowledge that the person has a history of mental health problems, imprisonment, addiction, homosexuality etc. Third, there are the 'tribal' stigma of race, nation and religion. In all of these cases, the stigma has the power to radically change people's views and responses: *"an individual who might have been received easily in ordinary social intercourse possesses a trait that can obtrude itself upon attention and turn those of us who he meets away from him, breaking the claim that his other attributes have on us"* and rendering him "*not quite human"* (p.15).

Goffman gives detailed accounts of the manner in which a person's stigma can affect the way in which people respond to that stigmatised person. He also explains how the stigmatised person tends to hold the same beliefs and identity as 'we' do and how *"the standards he has incorporated from the wider society equip him to be intimately alive to what others see as his failing"* (p.18). In cases where an individual's stigma is clear and unavoidable, Goffman describes him/her as 'discredited', and where it is not known, as 'discreditable'. The discreditable frequently try to control information about themselves to avoid revealing their stigmatised status. Doing so is described by Goffman as 'passing' (i.e. passing as 'normal').

Goffman also refers to 'courtesy' stigma, i.e. the prejudice people experience as a result of their proximity to a stigmatised person. Thus the parent of a problem drug user can be stigmatised simply because of the association with their offspring's addiction.

Not all are unsympathetic to the plight of the stigmatised. Goffman describes how support can come from others who share their plight. Support or action groups can develop and members can become representatives or 'speakers' for their stigmatised category, providing *"a living model of fully-normal achievement, being heroes of adjustment who are subject to public awards for proving that an individual of this kind can be a good person*" (p.37). Indeed, *"a stigmatised person may find that the 'movement' has absorbed his whole day, and that he has become a professional"* (p.38). Such descriptions may have some resonance for those working in, or familiar with, the user movement in the drug field.

Goffman, while listing potential stigmas, including drug addiction, at various points does not really deal with why some attributes come to be stigmatised and others do not. However, he is clear that the set of attributes that are stigmatised changes over time – referring, for example, to the reduction in stigma associated with Irish ethnicity and with divorce in the USA. He also recognises that people cannot be divided into the stigmatised and the normal: people generally experience both roles at different times and in different places. However, the problem is that some get 'typecast', playing the stigmatised role in almost all social situations.

### OTHER PERSPECTIVES

There is not the space here to go into the considerable body of other psychological and sociological literature on stigmatisation in any detail. However, two pieces of work that

have greatly contributed to the development of the concept of stigma will be briefly mentioned.

### Jones and colleagues

An excellent account of stigma from a social psychological perspective is given by Jones and colleagues in *Social Stigma: The Psychology of Marked Relationships* (Jones et al., 1984): an account which carries many implications for the stigmatisation of drug users. Jones and his fellow authors emphasise the universality of stigmatisation: *"we cannot escape frequent contact with those who deviate noticeably from norms of appearance and behaviour"* (p.4). Like Goffman, they see stigmas as differing across cultures and between individuals: *"a condition labelled as discrediting or deviant by one person may be viewed as a benign and charming eccentricity by another"* (p.5). Moreover, again like Goffman, they point out that nearly all of us have experienced both sides of the stigmatising relationship, experiencing negative responses to our acne, nationality, weight, glasses, baldness etc. but also reacting to the stigmas of others. This stigma can consist of a physical 'mark' or it can be more subtle: a *"deviant comportment suggesting drug abuse or alcoholism"* (p.8) or the knowledge that someone is dying of cancer.

Jones et al. explain how stigmas vary by the degree to which they are seen as justifiable by the stigmatised and the stigmatiser. One of the key factors underlying this variation is perceived blame: *"The effect of the marked person's responsibility for creating her or her own mark seems especially important"* (p.56). Those judged to be responsible are treated worse. The authors describe research undertaken by Vann and published in 1976 in which an overweight person's weight was attributed to different reasons: either a gland disorder or an *"excessive fondness for eating"*. Participants were then required to administer electric shocks to the overweight person. The author concluded that *"observers react more antagonistically … towards an obese confederate [by giving longer electric shocks] if he is held responsible for the disfavoured status than if he is held to be an innocent victim"* (Vann, 1976: p.116, quoted in Jones et al., 1984). People may be eager to blame the stigmatised for their stigma for self-serving reasons. Seeing homeless people on the street can make people feel guilty and powerless and blaming them can free them from this guilt: *"since it is a just world, the sufferers must deserve their fate, having brought their misfortune upon themselves through laziness or sin"*. Citing Lerner's 'just world hypothesis' (Lerner, 1980), Jones and colleagues describe how we seek to exclude ourselves from people who have suffered terrible accidents or illness: *"Are these paraplegics, blind people, and sufferers from cancer really innocent victims, and are we, therefore, candidates for suffering the same fate?"* (Jones et al, 1984: p.60). In the same way, it seems likely that we have an investment in blaming people whose lives have been shattered by addiction: it takes us out of the category of people who might suffer a similar fate and reaffirms our belief in a fair and just world. As we will see, blame and responsibility lie at the heart of debates about the stigmatisation of drug users.

Another important factor dictating the degree of stigma accorded to a particular 'mark', according to Jones et al., is the perceived danger posed by the stigmatised.

*"Investigations of a variety of blemishes have shown that the more dangerous the possessor is thought to be, the more rejected he or she is"* (p.65).

One way of lessening or escaping stigma is for the stigmatised to repent: *"The repentant deviant is one who acknowledges a fall from grace, and by that fact confirms the validity of the normative system his behaviour has transgressed."* According to Jones et al., the reformed or recovered drug addict is one such 'repentant deviant'.

Jones et al. describe how the process of stigmatisation stems from the normal way in which people make sense of the world. *"Stereotyping and categorising are interrelated … Both processes reflect the tendency of the human mind to organise and simplify the overwhelming complexity of the social and physical world"* (p.155). The problem comes when their membership of a particular group becomes the defining feature of their identity: their 'master status' (Goffman, 1963). Jones and colleagues assert that *"A blind person … can never just be a college student or a lawyer, at best he or she will be 'the blind college student' or 'the blind lawyer'"* (p.157). Such attributes can 'engulf' an individual's identity, becoming *"the filter through which his or her other characteristics are seen"* (p.296). It seems probable that 'the drug addict' is, likewise, a master status, fundamentally affecting how we understand and respond to drug users and blinding us to other attributes and other aspects of personality and lifestyle. But is such a process therefore unavoidable and inevitable? Jones and colleagues think not. *"We see no reason to assume that the level of stigmatisation is necessarily fixed – either for individuals or for societies. We are optimistic that the frequency and intensity of stigmatisation can be reduced in our society through a greater recognition of our avenues of susceptibility and a fuller understanding of the negative social consequences of stigma"* (Jones et al, 1984: p.300).

**Link and Phelan**

Link and Phelan (2001) in their paper *Conceptualizing Stigma* add another important dimension to the description of stigma: the importance of power relations. They describe five interrelated components that converge to result in stigma: labelling, stereotyping, separation of us and them, status loss and discrimination, and power differences. With regard to labelling, they point out that the majority of differences between people are ignored. Only some, such as skin colour or gender, carry social significance. Stereotyping occurs when a label links a person to set of undesirable characteristics, often in an automatic and unconscious way. This stereotyping of others as having bad characteristics facilitates the separation of 'us' and 'them'. Link and Phelan also point to language as another means of aiding this separation: in terms such as 'schizophrenic' or 'drug addict', *"incumbents are thought to 'be' the thing they are labelled"* (p.370), rather than a person with schizophrenia or a person addicted to drugs. They contrast this with the situation for people with diseases such as cancer, heart disease or flu, where there are no comparative terms. When people are labelled, stereotyped and set apart, they lose status and experience individual and structural discrimination. Finally, the creation of stigma is *"entirely dependent on social, economic and political power"* (p.375) – that is, a power imbalance between the stigmatised and the stigmatisers. This, Link and Phelan argue, is why groups such as those with mental disorder, obesity or physical disability are stigmatised, whereas

lawyers, politicians or Wall Street investors are not.[4] One group has to dominate in order to stigmatise another group, but the stigmatised group also has the potential to resist the stigmatisation process.

Link and Phelan conclude that efforts to change stigmatisation have to be multidimensional, including the ability to change either deeply held stigmatising beliefs within powerful groups or the power balance between groups.

In a later article, Link et al. (2004) revisited their stigma model, adding emotional responses as an extra dimension. According to this formulation, the stigmatiser is likely to experience anger, irritation, anxiety, pity and/or fear as part of the stigmatisation process, while the stigmatised may feel embarrassment, shame, fear, alienation and/or anger.

### Other distinctions

A common distinction has been made between 'enacted' and 'felt' or 'perceived' stigma (e.g. Jacoby, 1994). Enacted stigma refers to the discrimination experienced by the stigmatised in terms of exclusion from employment, housing etc. Perceived stigma refers to a stigmatised person's views on how his/her stigma is regarded by others: for example, how common stigmatising attitudes are among the general public. A further distinction is the concept of 'self-stigma' (Luoma et al., 2007), which describes the feelings of shame, fear and negative thoughts associated with stigmatisation and the self-exclusion (e.g. from treatment) that may result from it.

## WHY DOES STIGMATISATION HAPPEN?

While the authors referred to above have sought to describe stigmatisation and the processes that underlie it, a fundamental question that has rarely been addressed is why stigmatisation happens at all? The ubiquity of stigmatisation across human (and arguably some non-human) societies suggests that it is functional in some way: that it has purpose.

A number of 'functional' theories of stigmatisation have been proffered. At the individual level, it can enhance the self-esteem or social identity of the stigmatiser through 'downward comparison' with devalued groups (e.g. Stangor and Crandall, 2000). It has also been argued by many (including Jones et al., 1984) that stigmatisation, like stereotyping, is a way of making sense of the world. It provides us with a set of expectations about people: their likely behaviour, values and lifestyles. Part of this function may be to help us identify and avoid potentially dangerous people. This threat can be tangible and physical or psychological (as in Jones et al.'s threat to one's belief in a 'just world'). It also serves to strengthen the group to which a

[4] Although, writing at the time of the global economic downturn, Wall Street investors provide a good example of how the stigmatisation of particular groups can change over time, being blamed by many for the selling-on of subprime mortgage-backed securities which led in large part to the downturn. It is not inconceivable that some discreditable investors and bankers may be passing as 'normal' in some social contexts in the UK.

stigmatiser belongs. As Falk (2001, p.340) points out, this can be linked with the work of Durkheim, who saw the existence of deviant, stigmatised groups as functional, in part because they increase a sense of community among the unstigmatised.

Another important functional perspective holds that the process of stigmatisation is effectively hard-wired into our genetic make-up. Authors such as Neuberg and colleagues (2000) and Gilbert (2004) point out that the ubiquity of stigmatisation in human societies argues for it being rooted in our *"biologically based need to live in effective groups"* (Neuberg et al., p.33). Because humans are fundamentally social in their make-up, with survival linked to our ability to live and act reciprocally with other humans, there has arisen a stigmatisation of those who do not 'play fair', do not reciprocate, and who thereby threaten the functioning and survival of their group. Neuberg et al. refer to the examples of thieves, the physically disabled and traitors/cheats as groups who are very frequently stigmatised as, they argue, a consequence of their inability or wilful desire not to reciprocate. These authors are clear that they do not regard these innate propensities as deterministic: *"just because certain stigmas were adapted for the social and physical environments of our evolutionary past, this does not imply that they are adaptive today, or morally justifiable"* (pp.34–35). So some of the roots of stigmatisation may lie in the evolutionary development of mankind as a highly social animal. Similar processes have been observed in chimpanzees, which have been observed to reject diseased or incapacitated group members (Goodall, 1990, referenced in Gilbert, 2004).

## STIGMATISATION, STEREOTYPING, DISCRIMINATION AND PREJUDICE

A definition of 'stigma' has been given above, along with accounts of how stigma has been understood by a number of commentators. However, how does stigmatisation differ from terms such as 'stereotyping', 'discrimination' and 'prejudice'? It is worth pointing out at the outset that different authors have used all of these words in very different ways. As Link and Phelan (2001) point out, many writers on stigma offer no definition, provide their own or simply refer to Goffman's well-worn definition of an 'attribute that is deeply discrediting'. It is clear that stigmatisation revolves around a 'mark' – admittedly one that might be invisible – but a mark or 'stain' that denigrates an individual. Groups of individuals that have such a mark may become stereotyped – i.e. other traits or characteristics are (often wrongly) assumed to be associated with the 'mark' through a process of generalisation referring to a group prototype (Biernat and Dovidio, 2000). Stigmatisation is therefore intimately connected with stereotyping. According to Goffman (1963: p.14), *"A stigma … is really a special kind of relationship between attribute and stereotype"*, and in a number of accounts of stigmatisation, stereotyping is a necessary step on the road to stigmatisation (e.g. Link and Phelan, 2001). Prejudice is generally used to describe an antipathy towards an individual or a group based on an inaccurate (and stereotypical) generalisation. In a sense it is the flip-side to stigma in that *"the person who is stigmatised is almost always the target of prejudice"* (Dovidio, Major and Crocker, 2000): while the stigma is with the stigmatised, the prejudice is with the stigmatiser. Finally, discrimination describes the unfair treatment frequently experienced by the stigmatised. They may experience disadvantage in seeking housing, education or jobs, for example.

As its title suggests, this report focuses on stigma. However, given the considerable overlaps between these concepts, Chapter 4, which focuses on the research literature relating to drug users, also includes associated concepts such as discrimination, stereotyping and prejudice.

# 3. How stigmatisation has been understood and applied in other fields

## WHO ARE THE STIGMATISED?

A central point of agreement across virtually all commentators on stigma is its changing nature: even biological theories tend to accept that, while there may be an underlying predisposition to stigmatisation, its precise form is culturally determined (Neuberg et al., 2000). For all stigmatised groups there is therefore the hope of change. One group historically highly stigmatised in Western and other societies is homosexual people. While homosexual men and women are still stigmatised in many contexts in the UK, there is evidence of dramatic changes in attitudes, with younger generations increasingly less stigmatising of homosexual relationships. The British Social Attitudes survey results have shown that the proportion of people thinking that sexual relations between two adults of the same sex are 'always' or 'mostly' wrong has declined from 62 per cent in 1983 to 36 per cent in 2010 (NatCen, 2010). Another example here is unmarried motherhood, negative attitudes to which have greatly declined (Falk, 2001).

So, which are currently the most stigmatised groups in our society? The groups most frequently referred to in the research literature and other publications on the problems associated with stigma are groups such as those with mental illness, the disabled, minority ethnic groups and also those with drug and alcohol problems. As Room (2005) has pointed out, in much of this literature stigma is *"taken for granted as a discriminatory social evil"* (p.150). While Goffman's original work took a disengaged, sociological approach to the issue, much that has been published since has concentrated on the negative nature of stigmatisation, decried it and made recommendations about how it might be countered. According to Bayer (2008), as these researchers *"mapped the contours of suffering imposed by stigma, [they] tended to adopt a posture of advocacy"* (p.468) and impassioned language. There is a clear assumption in this literature that the stigmatisation of these groups is a bad thing – a social evil – and that it needs to be changed. While this is understandable given the vulnerability of many of the groups studied, such a stance precludes some logical possibilities that should be considered: for example, some forms of stigmatisation might, on balance, be a good thing. It might deter others from joining a stigmatised group (if this is a matter of choice). Some might argue that particular groups simply 'deserve' to be stigmatised, on account of what they have done to other people: i.e. stigmatisation can have a positive, moral function. The positive functions of stigma will be further considered in Chapter 5 in relation to drug use.

A further effect of the 'social evil' approach to stigmatisation may be that it has distorted our understanding of stigma. It could be argued that, in our current society, the most stigmatised groups in society at present are child murderers and paedophiles. These are undoubtedly highly stigmatised groups, where publically revealing oneself as belonging to such a group in almost any social context would result in social exclusion and, quite possibly, violence. Other such groups, which would attract similar, if slightly less, opprobrium are rapists and drug dealers. It is interesting, therefore, that the most stigmatised groups are not a central focus of the stigma literature – they are, rather, studied by criminologists, who employ concepts such as 'deviance' and 'moral panics' (see Room, 2005). The stigmatisation literature has instead focused on those groups who experience stigma on account of a status for which they cannot be readily blamed: the disabled or those with mental illness or a disease. Indeed, the blameworthiness of individuals and groups lies at the heart of a modern understanding of stigma – and yet this is a point largely missed in the literature. This observation is of great significance to the stigmatisation of drug users: a group which is seen by some as victims but by many as offenders, and, crucially, as a group of people who have brought their predicament upon themselves. Do they 'deserve' to attract the word 'stigma', with all the intimations of unfairness that this term seems to bestow?

For those groups where research and professional experience have clearly identified a negative impact of stigma, the term and the concept have become important weapons in the battle against unfair treatment. Perhaps this is most obvious in the field of mental health, where programmes have been set up explicitly to decrease the stigma associated with mental illness. A brief summary of recent developments in this field will be given before turning to drug use in the Chapter 4.

### MENTAL ILLNESS

There is a large body of research demonstrating that people with mental illness are heavily stigmatised (e.g. Corrigan and Penn, 1999; Link et al., 1997; Byrne, 1999). One of the most frequently cited studies (Link et al., 1997) showed that while the mental health of a sample of men with dual diagnoses of mental illness and substance abuse improved over a one-year period following treatment entry, levels of perceived stigma did not change: they continued to feel equally stigmatised. The authors concluded that stigma was a major stumbling block to successful rehabilitation. Surveys (e.g. Crisp et al., 2005) have also shown a high prevalence of negative attitudes among the general population towards people with mental illness.

Such concerns have led to a number of initiatives in the mental health field which explicitly target stigmatisation, involving government policy, voluntary agencies and professional bodies. In 1998, the Royal College of Psychiatrists launched its five-year programme, Changing Minds: Every Family in the Land (Crisp, 2000). This began and ended with surveys of public opinion concerning attitudes towards people with mental illness, to establish any changes over time. The programme itself was multifaceted, including a dedicated campaign website with a variety of campaign materials, a two-minute film shown in cinemas, leafleting and advertisements in the London Underground. The repeat survey in 2003 found a similar pattern of responses, although a number of small decreases in negative opinions occurred: in particular,

there was a tendency for fewer people to endorse the statement that people with mental disorders 'feel different from us' (Crisp et al., 2005). The authors are careful not to ascribe these changes to the campaign, but these surveys show how public opinion on stigma may change over time and that such changes can be measured.

Similarly, the Department of Health supported a campaign aimed at reducing the stigma and discrimination associated with mental illness over 2001 to 2003 (mindOUT), with a particular focus on the workplace. This remit has since been picked up by Shift, part of the government-supported National Mental Health Development Agency. Alongside this, in Scotland, the 'See Me' campaign has been underway since 2002.

Finally, the Time to Change initiative has recently been set up to 'end stigma and discrimination' associated with mental illness. With funding from the Big Lottery Fund and Comic Relief, the programme will include local community projects, a national campaign, support for legal cases and training for medical staff.

From these examples, it is clear that tackling the widespread stigma associated with mental illness is an on-going national priority throughout the UK. What of the stigma associated with drug use?

# 4. The stigmatisation of problem drug users

The preceding chapters have aimed to set the scene in terms of our general understanding of stigma and how these ideas have influenced initiatives in the mental health field. This chapter now turns to the main subject of this report, the stigmatisation of drug users. The aim in this chapter is to summarise what we know about the stigmatisation of drug users from research. It is divided into two main sections: the first focuses on the potential stigmatisers – i.e. studies of attitudes among the general public, professionals working with users and young people; and the second focuses on the experience of stigma from the perspective of drug users. Finally, the chapter looks at stigma and recovery and at multiple stigmas.

## ATTITUDES OF THE PUBLIC, PROFESSIONALS AND YOUNG PEOPLE

### Public attitudes towards drug users

Unlike for some issues, there is no regular, standardised survey of the public's attitudes to drug users which could be used to describe how people's views might have changed over time. Instead we have snapshots from one-off (or in one case, once repeated) surveys, which have employed different measures and were undertaken for different purposes.

Several UK surveys have found that around one-fifth to one-quarter of people know of someone with experience of drug addiction (Roberts, 2009; Crisp et al., 2005). So for a substantial number of people, attitudes to problem drug users are not just based on indirect sources such as the media. Detailed information on stigmatising attitudes among the general population is provided by the Royal College of Psychiatrists' surveys, referred to in Chapter 3. This study included questions on attitudes to drug addiction in both the 1998 and 2003 surveys, undertaken on behalf of the Royal College by the Office for National Statistics.[5] Respondents were asked how far each of eight statements applied to a person with a drug addiction. In both years, substantial proportions (60 to 78 per cent) agreed with drug addicts being 'dangerous to others', 'unpredictable', 'hard to talk with' and having 'only themselves to blame'. However, fewer than half thought that drug addicts 'feel different from the way we feel at times', 'could pull themselves together if they wanted', 'would not improve if given treatment' or 'will never recover fully'. People with drug addiction were considerably more stigmatised than those suffering from the mental illnesses included in the survey,

[5] The questions were included in the National Statistics Omnibus Survey, a household survey with a robust methodology.

including severe depression and schizophrenia, and people suffering from alcoholism. In particular, drug addicts were thought to be more dangerous, unpredictable, hard to talk with and to blame for their condition. While the patterns of responses to the 1998 and 2003 surveys were largely similar, there were some significant differences. In particular, there was a (statistically) significant drop in the proportion of people stating that drug addicts had only themselves to blame (from 68 per cent in 1998 to 60 per cent in 2003).[6] Conversely, there was a (statistically) significant increase in the proportion agreeing with the statement that drug addicts never fully recover (from 23 per cent to 26 per cent). Interestingly, in an analysis summing the data from both the surveys, it was found that a higher proportion of respondents in younger age groups expressed negative views about all of the mental disorders except panic attacks. Furthermore, while 87 per cent of people aged 16 to 19 expressed negative views about drug addiction, only 64 per cent of those aged 65 and over did so.

More recently, a survey of public attitudes to drugs and drug users in Scotland included a detailed set of questions on heroin users (Ormston et al., 2010).[7] Unusually, this survey included a focus on underlying beliefs about the causes of heroin addiction and attitudes to living near and working with recovering or ex-heroin users. On the issue of causes, 29 per cent agreed with the statement that 'most heroin users come from difficult backgrounds' and 53 per cent disagreed (14 per cent neither agreed nor disagreed).[8] On the statement 'most people who end up addicted to heroin only have themselves to blame', 45 per cent agreed and 27 per cent disagreed (with 25 per cent neither agreeing nor disagreeing). One might assume that these were competing explanations – i.e. that people either saw heroin users as coming from difficult backgrounds or only had themselves to blame. However, further analysis showed that this was not the case: using a table in the report to separate people into discordant (agreed with one statement, disagreed with the other) and concordant cases (agreed or disagreed with both), there appears to be more discordant (439) than concordant (376) individuals, but this difference is not very great. The authors conclude that these data may demonstrate that people are unsure of the causes of heroin use or that there may be other beliefs not addressed in these questions. Either or both may be the case, but it is also possible that for many people these views are not in opposition: i.e. they can still blame users while also recognising their damaged backgrounds, and vice versa. Interestingly, answers to both questions were associated with a number of socio-demographic variables, so that believers in difficult backgrounds tended to be younger, in managerial and professional backgrounds and have children. Believers in

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[6] There was also a significant decrease in the proportion of people stating that drug addicts 'feel different from the way we feel at times'. This seems hard to interpret in the context of drug addiction and the authors mention that some respondents had difficulty in understanding the statement.

[7] The drugs module formed one part of the wider Scottish Social Attitudes (SSA) household survey, which involved face-to-face interviews with 1,482 participants in 2009.

[8] For anyone trying to add up the percentages, 3 per cent of people failed to answer the 'difficult backgrounds' question and 2 per cent failed to answer the 'blame' question. Rounding percentages then led to a total of 99 per cent.

blame tended to be less liberal,[9] have no friends or family members who have used drugs and have fewer qualifications. While these findings are complex, they are also intriguing and suggest that there would be merit in further exploration of people's attitudes to the causes of addiction in future research.

Ormston et al. (2010) also examined how respondents felt about proximity to heroin users. All respondents were asked how comfortable they would feel if 'someone who was getting help to stop using heroin' was moving into a house or flat very near to them. Those who were in employment were asked how comfortable they would feel if they heard that they would be working with someone who had used heroin in the past. Only 26 per cent of the sample reported that they would be very or fairly comfortable with the prospect of a recovering heroin user moving in. By contrast, almost half (47 per cent) of those in work said that they would be very or fairly comfortable working with someone who had used heroin in the past. People in urban areas, and those on lower incomes were more likely to feel happy with heroin users moving in nearby (possibly reflecting the greater number of users in such areas). Those comfortable working with ex-heroin users were more likely to be older, to have tried cannabis, have a using friend or family member, be more liberal and be more socially connected with the area they lived in.

Another UK survey (Luty and Grewal, 2002) employed a postal survey to explore public attitudes to drug addiction. The response rate was 29 per cent, as one would expect for a survey of this sort, but this raises questions about the type of people who responded (and did not respond). Results showed that while 28 per cent regarded most drug addicts as having a mental illness, 38 per cent regarded them as criminals. Seventy-eight per cent thought that drug addicts were 'deceitful and unreliable', 30 per cent thought that they deserved whatever misfortune befell them, 62 per cent thought that the law was too soft on them and 40 per cent thought that drug addicts should have their children taken into care. As the authors conclude, *"the results clearly indicate a negative view of drug addicts"* (p.94).

Surveys undertaken in the USA confirm the greater stigmatisation expressed toward drug addiction in comparison to mental illness (Corrigan et al., 2009), and show how stigma extends to other members of the family (Corrigan et al., 2006). In the latter study, the authors employed a range of different 'vignettes' or descriptive stories, where the condition of the suffering person and the family relationship to the sufferer were manipulated. So, for example, 'Joan Smith is the mother/daughter/sister/wife of Frank Smith, a 30 year old man with schizophrenia/drug dependence/emphysema…'.[10] The different vignettes were randomly assigned to a sample of 968 people.[11] Results showed that the families of people who were drug dependent were the most

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[9] Measured through a liberal-authoritarian scale, which included items like 'schools should teach children to obey authority (agree/disagree).

[10] The gender of the two characters was also varied.

[11] The original sample consisted of 1,307 individuals drawn at random from a larger panel of individuals recruited to complete surveys regularly. Seventy four per cent of this sample completed the family stigma survey.

stigmatised, being viewed as most responsible for the person originally getting 'ill' and most likely to be at fault should the person relapse. Drug dependence was also thought most likely to 'rub off' on a family member, and was the condition that family members would feel most ashamed of. Thus, the authors concluded that families with a relative who is dependent on drugs are particularly prone to stigmatisation.

Other studies have been undertaken using samples of students, including some that have investigated stigma relating to HIV/AIDS. While the literature on AIDS-related stigmatisation is very large, certainly beyond the scope of this review, two studies have particular relevance. These studies attempted to disentangle the different stigmas that lie behind attitudes towards people with HIV/AIDS (Crandall, 1991; Chan et al., 2007). Both studies employed a vignette approach to manipulate the different ways in which HIV can be contracted, including sexual contact, blood transfusion and intravenous drug use, and for both the results showed those who had contracted HIV through intravenous drug use to be the most stigmatised. One of these studies, which involved medical students in southern China (Chan et al., 2007), also included a number of disease conditions for comparison: no disease, AIDS and leukaemia. The study found that injecting drug user without an accompanying disease was the most stigmatised condition and that the injecting drug user with AIDS condition was associated with a statistically significant reduction in the level of stigma.[12]

A more recent study on AIDS-related stigma (Decety et al., 2010) took a rather different approach to investigating the impact of different types of AIDS contraction on stigmatisation. This study looked at empathy for pain. Twenty-two participants were shown video clips of people experiencing pain and were told that the people in the clips fell into one of three groups: healthy; contracted AIDS through blood transfusion; or contracted AIDS through intravenous drug use. The participants were asked to evaluate the level of pain and distress the person in each clip experienced, and also to evaluate the level of distress that they felt watching the clip. They were also subject to brain scans, recording activity in areas of the brain associated with pain (including empathy with others' pain). Results showed that participants were significantly more sensitive to the pain of people in the clips who had contracted AIDS through blood transfusion than they were to those who had contracted AIDS through intravenous drug use; and expressed more empathy and personal distress in response to the former. These results were also reflected in the levels of recorded brain activity in areas associated with pain.

These studies show how contracting AIDS through injecting drug use adds considerably to stigmatisation, compared with other modes of contraction. The underlying issue governing these responses appears to be blame. Those who contract HIV through blood transfusion are blameless and therefore comparatively unstigmatised. Those who contract HIV through injecting illicit drugs are perceived to be responsible for their condition and, correspondingly, attract a higher level of stigmatisation. The finding in one of these studies that injecting drug users with AIDS

[12] In both these studies, stigmatisation was measured through a social distance scale, which included items such as 'a likeable person', 'a person who is similar to me' etc.

were less stigmatised than injecting users without AIDS is interesting. It seems to suggest that – at least among medical students in southern China – attitudes to problem drug users can involve compassion as well as blame.

**Attitudes of health professionals**

Psychiatrists, doctors, nurses and other professionals are all members of the public: they are subject to the broader influences that shape public attitudes and opinions on problem drug users. It is therefore to be expected that some of the stigmatising attitudes found among the general public are also found among those treating – or potentially treating – drug users. However, most of these professionals work directly with problem drug users, to varying extents, and therefore may have greater insight into the nature of addiction and the problems that drug users face.

Landy et al. (2005) examined attitudes to 'substance misusers' in a study of students from two UK medical schools. Comparing first-year and fourth-year students, they found that 66 per cent of the former and 72 per cent of the latter felt that substance misusers were not less deserving of treatment than other patients.[13] Smaller proportions disagreed with substance misusers posing a threat to other patients and staff: 17 per cent and 26 per cent respectively. There was therefore some decrease in stigmatisation between the two year groups, suggesting some effect of their education, although this was a cross-sectional study and so there could have been differences between the two cohorts of students. The authors concluded that *"a substantial proportion of 'tomorrow's doctors' continue to hold negative stereotypes about substance misuse"* (p.142).

Reviewing studies from the 1980s and 1990s, McLaughlin and Long (1996) concluded that *"the majority of health professionals hold negative, stereotypical perceptions of illicit drug users"* (p.283). Much of the work reviewed focuses on attitudes among nurses, whose prejudice, according to these authors, prevent them from carrying out *"effective and humane nursing care"* to problem drug users (p.283).

Research from the USA (summarised by Miller et al., 2001) has shown limited coverage of addiction-related subjects in medical schools and generally negative and pessimistic views towards drug addicts on the part of primary-care doctors. Contrary to the observations by Landy et al. (2005), American research has shown increasingly negative attitudes among medical students as their training progressed (Miller et al., 2001). Two ethnographic studies of the treatment of problem drinkers and problem drug users, one in inpatient care and the other in a 'safety-net emergency department', seem to show how negative views espoused during training continue into fully qualified practice. Merill et al. (2002) observed patient care and interviewed doctors and problem drug users who had been admitted to a hospital in the USA. As the researchers point out (p.327), by law, doctors working in the hospital were only able to treat opiate withdrawal in patients hospitalised for reasons other than their opiate

[13] It does not follow that the others agreed with the statement as one of the response categories was 'neither agree nor disagree'. No further breakdown of responses is given in the paper.

withdrawal. They were also able to prescribe opiates in the normal way for pain relief. The study found that doctors were concerned about being deceived by patients with opiate addiction: particularly where pain relief was needed or requested. A senior doctor was quoted as saying: *"All of us go through a bit of a hitch every time we are requested to prescribe narcotics for our patients … Are they trying to get more out of me than they really should have?"* (p.329). The research also showed that there was no standard approach to the treatment of pain, with widely differing practice between doctors and within the practice of individuals. Doctors took different approaches to distinguishing between real and feigned need. One doctor stated: *"Everybody had an idea of how to do it, and they are all different"* (p.330). One doctor also described how *"I can tell they are playing games by their intonation, their voice, their body language"* (p.330). On the other side of the relationship, opiate-addicted patients expressed fears about being mistreated and punished for their addiction. There was therefore considerable distrust on both parts, and opiate prescription for pain or withdrawal was often the focal point for this distrust. Doctors *"found themselves in a grey area between patient advocacy and police oversight"*, guarding the keys to the 'narc' cabinet (p.331).

A contrasting picture is presented by the other ethnographic study, which describes the difficult interactions between substance users and staff in an inner-city emergency department in California, which provided healthcare for the uninsured, vulnerable and disadvantaged (Henderson et al., 2008). On the one hand, health professionals in this study described a sense of mission and purpose. As a senior doctor pointed out *"many of [the nurses and physicians], especially the ones that stay, are truly dedicated, really good people who are here because they really want to help our patient population"* (p.1340). Nurses and doctors also reported that the majority of the dependent users were grateful for the care they received. On the other hand, the work could be very challenging. Verbal and physical violence were common, with some staff reporting at least one aggressive episode per shift during peak times. Nurses often had to handle these episodes, as the first point of contact. Another problem was experienced with users withholding important information about their drug and alcohol use, which could make it difficult to treat them. As with Miller et al. (2001), this study also found suspicions surrounding pain reported by 'drug-seeking' users. A senior doctor offered the following observation:

> *If you had two patients come in. One is a college student … and you compare that to a homeless, dirty, drug-using patient perhaps with the same complaint – maybe it's something like flank pain or something – I suspect you might … be much more kind of thorough in trying to figure out what's really going on with this college student and you might be more likely to kind of assume that it's something inconsequential [for the drug-using patient] because, 'Oh, they always come here and they just want drugs'* (Henderson et al., 2008: p.1342).

The researchers conclude that while staff at this hospital were committed to providing care to substance users, their training and experience led them to treat them differently from other patients: *"we found that the care had a different tone or quality when patients had alcohol or drug problems"* (p.1347).

These studies raise interesting questions about the stigmatisation of problem drug users in healthcare settings. The greater stigmatisation described in the study by Miller et al. (2001) seems to reflect the general hospital setting, where staff have not elected, in particular, to treat the marginalised and excluded. This raises a central tension: specialist services may be best able to deliver healthcare in an unstigmatising fashion, but the very fact that they are 'special' also serves to stigmatise through exclusion from mainstream services. This is an issue that crops up in other circumstances where problem drug users rub up against the general public: should users be separated or integrated?

Another unsurprising but stark conclusion that can be drawn from these studies is that drug addicted people can be very difficult to deal with in a hospital setting. Their stigmatisation in this setting appears to stem, in some degree, from the aggressive and manipulative behaviour shown by a minority. As both studies demonstrate, the majority of drug users do not behave in this way and yet they are often tarred by the same brush. Moreover, the difficult behaviour stems in large part from their addiction: the experience of withdrawal and the driving need to get drugs. Blame and distrust may be natural human responses, but they seem futile and are destructive to relationships between professionals and drug users.

A further key question is whether blaming and stigmatising responses among health professionals will prevent problem drug users from seeking help (be that for primary healthcare or for treatment needs). Stigma may be one of the main reasons for the low proportion of problem drug users in treatment (Kelly and Westerhoff, 2010). This might occur through a number of mechanisms, including a desire to avoid the medical label of addiction, fear of being seen by others attending treatment services, fears about employers finding out about their addiction, and also previous bad experiences of healthcare.

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

**Attitudes of young people**

It was noted above that the young people in the Royal College of Psychiatrists' survey expressed more negative views about most mental disorders, including drug addiction, than older people. It was also noted that Ormston et al. (2010) found that while young people were more likely than older age groups to recognise the difficult backgrounds of heroin users, those in employment were less comfortable than older people with the idea of working with an ex-heroin user.

The review identified two studies that focused in particular on the stigmatising views of young people. A group of 23 recreational drug users aged between 16 and 19 were interviewed by Power and colleagues (1996) in London and asked about their views on heroin use. Twenty-one of the 23 said that they would never try the drug and used

words such as 'dirty', 'evil' and 'disgusting' to describe it. Accordingly, people who used heroin were stigmatised: *"It's a bad drug, it's disgusting. I wouldn't touch it with a bargepole. Those who use it are 'dirty' people"* (p.75). Injecting was also heavily stigmatised: *"I would never do it [inject] … I think it's foul"* (Power et al. 1996: p.76).

A quantitative Canadian study (Adlaf et al., 2008) explored the impact of age and own drug use on attitudes towards addiction in a survey of 4,078 school students aged 12 to 19. Analysis showed a clear decline in stigma across age, with individual experience of drug use and close association with drug-using friends being important factors in this decline. The authors observed that any positive role of addiction-related stigma in preventing young people from using drugs appears to be temporary. Nevertheless, they concluded that decreasing the stigmatisation surrounding addiction could have positive and negative effects: while it would be beneficial for problem users in reducing barriers to treatment, there is the possibility that it could lead to greater drug use among young people.

This latter study raises another important issue that runs through the stigmatisation literature: is the stigmatisation of drug addiction a wholly negative thing? This question will be addressed in more detail in Chapter 5, but in the context of this research on children it is worth making the following observations here. Many attempts have been made to prevent children from offending, drug use or coming to harm, through scaring them about the possible extreme consequences associated with adolescent risk behaviours. Pictures and videos are frequently deployed, depicting powerful and often terribly sad stories concerning drug addiction, road accidents, death and disaster. They frequently involve personal accounts from ex-drug users and criminals – and some have involved trips to prison (Lloyd, 1995). While such approaches are popular with children and may well be a useful developmental experience for offenders and ex-users, there is little or no evidence that 'scare straight' approaches have had any positive effect on youth crime (Lloyd, 1995; Petrosino et al., 2003). Scare tactics or 'fear arousal' approaches to drugs education in schools have similarly shown poor results (e.g. Beck, 1998). This may well be because children cannot identify with these extreme experiences suffered by adults. Such stories invoke compassion, but have little direct bearing on young people's lives.

It therefore seems unlikely that either the stigmatisation or the destigmatisation of problem drug users would have much impact on young people's early drug use. However, it does not follow that there is no point in informing children about addiction and exposing them to ex-users who can describe their experiences. There may be worth in such approaches if the accent is on developing compassion and understanding: preventing the social stigma that even young children quickly develop towards problem drug users rather than 'scaring them straight'.

## PROBLEM DRUG USERS' EXPERIENCES OF STIGMA

### The pharmacy

Many studies have been undertaken which have focused on problem drug users' experiences of stigma. In particular, research has explored users' experiences of

stigma in a variety of service contexts. One of the key public arenas where problem drug users' worlds collide with those of wider society is the pharmacy. It is here that many injecting drug users receive their methadone, which is drunk from a small plastic cup under the supervision of pharmacy staff, or obtain clean syringes and other paraphernalia for injecting. This of particular significance because pharmacies may offer little or no opportunity for them to hide their drug-user identity: either from pharmacy staff or from other customers. In Goffman's terms, they are discredited. Pharmacies therefore provide great potential for the enactment of stigmatising interactions of the classic Goffman type: conversations between the stigmatised and strangers, where the fact of the stigma hovers over and fundamentally influences the nature of the exchange.

While there is a large literature on the effectiveness of needle and syringe exchange, only two qualitative UK studies were found that had focused in detail on the views and feelings expressed by problem drug users in the pharmacy context – and, in one of the studies, by pharmacist staff (Matheson, 1998a and 1998b; Simmonds and Coomber, 2009). Matheson (1998a) reported on interviews with 124 problem drug users attending 23 pharmacies in four cities in Scotland. Over half of the sample were satisfied with how they were treated in the pharmacy. Referring to the pharmacists, one user described them as *"pretty sociable, easy going, easy to speak tae and they're the sort of people you could, if you've got a problem or a, you could actually ask them and they would dae their best tae help you there ken"* (p.34). Several felt that they were treated just like other customers, and in many cases where there had been initial concerns, these seemed to evaporate when users and staff became familiar with one another. However, a substantial proportion reported negative experiences, associated with the attitudes of pharmacists and other staff:

> *I went in there an' it was two young girls [assistants], younger than me, about 16. I thought 'shit, I don't want to ask them', but I had to. I was a, 'do you prescribe methadone?', an' they just sat there, looked at me, looked at each other, looked back, 'Eh no …' 'Oh right …' An' they they sort o' laughed, so I just walked oot ken'* (Matheson, 1998a: p.35).

Some felt that they were looked down on, spoken to sharply or watched with suspicion. This was associated with a sense of shame on the part of users.

An important issue was stealing. Some interviewees admitted to shoplifting; some referred to other users' shoplifting. A key factor here was how users reported being treated by staff. If they felt they were treated well, they felt obliged not to steal, but where staff were rude they were tempted to do so. However, there was also some recognition that this was a two-way process: while pharmacist staff attitudes affected user behaviour, user behaviour also affected staff attitudes.

The author concludes that *"Conflict is damaging to drug users at a personal level in which self-esteem can be lowered. Conflict can also be damaging at a group level, because it promotes the stigmatisation of drug users by some pharmacists who, as a result, may treat all drug users as 'difficult' clients"* (p.38). Matheson's description of the amplification of users' difficult behaviour as a consequence of the responses and

attitudes of staff brings to mind labelling theory, and the way secondary deviancy can result from labelling by people in positions of authority. On a practical note, the author recommends that undergraduate pharmacy education should cover working with drug users; and that drug users should be made more aware of the position of the pharmacist.

Simmonds and Coomber's study included interviews with 91 injecting drug users and the 12 pharmacists providing needle exchange services in a city in the south-west of England. The pharmacists voiced a range of views: some seeing the needs of a drug user as being equal to any other customer, but others expressing concern about customers' reactions to drug users and referring to shoplifting.[14] Approximately half of the sample of users described feeling stigmatised when using a syringe exchange:[15] *"they keep an eye on your, you know, embarrassing"* (p.124). Another user described how pharmacist staff *"don't smile at you or nothing, know what I mean … if you're in there with other people and that, customers, you don't know what they're going to say and you feel uncomfortable"* (p.125). As with the previous study, users reported that the sense of stigma declined with increasing contact and familiarity.

The authors reviewed users' experiences of stigma in a range of other contexts and concluded that "*The effects of stigma on IDU populations are sufficiently far-reaching for health care providers and others whose remit is to reduce the harms emanating from injecting drug use to seriously consider its impact, its production and how best to address the problems it causes"* (p.128). They discuss a number of possible ways to address users' experiences of stigmatisation in pharmacies. One approach would be to have specialist provision of needle exchange services for drug users around the city, but, as the authors point out, the costs would be high. Alternatively, they suggest that pharmacies could be adapted to limit contact between users and other customers, by providing separate entrances, for example. Better training for pharmacy staff is also recommended.

Similar negative experiences in pharmacies are also described by Neale et al. (2008) in their wider study of users' experiences of generic services. In particular, they describe how staff would give other customers priority: *"They [pharmacy staff] will make you wait around the corner and serve all other normal people first … like we are scum"* (p.150).

Finally on the issue of pharmacies, Anstice et al. (2009) looked at experiences of supervised methadone consumption as reported by 64 drug users in Ontario, Canada. Familiar concerns were reported about variations in the attitudes of staff, with users in some sites being made to wait while other customers, who had arrived after the users,

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[14] A survey of pharmacists providing syringe exchange similarly identified concerns about shoplifting, but also identified concerns about customers being upset by intoxicated users (Sheridan et al., 2000).

[15] The study also included a specialist 'hub' facility. But this was viewed as being non-judgemental in its approach and these users are therefore very likely to have been referring to the pharmacies.

were served. The layout of pharmacies was identified as a key issue. On the one hand, users were embarrassed: *"we have to drink out of a brown bottle in front of everybody, and it's very embarrassing"* (p.801), but on the other hand, separation of users and other customers was perceived as ostracising: *"[H]e has a separate entrance for us, which to me means that that separates us from the regular customers right off the hop, so that gives you the sense of 'you're not worthy; we have to hide you coming in'"* (p.802).[16]

In conclusion on these studies, as outlined above, pharmacies represent a key context in which problem drug users may feel stigmatised. It is also a key context in which the public come across problem drug users and where potential stereotypes are either challenged or confirmed. Users frequently feel 'outed' and, to some degree, humiliated by their visits to pharmacies. They are often unable to 'pass' as 'normal' pharmacy users: drinking pink liquid from a small cup or exchanging syringes reveals their addict identity to pharmacy staff – and also, users often feel, to other customers. Whether or not other customers realise what is going on in these transactions is an interesting question. Research in Scotland on pharmacy customers found that the vast majority were unaware that needle exchange services were being provided (Lawrie et al., 2003). The majority were also supportive of the idea, although they were less supportive and less well-informed about methadone services. The attitudes of pharmacy staff appear to be a crucial factor in the extent to which users feel stigmatised. There is some evidence of a self-fulfilling prophecy, in that distrustful and unfriendly treatment from staff may provoke worse behaviour among users. The need for effective training of pharmacy staff is clearly a high priority.

Whether or not problem drug users should be separated from other clients is a difficult question. If users are separated in this way, they may escape the immediate discomfort of staring eyes and quizzical looks, but they are also clearly being treated as 'different', which carries its own stigmatising load. Needle and syringe exchange, which can be done quite subtly and which may be more acceptable to the public, can presumably be carried out comparatively discreetly, even under the public gaze. Drinking methadone is harder to hide and is bewildering to those who do not understand what is happening: as one user quoted in Anstice et al. (2009) pointed out, *"How many people walk in a pharmacy and drink something and walk out?"* (p.801). People taking methadone in pharmacies need to be offered privacy.

As well as the personal effects of stigmatisation on problem drug users, there are the practical impacts of such stigmatisation on the use of needle and syringe exchange services. As Simmonds and Coomber (2009) point out, problem drug users may feel too embarrassed to use needle exchange services, with the concomitant increase in the risk of needle sharing. Likewise, it may present an extra hurdle for those on methadone maintenance, making it less likely that they will take their methadone and more likely that they will relapse and use street drugs.

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[16] See also Radcliffe and Stevens (2008), who also report users finding the separation of being asked to 'stand in the corner' or to come in at certain quiet times of the day humiliating (pp.1069–70).

### Users' experiences of other generic services

This review has uncovered few studies of problem drug users' experiences of stigmatisation when using other generic services. Neale et al. (2008) looked at the generic health and social services experiences of 75 current drug injectors in West Yorkshire. They found that users were generally positive about their experiences. Although many had not had problems accessing a GP, others avoided GPs for fear of children being taken into care or embarrassment. Some reported hostile and unhelpful attitudes, but felt that these had to be put up with because of the difficulty of being accepted by another practice. More negative reactions appeared to have been experienced in hospitals, where participants were frequently made to feel that they were wasting valuable resources and were treated differently from other patients. Problems had also been experienced with housing and homelessness services. Users reported that those in housing departments gave them low priority, disbelieved them and were negative and hostile.

McLaughlin et al. (2000), focusing on 20 users in Northern Ireland, found that users generally reported receiving poor care from GPs in comparison with specialist addiction services.

### Addiction services

The process of seeking help for a drug problem necessitates a user recognising that he/she has a problem with their drug use. Attending a drug service that is attended by other users, seeing a psychiatrist and/or other professionals, being assessed and receiving treatment all serve to cement the identity of drug user/abuser/misuser/ addict. Drug treatment services can therefore form part of the process by which users' identities become reduced to their one 'master status': drug user. In their research on 53 problem drug users who had dropped out of English treatment services, Radcliffe and Stevens (2008) describe how their sample had ambivalent attitudes towards treatment services. Many were seeking conventional goals and lifestyles and regarded treatment services as being for 'junkies', a status from which users took pains to distance themselves:

> *You see I am not a drug user, you know, I don't smoke crack cocaine, I don't take Valium and all that, all right I take heroin but, you know, I don't do it in front of anyone, it is something that is very private … I used to get up every morning for the kids, you know what I mean, get them washed, dressed, ready for school* (p.1069).

Interviewees expressed frustration with substitute prescription programmes that necessitated lengthy assessments and attendance at a pharmacy – and conflicted with a conventional lifestyle.

The authors conclude that *"more needs to be done, both to avoid the association of treatment services with the stigmatised category of the junkie and to help those in treatment to escape the social world that is, in part, structured by this identity"* (p.1072). They argue that services in mainstream healthcare settings that 'medicalise'

rather than criminalise drug use will be less stigmatising and more likely to attract those who are able to distance themselves from the 'junkie' status.

Warburton et al. (2005) provide a fascinating account of the views and experiences of 'occasional and controlled' heroin users accessed through an internet survey. An online questionnaire was completed by 123 respondents and in-depth qualitative interviews were undertaken with 51 users.[17] The users interviewed did not see themselves as 'addicts' and *"were keen to avoid being labelled or thought of in this way"* (p.48), which led many to hide their use. The authors point out that *"In many ways this was about protecting an individual's self-image. As well as simply not wanting people to know about their heroin use because of the negative stigma associated with it, this process allowed respondents to maintain a 'non-addict' self-image"* (p.48). Users described the negative image of heroin users:

> *You know the general conception of someone who takes heroin, it's not measured, it's pretty extreme* (p.50).

There was a strong fear that they would be rejected by others if their drug-using status were to be revealed:

> *…my family wouldn't want anything to do with me. That's what scares me the most, being ostracised. I haven't done them any wrong, but it's what they learn from the media* (p.51).

The authors are confident that *"Not thinking about themselves as an 'addict' or a slave to heroin undoubtedly contributed to their capacity to control their drug use"* (p.53).

Users also expressed concern about getting too closely involved with drug services, which tended to assume that anyone using heroin was a dependent user:

> *They see you as a particular type of person whether you are or not, so if you are working and trying to minimise problems they can't really cope with that, they don't really understand that* (p.52).

Warburton and colleagues conclude that public understanding of heroin use is rooted in the stereotype of the chaotic, offending 'drug addict'. Moreover, they argue that this label may, to some extent, be self-fulfilling – i.e. the user who accepts or internalises this stereotypical 'junkie' identity will then behave in the expected manner. As a result, *"policy should do all that it can to undermine this stereotype"* (p.59).

In another interesting study of the relationship between treatment and stigma, Semple et al. (2005) compared the experiences of a sample of 292 methamphetamine (meth) users in California: 210 had never been in treatment and 82 had. They found that having been in treatment was associated with significantly more experiences of rejection (for example, from friends or family), those who had been in treatment being

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[17] Of the users identified for interview, 17 were accessed through the online survey and a further 37 identified largely through 'snowballing' from this initial interview sample.

twice as likely to report experiences of rejection. Those who had been in treatment also scored significantly lower on stigma coping strategies, which included items such as hiding their meth use and seeking support from other meth users, and significantly lower on expectations of rejection, which consisted of questions relating to others' negative attitudes. The authors suggest that the increased experiences of rejection may stem from 'negative labelling': entry into treatment signifies that they have a serious drug problem, with the attendant 'drug addict' label. Those so labelled may be more likely to experience rejection. They also suggest that individuals who have higher expectations for rejection might avoid treatment in order to avoid this process of negative labelling, thus explaining the lower score on stigma coping strategies among those that have been in treatment. The lower score on coping strategies among those who had been in treatment is explained in terms of people wanting to avoid treatment needing to control information about their use.

The authors stress that this is preliminary research, but conclude that it implies that drug use stigma may be a barrier to seeking treatment and may play a role in the non-completion of treatment programmes. Thus the studies undertaken by Radcliffe and Stevens (2008), Warburton et al. (2005) and Semple et al. (2005), which included users who were not currently in treatment, suggest that the stigmatisation associated with treatment is a potential problem in itself. Other research has also demonstrated the particular stigmatisation of users in treatment (Conner and Rosen, 2008; Luoma et al., 2007). Anitha (2007) describes the under-reporting of drug problems among prisoners, because of 'the stigma of being seen to ask for help' in an environment where *"Everyone wants to be seen as a big, hard man"* (p.80).

By accepting the need for treatment, users may lose control of the information surrounding their drug user identity. There may also be an escalation in the stigma associated with their use, as they move from 'user' to 'addict', with the attendant implications of loss of control over their drug use. There is an echo here within the alcohol field, where studies have shown how some drinking cultures accept heavy drinking so long as control is maintained. A practical implication of this conclusion is that the provision of treatment through general primary healthcare (or at least shared care) may reduce the stigmatising effect of specialist treatment (Latowsky and Kallen, 1997).

**The particular stigma of methadone**

A number of authors have pointed to the special stigma associated with methadone substitution treatment – and, in particular, methadone maintenance, where users are prescribed methadone for a prolonged, indeterminate period (rather than being on a reduction schedule, to assist with detoxification). A number of commentators have argued that, while the evidence base for methadone maintenance is strong, the stigma associated with its use has restricted its expansion and its optimal delivery (Joseph et al., 2000; Vigilant, 2004; Latowsky and Kallen, 1997; Bell et al., 2002). This stigma can be seen as stemming from its status as a 'non-treatment': *"From the beginning of [methadone maintenance treatment], the program has been stigmatised by the belief that methadone treatment merely substitutes one drug for another"* (Joseph et al., 2000, p.358; but also Latowsky and Kallen, 1997 and Bell et al., 2002). This is

contrasted with the nobler goal of abstinence. These commentators suggest that such views are prevalent among the general public, many treatment staff and heroin users themselves (Bell et al., 2002).

Users' experiences of the stigma associated with methadone maintenance are described by Vigilant (2004) in his interviews with 45 patients on methadone maintenance.[18] Vigilant describes stigma occurring at a number of levels: public shame, institutional shame and private shame. Public shame occurred in public places, but also in treatment and support groups. Users referred to the public shame of attending methadone clinics, in some cases having to stand in line on the pavement. Some also described the strongly negative stance of Narcotics Anonymous and Alcoholics Anonymous toward methadone. This could lead to patients 'passing' as abstinent:

> *I go to NA meetings but I don't tell people that I'm on methadone because some people don't consider that clean time or sobriety. People don't understand, and I don't know how to explain it to them. They always tell me that I'm substituting one drug for another* (p.408).

At the institutional level, Vigilant describes the stigmatisation among some patients of those who are on high doses of methadone: *"People that want to be on 175 milligrams, they don't care – they just don't care. Personally, I don't think anyone needs more than 55 milligrams"* (p.409). Lower dosage was associated with the less stigmatising prospect of eventual recovery, but higher dosage was associated with being a 'methadone lifer' (p.409), underlining the relative stigma of methadone maintenance compared with abstinence, referred to above.

At the institutional level, patients were also subject to a regime of control. In particular, random drug tests – to ensure that patients were not topping up with illicit heroin or other drugs – were regarded as humiliating and stigmatising: "*I have to piss in a cup in front of somebody"* (p.411). Vigilant sees the various restrictions surrounding methadone maintenance, including supervised consumption and urine testing, as reflecting its uneasy position between two competing paradigms: full medicalisation and full criminalisation (p.415).

According to Vigilant, the private level of shame refers to the 'felt' stigma of regret and loss, fostered by *"societal expectations of what constitutes 'success'"* (p.414). This is not the type of interactional stigma described by Goffman.

Another type of public shame referred to in the literature involves the management of the treatment status when seeking employment and other discretionary opportunities. Many seek to hide their status and as a consequence are *"fearful of being suspended, fired, or not hired if their status becomes known to current and potential employers,*

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[18] It should be noted that the sample is unlikely to reflect the wider population of methadone maintenance patients in Boston, USA, with only six patients being unemployed, 12 on 'state sponsored disability' and 27 in employment.

*despite the fact that they are not impaired by methadone maintenance and can perform job tasks for which they are qualified"* (Joseph et al., 2000: p.358). The issue of stigma and recovery is considered in more detail later in this chapter.

### Stigmatisation among the stigmatised

The quotation presented above from Radcliffe and Stevens' (2008) research demonstrates how problem drug users can maintain a sense of self-worth by comparing themselves favourably with other users who *"smoke crack cocaine"* and *"do it in front of anyone."* This is a familiar theme elsewhere in the literature, with steroid injectors anxious to dissociate themselves from the junkie image (Simmonds and Coomber, 2009) and the already-described discomfort of the methadone patient in the NA (Narcotics Anonymous) meeting.

Simmonds and Coomber (2009) also describe how 'responsible' injecting (non-steroid) drug users in their research condemned other users – *"the lazy, the homeless and those that simply 'don't care'"* (p.127). The authors point out that in such situations *"stigma is being used as a mechanism … to displace acknowledgement of their own risky behaviour … by focussing on the behaviour of others – others not like them but worse in definable ways"* (p.127). The danger is therefore that this focus on those who are taking greater risks 'allows' people to take relatively smaller risks in their own drug use.

### Users' experiences of policing

Lister et al. (2008) provide a revealing insight into users' day-to-day experiences of street policing in England. Drawing on 62 interviews with current or ex-problem drug users, the team found that the majority of their contacts with the police were coercive, adversarial and frequently perceived to be unjustified. The great majority felt that they were targeted because they were well known to the police as problem drug users. The most stigmatising experiences related to policing in public places. One user described the following typical interaction:

> *'You.' 'Yeah?' 'Come over here, got anything on you?' 'No.' 'Any sharps on you?' 'No.' 'Can you empty your pockets?' This is in the street, you know, everybody's moving up and down, empty your pockets and onto the bonnet of the car or the sidewalk if they're walking. You know, they do a search. 'Where you been, who you been with, where have you just come from, where are you going?' Questions like that. 'When was the last time you used? Who are you scoring off?'* (p.41).

The authors report that many users felt that the police intended to shame them by conducting stop and searches and exposing their drug use in public.

> *Even if I'd be going for an official appointment somewhere, if I was going to sign on or whatever, and it's* [as] *soon as they see you, they're collaring you and they PNC'ing you and they're stopping you, and they're embarrassing you in the street by making you spreadeagle on the car while they search you, or throwing you in the back of the van and strip searching you, just trying to*

*belittle you in public. Just to embarrass you in public because people walking by are looking at you getting searched and that. Doesn't look nice, doesn't look nice, it's not nice, it really pisses me off, it's like invading me privacy* (p.42).

Although from a police perspective such activity was part of their regulatory approach to policing drug users and drug markets, it was perceived by users as unjust and punitive. Such perceptions were particularly keenly felt where users were in recovery but still received the same treatment:

*Just every time they see me, 'Mr [name] just come here, can I have a word with you', just does me head in all the time. I'm doing well for myself; do you know what I mean? Every time they see me they've got to stop me, every time. All right stop me once or twice if I look suspicious or I'm acting suspicious, fair enough, check me out, ask me questions but not every time you see me, stop me. I'm doing well now, I'm not committing crimes and they know that. But still they just – they just do it, they just like treating us like a piece of shit, they do* (pp.44–45).

The authors report that this was a common experience among users in recovery, primarily because the police were acting on information about previous criminal involvement. They go on to conclude that this process *"can impede a problem drug user's attempts to establish an identity unrelated to drug use and offending and, in turn, reintegrate themselves into mainstream society"* (p.45).

There are therefore implications here for the policing of problem drug users. It is manifestly the case that some homeless drug users pose a number of problems in public spaces, some of which demand a police response. However, it should not be necessary for the police to publically humiliate users as part of this process. This must certainly add to the stigmatisation and alienation of current problem drug users and may be particularly damaging in the case of recovering users.

**Impact of stigmatisation on problem drug users**

The views and feelings of problem drug users have been touched on above in the context of their experiences of using services, but the contexts and sources of stigmatisation are wider. Buchanan and Young (2000) asked 200 problem drug users in Merseyside about their feelings when in the presence of non-drug users. Many felt rejected and stigmatised: *"They look down on me as scum of the earth and as someone not to be associated with"* (p.415). Others referred to feeling anxious in the presence of 'normal' people: *"I feel nervous in case I slip up, I know they would look at me in disgust"* (p.415). This could lead to avoiding contact with non-drug users. These authors describe how *"Discrimination has led many problem drug users to internalise and blame themselves for their position. This loss of confidence and self-esteem is a serious debilitating factor"* (p.414) and a key obstacle to recovery.

Harris (2009) refers to some of the experiences of stigma in a group of 40 people with chronic hepatitis C. Harris describes how *"'dirt' or 'dirty' was a frequent descriptor used by participants when talking of themselves in relation to their hepatitis C or past drug use".* One interviewee described how *"When I'm around the mums group and all those*

*clean sort of people, and sometimes even around alcoholics that didn't touch drugs, I can just feel a bit dirty"* (p.42). Another referred to her treatment in hospital: *"I was supposed to have lots of baths. The nurse came in and in no uncertain terms told me that I wasn't allowed to use the bath and she was just really unpleasant [because] I was a dirty junkie who had hep C … She didn't say 'junkie' but that was the implication. That I would scum up the bath for someone else"* (p.43).

Ahern et al. (2007) looked at the impact of stigma and discrimination on the health of illicit drug users. They suggest that stigma could impact on problem drug users' health through exposure to chronic stress, brought on by the rejection of others, withdrawal, isolation and mental health problems. They suggest that persistent stress of this sort could also have an impact on physical health through neuroendocrine processes. Their research involved interviews with 1,008 people reporting use of crack, cocaine and/or heroin in New York. Measures of discrimination and alienation were associated with poor mental health, and discrimination was associated with poor physical health. As the authors point out, it is not possible to rule out the possibility that poor mental and physical health led to reporting more problems of discrimination and alienation, rather than vice versa, but it suggests that this association merits further investigation through a longitudinal study.

A rather different take on the impact of stigmatisation on problem drug users is provided by Martin and colleagues' study of the recognition of facial expressions (Martin et al., 2006). There are six basic non-verbal, emotional facial expressions: happiness, sadness, fear, anger, disgust and surprise, and these provide vital information in social interaction. Martin et al. propose that these are innate expressions that have become adapted to different cultural contexts and that they are recognised through largely separate neural systems in the brain. Their study focused on 20 current opiate users, 20 abstinent people in rehabilitation and 20 controls. Participants were asked to respond as quickly as possible to pictures depicting the various facial expressions. While current users were slower to recognise facial expressions, they were significantly more likely than the abstinent group to accurately recognise the facial expression of disgust. The authors conclude that repeated exposure to other people's disgust may have sensitised drug users to this reaction. This is an intriguing idea, but it should be noted that the sample size was small and that there is therefore the need for replication of the study.

These studies show that stigmatisation has a profound impact on problem drug users, including on their sense of self-worth. As Goffman (1963) and Jones et al. (1984) explained, a necessary part of the stigmatisation process is that the stigmatised person accepts the 'normal' world view and *"be intimately alive to what others see as his failing"* (Goffman, 1963: p.18). In more prosaic terms, it takes two to tango. Moreover, a stigma or mark may or may not form an important part of a person's sense of self, but *"when a mark becomes a focal point of the self-concept, the stigmatising process is engaged"* (Jones et al., 1984: p.150). Thus, in order for stigmatisation to take place, the stigmatised person must, at some level, accept the social meaning of his/her stigma and feel the associated rejection, and the stigma must be central to a person's sense of self. Problem drug users fit this bill very well: for many, drug use becomes the central, defining feature of their lives, with much of their waking day (and sleepless

night) devoted to thinking about their drugs and how they will be able to obtain them. As has been demonstrated, they are also keenly aware of what this means in the eyes of others: they feel their difference and largely accept the judgments of others. The result is not just the type of social awkwardness described by Goffman, it is often a more profound separation of worlds, and users can consequently feel a strong sense of social rejection and isolation. This is a very powerful process that can be deeply undermining and debilitating. It may be a contributor to poor physical and mental health and may well make recovery more problematic. The profundity of the experience of social rejection may have its roots in our biological make-up as a highly social animal, as Neuberg et al. (2000) and others have argued in the context of stigma: we feel rejection exquisitely because sociality lies at the heart of our make-up.

One question not really addressed in the literature is the extent to which problem drug users can avoid this process of stigmatisation through living in social worlds where problem drug use is the norm. Goffman (1963) notes that *"Those who come together into a sub-community or milieu may be called social deviants and their corporate life is a deviant community"* (p.170). He refers to 'drug addicts' as one such group, who by setting up this alternative lifestyle, can *"openly take the line that [they are] as good as anyone else"* (p.172). Drug users may therefore be able to insulate themselves from stigmatisation in this way. However, wherever their lives rub up against 'normal society', they will experience stigmatisation.

### STIGMA AND RECOVERY

While largely bypassed as an issue in the literature, Room (2005) perceptively points out that *"policies against stigma usually carefully exclude from their scope those who are at the time under the influence of alcohol or using drugs"* (p.151). Much of the discussion about what to do about drug-related stigma revolves around the stigmatisation of the ex-user. While in the popular imagination the current user is clearly to be blamed for his/her predicament, the recovered or recovering addict is frequently seen as relatively blameless and must be given every chance to reform. As noted earlier, the 'repentant deviant' plays a vital role in confirming the validity of social norms by admitting to having transgressed those norms and seeking absolution. Nevertheless, stigma still haunts the ex-user.

There is a growing recognition that problem drug users do not just have a drug problem: they often suffer from a broad range of social, psychological, economic and health problems (Miller and Miller, 2009). The provision of a wider range of 'wrap-around' care or interventions has been associated with better treatment outcomes (McLellan et al., 1998) and has led to calls for treatment to be multifaceted (Miller and Miller, 2009). Therefore users' access to employment, education, training, accommodation and psychiatric services is likely to be key to their rehabilitation. Stigma can be a significant stumbling block: both in terms of the internalisation of blame and difference on the part of the user, and in the stigmatisation of users (and ex-users) by employers and professionals.

In their research on a small sample of female problem drug users released from prison in San Francisco, van Olphen et al. (2009) have shown how the double stigma of drug

use and prison compounded their problems. Their criminal history limited their job prospects: *"When I tried to get a job, behind me being a felon, I was unable to get a lot of jobs that I applied for. Because they say be honest about your history. And you're honest. And then you end up lying anyways because you need the work. And they're not going to hire – I have been so institutionalised"* (p.4). Likewise, many had to live in precarious accommodation: *"[the shelter] is drug infested … a lot of dope and it's dirty. It's scabies, body lice, hepatitis, TB, crabs, you name it"* (p.4). A similar picture is presented by Tiburcio's research in New York (Tiburcio, 2008).

Klee et al.'s (2002) study of 70 problem drug users attending education, training and employment services found that there were multiple barriers preventing access to employment for the users. They found that *"Stereotypes of drug users in society are a major barrier to them returning to working life. In general, they are seen as deviant, dishonest, unreliable manipulative individuals prone to poor health and self-neglect"* (p.4). Reflecting such generally held views, interviews with 20 employers showed them to be concerned about trustworthiness and absenteeism. There were also references to problem drug users being a hazard to other workers, moody, unreliable and *"generally tarnishing the company's image"* (p.35). However, when asked about drug users who had actually been employed in the past, most employers felt that they had got on with their colleagues as well as anyone else. As with van Olphen et al.'s research, problem drug users in Klee et al.'s study identified a criminal record as a major handicap.

Recent research in the UK sheds further light on employment issues from the perspective of the employer. Spencer et al. (2008) conducted a web-based survey of employers (with 135 responding) and interviews with 52 employers in selected areas. Six per cent of the survey respondents reported having employed an individual who, at the time of the appointment, they knew to be a problem drug user. When asked if they would hire a person otherwise suitable for the job if they admitted to a history of drug use, 26 per cent said yes, 26 per cent no and 48 per cent said it depended on the nature of the drug-use history. The large majority of the latter group reported that they would say no if the drugs history involved heroin or crack cocaine. Thus, as the authors conclude, *"a lifetime stigma appears to attach to the usage, or past usage, of heroin and crack cocaine"* (p.51). Respondents were also asked about their experience of employing problem drug users. Of the 23 employees responding, seven had found it 'mostly positive', six 'mostly negative' and ten 'mixed'. The interviews fleshed out some of these views: in particular, employers were nervous of the risks that they perceived to be involved in employing problem drug users – in terms of issues such as reliability, relapse and intoxication at work. Those among the interview sample who had employed users in the past tended to report positively on their experiences. Nevertheless, as the authors point out, *"the myth of the unpredictable PDU [problem drug user] employee who is high risk does have a seed of reality"* (p.68). Moving from a chaotic drug-using lifestyle to becoming a reliable employee is a major transition and, as such, should be *"an end goal of treatment and rehabilitation"* (p.68).

A recent quantitative study from the USA offers a comparative analysis of the employment experiences of people with previous substance use disorders[19] and those without in a nationally representative longitudinal survey (Baldwin et al., 2010). Perhaps surprisingly, they found similar proportions of ex-drug users and non-users to be in employment. However, they also found significant differences in the proportions that had experienced job losses within the preceding year. A range of other factors, such as mental health, were also associated with drug use and job loss, so the researchers took account of a range of such factors in a multivariate analysis. This showed that, taking account of these other factors, those with former drug use disorders had a job loss rate 23 per cent higher than would be expected if they did not have such disorders. The authors concluded that employer discrimination may be one cause of this poor job stability. It is important to note that both people meeting criteria for drug abuse and people meeting criteria for drug dependence were included in this study and that no attempt was made to investigate whether there were differences between these groups. Problem drug users, as defined in this report, are more likely than others to drop out of such longitudinal surveys, and so even the dependent group may not be representative of injecting drug users or regular use of heroin and/or crack cocaine. Studies of clinical populations consistently find high rates of unemployment among problem drug users.

It is important to avoid being glib about the employment of problem drug users. Undoubtedly, problem drug users are discriminated against by employers and providers of other services. However, there are also risks attached for employers: as Spencer et al. (2008) point out, the chaotic lifestyle commonly associated with problem drug users in the early stages of treatment may mean that they are not ready for full-time paid employment. Volunteering, training schemes and supported employment in various forms are therefore needed for users at this stage in their drug careers. However, problem drug users who are stabilised on methadone or abstinent can make excellent employees and so it is unacceptable that a life sentence of stigma seems to be attached to the past use of heroin and crack cocaine. In the USA, the Americans with Disabilities Act of 1990 specifically prohibits discrimination against persons with former substance use disorders in the workplace (Baldwin et al., 2010). There may be similar scope to include problem drug users within British discrimination legislation.

Finally, while Spencer et al. (2008) point out that full employment is an ambitious and ultimate goal for problem drug users, there may be other employment options that can be used to integrate current drug users and thereby decrease stigmatisation. One of these is voluntary work, which provides an opportunity for problem drug users to acclimatise to the workplace, without bearing the responsibilities of full employment. It also provides a valuable means of contact between drug users and the general public, with the potential to decrease stigmatisation. With regard to those problem users who are most chaotic and marginalised, Myers (2002) provides an interesting ethnographic account of the employment of such people in the bodegas within a two-and-a-half block stretch of an avenue in Brooklyn, New York. Bodegas are small Hispanic grocery stores, of which there are very many in this area of New York, owned mostly by

[19] Defined as persons meeting DSM-IV criteria for lifetime drug abuse or dependence.

Dominicans and open long hours. Myers found that, given keen competition, owners tried to keep costs down through using local people with psychiatric and/or drug dependency problems. These people were not officially employed and did odd jobs, often in return for food. The flexibility of these arrangements appeared to suit the chaotic and unpredictable nature these people's lives. They are described as severely stigmatised people, suffering from *"mental illness, addiction, poverty and social marginality"* (p.79), but they became accepted and (to some degree) celebrated characters: 'mascots', as Myers refers to them.

While there are clearly great dangers in these sorts of arrangements in terms of the exploitation of vulnerable people, they seemed to operate to mutual benefit in the bodegas. There is the possibility that our rather structured, rule-bound and risk-averse society might lead to the further exclusion and stigmatisation of the most marginalised.

### MULTIPLE STIGMAS

The stigma associated with problem drug use is complex: it does not simply revolve around the person's drug-taking behaviour, because this is usually hidden. The stigmatising process involves others picking up on cues and information that may be subtle and uncertain. A seller of *The Big Issue* is likely to be a problem drug user, but he/she might not be. Clothing, cleanliness, weight and skin complexion may also raise questions in people's minds that may well be misguided. Jones et al. (1984) describe *"a deviant comportment suggesting drug abuse or alcoholism"* (p.8), and it is often just that: a suggestion.

As well as being complex and uncertain, the stigma associated with problem drug use may also be only one part of a linked set of stigmas. Commonly co-occurring stigmas include being female, Black, an offender, homeless and/or a sex worker. Research has suggested that female problem drug users may be more stigmatised than males – especially if they are mothers or mothers-to-be (van Olphen et al., 2009; Simpson and McNulty, 2008). Minior et al. (2003) looked at the multiple discriminations experienced by 1,008 Black and Latino substance users[20] in New York City. They found that 79 per cent and 70 per cent of Black and Latino users respectively reported experiencing discrimination on account of their drug use. Figures for discrimination due to imprisonment were 40 per cent for both groups; and for race were 39 per cent for the Black group and 23 per cent for the Latino group. The users were asked about the domains where the drug-related discrimination was experienced. In both groups, the police were most frequently referred to, with family, friends and employers also very frequently cited. In terms of the most significant type of discrimination, drug use scored highest for both groups.

Another type of multiple stigmatisation that has been frequently addressed in the research literature is the link between intravenous drug use and viruses such as HIV and hepatitis C. As described above, research on the mode of transmission has shown that contraction through intravenous drug use is most stigmatised. Hepatitis C, while

[20] Cocaine, crack and/or heroin use in the previous two months.

perceived as having secondary status to HIV (Treloar and Rhodes, 2009), is more closely associated with intravenous drug use because this is by far the most common route to its contraction in the developed world (Butt et al., 2007), unlike HIV. There is therefore an assumption that people with hepatitis C are – or have been – intravenous drug users, with the attendant blame for acquiring the disease and putting other people at risk of infection.[21] Butt et al. (2007) interviewed 26 people with chronic hepatitis C in British Columbia. Interviewees described the stigmatisation they received in general healthcare, one person describing how he *"wasn't well liked"* as a drug user, but when he developed hepatitis C he was treated *"like I was a lower lowlife than before"* (p.211). Another described the response of her grandmother: *"Well, you could come and visit, but where are you going to use the washroom?"* (p.211). Reactions to stigma varied: ten blamed themselves to some degree (see also Treloar and Rhodes, 2009), but others challenged stigmatising views and sought to educate others about the disease.

[21] Another context where incorrect assumptions can be made about injecting drug use is diabetics who need to inject with insulin in public places.

# 5. Discussion and conclusions

While the previous chapter focused on the empirical research literature, the aim of this chapter is to discuss some of the key themes coming out of this work, in places drawing on a wider literature and offering personal perspectives and conclusions.

## THE WIDER CONTEXT: FEAR OF DRUGS

What is it about problem drug use that generates such extreme, stigmatising responses? First, it should be recognised that while much of the harm caused by problem drug users is enacted on themselves and those closest to them, a considerable amount of indirect damage is also caused to society. Most obviously, this is in terms of acquisitive crimes committed to buy drugs. This is enough to make many feel angry towards problem drug users: those who own shops from which problem drug users repetitively steal in order to buy drugs, or people whose homes are burgled in the same cause. Such crimes are associated with a considerable emotional – as well as financial – cost. Society also bears the cost of treating the medical conditions associated with injecting drug use, and the cost of drug treatment itself. Homeless users are frequently associated with 'public nuisance': begging, leaving drug-related litter etc. More indirectly, there are also the damages caused to communities by some drug markets, and the wider environmental, political and social damages caused to distant production and transit countries by the international trade.

Nevertheless, at the individual level, many of these damages are subtle and uncertain. Production, use and supply of Class A drugs are, by necessity, clandestine activities and many of the associated harms are therefore largely unseen and indirect. We may have suspicions that a burglar, beggar, shoplifter or vaguely threatening person on a street corner is a problem drug user, but this is often unclear. Because the impacts of problem drug users are largely hidden, and also because their number is actually relatively small (approximately 330,000; Hay et al., 2008),[22] people's understanding of problem drug use tends to come from remote sources – the media (including the internet, television, films, magazines and books) and anecdote – rather than from direct experience. This provides fertile ground for the growth of myths and stereotypes: for example, the prevalent belief in instant addiction and the myth of the drug dealer offering free drugs at the school gates (Coomber, 2010). The extreme stigmatisation of problem drug users therefore can only have a limited grounding in the direct harms that people experience. There appear to be other forces at play.

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[22] Compared with approximately 3 million dependent drinkers (Institute of Alcohol Studies, 2010).

In part, the stigma associated with problem drug use reflects wider public fears about illicit drugs in general. A number of writers have pointed to the particular and extreme fears associated with drugs (e.g. Coomber, 2010; Fitzgerald and Threadgold, 2004; Reinarman, 1997).

**History of drug fears**

There is a long history of public concern and panic about drugs and drug users. There is not the space here to do this literature justice and a only a brief example is given, drawing extensively on Kohn's excellent account of public concerns about drugs in the early twentieth century (Kohn, 1992).

During the nineteenth century, when the use of products containing cocaine and opium was widespread in the UK and USA, there was a growing awareness that these drugs could lead to compulsive and self-destructive use, concerns that were eventually expressed in legal regulation in both countries towards the end of the century. However, as Kohn (1992) points out, such problems were seen as individual problems, affecting a minority of unfortunates – many of them medical professionals, who had become addicted to the drugs to which they had ready access, or their patients.

More profound social concern about drugs at the societal level developed in the USA over this period and this set the style in terms of the powerful mix of drug fears and racial stereotyping that characterised public concerns about drugs in that country over the next half century. Over the 1880s and 1890s, cocaine use was associated with Black men and opium smoking with Chinese men, and, most powerfully, both were associated in the popular imagination with the seduction and rape of White American women (Kohn, 1992; Blackman, 2004).

As in many social phenomena, the UK lagged some way behind the USA. However, by the 1920s, London had a full-blown drug panic of its own. The initial impetus to this panic surrounded the use of drugs by Canadian soldiers in 1915. The commander of a unit of Canadian soldiers stationed near Folkestone suspected that a number of his men were taking cocaine and used one of his soldiers to trap one of the suppliers. The solider bought two shillings worth of 'snow' from a man in a pub, who was subsequently arrested, along with a prostitute who was also dealing in the drug. The publicity surrounding this and other cases led to the Canadians being blamed for spreading cocaine use, and fears arose about the fitness of troops to fight in the war. Over the mid 1900s, sensationalist American films were also being shown, further adding to rising levels of concern, and *"Quite suddenly, the drug panic had arrived"* (Kohn, 1992: p.39). Kohn references the increasingly sensationalist headlines that appeared in the press, such as 'London in the Grip of Drug Craze' and 'Cocaine Driving Hundreds Mad'.

Other concerns revolved around opium smoking, which was associated with the Chinese community in the docklands of the East End of London. Kohn points to a range of influences that led to a coalescing of fears around this drug use. This period was a time of considerable xenophobia, reflecting the nationalistic sentiment accompanying the Great War. There were also fears about the liberation of women, who were increasingly taking on new roles and new freedoms while men were away fighting.

Moreover, the arrival of Chinese men in the docklands was not accompanied by a similar influx of women and they therefore used white prostitutes and married white women. This was seen as completely unacceptable. Kohn quotes an *Evening News* editorial of the time: *"To the ordinary decent Briton there is something repulsive about inter-marriage or its equivalent between white and coloured races"* (p.59). Fears around opium reflected this concern about miscegeny: that it was being used to dope and seduce White women.

Fears surrounding the seduction and destruction of innocent young women were further stimulated by the death of a successful theatre star, Billie Carlton, in 1918, on the morning after the Victory Ball at the end of the First World War. As part of the West End 'Bohemian' set, she had apparently regularly used opium and cocaine supplied by her dress designer (Kohn, 1992). However, on this particular night she got things badly wrong and died of an overdose, causing great scandal, with the media depicting her as an innocent, brought down by degenerate men.

A similar reaction met the death of the professional nightclub dancer Freda Kempton, who died from a (probably purposeful, according to Kohn) overdose in 1922. She had regularly brought cocaine from a notorious Chinese man known as Brilliant Chang, who appeared as a witness in the trial that followed but was not charged. The case stoked the already existent fears surrounding the seduction of innocent young women by drug-peddling Chinese men. A further case contributed to this growing scare: the Chinese owner of a laundry service in Cardiff was found dead, surrounded by three unconscious White women, fuelling myths about white women being taken into slavery by Chinese men (Kohn, 1992).

Drug fears have surfaced frequently since these times: the links between Black men, jazz, cannabis and young women in London in the 1940s and 1950s; marijuana and its propensity to make young people commit 'violent and bloody deeds', as depicted by Harry J. Anslinger, Commissioner of the Federal Bureau of Narcotics in the USA; Mods and their use of amphetamines in the 1960s; the death of Leah Betts and ecstasy use and dealing in the 1980s/90s; and most recently mephedrone and fear of addiction and death in the 2000s.

**The media and drug fears**

While all of these waves of public panic have some basis in potential harm – particularly to women and young people – they have become overblown, often wildly so, with a tendency to reflect or stand in for some of the wider concerns of society. As Kohn (1992) put it, reflecting on more recent times, *"anxieties about drugs are still about much more than drugs"* (p.181). The question of why our society – and societies like it – seems to fear drugs in such a disproportionate way is a complex one. However, the media clearly play a crucial role in stoking fears and amplifying dangers. As Reinarman (1997) put it, *"the mass media has engaged in … the routinization of caricature – rhetorically recrafting worst cases into typical cases and the episodic into the epidemic"* (p.101). This obviously does not just pertain to drugs: it could be said to apply to a broad range of topics, such as immigration, paedophilia, knife crime, 'feral youth' etc. However, this is not a random process: the media's focus on such issues reflects their propensity to shock and unsettle the reader. The key ingredients in such

stories appear to be a perceived personal danger to the reader (either directly or, more frequently, to their children) and the presence of 'foreign' others and/or 'foreign' substances: a combination of danger and stranger. These features seem to pertain to the numerous drug fears referred to above: fears about the safety of children (and women in the nineteenth century cast as children) and fears about outsiders, including ethnic minorities and the ruthless, inhumane dealer, who will stop at nothing to 'push' drugs to young people (Coomber, 2010). Problem drug users similarly deliver on both fronts. They are perceived as archetypal outsiders, separated from the rest of humanity by their alien lifestyles, driven by their need for drugs. They are also perceived as a danger to loved ones, not only in terms of burglary and violent crime, but also, and perhaps more importantly, in terms of the potential for one's child to become one of 'them': to be lost to addiction.

### MULTIPLE CAUSES OF STIGMATISATION

Causes of the stigmatisation of problem drug users therefore appear to be multiple and complex. They include the actual harms caused by the users themselves and the more general fears surrounding illicit drugs. Other key influences that are discussed later in the chapter are the illegality of drugs and the blame attached to their use. Are there other causes? One very important factor that has not been discussed hitherto is the particular stigma associated with injecting drug use. The research referred to earlier with young teenagers (Power et al., 1996) included specific references to injecting: *"I would never do it … I think it's foul"*. Another referred to it as 'dirty and dangerous'. Harris (2009) suggests that part of the horror of injecting relates to that fact that it is seen as 'unnatural', in that none of the body's natural openings, such as mouth or nose, are used. The common view that it is 'dirty' presumably stems from the fact that, in an unhygienic environment, it provides the means to inject bacteria, viruses and contaminants directly into the bloodstream. People feel very strongly about injections, as the widespread nature of injection phobia demonstrates. The association between the problem drug user and the powerful symbol of the syringe undoubtedly contributes substantially to their stigma.

### MEDICALISATION

One of the resounding messages coming out of some sections of the stigmatisation literature is that society needs to move away from seeing drug addiction as a criminal and/or moral issue and should see it instead as a disease (Hanson et al., 2002; Leshner, 1997; Blume et al., 1996). This viewpoint, tending to come from doctors and psychiatrists, sees the choice as a simple one: either drug addiction is a moral issue, involving *"voluntary, self-inflicted and immoral behaviours"* (Blume et al., 1996: p.853), which is therefore stigmatised and treated punitively through the criminal justice system; or it is a treatable disease of the brain, requiring a medical response. The 'rewiring' of brain circuitry involved in this disease results in people being unable to stop using without treatment (Hanson et al., 2002). However, as Leshner points out (1997: p.46), addiction is not simply a brain disease: *"It is a brain disease for which the social contexts in which it has both developed and is expressed are critically*

*important".* It can only develop if people take the decision to use illicit substances and it therefore necessarily involves volition.[23]

While a potentially attractive idea as a way of destigmatising problem drug use, the medicalisation approach ignores the fact that many diseases have been stigmatised throughout history, even where their aetiology seems to preclude personal responsibility. The stigmatisation surrounding leprosy has spawned a general term for an outcast or stigmatised person: 'a leper'. Moreover, modern-day diseases such as AIDS and hepatitis C are heavily stigmatised. Unfortunately, therefore, calling something a disease does not obviate the potential for stigma (Hunt and Derricott, 2001). Moreover, as Room (2005) has pointed out, these two views – moral and medical – can often happily exist side by side: *"in spite of two centuries of claims that addiction is a disease, and more recently that it is similar to other chronic disease states, the idea that addiction is rooted in repeated bad choices remains widely compelling"* (Baumohl et al., 2003, referenced in Room, 2005). People can see addiction as a disease and a moral weakness.

While medicalisation might not be the simple answer that some take it to be, the policy and practice implications that flow from this perspective may be preferable to those that stem from a criminalising paradigm. It seems logical to assume that the more a set of behaviours is criminalised, the more stigmatised those behaviours become.

### CRIME, MEDIA AND LANGUAGE

It is certainly the case that the illegality of 'controlled'[24] drugs contributes to the stigmatisation of the drug user. As Hunt and Derricott (2001) point out, "*through legislation the state says drug use is a crime and is therefore bad,* ipso facto*, drug users are bad and rightly stigmatised"* (p. 191). However, this is not a simple relationship, such that illegality leads to stigmatisation and legality leads to destigmatisation. Drunkenness is legal (in most situations) but stigmatised in many contexts, and cannabis use, while experiencing a current renaissance in stigmatisation, has been socially accepted in many quarters while retaining its illegal status.

While the law is a powerful stigmatising force in itself, researchers have also pointed to the wider ideological paradigm of prohibition as an equally powerful force. According to Buchanan (2004), *"the war on drugs is a war on drug users, a civil war against an enemy within"* (p.121). Thus, the problem drug user can be seen as a casualty of the war of words that surrounds national and international debates about drug policy, as politicians compete to be 'tough on drugs' and, by doing so, add to the victimisation of

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[23] This is not strictly true in that routes into illicit drug addiction can occur through an iatrogenic process, whereby people have become addicted to prescribed opioid painkillers in the first instance. Theoretically, it may also be possible that people could be 'forced' into addiction through the application of drugs against their will. However, in the vast majority of cases, this sentence holds true.

[24] 'Controlled' is a contested term. While controlled by law, it has often been pointed out that the illegality of drugs leads to production, markets and consumption being uncontrolled (in terms of choice, strength, purity etc.).

drug users (Buchanan and Young, 2000; Room, 2005). Tempalski et al. (2007) see this policy environment as contributing not only to the stigmatisation of drug users, but also to the NIMBY (not in my back yard) response to drug services, whereby it can be very difficult to find any acceptable location for the introduction of drug services.

The clear audience for politicians talking tough on drugs is the media and it is undoubtedly the case that the media are a crucial influence in how the general public forms an understanding of addiction and problem drug users. The pejorative term 'junkie' is frequently used in the bestselling newspapers in the UK and there is a strong note of invective in many of their articles. It is therefore perhaps unsurprising that they hold the sort of views described in Crisp et al. (2005): that problem drug users are dangerous, unpredictable and have only themselves to blame. Some problem drug users are certainly dangerous and unpredictable, but the majority are not violent.[25]

The language that is used to denote problem drug use and problem drug users is important. An interesting study showing how even mental health professionals are influenced by language was undertaken by Kelly and Westerhoff (2010). They provided 728 mental health providers attending conferences with two randomly allocated vignettes, which differed only in terms of the following phrase: 'Mr Williams is a substance abuser' or 'Mr Williams has a substance use disorder'. A number of questions were asked about Mr Williams. Multivariate statistical analysis showed that the group of people given the vignette describing Mr Williams as a substance abuser were significantly more in agreement with the idea that Mr Williams was personally culpable for his condition and that punitive measures should be undertaken.[26] While the difference was significant, it was quite small, but the authors conclude that *"Referring to an individual as a 'substance abuser' may elicit and perpetuate stigmatizing attitudes that appear to relate to punitive judgements and perceptions that individuals are recklessly engaging in wilful misconduct"* (p.4). The term 'substance abuse' is frequently used in the drug field, although the UK Government generally uses the term 'misuse'. However, the central US government drug research agency is entitled the National Institute on Drug Abuse.

White and Kelly (2010) have weighed in heavily against the use of the words 'abuse' and 'abuser'. As they point out, abuse is a highly inaccurate term: drug users treat their substances with great devotion, they do not abuse them. They trace the term to religious and moral objections to alcohol in the seventeenth century, with its associations with sinful acts and forbidden pleasure, but it also has modern associations with sexual and physical violence. White and Kelly (2010) also point out that the use of the term contributes to the stigma attached to problem drug use and inaccurately implies a sense of volition. They call for the term to be dropped from the

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[25] Surveys of problem drug users who have been arrested (Boreham et al., 2007) or are in treatment (Jones et al., 2007) show the large majority of self-reported offences to be acquisitive rather than violent. There is a much closer association between heavy drinking and drunkenness and violent offences (e.g. Boreham et al., 2007).

[26] This was one of three factors coming out of an exploratory factor analysis.

*Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) and from the names of US government organisations where it appears.

This would seem to represent a good start in the area of terminology, but there remain questions about other terms in common usage. 'Misuse', the favoured term of the UK Government, is a peculiar term. What is the correct use for crack cocaine? Likewise, the term used predominantly in this report, 'problem drug user', could be said to denote the person as being a problem (rather than the drug use, which is the origin of the term). While 'drug addiction' sounds relatively neutral, the term 'drug addict' seems to have taken on a much harsher connotation. There is, perhaps, a tendency for all of these terms for drug users to take on a stigmatising flavour, simply because they are used to denote a stigmatised group. More research is needed on the use of language and the impact that this language has on attitudes towards drug users.

## THE BLAME GAME

Jones et al.'s (1984) discussion of the centrality of perceived responsibility to the process of stigmatisation was referred to earlier. Blame and responsibility crop up throughout the literature on the stigmatisation of drug users. A considerable proportion (60 to 68 per cent) of the respondents in Crisp et al.'s (2005) surveys thought that problem drug users had 'only themselves to blame'. Indeed, blame seems to lie at the heart of negative attitudes towards drug users: it appears to be the unifying factor lying behind the day-to-day stigmatisation that occurs in the media and wherever problem drug users interact with healthcare professionals, pharmacists and the general public.

This notion of blame seems to have two central elements. First, problem drug users took illegal drugs in the first place: they then went on to try increasingly more dangerous drugs and effectively chose to take the path that has led them to their predicament. Second, people perceive problem drug users to have a choice not to take drugs. They have to find the money to buy the drugs, then buy them and take them. This looks like a string of voluntary behaviours that would only be carried out by someone who did not want to stop taking drugs.

With regard to the first element, it is true that poor and self-destructive choices lie behind virtually all cases of drug addiction. However, research has shown that the factors that lie behind addiction are primarily genetic and social: genetic predisposition and early family environment being influential causal factors. In this light, blame makes very little sense: if the roots of a problem drug user's addiction lie in his/her genotype and in growing up in a difficult and uncaring family environment, can he/she be blamed? Clark (1998) points out that this personal responsibility view of addiction assumes "*that there is something irreducibly personal driving the initial choice to use drugs, something that derives neither from an individual's environment nor his biological endowment*" (p.9).

The second element demonstrates how peculiar the condition of addiction is. It goes against what is commonly understood about people and how they behave. It is

unsurprising that people find it difficult to understand that one of the defining features of addiction is that people do not feel that they have a choice: they are driven to use.

In Chapter 2 it was also noted how blaming people for their stigma can be psychologically functional, in that it provides a convenient explanation for why 'they' are in the state they are in and 'we' are not. If the problem drug user is to blame on account of a weak will and flawed character, this allows us to continue to believe in a 'just world', where people get what they deserve. There may therefore be a resistance to understanding the root causes of an individual's addiction: there may be an investment in simply apportioning blame for the current state of addiction on an individual's current behaviour.

These considerations argue for educating people about the causality of addiction and the nature of the state of addiction. There is a need for public education and there is a need for education for professionals – in particular for general healthcare staff and pharmacy staff.

### WHAT ABOUT THE POSITIVE SIDE OF STIGMATISATION?

It is premature to be discussing ways of countering stigmatisation before establishing whether, on balance, it is actually worth countering. A number of commentators have pointed out that stigma may be playing a vital role in preventing others from taking drugs in the first place and/or escalating their use. More generally, Bayer (2008) has pointed to the stigmatisation of smokers as an example of state-supported stigmatisation that may have led to a decrease in the smoking population. He asks the question *"is it morally acceptable to embrace or foster stigmatisation if in so doing we reduce the burdens of disease and premature mortality?"* (p.468). Furst et al. (1999) have suggested that the stigmatised image of the 'crack head' may have been an influence in the declining use of the drug over the 1990s: *"being acutely aware of the stigma attached to being designated as a crack head by peers and significant others appears to have acted as a symbolic constraint against crack smoking"* (p.177).

Perhaps the most strident plea for the utility of drug-related stigma is made by Satel (2007) in her article 'In Praise of Stigma'. Satel seeks to separate the stigma associated with drug use from the stigma associated with treatment: *"we don't have to neutralise the moral valence of all addiction-fuelled behaviour to destigmatise the treatment process"* (p.147). Rather than seeing stigma as a barrier to treatment, Satel suggests that it can be a way to persuade people into treatment: "*'Eliminating stigma' may backfire by making more addicts comfortable continuing drug use and avoiding treatment"* (p.148). She also suggests that shame and other negative consequences of addiction are an effective deterrent to young people.

In a recent article in the UK, McKeganey (2010) provides an interesting discussion of the extent to which the stigma associated with drug-takers can be divorced from the stigma associated with drugs. He suggests that the latter – 'good' stigma – has been *"an important social barrier in reducing the wider adoption of a pattern of illegal drug use"* (p.14) and notes that, in general, the higher the level of stigma associated with a drug, the lower its prevalence. He queries whether the stigma associated with

individual drug users – 'bad' stigma – can be separated from the good, and if it cannot, how society gets the balance right.

The separation of drug-related and person-related stigmas is an idea that arises elsewhere in the literature. In Goffman's terms, there cannot be a stigma relating directly to a drug: the stigma is a mark borne by a person, who is stigmatised in his/her interactions with others on account of this mark. However, whether or not it is called 'stigma', McKeganey is right that the 'image' associated with a drug is a crucial factor affecting its use. The interesting question is whether the image of a drug can be dissociated from the stigma the user of that drug experiences, and, therefore, whether the user's stigma could be reduced without improving the image of the drug. It seems inevitable that if a drug becomes more socially unacceptable, so too will the users of that drug. An example of this is the widely publicised deaths purportedly associated with drugs such as ecstasy and mephedrone, which have then led to the demonisation of these drugs and the public shaming of young people using them. But is this a two-way street: i.e. if the image of the users of a drug changes, does the image of the drug also change? In many situations, this must also be the case: a widening in the social backgrounds of those using cocaine over the past decade has, no doubt, led to a change in the image of the drug. However, in the specific case of the extreme stigma experienced by problem drug users, it is hard to see how a more sensitive and understanding approach to their condition could somehow lead to an increase in Class A drug use. The extreme social exclusion of many problem drug users suggests that a small change in their social standing will have a negligible impact on the social acceptability of heroin and crack cocaine. Even a full-blown campaign of the 'have-you-hugged-an-addict-today' variety (Satel, 2007: p.148) seems unlikely to have the effect of rendering heroin a fashionable drug.

Satel's idea that shame may act to propel problem drug users into treatment, rather than repel them from it, also needs to be considered. The research reviewed above has shown how users frequently feel especially stigmatised when they interact with healthcare staff and pharmacy staff – at those very locations that they will have to negotiate in order to get treatment. Outside of these settings, users may well be able to insulate themselves from the stigmatisation of broader society by living within 'deviant communities', where problem drug use, and the lifestyle that accompanies it, is the norm. Moreover, as we have seen, discreditable users who are avoiding the labels that come with treatment are likely to be repelled by the additional shame that would come with treatment. It seems highly unlikely that shame is the force for good that Satel implies.

## IS STIGMATISATION INEVITABLE?

Even if one accepts that, on balance, the stigmatisation of problem drug users is a bad thing, whether or not anything can be done about it is another question. It is clear from the earlier chapters that stigmatisation is ubiquitous in human societies: an *"ingrained human proclivity"* (Jones et al., 1984: p.299), which may spring from biological processes that helped us to survive in the past. So, whatever the consequences, perhaps we are doomed to stigmatise and be stigmatised? Jones et al. think not: *"We see no reason to assume that the level of stigmatisation is necessarily*

*fixed – either for individuals or for societies. We are optimistic that the frequency and intensity of stigmatisation can be reduced in our society"* (p.300). Indeed, it is generally accepted that stigmas are not fixed: they vary over time and place. There may be a natural tendency for humans to stigmatise, but we may well be able to influence who is stigmatised and how. The need to try to do so is captured well by the same authors: *"The psychic pain of feeling rejected and discredited, of surmising that others want to avoid you and can barely suppress their revulsion in your presence, must be of concern to anyone with a capacity for human empathy"* (p.301).

## HOW CAN STIGMA BE TACKLED?

Stigmatisation is enacted through a complex social interaction between individuals. Interventions therefore somehow need to intrude on these personal and public relationships, either through influencing the mindset of the parties involved or through influencing the wider cultural context in which they take place. This is likely to present a significant challenge.

Corrigan and Penn (1999) identify three strategies aimed at countering stigma: protest, education and contact. By protest, they mean activism by advocacy groups aimed at challenging public stigmatisation. Education refers to reducing prejudices by providing information that contradicts them. Contact approaches involve bringing the members of stigmatised groups together with 'normal' people, in the hope of increasing understanding and dispelling myths.

### Protest

In the context of mental health, Corrigan and Penn (1999) are discouraging about the potential for protest to have a significant impact. They focus in particular on attempts to suppress stigmatising responses, citing the potential for 'rebound' effects, whereby individuals in experiments who have been told to suppress particular thoughts think them all the more (e.g. 'don't think about sex'). However, they concede that approaches targeting the media may be more effective and it is this aspect that seems to have resonance in the addiction field. As pointed out earlier, media reporting on problem drug users if often highly stigmatising. There may be a role here for advocacy groups to challenge this sort of reporting. For example, one could imagine a campaign to try to ban the use of the word 'junkie' in the media (with the hope that it would not be replaced with something worse). This could be led by user groups. White's campaign to get the term 'abuse' dropped from official language also seems one worth supporting (White and Kelly, 2010). Indeed, as noted above, language in the drugs field is generally rather bemusing and there is a need for more semantic analysis of how language is used by the different voices engaged in drug discourse. An example of what appears to have been a successful campaign to move the media on in terms of their use of stigmatising language is the public outcry that followed *The Sun*'s first edition headline on 23 September 2003, 'Bonkers Bruno Locked Up', which was changed in later editions to 'Sad Bruno in Mental Health Home'. In 2006, the Press Complaints Commission introduced a code of practice, which banned the use of stigmatising terms such as 'schizo' and 'nutter'.

This should not be regarded as a trivial issue. The 'junkie' label, with its associations with dirt and criminality (Radcliffe and Stevens, 2008), is profoundly stigmatising in the UK.[27] The power of the word in conjuring up negative images of problem drug users may be a significant obstacle to efforts to instil a more sympathetic attitude in the general public. It may also have the unintended consequence of undermining government efforts to treat people and help them recover.

Protest is one way in which power relations can be challenged: a necessary ingredient of attempts to change stigmatisation, according to Link and Phelan (2001). Of relevance here is the substance use of powerful groups: the well-used bars of the Houses of Parliament, the cocaine use of bankers and celebrities, and the notoriously excessive use of drugs and alcohol by members of the press. Should there be such a huge gulf in stigmatisation between the heroin addiction of the homeless drug user and the celebrated drinking feats of some former Fleet Street journalists?

Another form of activism, if not protest, that can be particularly powerful is where well-known, well-liked and well-respected individuals speak up for particular minorities. A recent example is Joanna Lumley's support for the Gurkha Justice Campaign. Closer to the issue of problem drug users, Stephen Fry has done much to raise the issue of bipolar disorder by appearing in a television programme on the subject and speaking openly about his own experiences. For example:

> *I'm in a rare and privileged position of being able to help address the whole business of stigma, and why it is that the rest of society finds it so easy to wrinkle their noses, cross-over, or block their ears when confronted with an illness of the mind and of the mood – especially when we reach out with such sympathy towards diseases of the liver or other organs that don't affect who we are and how we feel in quite such devastating complexity* (quoted in Millar, 2007: p.164).

Drug addiction has affected a large number of stars and celebrities, and there may well be the potential for more popular, iconic figures to speak out about their problems and contribute to a greater understanding of the condition.

**Education and training**

Education and training have already been referred to at various points in this report. It is a logical approach to some of the responses of professionals and the general public, which seem to demonstrate a lack of knowledge and understanding about the nature of addiction and its causes.

Education could be useful at a number of levels. Public education, while ambitious, makes sense if it is accepted that stigma is rife within the general public, which the surveys considered earlier seem to suggest. It has already been suggested that drug

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[27] The term may have different connotations in other countries. For example, its use in the Netherlands appears to be associated more with user empowerment, as in the naming of the Rotterdam Junkie Union.

education in schools could provide a balanced perspective on addiction, including its causes and consequences. This could form part of drugs education within Personal, Social, Health and Economic (PSHE) education. It is also important that drugs education does not contribute to the stigmatisation of problem drug users. Current government guidance recognises the importance of avoiding heavy-handed and stigmatising accounts of addiction, given the potential for children to come from families with addiction problems (DfES, 2004).

The education and training of healthcare and pharmacy staff arises as a significant issue in the research literature. Given the extensive damage caused by problem drug users to themselves, their families, their communities and society, and the importance of the early identification of drug-related problems, there are frequent pleas for addiction to form a more significant part of medical training for doctors and nurses. Likewise, there appears to be a strong case for training for pharmacy staff. While training already exists, there needs to be an exploration of best practice in this field. There is also a pressing need for research on the range of approaches currently adopted in pharmacies in terms of design and procedures, with the aim of providing recommendations on best practice.

The police may also need better training in dealing with drug users in public spaces. While only one study is reviewed above, it suggests that the police can contribute to the stigmatisation of problem drug users through publically searching them in the street, which can be a humiliating experience.

The way in which problem drug use constitutes a 'master status' also carries implications for the education and training received by helping agencies. As discussed earlier, the various labels used to describe addiction constitute a 'master status' – i.e. they engulf a person's identity and become *"the filter through which his or her characteristics are seen"* (Jones et al., 1984: p.296). People are both repelled and fascinated by addiction and, on knowing that an individual is 'an addict', they are liable to home in on this central identity to the exclusion of all else.[28] Unless users can manage information about themselves and 'pass' as normal, it seems likely that the tunnel vision of those around them may actually cement their user identity and accentuate their problems. Such processes may lie, in part, behind some users' reluctance to become involved in treatment and thereby take on this master status. It may therefore be important for treatment and other helping agencies to make greater efforts to focus on the whole person, rather than dwelling exclusively on the minutiae of their drug use (to the extent that this is done). A strong emphasis should be put on any remaining mainstream interests that users have. Put succinctly, some addicts are also birdwatchers.

It has also been suggested that users may profit from a greater understanding of their condition (Finnell, 2000). Finnell argues that users' feelings of guilt and failure can be

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[28] The majority of researchers are also implicated in cementing the user's identity. Users are interviewed because they are users and the questions asked usually revolve only around aspects of their drug use.

addressed through teaching them about the neurobiological basis of addiction and thereby reducing the stigma that they experience. While this is an interesting idea, one would want to see a balanced approach to the complex and multiple causal influences acting on pathways to addiction. One would also not want users to feel that their addiction was in some way predetermined and that there is therefore little they can do about it.

Finally, it has been shown that the families of users are frequently subject to 'courtesy stigma': taking on some of the shame and ostracism felt by the drug user. It has long been recognised that there is a need for support for the families of users, but perhaps less well recognised is the need for families to receive some education about addiction and its causes. This might have some impact on the self-blame felt by many drug users' parents.

### Contact

The general public's understanding of problem drug use may be shaped by a number of influences: the media, for example, and personal experiences of friends and families with drug problems. But it is also shaped by experiences in city and town centres, most often with marginalised homeless users. As with healthcare services and pharmacies, town centres provide another location where the public rubs up against problem users and where public images of problem drug users are therefore forged. *The Big Issue* has proved an effective way to encourage positive contact between marginalised people (many of whom are problem drug users) and the general public. There are likely to be many other ways of employing homeless drug users that would encourage good contact and break down the 'street beggar and harassed city worker' stereotypes.

Another area where contact can be encouraged is employment. Volunteering seems to be a promising way of overcoming some of the initial fears felt by employers and enabling them to get beyond the 'junkie' stereotypes.

### Campaigns and social marketing

Lavack (2007) provides a useful overview of previous attempts to raise public awareness about addiction. One annual campaign she highlights is the Recovery Month initiative in the USA, supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). Recovery Month *"highlights the societal benefits of substance abuse treatment, lauds the contributions of treatment providers and promotes the message that recovery from substance abuse in all its forms is possible"*.[29] A key aim is educating the public about the nature of addiction in order to reduce the stigma associated with addiction and treatment. This campaign has achieved quite a high profile. In September 2008, Arnold Schwarzenegger, Governor of the State of California, issued a proclamation supporting Recovery Month:

> *There is much we can do as a state to effect positive change in the lives of those with substance abuse problems. It is vital that we educate the public on*

[29] SAHMSA: www.recoverymonth.gov/About-Recovery-Month.aspx

*the realities of drug and alcohol addiction and the possibility of recovery. By removing the stigma from substance abuse, we can focus on the inspiring stories of men and women who have bravely faced and conquered their problem….*

*It is my hope that all Californians use this month to educate, encourage and inspire those suffering from substance abuse to end their dependence. By forming supportive and understanding communities, we each can play a role in making our state stronger, safer and healthier.*[30]

Another current campaign in the USA is the National Advocacy Campaign,[31] which has the twin aims of eliminating discrimination against people in recovery from addiction and expanding the availability and quality of treatment. It is run by the Legal Action Center[32] and the State Associations of Addiction Services[33] and includes a strong focus on removing legal and policy barriers to users with drug offence convictions accessing benefits, employment and accommodation.

White (2009) gives a detailed and research-based argument for a long-term campaign to lower stigma associated with medication-assisted treatment and recovery in Philadelphia. His approach includes attempting to influence public, professional and user views, portraying the contributions of people in medication-assisted treatment to their communities and increasing links between treatment services and communities.

All of these US-based approaches have a strong focus on recovery, reflecting the wider and increasingly influential recovery movement in the mental health field over the past 15 to 20 years. This reveals a key issue: it is easier to fight against the stigmatisation of the ex-user than against the stigmatisation of the current user.

**Legal and rights-based approaches**

The National Advocacy Campaign referred to above raises the issue of legal approaches to opposing the stigmatisation of drug users. As Burris (2006) points out, the law is most often seen as a way of prohibiting discrimination. This can prevent discrimination and provide recompense where it occurs. However, Burris also points out that *"It addresses behaviour, but does not necessarily change the attitudes that produce the behaviour"* (p.529). It cannot protect the stigmatised from rejection by other family members, or from all the often subtle human interactions that serve to denote their different, ostracised status. Even in more palpable cases, such as employment decisions, there are a host of other variables distinguishing applicants and

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[30] http://gov.ca.gov/index.php?/print-version/proclamation/10482

[31] www.saasnet.org/~saasneto/drupal-6.6/node/23

[32] Which describes itself as "a non-profit public interest law firm and policy organization that specializes in fighting discrimination against and protecting the rights of people with alcohol or drug problems, HIV/AIDS or criminal records".

[33] A national organisation advocating on behalf of state associations of addiction, prevention, treatment and recovery providers.

it is therefore very hard to prove 'intent' to discriminate on the basis of a history of drug use.

The idea of challenging stigmatisation through legislation has been more fully explored in the mental health field. Peay (2004) reviewed relevant legislation (including the Mental Health Bill, which later came into force as the Mental Health Act 2007, the Disability Discrimination Act 1995 and the Human Rights Act 1998) and concluded that legal protection may be of limited use in the context of the stigmatisation of mental illness:

> *Whilst the law might encourage people to be fair in their treatment of others, and may provide redress for those subject to unfair discrimination, the fundamentals of fair treatment lie in our attitudes to others. Law may overtly attempt to rectify any imbalance, but is very presence may be as much counterproductive as beneficial* (p.372).

In his historical review of discrimination towards those with physical or mental disabilities, Millar (2007) concluded that the main drivers for change had been campaigning supported by research; political support, especially from the Labour governments since 1997; and positive media representations of disabled people. Indeed, summing up from a broader review of the historical changes in the treatment of a number of minorities, Thane (2007) concludes that the most powerful influence has come from stigmatised groups speaking out.

There is neither the time nor space here to do justice to the question of how important legal changes have been to improvements in the treatment of other minority groups. Undoubtedly, law has played an important role in the area of race discrimination, for example. However, in some areas it appears that while legal changes may be important for symbolic reasons, they may be of limited practical value. Ultimately, the complex, interactional nature of stigma may mean that the law is too much of a blunt tool where one is ultimately looking to change people's attitudes towards others.

**Other approaches**

One approach occasionally referred to in the literature is helping users to (in Goffman's terms) control information about themselves and 'pass' as 'normal'. Goffman (1963) refers to the stigma symbol presented by *"the arm pock marks of drug addicts"* (p.61). An early study (Shuster, 1968) reported on an operation to remove the needle track marks from the arms of 16 current and former addicts. The author concluded (in a rather impressionistic way) that those who had been 'clean' for several years *"benefited a great deal by this operation. It has contributed to their rehabilitation, aided their social adjustment and given them courage to face new environments and new situations"* (p.3133). Outcomes were less favourable for active or recently 'cured' users.

Chaotic problem drug users also frequently experience dental problems. This is another area where interventions can decrease the stigmatisation of users and help them to obtain employment and achieve integration.[34]

At the individual level, protest or resistance can also help users and ex-users to escape stigmatisation. Goffman's words about 'heroes of adjustment' (Goffman, 1963: p.37) who can become professional advocates for their movements were quoted earlier. Anyone familiar with the user movement in the UK will recognise the potential for social integration and personal development offered by such roles.

**Users and ex-users**

When it comes to considering action on stigma, it is clear that people have attempted to draw a distinction between the ex-user and the current user. This reflects the largely unstated assumption that users are in many ways fair game – or at least, that their stigma is beyond the help of official agencies. It is true that ex-users make more readily worthy recipients of public sympathy and help, and yet, as the research shows, they are still discriminated against. However, it is also the case that the stigmatisation of current problem drug users accentuates their problems and may prevent their access to treatment, healthcare and integration. It might also be questioned whether it actually makes sense to separate the two: is not the ex-user tarred by the same brush as the current user in any case? While it may be harder to drum up public support, it seems important that attempts to destigmatise drug users operate across the boundary between the current and ex-user; a boundary that is, in any case, rather blurred.

**Research**

Stigma is in some ways a rather abstract concept, and yet it is quite readily measured and studied. However, few in the UK have chosen to do so. This has led to significant gaps in our understanding: in particular, we know little about the attitudes of people working in generic services towards problem drug users. We also need research on how the media report stories on drug users and the language that they and others use. We need a better understanding of the potential for stigma to prevent drug users accessing treatment: with the aim of identifying less stigmatising portals to helping services. While some work has already been done on the dilemmas surrounding pharmacy services for users, there is a need for more research.

There would also be considerable worth in maintaining some basic questions in regular surveys so that the attitudes of the general public can be monitored. The questions included in the Scottish Social Attitudes Survey (Ormston et al., 2010) demonstrate the potential for exploring public understanding of addiction. Given the complexity of these

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[34] See Saville, S. (2006). *Teeth – not just for eating*. Conference presentation at www.exchangesupplies.org/conferences/NDTC/2006_NDTC/speakers/sebastian_saville.html

findings, there is the need for qualitative research that can explore these issues in a more detailed and holistic way.

## POLICY

The pervasive fear of illicit drugs and the particular stigma attached to problem drug users has a considerable impact on politicians' and policy-makers' room to manoeuvre on drug policy. Whatever their personal opinions, senior politicians tend to trot out the tough talk expected of them: usually to the applause of the popular press. However, it need not always be this way. As the political support for Recovery Month in the USA shows, there is scope for compassion rather than stigmatisation – at least when it comes to the issue of recovery. Given the evidence for the negative effects of stigmatisation on the potential for problem drug users to reintegrate socially and move on from their addiction, this should make countering stigmatisation a policy priority.

## CONCLUSIONS

A key conclusion from this review is that stigmatisation matters. We feel rejection exquisitely because we are deeply social in our makeup and are unavoidably responsive to the behaviours, expressions and words of others. Stigmatisation therefore has a serious impact on the lives of those it afflicts. It is also clear that problem drug users are a highly stigmatised group, in the classic sense described by Goffman. To be a problem drug user, addict, junkie or drug abuser is to have a master status that greatly affects one's interactions with others: with members of the public, nurses, doctors, pharmacists and police officers alike. It is a status that obscures all others, and it is a status that frequently incites disgust, anger, judgment and censure in others. No wonder then that stigmatisation has a profound effect on drug users: certainly on their sense of self-worth and probably on their ability to escape addiction.

There is nevertheless a problem with simply saying that problem drug users are a stigmatised group and that therefore, like other stigmatised groups, we should do something about it. While Goffman's description of stigma was descriptive, sociological and quite impartial, his ideas have become a rallying cry for those seeking to draw attention to the unfair treatment of minority groups. As Bayer (2008) has argued, researchers in this field have *"tended to adopt a posture of advocacy"* (p.468) and largely focused on blameless groups, such as the disabled and mentally ill, whose treatment by others appears to be patently unfair. The problem is that drug users are clearly not 'blameless', at least in the conventional meaning of the word.[35] Indeed, blame lies at the heart of their stigmatisation. So, ironically, this entrenched sense of culpability, while driving people's stigmatising attitudes towards problem drug users, at the same time makes this group a hard one to include within a paradigm of unfairly stigmatised groups.

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[35] As pointed out earlier in relation to Clarke (1988), there is a philosophical standpoint that all decisions are reducible to genetic and environmental influences and so no-one can ultimately be to blame for their decisions.

A major aim for those wishing to do something about the stigmatisation of users therefore becomes one of challenging this widespread sense that problem drug users 'only have only themselves to blame' for their condition. Hitherto, this has largely been undertaken by the application of a rather simple medical model: addiction is a brain disease and, like any other disease, one cannot blame the patient for its contraction or development. However, while some aspects of the state of drug addiction are certainly disease-like, others are inherently social and psychological. The root causes of addiction are perhaps best understood as a complex nexus of genetic and environmental risk factors that develop over time. Vulnerability to addiction stems from a combination of genetic and environmental factors that predispose users to addictive use once exposed to a substance or activity (Kreek *et al.*, 2005). This accretion of risk interacts with the social, psychological and physiological impacts of the addiction itself to produce individuals who are frequently socially excluded, with precarious or non-existent employment, housing and relationships. Such a model of addiction leaves little room for simplistic blame: how can an individual be blamed for his/her genetic and early family background?

A further conclusion is that there needs to be a consideration of the role of stigmatisation in preventing the social reintegration of problem drug users. If recovery really is to be the ambitious 'new' goal of drug treatment, then politicians and policy-makers will have to look carefully at the question of stigma and how they and others can shift society towards a more compassionate approach to this deeply stigmatised group.

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