

Getting Serious about Stigma: the problem with stigmatising drug users

An Overview

What is stigma?

Stigma is a 'stain or attribute' marking out someone as unacceptable. It leads to prejudice and discrimination.

Dictionaries define stigma as an indelible mark or a stain, and the term is generally applied to an attribute or status that makes a person unacceptable in other people's eyes.¹ Stigma is different from disapproval of particular behaviours because it is not necessarily linked to the actions of an individual, but rather to what is assumed about 'someone like that'. It also goes beyond stereotyping, as the stereotypical perception of who or what the person is becomes their defining feature, obscuring other aspects of their individuality and becoming fixed and hard to change. Such stigma then often leads to prejudice and active discrimination.

Stigma and drug use – what's the problem?

The continuing stigmatisation of people with drug dependence will undermine the Government's efforts to help them tackle their condition and enable recovery and reintegration into society.

People with a history of drug problems, as discussed in more detail below, are heavily stigmatised and are seen as both blameworthy and to be feared. As a result they are subject to exclusion and discrimination in many areas.

The stigmatisation of people with drug problems has serious consequences for government policy. Key policies seeking greater reintegration and recovery, moving people from benefits into work, and a focus on public health will not succeed while stigmatising attitudes are pervasive. If people with drug problems are seen as 'junkie scum' and 'once a junkie always a junkie', people will be reluctant to acknowledge their problems and seek treatment, employers will not want to give them jobs, landlords will be reluctant to give them tenancies and communities will resist the establishment of treatment centres. As a result, drug problems will remain entrenched rather than overcome.

Many would argue that, since drugs such as cannabis and heroin are illegal, this stigma is necessary to demonstrate society's disapproval of drug use. However, while society needs to set norms for behaviour and people need to take responsibility for their action, stigmatisation of people who have developed drug problems goes beyond that. Such stigma sees all people with drug problems as conforming to a stereotype (evil, thieving, dirty, dangerous etc.) and applies the label for life, and in so doing impedes the recovery that society wishes to promote.

Therefore, if the Government and society are serious about recovery and a 'rehabilitation revolution', they need to get serious about tackling the obstacle of stigma in all its many forms.

¹ Lloyd, C. (2010). *Sinning and Sinned Against: The Stigmatisation of Problem Drug Users*. London: UK Drug Policy Commission. (Available at: http://www.ukdpc.org.uk/resources/Stigma_Expert_Commentary_final2.pdf)

The nature and impact of stigma towards drug users

Stigma experienced by drug dependent users and their families often delays people seeking help. They fear that once they do, they will be stuck with the label 'hopeless addict' for life.

Professional attitudes all too often reinforce stigma and lower expectations of recovery.

Stigma puts barriers in the way of recovery and reintegration, for example by making it difficult to find a job.

The negative attitudes that drug users experience and the impacts they have on them and their families are demonstrated by the way in which the people in our research focus groups responded when asked what stigma meant to them.²

Figure 1: Graphical representation of the words used by focus group participants when asked what stigma meant to them



Stigma prevents help-seeking

Stigma can prevent people with drug problems recognising their emerging problem and seeking help. Asking for help would mean admitting to themselves and others that they are one of those 'hopeless addicts' and acquiring that label and all that goes with it. The feelings of shame and worthlessness engendered through stigmatisation also prevent people accessing treatment because they feel they are 'not worth bothering with'.

Similar feelings were experienced by the families of people with drug problems, who described being too ashamed to speak to anyone about the issue and of feeling that they should be able to 'sort things out themselves'.

² Jones, R., Simonson, P. and Singleton, N. (2010) *Experiences of stigma – everyday barriers for drug users and their families*. London: UKDPC. (Available at: http://www.ukdpc.org.uk/publications.shtml#Stigma_reports)

Stigma is widespread

Stigma also has a big impact on recovery once in treatment. The low self-esteem of people in treatment prevents a belief in recovery. In our focus groups we were given many examples of how the attitudes of other people, including staff in a multitude of agencies, reinforce these negative feelings by presuming failure and not rewarding positive achievements. This stigma occurred in a wide range of settings:

- drug treatment services
- pharmacies
- GP surgeries
- hospitals (A&E, midwives, other staff)
- dentists
- social services
- employment (employers, staff, job centres)
- housing landlords
- criminal justice system (police, probation, prisons and courts).

However, we also heard of examples of good practice – professionals who were supportive and ‘treat us like human beings’ – in these same areas, so stigma is not inevitable. Indeed, some services can also actively help destigmatise, such as dentistry. Poor dentition is often associated with long-term opiate use and so this stigma can be addressed through good dentistry, allowing a person to engage with employers or new neighbours without obviously looking like an ‘addict’.

Stigma is cumulative and long-lasting

Sometimes there may be perceived stigma, where people assume that attitudes towards them will be negative or interpret looks, words and actions as judgmental, whether or not this is the case. However, these perceptions arise because of the way that people with a drug problem or their families observe other people talking about and behaving towards drug users on a daily basis. In this way, stigma affects people twice – once, directly, by the actual behaviour and then again through the impact of the anticipation or fear of stigma.

However, we also identified numerous examples of enacted stigma, where negative attitudes have led to discrimination or unfair behaviour. For example, being made to wait while other people who arrived later are seen or served, having to wait in a separate area, being seen after all ‘normal’ clients have gone home or having one’s confidentiality breached by loud remarks such as ‘Here is your methadone’. When this occurs day after day it will inevitably reinforce feelings of worthlessness and make seeking help appear a waste of time.

Stigma can also impede recovery in practical ways. Being made to wait for medication could make a person in employment late for work and cost them their livelihood. Being late for an appointment at the job centre or with social services could lead to benefit sanctions or the loss of access to one’s children since people with a history of drug dependence may not be believed when they say they were late because they were made to wait for an appointment elsewhere.

We also heard numerous examples of insensitive and inhumane treatment by healthcare staff. Undoubtedly a few drug users may at times seek to abuse the system to obtain drugs. But this appears to have led to a belief among some staff that everyone with a history of opiate dependence attending A&E departments is only there to get drugs, broken arm or appendicitis notwithstanding!

Child protection vs family support and encouragement – a delicate balance

Another topic frequently raised as having a key impact on recovery and help-seeking concerned children. Finding the balance between protecting children from harm and keeping families intact is hugely challenging for social workers. The desire to care properly for their children is a key reason for many drug users to try to overcome their drug dependence, so child-protection measures and interaction with social workers generally can have a huge impact on help-seeking and recovery to the detriment of the children, parents and wider family members alike. Social workers were seen as stigmatising insofar as some interpreted every infringement, such as being late for an appointment, which for other people would be considered minor matters, as being related to drug use and a sign of continued drug problems. Some social workers appear also to be reluctant to acknowledge progress in recovery. We were given numerous examples of people being told that they might have greater access to their children, such as through an additional supervised visit, if they stayed off drugs for six months or a year, only to be told when they did so that they would have to wait another few months. Not surprisingly, this can lead to relapse and a self-fulfilling prophecy.

Figure 2: Examples from the focus groups and web survey of the impact of stigma on treatment recovery

“Makes you feel like there’s no point in trying to get better if people’s attitudes are entrenched and they don’t give you a chance.”

“We used to get it [Methadone] at 9.00am so that we had it before college, and there’s a new chemist in and she’s like “No, you’ll wait until 9.30am.” So there’s about 30 people waiting outside the chemist, and I’m terrified in case any of my aunties pass. I’m having to leave later to go and get it until the normal chemist comes back...”

“I wouldn’t approach the doctor for a good few years due to feeling ashamed and because it was family doctor who knew my family I felt quite apprehensive of making the appointment to discuss drug use.”

“Especially up here. You get people that ...that will actually phone up and inform on people... that the person that’s working for them has got a drug problem, which has happened to a couple of people up here I know that have lost their jobs.”

“Well, I’ve started doing pensioners’ nails here [as a volunteer], giving manicures and painting their nails on Wednesday afternoon. When they find out I used to be a drugs user half of them wanted nothing to do with me. There was only two ladies that would speak to me.”

“I was told by my employer - a recovery service in the north west - that if I did not come off my subutex, which I had been maintained on since I was offered the job, I would lose my job...I had come so far and the services that should have been supporting my integration into mainstream society put their own political/morally driven agendas ahead of the needs of one of the people they should of in fact been supporting. I have never had any issues of discipline or incapability at work.

“... when I got to the end of my detox I was going through slight withdrawals once I’d finished my methadone, and I asked for respite. There was no respite places so I had to sign what’s called a Section 25. It’s a foster thing. It was just to get a bit of help so I could get myself well again to get my daughter back. And when I did feel better, I asked “Right, can I get her returned now” because ... I was led to believe it was a voluntary basis, and ... I was refused. And I’m gutted because I really think if they’d have gave her me back when I asked for her, when I was 100% fit and mentally fit and stuff, I think things would be really different today. As it goes, I was refused and it was like “Oh, that’s it” ...”

Stigma undermines employment and reintegration

Employment and housing are other areas where stigma can be a huge obstacle to recovery from drug problems. The importance of employment, formal or informal, for well-being and participation in society is well-established, and for people who have had drug problems it can be vital for establishing a new social identity. However, a study of employers found almost two-thirds would not employ a former heroin or crack user even if they were fit for the job.³ In our current research, former drug users reported having job offers withdrawn once their former drug using status was known. The impact of a criminal record for drug or other offences also impedes finding employment, especially in an era of increasing risk aversion, when Criminal Record Bureau (CRB) checks are increasingly being used. Disclosure of a history of drug use makes it difficult to get a job, but concealing it is not a good basis for employment and can lead to dismissal if found out later.

Family members of people with drug problems also reported problems at work. The expressed attitudes of work colleagues towards drug users can make it difficult for family members to disclose their situation and is painful for them to hear. Many reported having given up their jobs or having avoided promotion as a result of, or due to fear of, the consequences of disclosure; others maintained silence about their situation, but at a cost in terms of stress.

Stigma exacerbates problems for people with a history of drug use in securing a roof over their head. The shortage of social housing is a problem for a wide range of marginal groups, but in areas where drug use has been a problem, the bar is raised even higher for people who have had drug problems and they may be excluded from certain properties. Landlords can appear to assume that people never recover from drug dependence. This same attitude can lead to continued stopping and searching by police, even after a person has ceased using illegal drugs. Such attention can lead to problems in maintaining recovery.

The stigma associated with medication

Other recent research⁴ has highlighted the stigma against methadone as a treatment option across a range of settings, including political and media discourse, the drug treatment sector and among drug users themselves. Although the authors focus on the American experience, the same issues have been evidenced in our research. A respondent to an online survey conducted as part of our research cogently described the stigma around methadone and methadone treatment centres and how this affected him:

“...attending drugs clinics and drug centres has a huge stigma and has at times in the past prevented me from seeking help.”

And focus group participants stated:

“When you’re on methadone or heroin it’s as if you’ve got a plague, isn’t it?”

“They don’t give you the chance. Work – there’s no point in us going for work. If you’re on methadone... there’s no point in going for any work”

It is unlikely that people with chronic conditions such as asthma, diabetes or mental health conditions who are taking prescribed medication suffer the same opprobrium as that experienced by drug-dependent heroin users on a programme of medically-assisted recovery.

3 UKDPC (2008). *Working Towards Recovery*. London: UK Drug Policy Commission. (Available at: http://www.ukdpc.org.uk/publications.shtml#Employment_report)

4 White, W.L. and Mojer-Torres, L. (2010). *Recovery-Oriented Methadone Maintenance*. Great Lakes Addiction Technology Transfer Center, the Philadelphia Department of Behavioral Health and Mental Retardation Services, and the Northeast Addiction Technology Transfer Center.

Public attitudes to those with drug dependency problems

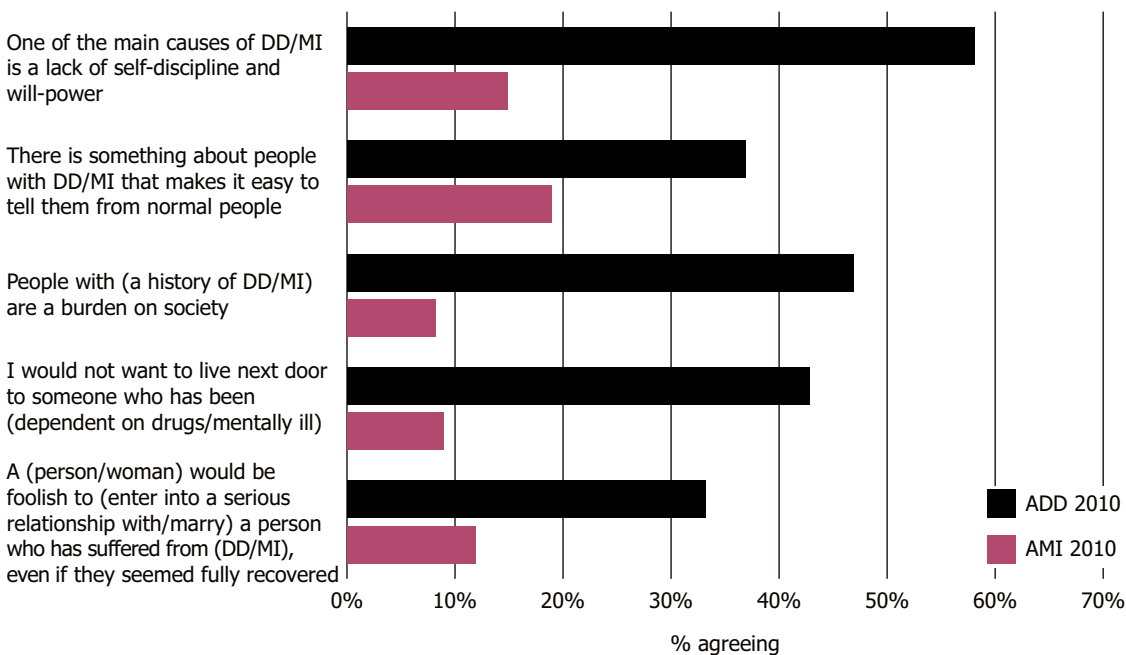
The public, by and large, holds some strongly stigmatising attitudes towards people with drug dependency problems, to a much greater extent than people with mental health problems, who also experience stigma.

To provide a broader view of public attitudes towards people with a history of drug dependence and to compare them with attitudes towards people with mental illness – a group for whom the issue of stigma has been recognised for some time – the UKDPC commissioned a survey of 3,000 adults living in private households across the UK in April 2010.

Other studies of public attitudes have included questions relating to attitudes to drug use and addiction, but these have mainly been limited to one or two questions and small-scale or one-off studies.⁵ A recent Scottish Social Attitudes survey considered attitudes to cannabis and heroin use and to treatment and recovery. It revealed “a lack of consensus about the causes of persistent heroin use, perhaps rooted in a lack of public understanding but also perhaps reflecting the complexity of drug use”.⁶

A large part of the UKDPC survey involved presenting a number of attitude statements to respondents, who were asked to say how much they agreed or disagreed with each statement. Most of the statements were based on statements in the Attitudes to Mental Illness (AMI) survey, which is conducted annually on behalf of the Department of Health to monitor its Shift anti-stigma campaign.

Figure 3: Comparison of responses to the 2010 Attitudes to Drug Dependence (ADD) and Attitudes to Mental Illness (AMI) surveys – proportions agreeing with statements relating to fear and blame



5 Luty, J. and Grewal, P. (2002). A survey of the British public's attitudes towards drug dependence. *Journal of Substance Use*, 7, 93–5; Crisp, A., Gelder, M., Goddard, E. and Meltzer, H. (2005). Stigmatization of people with mental illness: A follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists. *World Psychiatry*, 4 (2), 106–13; NatCen (2010). *British Social Attitudes. 26th Report*. London: Sage.

6 Ormston, R., Bradshaw, P. and Anderson, S. (2010). *Scottish Social Attitudes Survey 2009: Public Attitudes to Drugs and Drug Use in Scotland*. Edinburgh: Scottish Government. (Available at: <http://www.scotland.gov.uk/Publications/2010/05/19111419/0>)

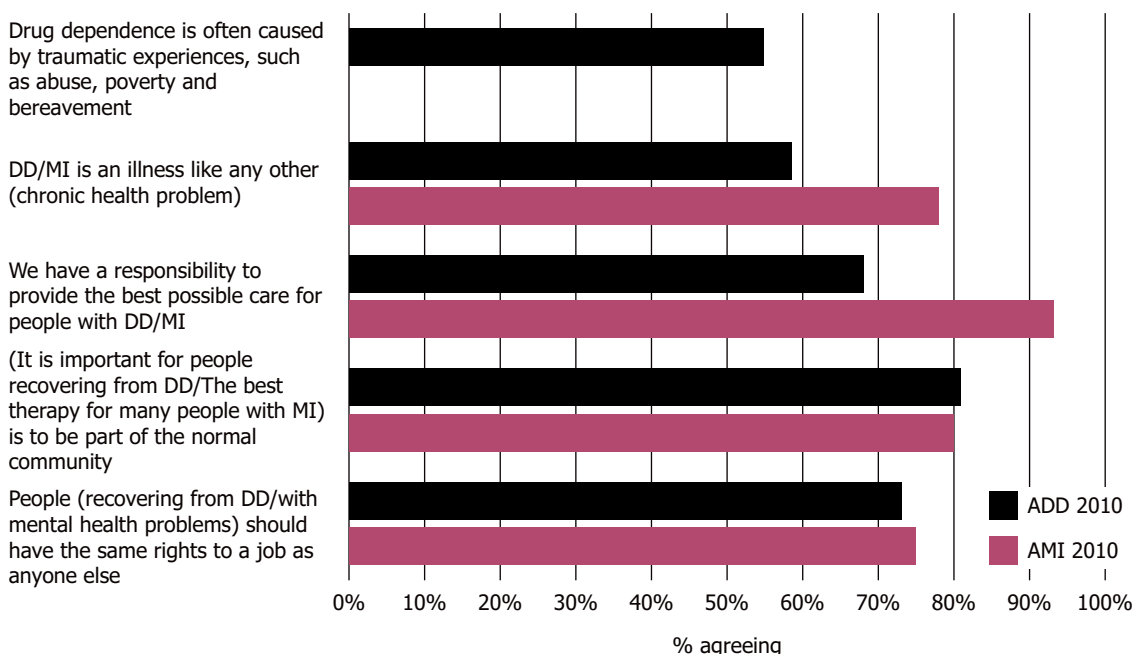
People with drug dependence elicit blame and fear

In the expert commentary commissioned as part of the UKDPC stigma research programme, referred to earlier, Lloyd highlighted the importance of both fear and a belief that individuals are to blame for their condition in the generation of stigma. A number of the statements in the attitudes survey tapped into these beliefs and revealed high levels of blame and intolerance and of fear and exclusion of people with a history of drug dependence.

Attitudes towards people with drug dependence were far more negative than those expressed in the 2010 AMI survey towards people with mental illness, as shown in Figure 3.

Conversely, significant proportions of people endorsed statements that show some sympathy towards those with a history of drug problems, albeit not to the same degree as towards those with mental health problems. What is striking is the view that both groups should have the same opportunity as others to get a job and live in the community – a boost to efforts to help people rebuild their lives (Figure 4).

Figure 4: Comparison of responses to the 2010 Attitudes to Drug Dependence (ADD) and Attitudes to Mental Illness (AMI) surveys – proportions agreeing with statements relating to sympathy and care



People support help for drug users, but ‘not in my back yard’

The apparently paradoxical attitudes towards people with a history of drug dependence may reflect a lack of knowledge about drug dependence. Increasingly, research reveals dependence and addiction to be a complex phenomenon with a host of potential contributory causative factors: genetic, biological, social and environmental. This calls into question the extent to which people can be blamed for their drug dependence and how easy it is for them to ‘just stop’. Nevertheless, for people to recover from drug problems it is necessary for them to want to stop and that they take responsibility for doing so, but they will need support to do this, and recovery will take time. This appears to be recognised by many of the respondents to our survey.

Another possible factor in the apparently contradictory responses is the difference between what we say and what we do. While people recognise the importance of providing support for individuals in recovery and the need for them to be part of the normal community, they do not want them as neighbours and are fearful of having treatment and support services in their neighbourhoods. However, as fewer than half of the respondents to the survey reported knowing someone with a history of drug dependence, these fears would appear, in general, not to be based on personal experience. Indeed, people who currently, or in the past, had lived, worked or been friends with someone with a history of drug dependence had less negative attitudes than people who had not. This is also apparent from the Scottish Social Attitudes survey.

Stigma also affects the families of drug users

There were also two statements in our survey that related to attitudes towards the families of drug users. Parents of people with drug problems are concerned about disclosing this, partly because they are concerned that people will blame them (as often they blame themselves, at least to begin with). Our survey showed that these fears are not entirely without foundation:

- Almost 1 in 4 respondents agreed with the statement that “Most people would not become dependent on drugs if they had good parents”.
- 1 in 3 respondents agreed that “Parents would be foolish to let their children play in the park with the children of someone who has a history of drug dependence”.

Stigma – the pervasive public discourse

Press reporting of drug use is dominated by themes of crime and celebrity and may use pejorative language that frames the public understanding of drug dependency. Rarely is recovery and integration spoken about.

Our study was designed to investigate the factors that influenced the public attitudes that we found. Further work is needed to identify how such attitudes are formed and what underpins them. However, the media will make some contribution to this:

- 64% of the respondents to our public attitudes survey agreed that “People with a history of drug dependence are too often demonised in the media”.

Our research programme included a study examining the way in which drug users are portrayed in the print media.⁷ This study looked at all items (in total over 6,000) that mentioned drug use or drug users in a sample of eight leading newspapers in each of three years: 1995, 2002 and 2009.

The overriding image is crime

The study found a frequent association in reporting between drug use and crime, with many stories about drug use and users being triggered by events in the criminal justice system. This was particularly true in the English regional press. The top five triggers of press coverage were:

- criminal justice related (25% of items)
- charity / business / public body activity (13%)
- a death (8%)
- media investigation / debate (7%)
- government activity (7%)

Crime also featured as one of the most common consequences of drug use, where any such link was made.

Certain images of users dominated the press coverage in the periods covered. The most ubiquitous was the cocaine-using professional (often a sports person), celebrity or public figure or the cannabis- or ecstasy-using young person. Other common images included the heroin-using offender or parent. Overall, professionals featured in 24% of items where user background was mentioned, a young person in 21%, celebrities or public figures in 17%, offenders in 16% and a parent in 4%.

While offenders and parents were often labelled pejoratively and generally condemned and the consequences of their drug addiction shown as crime or family breakdown, the celebrities and young people were treated more ‘positively’. There was little consideration in the coverage examined of the causes of drug use, and the treatment of drug problems and the issue of recovery were very rarely mentioned, except in the context of celebrities checking into ‘rehab’ clinics.

7 Loughborough Media Communications Research Centre (2010). *Representations of Drug Use and Drug Users in the British Press*. London: UK Drug Policy Commission. Available at: http://www.ukdpc.org.uk/publications.shtml#Stigma_reports

Language frames and reinforced perceptions

The tenor of the coverage was also considered. While most was found to be ‘neutral’ reporting of such things as court cases, where remarks were made they were more likely to be condemnatory than empathetic. Overall, 15% of remarks about drug users were condemnatory in tone, whereas 7% showed empathy. The use of the words ‘addict’ and ‘junkie’ and the frequency with which these were linked to negative adjectives such as ‘vile’ or ‘evil’ was also considered. The label ‘addict’ was used in only 8% of news items, but in about 1 in 5 of these cases it was used with negative adjectives attached. The term ‘junkie’ was used in 2% of items. Offenders and parents were more likely than other groups of people who used drugs to be condemned or labelled an addict or junkie, and more often with negative adjectives attached.

The study only considered newspaper coverage. Other media, such as the broadcast media and, increasingly, the internet and social networking platforms, are clearly also important. A recent study has shown how negative the television portrayals of people with mental health problems can be,⁸ and the same would probably be true for people with drug problems. The political and policy discourse in recent years has also often focused on people with drug problems as offenders or welfare recipients (often with the implicit connotation of ‘scroungers’). While this has contributed to an increase in spending on drug treatment services, it will also have added to the pervasive message that people with drug problems are criminals first and foremost.

This negative framing and use of pejorative language matters because the way in which people with drug problems are spoken of makes a difference. In our focus groups, the cumulative impact of hearing frequent comments such as ‘junkie scum’ and ‘they deserve to be shot’ was made very clear. A study among mental health professionals in the USA showed that simply describing someone as a ‘substance abuser’ rather than as someone with a ‘substance use disorder’ evoked more negative comments and more punitive treatment.⁹

What can be done to reduce stigma towards people with a history of drug problems?

- **Improve the knowledge and understanding among the general public about drug dependency and recovery to reduce the levels of fear and blame.**
- **Ensure training and workforce development across the range of professions who work with people with drug problems to improve service responses.**
- **Remove the legislative and administrative restrictions which reinforce stigmatisation towards people with drug dependency and addictions.**
- **Support and promote self-help and mutual aid bodies and the nascent drug-user recovery communities as vehicles for reintegration and ‘normalisation’ of recovery.**
- **Engineer new ways to support and promote community participation and increased contact with recovering drug users in order to foster more constructive perceptions.**

As our research shows, stigma towards people with current or past drug problems is widespread and is a problem not just for the individual but also for society. The stigmatisation of people with drug problems makes it difficult for them to seek help and slows or prevents recovery. As a result, many key government policies will be less effective. Therefore, if we are serious about increasing the extent of recovery we need to be serious about tackling stigma.

What can be done? The good news is that there are examples from other sectors that show that attitudes and behaviours can be changed, for example in the field of mental health and with respect to HIV/AIDS.

8 Philo, G., Henderson, L. and McCracken, K. (2010). *Making Drama out of a Crisis: Authentic Portrayals of Mental Illness in TV Drama*. Shift.

9 Kelly, J.F. and Westerhoff, C.M. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy*, 21 (3), 202–7.

There are a number of key areas for potential action that have been highlighted in our research:

1. Improve the knowledge and understanding among the general public about drug dependency and recovery to reduce the levels of fear and blame.

Public understanding about the complex and interrelated causes of drug dependency and the nature of drug treatment and recovery is limited.

Coalitions and campaigns

In the mental health field, major campaigns and programmes such as the government's Shift programme and the mental health coalition campaigns Time to Change and See Me have helped improve public attitudes and promoted more positive images of people with mental health problems. Such approaches were also adopted in efforts to help address public fear and stigma around HIV infection and in more recent attempts to challenge public reactions to people with facial disfigurement. The new national Public Health Service and the local Health and Wellbeing Boards have a unique opportunity as they start work to help choreograph and support efforts to assist the public to better understand drug dependency, addiction and recovery.

Broad-based coalitions and campaigns to support education to enhance public knowledge about recovery from drug dependence – bringing together government departments, drug treatment and service providers (both in the NHS and civil society) and offender support services – could turn into powerful champions to address the public stigma towards those trying to rebuild their lives. This is not without challenges; service providers are increasingly subject to market competition, and there are many professional and ideological rivalries about how best to help people recover. Nonetheless, the model has proved effective in other arenas and we believe the Royal Colleges, the Department of Health, the national Public Health Service, leading civil society service providers and service user groups should examine setting up such a coalition.

The media as a source for improving knowledge

Newspapers and the broadcast media have been influential in helping the public better understand various social challenges, especially around mental health, but also on other contemporary issues where stigma has been seen as a hurdle to integration. The Press Complaints Commission (PCC) has proved to be an important contributor in subtly shifting the reporting of some issues. The Editors' Code of Practice has a section devoted to discrimination which states "the press must avoid prejudiced or pejorative reference to an individual's race, colour, religion, gender, sexual orientation or to any physical or mental illness or disability"¹⁰ – those working with or on behalf of people with mental health problems think this statement has been significant in altering journalistic practice. It is a moot point whether those with a drug dependency or addiction fall overtly within the ambit of this clause. It would be enormously helpful if the Editors' Code of Practice Committee could clarify this and advise editors accordingly. Newspapers and broadcast media could look to use informed feature items to help provide a balance to the regular crime and celebrity news.

10 Press Complaints Commission. *Editors' Code of Practice*. (Available at: http://www.pcc.org.uk/assets/111/Code_A4_version_2009.pdf)

2. Ensure workforce development across the range of professions who work with people with drug problems to improve service responses.

Training for professionals

It is clear that improved training of the many paid staff who come into everyday contact with drug dependent users is likely to be beneficial for many groups. For example, a recent study showed that newly qualified social workers considered themselves particularly unprepared for dealing with people with substance use problems.¹¹ The training and provision of protocols for medical staff with regard to pain relief for people with opiate dependence and/or on methadone is another area of need.

Staff in drug treatment services, both in the NHS and the voluntary sector, may also hold or develop stigmatising attitudes, often unwittingly. Conflict often occurs around reductions in methadone prescription: clients who want to reduce their methadone use can feel that staff do not listen and are disempowering and untrusting, but staff are following evidence-based guidance and may be concerned about relapse.

The new Substance Misuse Skills Consortium (SMSC) in England is ideally placed to act as a powerful champion in tackling workforce attitudes and behaviours that might act as a barrier to improving recovery outcomes. It could perhaps revisit the valuable Skills Framework to ensure that it embraces challenges to stigma across all treatment and recovery services.

Action to address stigma towards drug users and promote belief in recovery will also benefit the families of drug users. However, it is also important to ensure that specific services and activities are available to address the families' needs in their own right and to raise awareness of the significant impact that stigma has on them.

Promoting good practice

There is also a need to share good practice. For example, while our study included many examples of stigmatising practices in pharmacies and GP practices, examples were also given of good practice that could be promoted. Pharmacies, especially big chains, where there are frequent changes in staff, seem to be a particular problem, but equally they provide an opportunity for improvement that could have widespread reach.

The promotion of good practice should encompass assistance with managing stigma. For example, the removal of visible evidence of drug use – such as the correction of poor dentition caused by opiate use or the removal or concealment of scarring caused by injecting – may be a key means of reducing an individual's experience of stigma and should be made more easily available. Providing advice and support on the need for disclosure of criminal records or medication, such as methadone, is another area that would help support rehabilitation and recovery.

Leadership

Leadership will also be important in challenging stigma. Leadership from the very top of organisations will be crucial in raising the ambitions of staff for their clients and, as has been demonstrated in the education sector, a focus on leadership and leaders is an essential ingredient for change. It is also important that there is leadership within government, with a clear recognition of the need to address stigma and to consider the impact of language used within government pronouncements.

Looking further afield, there are many other sectors and professions where attitudes to those with drug dependency problems act as impediments to recovery and reintegration. Again, the new SMSC is potentially ideally placed to open up dialogue with skills champions in other sectors to see what can be done about this through workforce development.

The various regulators and inspection bodies (e.g. for police, probation, prison, social care and healthcare services) might also be encouraged to examine how staff, in their everyday work, might unwittingly display attitudes and behaviours that reinforce the stigma perceived by recovering drug users and their families.

11 Galvani, S. and Forrester, D. (2008). *What Works in Training Social Workers about Drug and Alcohol Use? A Survey of Student Learning and Readiness to Practice*. London: Home Office.

3. Remove the legislative and administrative barriers which reinforce stigmatisation towards people with drug dependency and addictions.

Criminal records

There are some areas in which stigma has become formalised. For example, many drug treatment services demand that ex-drug users are abstinent for two years before they will employ them. But this time limit is arbitrary and creates a barrier to recovery. Similarly, we have heard the allegation that some government contracts require that companies holding them do not employ anyone with a criminal record, irrespective of the appropriateness of this. Such clauses inevitably exclude some recovered drug users from employment. Also, as the crime reduction charity Nacro's work associated with their Change the Record campaign has shown, many employers are demanding CRB checks, even where these are not lawful, and are excluding ex-offenders, whose offences are in fact spent under the Rehabilitation of Offenders Act.

Fairness in legislation

Legislation will not necessarily change attitudes, but it can impact on behaviour, as was demonstrated in the case of the Disability Discrimination Act (DDA). People with substance dependence were specifically excluded from the protection afforded through the DDA unless they had other disabilities or were dependent on prescribed medication. This also meant that family members or carers of these people were not protected. This exclusion has been carried forward into the new Equality Act. There is no such exclusion in the equivalent US legislation and consideration should be given to removing it here.

There is also the anomaly of the definition of addiction for the purposes of the new Equality Act. Someone whose addiction is caused through the authorised prescribing of medication by a medical practitioner will be offered some protection by the legislation. However, someone whose drug addiction has been brought on by their own use of drugs will be excluded, despite both being addictions. Anomalies such as these simply perpetuate and reinforce the stigma for individuals and their families. The Government and Parliament should re-examine the Equality Act regulations and guidance in order to ensure people with drug addictions are not excluded from the Act's provisions.

Administrative barriers

There are also many instances where financial and other institutions (e.g. financial, housing and accommodation providers) erect administrative barriers, such as residency or address requirements, that unwittingly inhibit efforts of people to rebuild their lives.¹² However, there are some examples of innovative practice, such as the schemes run by the Co-operative and Barclays banks to enable prisoners who are shortly to be released to open bank accounts. The Coalition Government's plans to reduce the use of imprisonment should focus on providing leadership not simply to reduce reoffending but also to tackle the burden of stigma and shame that financial exclusion brings with it.

As part of an effort to become more active and coordinated in challenging public perceptions as suggested in the next section, those in recovery and their self-help support groups should use more publicly visible efforts to identify and 'shame' institutional examples of stigma.

12 See for example Bath, C. and Edgar, K. (2010). *Time is Money: Financial Responsibility After Prison*. London: Prison Reform Trust.

4. Support and promote self-help and mutual aid bodies and the nascent drug-user recovery communities as vehicles for reintegration and ‘normalisation’.

The value of mutual aid

There is no doubt that the general public holds some fairly negative views about people with drug dependency problems. This is not surprising given the prevailing political and media narrative and, of course, many people’s actual experiences as victims of crime. In this respect, one could argue that those recovering from drug dependence have to work harder and longer to demonstrate personal responsibility and ‘atone’ for past lifestyles. However, anecdotal evidence suggests this is different in some other countries, especially those with a strong public health ethos around drug dependence, such as Portugal. Mutual aid and self-help efforts therefore can be hugely important and symbolic in shifting the negative views against those rebuilding their lives. In many ways this is an example of Big Society at its best.

Through mutual aid, change and improvement can be made more visible, as the Scottish Drug Recovery Consortium, with support from the Scottish Government, is demonstrating. Throughout the UK, along with a long tradition of the open but ‘quiet’ AA (Alcoholics Anonymous) and NA (Narcotics Anonymous) movements and the more ‘secular’ SMART recovery initiatives, recovery communities are developing. Self-help support groups for family members can also be extremely valuable as the stigma around drug use can lead to extreme isolation for many. The Government, local Health and Wellbeing Boards, charitable foundations and philanthropists should be encouraged to support such efforts financially. These bodies, and the recovery movement, demonstrate the power of hope and commitment, and diversity in such groups needs to be maintained to allow support for different approaches to recovery.

Making recovery visible and supported

Recently, ‘recovery marches’ have been held in the North West of England and Scotland, in which recovering drug users make their presence and commitment to self-improvement publicly visible. In the USA, the Governor of California joins a similar annual march. The US drug czar also vocally endorses mutual aid recovery marches and joins them. While it might be considered that this is not the ‘British’ way, the sight of national leaders and figureheads joining a very marginalised group would go a long way in both encouraging those in recovery to ‘stay with it’ as well as helping to change public perceptions.

Many activists and advocates working in the mental health and disability fields are firmly of the view that their campaign of complaints to bodies such as the PCC and broadcasting regulators about inappropriate stigmatising reporting has been instrumental in supporting and encouraging change by the media. The development of initiatives such as WordsMatter¹³ could play a valuable part in helping those recovering from drug problems challenge some of the language and reporting about them.

13 An initiative currently being developed for a consortium of mental health organisations, see <http://wordsmatter.org.uk>

5. Engineer new ways to support and promote community participation and increased contact with recovering drug users in order to foster more constructive perceptions.

Demonstrating responsibility and integration

Our research shows that those who have closer contact with people with a history of drug problems have more positive attitudes towards them. At the moment, it is clear from our findings that disclosing a history of drug problems, such as at a job interview, is likely to lay people open to negative consequences, so people will be reluctant to do so. As a result, positive images of recovery are limited.

However, in addition to activities such as the recovery marches already mentioned, there are examples of projects that seek to foster improved community relations; these need to be supported. For example, the Reading User Forum is planning to undertake a project, similar to a successful one in Copenhagen, in which members undertake visible patrols picking up drug litter in known drug hotspots. The production of videos presenting case studies, such as that by Camden Frontline,¹⁴ is another way of providing more accurate information about the different pathways into drug problems and positive images of how the different services help to provide treatment and support recovery.

Conclusion

- **The contrast with progress in tackling stigma in mental health is stark**

The mental health field has demonstrated how attitudes and, more importantly, behaviour can change. The Time to Change programme has begun to demonstrate reductions in the experience of stigma among mental health service users. Media reporting characterised by the use of terms such as ‘nutter’ is largely a thing of the past due to action within the newspaper industry. However, these changes are the result of long-term efforts by many people on many fronts.

- **Recovery ambitions will be stymied and public spending suboptimal**

In the drugs field, we are beginning what is likely to be a long journey to demonstrate how dysfunctional stigma towards those seeking to haul themselves out of drug dependency can be. It not only stymies public policy efforts to change people’s behaviours; as the evidence from our survey of users and families shows, it locks people into a world they desperately want to get out of. It is in effect a classic ‘lose-lose’ situation. The individual loses, as does wider society.

- **Personal responsibility and tackling stigma are not mutually exclusive**

Drug users are expected by society to change their behaviours and demonstrate better personal responsibility. But, in return, society has to look at itself, to begin to challenge the negative attitudes and barriers that can keep those with addictions and drug dependency problems locked into dysfunctional lifestyles. The public needs to understand better the nature of addiction and the routes out of it.

If society is serious about promoting recovery from drug problems it has to get serious about challenging stigma.

¹⁴ See <http://www.camden.gov.uk/ccm/content/policing-and-public-safety/community-safety/camden-drug-action-team.en;jsessionid=AD49ABFAB042C4C101438A6F42943DB3>