



UKDPC

UK DRUG POLICY COMMISSION

Getting Serious about Stigma in Scotland: The problem with stigmatising drug users

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Policy Report
February 2011

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Published by:
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This publication is available online at
www.ukdpc.org.uk/publications.shtml#Stigma_reports

ISBN: 978-1-906246-30-3

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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.

The views, interpretations and conclusions set out in this publication are those of the author and are not necessarily those of the UK Drug Policy Commission.

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Acknowledgements

The UK Drug Policy Commission is very grateful to the Scottish Drugs Recovery Consortium, the Paul Hamlyn Foundation and the Esmée Fairbairn Foundation for their financial support for the research reported here.

The project benefited from the support and assistance of a Steering Group who provided valuable advice and assistance and included representatives from the following organisations:

- Scottish Drugs Recovery Consortium
- Scottish Government
- Scottish Drugs Forum
- Scottish Families Affected by Drugs
- Family Addiction Support Service (FASS)
- The Wise Group
- Lanarkshire Recovery Consortium

The fieldwork for the public attitudes survey was conducted by TNS-BMRB and we are grateful for the assistance provided by them, in particular to Brigitta Horup and Sian Llewellyn-Thomas, who had the main responsibility for the survey and who undertook the initial analysis of the survey which is drawn on in this report. The analysis of newspaper reporting was undertaken by Loughborough Communications Research Centre led by Dr James Staney.

And, above all, we are grateful to the current and former drug users and their families who so willingly participated in the focus groups and shared their feelings and experiences with us; to the people in the many agencies and support groups who helped us to organise the focus groups; and to the many members of the public who gave their time to take part in the survey. Without their generous assistance there would be no research.

Summary

Previous research has indicated that stigma towards current and former drug users and their families can cause considerable distress and may present a 'hidden' barrier to accessing help and achieving recovery from drug problems. Therefore, the UK Drug Policy Commission (UKDPC) has undertaken a programme of research to investigate the extent and nature of stigma towards people with a history of drug problems and their families in the UK.

The main study was funded by the Paul Hamlyn Foundation but, as part of the work in Scotland to realise the ambition in the Scottish drug strategy *The Road to Recovery*, the Scottish Drugs Recovery Consortium (SDRC) commissioned a boosted sample in Scotland. This report describes the findings and implications of the research in Scotland.

Overall the research, which was conducted in 2010, shows that the stigmatisation of people with drug problems has serious consequences for the delivery of government policy. Key policies such as those seeking greater reintegration and recovery and to move people from benefits into work will not succeed while stigmatising attitudes are pervasive. **If we are serious about recovery, we need to be serious about tackling stigma.**

WHY STIGMA MATTERS

A qualitative study of the stigma experienced by current and ex-drug users and their families and the impact this has had on their lives was undertaken using focus groups and a web survey. The principal findings of this research were as follows:

- Feelings of shame and worthlessness prevent people and their families seeking help, which may exacerbate their problems.
- Low self-esteem prevents a belief in recovery, to which the long-term nature of stigma contributes.
- Participants in the research reported being stigmatised by professionals in a wide range of healthcare and social care settings. For example, many participants reported having problems obtaining pain relief, even when quite severely hurt, because of an implicit assumption that they were just after a 'fix'.
- The negative attitude of some social workers was an issue raised in many of the focus groups, both with drug users and their families. For many drug users the desire to care properly for their children is a key reason for trying to overcome their dependency, so this is an area that can have a huge impact on help-seeking and recovery, although clearly a balance must be struck with respect to child protection.
- Stigma makes it difficult for people recovering from drug dependence to obtain jobs, which are important for reintegration and participation in society. For

example, people in our study reported having offers of employment withdrawn when their history of drug use became known.

- The stereotypes and associated fear attached to people with drug problems and the assumption that they never change can cause difficulties for people with drug problems in both getting and retaining accommodation.

ATTITUDES TO DRUG DEPENDENCE IN SCOTLAND

A large UK-wide survey of public attitudes towards drug users was carried out in early 2010 (involving about 3,000 individuals). It included a boosted sample of 566 people aged 16 and over living in Scotland.

Significant proportions of people in the Scottish sample endorsed statements that show sympathy towards those with a history of drug problems and suggest they tend towards the view that drug dependence is an illness similar to other chronic conditions and are supportive of efforts to overcome it.

- Two-thirds (66%) of respondents agreed that "We have a responsibility to provide the best possible care for people with drug dependence" (32% strongly agreed).
- Over half (58%) of respondents agreed that "Drug dependence is an illness like any other chronic health problem".
- 55% of respondents agreed that "Drug dependence is often caused by traumatic experiences" and that "We need to adopt a far more tolerant attitude towards people with a history of drug dependence".
- The vast majority of respondents to the survey (83%) rejected the statement "People who become dependent on drugs are basically just bad people", with almost two-thirds disagreeing strongly.
- A clear majority (82%) of respondents agreed that "Virtually anyone can become dependent on drugs".

Respondents in Scotland also strongly believed that those with drug problems should have the same opportunity as others to get a job and recognised the importance of being part of the community to recovery from drug dependence.

- 80% of respondents agreed that "It is important for people recovering from drug dependence to be part of the normal community".
- 75% of respondents agreed that "People recovering from drug dependence should have the same rights to a job as anyone else".

Although there appears to be uncertainty, on balance, people in Scotland would appear to consider recovery from drug dependence to be possible – slightly more people disagreed with the statement "People can never completely recover from drug dependence" than agreed with it. However, only a small proportion, less than 1 in 10, think that people who have stopped using illicit drugs but are being prescribed medication such as methadone can be considered recovered – over three-quarters of respondents thought they could not. These attitudes towards medication-assisted recovery are more negative than for the UK as a whole.

The survey also revealed high levels of both blame and intolerance and, in particular, levels of fear and exclusion of people with a history of drug dependence that were significantly higher than in the UK as a whole:

- Over half (56%) of respondents in Scotland agreed that "There is something about people with drug dependence that makes it easy to tell them from normal people".
- Respondents in Scotland were more likely than people in the UK as a whole to agree that "Increased spending on services for people trying to overcome drug dependence is a waste of money" (32% did so, compared with only 24% in the UK).
- Over half (55%) of the Scottish sample agreed that "People with a history of drug dependence are a burden on society" (compared with 47% in the UK as a whole).
- Similarly, 49% agreed that "I would not want to live next door to someone who has been dependent on drugs" (compared with 43% in the UK as a whole).
- 40% of Scottish residents agreed that "A person would be foolish to enter into a serious relationship with someone who has suffered from drug dependence, even if they seemed fully recovered" (33% in the overall UK sample agreed).
- Scottish residents were also more likely to disagree with the statement that "Residents have nothing to fear from people coming into the neighbourhood to use drug treatment services" (46% disagreed, compared with 33% overall).

This survey has captured a snapshot of public attitudes to drug dependence in Scotland and provides a baseline against which change can be measured.

THE PORTRAYAL OF DRUG USE AND USERS IN THE MEDIA

Loughborough Communications Research Centre undertook an analysis of a sample of British newspapers' reporting of drug use stories over three time periods, including two Scottish papers (*The Daily Record* and *The Herald*). The overall findings were as follows:

- The reporting and portrayal of drug users was dominated by two overriding themes: crime reports, and professional sports people and celebrity figures.
- The drugs most often mentioned in news items were heroin, cannabis, cocaine and ecstasy.
- The issue and challenges of treatment and recovery were barely mentioned – except in the context of celebrities.
- Most reporting is considered to be 'neutral', but the linkage to crime aspects (rather than health) was overpowering.
- Where adjectives and labels are used they are more likely to be negative, using language such as 'vile', 'hopeless', 'dirty', 'squalid' and 'evil'.

The Scottish newspapers included in the review generally followed the pattern for the sample as a whole, but with a greater concentration on heroin and other opiates in their coverage.

WHAT CAN BE DONE ABOUT STIGMA

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. Our research suggests that there are a number of key areas for potential action:

- **Improve the knowledge and understanding among the general public about drug dependency and recovery to reduce levels of fear and blame.**
To address public attitudes we suggest the formation of a broad coalition of groups working in the sector to develop campaigns similar to those that have been successful in addressing stigma towards people with mental health problems. The media also has a role to play and such a coalition could work with key people in the Scottish media to identify ways in which they can foster public understanding of drug problems, treatment and recovery.
- **Ensure workforce development across the range of professions who work with people with drug problems to improve service responses.**
Our study found many examples of stigma in the wide range of settings in which professionals come into contact with people with a history of drug dependence and their families, but there were also examples of good practice. The issue of stigma needs to be incorporated in professional training and workforce development programmes and examples of good practice identified and shared.
- **Remove the legislative and administrative barriers that reinforce stigmatisation towards people with drug dependency and addictions.**
Our study also revealed many instances where stigma has become formalised. These often arbitrary requirements provide barriers to recovery by restricting people's opportunities to participate in society.
- **Support and promote self-help and mutual aid bodies and the nascent drug-user recovery communities as vehicles for reintegration.**
Peer support is often a key component in achieving and sustaining recovery. Recovery communities can also provide a way of making recovery more visible and in this way challenging stigma and promoting greater public understanding of recovery.
- **Develop new ways to support and promote community participation and increased contact with recovering drug users in order to foster more constructive perceptions.**

This research highlights the importance of tackling stigma if people with drug problems and their families are to be able to access the support they need to overcome these problems. There is a need to challenge the entrenched and widespread assumption that drug users are solely culpable for their condition by educating people at all levels in society – including health professionals and the media – about the causes and nature of addiction. Stigma, by making assumptions about individuals and denying the possibility of change, works against government policy by putting barriers in the way of recovery.

1. Background and methods

WHY UNDERTAKE RESEARCH ON STIGMA?

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 (Lloyd, 2010). 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 irremovable. Such stigma then often leads to prejudice and active discrimination.

It is generally accepted in the drug treatment field that stigma towards current or ex-drug users and their families is a barrier to recovery. Although there is much anecdotal evidence from the UK to support this there has previously been little 'hard' evidence. Previous UK Drug Policy Commission (UKDPC) research projects have identified some examples of the way in which stigma and associated discrimination can be a barrier to recovery from problem drug use, social inclusion and equality of opportunity and can reduce the effectiveness of services and policies seeking to address drug problems. For example, employment is a key component of recovery and rehabilitation for former drug users and an important element of welfare reform proposals. However, a survey of employers found that almost two-thirds would not employ a former heroin or crack user, even if they were otherwise suitable for the job (Spencer et al., 2008). Similarly, research on the impact of a relative's drug problems on adult family members described the feelings of guilt and the concerns about people's attitudes that lead to isolation of family members and inhibit help-seeking (UKDPC, 2009).

Scotland has a relatively high prevalence of drug use problems compared with most other countries and the rest of the UK. In terms of the prevalence of 'problem' drug misuse in Scotland, Hay et al. (2009) estimated that there were 55,328 people misusing opiates and/or benzodiazepines in 2006, corresponding to 1.62% of the Scottish population aged 15–64 (a similar study in England found a prevalence of problem opiate and crack use of 0.94% in 2008/09 (Hay et al., 2010). With respect to more general drug misuse, the Scottish Crime and Justice Survey 2009/10 (MacLeod and Page, 2011) found that around a quarter (25.2%) of all adults aged 16+ in Scotland reported having taken one or more illicit drugs at some point in their lives, while 7.2% reported using drugs in the last year and 4.2% reported use in the last month. In 2009, 545 drug-related deaths were registered in Scotland (GROS, 2010). However, 10,325 individuals were reported to have newly entered drugs treatment in 2009/10, as reported by the Scottish Drug Misuse Database (ISD Scotland, 2010).

The Scottish Government's drugs strategy *The Road to Recovery* (Scottish Government, 2008) articulated a new vision, with recovery-oriented treatment and rehabilitation services that respond to individual needs as its centrepiece and support for families affected by drug use as a key priority. However, findings such as those described above suggest that stigma may pose a significant barrier to recovery from drug problems and hence to the success of this strategy and those within the other countries of the UK.

The UKDPC therefore decided to undertake a programme of research to investigate the extent and nature of stigma towards people with a history of drug problems and their families and the impact that this has on their lives and the course of their drug problems and on policy and services that seek to address these issues across the UK. Some funding for the first stage of this programme of work was obtained from the Paul Hamlyn Foundation and, in order to allow a more in-depth look at the issue of stigma in Scotland, the newly established Scottish Drugs Recovery Consortium – an independent charity established to drive and promote recovery for individuals, family members and communities affected by drugs across Scotland – provided additional funding for extra research in Scotland. The key findings for Scotland and the implications for drug policy and practice that emerge from the first stage of this programme of work are described in this report.

METHODS USED

To provide a backdrop to the research project the UKDPC commissioned an expert review of the published research evidence concerning the stigmatisation of problem drug users, which was published as the UKDPC report entitled *Sinning and Sinned Against: The Stigmatisation of Problem Drug Users* (Lloyd, 2010). This raised some fundamental issues about perceptions of addiction and the extent to which it is seen as a moral, medical and social issue, and also raised questions concerning personal responsibility and the 'blame' attached to addiction.

To consider the extent to which the findings from the review apply within the UK at the present time, the current UKDPC programme includes several other research components:

- a qualitative study of experiences of stigma and the impacts these have had on people with a history of drug problems and their families;
- a survey of public attitudes towards people with a history of drug dependence, which included a boosted sample for Scotland; and
- an analysis of the representation of drug users in the print media.

Qualitative study of the experience and impact of stigma

The aim of this component of the research was to investigate:

- the nature of stigma towards people with drug problems or who have recovered from such problems and the impact this has had on the course of their drug use and recovery; and

- the stigma experienced by family members of people with drug problems and the effect this has had on their lives.

The study used focus groups to identify the main types of stigma experienced and the impact this has had. In order to represent as wide a range of experiences as possible groups were identified through a range of sources, including peer support networks, services and service-user representatives. They were also selected to include people from different socio-demographic groups as well as from across the country. In total 18 focus groups were conducted, of which eight were held in Scotland. These covered urban and rural areas and mainland Scotland and the islands and took place in:

- Shetland (family members)
- Shetland (current and ex-users, all ages, men)
- Aberdeen(shire) (ex-users, men and women, 25+ years)
- Paisley (young people (male), current and ex-users)
- Glasgow (young people, male and female, current and ex-users)
- Dumfries (women, 25+ years, ex-users)
- Glasgow (family members)
- Glasgow (women, 25+ years, ex-users).

The focus groups sought to discuss a wide range of potential areas of stigma and to identify the impact that this had on participants' lives and the course of their drug use and recovery.

The number of people who could be involved in focus groups was limited by both the time and the resources available. We tried to organise focus groups through a variety of different organisations and to hold them at different times of day to try to ensure that a wide range of people were able to take part. Nevertheless, it was inevitable that some groups would not be properly represented. Hence, to expand the range of people able to take part we also undertook a web survey of current and ex-users and their families.

The web survey was conducted between August and December 2010. The questionnaire was developed based on the information coming from the focus groups, and links to the survey, which was hosted by SurveyMonkey, were distributed through a wide range of services and support groups. Of the 164 people who responded to the survey over a fifth (35 individuals) said they were living in Scotland. These were fairly evenly split between people who responded because they had experienced drug problems themselves and those who were family members of someone with a history of drug problems.

The results from the study as a whole provide valuable evidence concerning the extent and impact of stigma on which to base action to mitigate any harm it causes. More details of the methods used in this part of the research can be found in the main research report of the UK-wide study (Jones et al., 2010).

Survey of public attitudes

The UKDPC commissioned the survey research company TNS-BMRB to conduct a public attitudes survey to gauge opinion in the UK towards people with drug dependence. The aim of the research was to investigate the extent and nature of stigma among the general public towards people with drug dependence and people who have recovered from drug dependence.

The survey used the same methodology and a similar questionnaire as the Attitudes to Mental Health research, which TNS-BMRB has conducted in England since 1993, originally on behalf of the Department of Health but which is now under the management of the Shift programme. This research monitors public attitudes towards people with mental illness and therefore provides a useful benchmark against which to compare attitudes towards people with drug dependence.

In addition to providing valuable evidence concerning public attitudes towards people with a history of drug dependence in 2010, it also provides a baseline against which to monitor change in the future.

A set of questions was placed on TNS-BMRB's Face-to-Face Omnibus Survey. The overall sample size was 2,945 adults (aged 16+), selected to be representative of adults throughout the UK, including boost samples in Scotland (the achieved sample size in Scotland was 566). A random location sampling methodology was used.

Interviews were carried out face to face using computer-assisted personal interviewing and were conducted in respondents' homes. Interviewing took place from 7 April to 2 May 2010. The data were weighted to be representative of the target population by age, gender and working status.

The main part of the survey involved asking people to agree or disagree with a range of attitude statements. These were mainly based on statements included in the annual Attitudes to Mental Illness (AMI) survey commissioned by the Department of Health (to monitor its Shift campaign, which aims to reduce stigma towards people with mental illness). Some additional questions were added to look at specific issues that were a particular concern of the project, such as attitudes to recovery and towards family members of people with drug problems. Most of the questions used were the same across both surveys but with the term 'mental illness' or 'drug dependence' used as appropriate. Other attitude statements were adapted for the attitudes to drug dependence research and some additional new statements were developed.

In deciding the term to replace 'mental illness' and related terms in the attitude statements, discussions were held with a number of experts. We were anxious to avoid terms that automatically might be considered pejorative, such as 'addict' or 'problem drug user'. However, we wanted the focus to be on people with quite severe drug problems rather than the casual or infrequent user. Thus we opted for 'drug dependence' as a base and used terms such as 'people with a history of drug dependence' in the statements. The use of these terms was tested in a small pilot study and they appeared to be generally understood by the general public in the way we

intended, i.e. relating to people with severe drug problems, now or in the past. However, to provide additional clarification the following sentence was added to the preamble: "By drug dependence, we mean an overwhelming need to use drugs such as cocaine, heroin and cannabis."

In the analysis presented in this report, attitude statements are reported as the proportions 'agreeing' or 'disagreeing'. The 'agree' category combines the responses 'agree strongly' and 'agree slightly'. The 'disagree' category combines the responses 'disagree strongly' and 'disagree slightly'.

In this report, we have only reported on differences that are statistically significant at the 95% confidence level or higher. That is, if a finding is determined to be statistically significant we can be 95% confident that the differences reported are real and have not occurred just by chance. The significance tests used were either t-tests or tests for differences between proportions. It should be noted that these tests are based on the assumption that a simple random sampling method is used. This survey did not use a simple random sample; however, it is common practice in such surveys to use the formulae applicable to simple random samples to estimate confidence intervals. As a result, there might be overestimation of significant differences. In the case of tests for differences between proportions, a design effect of 1.2 was included in the calculations to partially counteract this.

More detail of the methodology and analysis procedures is given in the report of the UK survey (Singleton, 2010).

Media analysis

The UKDPC commissioned Loughborough Communications Research Centre, to undertake a comprehensive and systematic study of the coverage of drug users and drug use in print media in the UK, to improve our understanding of the way drug users and drug use are represented in the British press.

This research aimed to provide a better understanding of the changing way drug users and drug use have been presented to the general public via the print media. Specifically, it sought to capture how drug users and drug use in general are portrayed and how this varies between different actors in the population and between different newspapers. The research only considered news items¹ that specifically dealt with drug use and drug users, rather than stories that dealt with drugs in other contexts, such as large police or customs seizures.

The research examined four UK national newspapers, two Scottish newspapers and two English regional newspapers – one an urban paper, the other covering a region. The following newspapers were selected: *The Times*; *The Guardian*; *Daily Mail*; *Mirror*; *The Herald*; *The Daily Record*; *The Northern Echo*; and *London Evening Standard*. The

¹ For this study, 'news items' included: news reports, editorials, columns, features, first-person pieces, diaries, readers letters, charts and graphs and interviews.

research focused on three one-year time periods: 1995, 2002, 2009. These dates were constrained by the availability of newspapers via Nexis² but sought to span a broad period during which the emphasis of drug policy has evolved.

The relevant stories were purposively selected through searching the Nexis newspaper database. Each of the newspapers listed above was searched throughout the three one-year time periods using research terms that included the names of a range of 13 controlled Class A, B and C drugs. In some cases these were combined with additional search words, such as 'skunk' in the case of cannabis, 'MDMA' in the case of ecstasy and 'crystal meth' in the case of methamphetamine. The resulting stories were then saved and the team of coders analysed all stories that mentioned drug use and/or drug users, discounting duplicate stories and those not relevant. The content analysis only examined those stories that referred in some way to drug users or drug use. Any stories on the economics of the drugs trade, smuggling, police drug hauls, drugs raids or cannabis farms that were thrown up by the search were not analysed. However, it is likely that the regularity and prominence of such reports will also tend to frame perceptions of drug users. Throughout the study checks were made to ensure the reliability of the coding process.

For each newspaper and relevant story the content analysis examined:

- frequency of coverage
- type of article (editorial, news story, health page etc.)
- subject of the story (age, race, class, religion etc.)
- type of drug
- background context (attempts to contextualise use)
- geographical location (region, city, estates)
- tone of coverage (positive, negative, no clear direction)
- key adjectives used by the press.

The study also involved an exercise looking at the accuracy and balance of reporting and a brief review of the literature on the media representation of another stigmatised group, people with mental health problems.

More information on the methods used including the search terms and coding manual can be found in the full research report (LCRC, 2010).

THIS REPORT

The key findings and their implications for Scotland from each of these research components in turn can be found in Chapters 2, 3 and 4 of this report. Chapter 5 then considers the opportunities for action to tackle stigma, drawing on examples from other fields, such as mental health, that have already tackled issues of stigma.

² Nexis is an electronic newspaper database.

2. Why stigma matters

This component of our research showed that the stigma associated with problem drug use is keenly felt by drug users and their families and has a huge impact on their self-esteem and their sense of self-worth. As described below, it can also act as a significant barrier to policies aimed at tackling drug problems.

The negative attitudes that are experienced by drug users and their families and the impact this has is reflected in the ways in which the people in our focus groups responded when asked what stigma meant to them personally, as shown in Table 2.1. Many of these examples came up time and time again and were amplified by examples of these experiences.

Table 2.1: What current and ex-drug users and their families associate with the term 'stigma'

Attitudes encountered	Feelings experienced
Disempowering	Shame
Judged	Embarrassment
Inflexible	Outcast
Labelled	Self-conscious
Stereotyped	Lonely
Bias	Unable to be open
Exclusion	Weak
Condemn	Different
Thinking badly about a group	
Making assumptions	
Unfair treatment	
Sticking with you even when things are a long time past	
Tarred with the same brush	
Look down their noses	
Spit at you	
Blanked	

A recurring theme was being judged and labelled, stereotyped or “tarred with the same brush” regardless of personal circumstances or actions.

The feelings of shame and worthlessness engendered prevent people with drug problems and those closest to them recognising their emerging problem and seeking help. For example, some people in our study described how they were reluctant to admit

to themselves or others that they were one of those “hopeless addicts”, as in the case of the Scottish web survey respondent who wrote:

It stopped me asking for help as I didn't want to admit that I was one of those people whom people were lambasting

WS032

Once they had sought help they would acquire that label and all that goes with it – so only when the problem had got so far that there was no escaping the label was any help or treatment sought. For others, it was the feeling that they were worthless and “no good” and hence a lost cause that delayed help-seeking:

Because already you feel quite ashamed ... if I'm taking drugs or not taking drugs, I'm still getting treated the same way ... so what's the point? They're always going to treat me like that, so maybe I am like this. Maybe I am that. It's kind of hard to get over

Glasgow YP group

The concern about the possible impact of acknowledging a drug problem and accessing services can be particularly acute in small communities, as described by a Scottish respondent to our web survey who said:

I live in a small community with only one methadone dispensing pharmacy. I have always had a job & was very unsure about seeking help with my opiate addiction because of the fear that I may lose my job or my family stigmatised just because I was seen to be either attending my local methadone clinic, or seen collecting / being observed taking methadone. It seems to be the public's perception that if you are a methadone user that you are of no use to society. Though as I have said above I have never been unemployed, have a responsible job in the social care sector & no criminal convictions.

WS092

Similar feelings were experienced by the families of people with drug problems too, 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. For example:

in Shetland, in particular, I think it's about keeping quiet.

Shetland Family group

you didn't want to tell anybody and you didn't even want to tell your family or your friends. ... You kind of kept it under wraps for a long, long time

Glasgow Family group

Stigma also has a big impact on recovery once in treatment. Low self-esteem prevents a belief in recovery to which the long-term nature of stigma contributes. In our groups we were given many examples of how the attitudes of people, including staff in a multitude of agencies, reinforce these negative feelings by presuming failure and not rewarding positive achievements.

In the web survey, respondents were asked about the extent to which they had experienced stigma from 13 different groups of people and, if they had experienced

stigma, how big an impact this had had. First, they were asked "To what extent have you experienced stigma from the following groups of people?" with response categories 'very often', 'quite often', 'rarely' and 'not at all'. Second, they were asked "For those groups that you feel have stigmatised you, how much of an impact has this had on your health and well-being and your life generally?" to which they could respond 'big impact' 'little impact' or 'no real impact'. Although the survey sample was self-selected and so cannot be considered representative of all people with a history of drug problems and their families, the pattern of responses provides an insight into the comparative frequency and impact of stigmatisation between different groups. Table 2.2 shows the ranking given to stigmatisation by different groups by the 35 Scottish respondents to the survey.

As can be seen from the web survey responses, the experience of stigmatisation by families, friends and neighbours can be particularly hurtful. If people are to recover and rebuild their lives, taking on normal roles and responsibilities, they need to be supported and included in a community. Families and friends are the people we hope will provide support in difficult times, but they may also be the people who have borne the brunt of the negative behaviours associated with drug problems.

Table 2.2: Ranking of the frequency and impact of stigmatisation by different groups of people by respondents to the web survey

Respondent with history of drug problems				Family member/close friend			
Stigmatise very/quite often		Stigma has big impact		Stigmatise very/quite often		Stigma has big impact	
1	Police	1	Friends/relatives	1	General public	1	Friends/relatives
2	Jobcentre staff	2	Employer	2=	Friends/relatives	2	Hospital staff
3=	Friends/relatives	3	Police		Police	3=	Social workers
	Employer	4=	General public		Hospital staff		Police
5=	General public		GPs	5=	GPs	5=	GPs
	Hospital staff		Jobcentre staff		Teachers		General public
7=	Work colleagues	7=	Hospital staff	7	Social workers		Teachers
	GPs		Work colleagues	8=	Pharmacists	8=	Employer
9	Pharmacists	9=	Pharmacists		Probation		Drug service staff
10	Social workers		Social workers	10	Employer	10=	Work colleagues
11	Probation	11	Drug service staff	11	Drug service staff		Pharmacists
12=	Drug service staff	12	Teachers	12	Jobcentre staff		Jobcentre staff
	Teachers	13	Probation	13	Work colleagues		Probation

Participants in our research reported being stigmatised in a wide range of settings, including services they have accessed to help them tackle their drug problems and reintegrate into society:

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

However, it is important to note that participants in our study also gave examples of good practice in these same areas, and of professionals who were supportive and “treat us like human beings”, so stigma is not inevitable and there is good practice from which to learn. Indeed, some services can not only demonstrate good practice by not stigmatising, but can also actively de-stigmatise. A simple example would be dentists. Poor dentition is often associated with long-term opiate use, but this visible sign can be removed through good dentistry, allowing a person to engage with employers, new neighbours etc. without being perceived as someone who has had a drug problem.

Sometimes there may be perceived stigma, in which a look is interpreted negatively or the fact that someone has not been in touch for a while is interpreted as avoidance, whether or not this is the case. However, as the participants in our research made clear, these perceptions arise because of the way they observe people talking about and behaving towards drug users on a daily basis. Indeed, in some cases this could go as far as physical violence towards people identified as ‘junkies’. In this way, stigma affects people twice – once in the way that people’s behaviour towards drug users affects those users and their families, and again through the impact of the anticipation or fear of stigma.

In several of the groups, the contribution that the media, both traditional and online, can make towards stigmatisation was highlighted, whether through sensationalising drug stories (Lerwick), reporting alleged evidence as fact (Paisley), ‘naming and shaming’ (Glasgow) or online local news sites that have unmoderated comments containing calls for junkies to be shot or hung being allowed space.

A participant in a focus group in a rural area who had been in jail was on the receiving end of the media’s attention:

It came on the radio before I came out of jail that I got this house across the road from school and so they set up ... The neighbours set up a campaign to try and get me out before I even got in ... I was made out to be worse than a paedophile would have been. That’s how it made me feel. I felt like I couldn’t walk in the street without everybody was looking at you. Some days I couldn’t

go outside the front door. I think it made my drug habit even worse because I just wanted to blot everything out, and that was pretty much pure hell.

A participant in the group in Aberdeen argued that it was the media and general public's appetite for bad news that leads to the predominance of negative stories about drug users being highlighted:

Everybody's got a bad impression. They're saying about the news. Well, the news only reports bad stuff. It only reports the bad things. The people that gossip only gossip about bad things. They don't sit and gossip about how well somebody is doing. That never happens.

Media coverage and the resultant comments also has a big impact on the family members of people with drug problems:

...when the papers and politicians are giving negative press and this starts the conversation of see what so and so says about the junkies and what they are going to do to them and they are all a waste of space, this is when we are at our lowest because if that what sells papers and gets votes any hope we have slowly starts ebbing away.

WS087

Our research also identified numerous examples of enacted stigma, when negative attitudes have led to discrimination or unfair behaviour. This could entail what might seem comparatively minor slights, such as being treated as different from, or less important than, other people. For example, a respondent in the Aberdeen focus group has been 'clean' for five years, but when visiting local shops (that he admitted he had shoplifted from prior to his recovery) he finds he is followed by security guards, and has been approached by a guard and told: "Once a junkie, always a junkie. You'll never change." People reported similar treatment in pharmacies and healthcare settings, such as being made to wait while other people who arrived later are seen or served, having to wait in a separate area and be seen after all 'normal' clients have gone home, or having their confidentiality breached by loud remarks such as "Here's your methadone".

Occurring day after day, this type of experience inevitably reinforces feelings of worthlessness and makes seeking help appear a waste of time. It can also impede recovery in practical ways. Being made to wait for medication can make a person who has gained employment late for work and cost them their job. Being late for an appointment at the jobcentre or with social services can lead to benefit sanctions or 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 had been made to wait for an appointment elsewhere.

We also heard numerous examples of apparently inhuman treatment by healthcare staff. The fact that some drug users may at times seek to abuse the system to obtain drugs if they can not get them on the street appears to have led to a belief among some staff that everyone with a history of opiate dependence attending accident and emergency departments is only there to get drugs, broken arm or appendicitis notwithstanding. This may stem from a legitimate concern and lack of knowledge about how to prescribe pain

relief for people on a medication such as methadone or with a tolerance to opiates, but this is an area that causes much suffering and needs to be addressed. A focus group participant in Aberdeenshire described how he had suffered severe damage to his hand, with fingers nearly severed, but wasn't allowed any pain relief:

And I'm sitting there in Aberdeen and she's saying "You're on methadone. I can't give a painkiller for you."

A separate respondent related their experience when they went into hospital with a burst appendix. They had to contact their prescribing doctor and ask them to tell the hospital doctor that they would need additional pain relief as they had a tolerance to certain drugs. The usual dosages offered to non-dependent patients would have had no effect on them. They also told of how their proactive stance was perceived:

A nurse then came into the ward I was in, slammed down a cup with my methadone in it saying "now you have got what you wanted" ... I felt that if I had not been on a methadone script that the hospital staff would have been a lot more understanding ... I was very surprised that they did not have any staff that had the specialist knowledge, to understand the amount of pain I was in and prescribe adequate pain relief in conjunction with my methadone.

WS092

The potential for neglecting or overlooking a serious illness was described by another Scottish respondent to the web survey:

I have had a few occasions now when I have had to visit to ... be taken to A&E regarding severe illness, vomiting blood on one occasion, only to have them instantly assume I was looking to take advantage of the system to obtain drugs ... I'm often reluctant to approach ... medical staff about any health issues in case they assume I'm "just out to score"

WS058

Many of the problems faced by drug users in hospital are also apparent in relationships with GPs. However, many of participants/respondents related how they were initially too embarrassed or ashamed to even disclose a drug problem to their GP. The following statement by an online respondent was echoed by many:

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

WS039

In some cases GPs were perceived as being reluctant to engage with someone with a drug problem. For example, a participant in the Shetlands related how he was referred to the community drugs team, which only has one doctor, by his local GP, not just for prescribing but for everything:

You phone the doctor ... and straightaway it's "Oh, you contact CADS [Community Alcohol and Drugs Service]." They don't want anything to do with you, the doctors here.

Shetland focus group1

The attitudes of practice staff to people with drug problems and their families could present additional barriers:

I was getting treatment from my surgery and had a good relationship until my son got a drug habit – this had an affect on the medication I was being prescribed and I felt I was not getting the treatment I should have. Also my son (who is deceased) and his partner were staying with me for support as they were having a baby [they] went to the surgery and were informed that only two people of their kind were allowed in the surgery at a time. I challenged this ... They said that drug users upset their other patients. WS037

Another topic that was frequently raised as having a key impact on recovery and help-seeking concerned children. Several of the participants in our study reported having children who had been taken into care, were being looked after by grandparents or were on a risk register. Therefore, interactions with social workers were raised in many of the focus groups, including those involving family members. Perhaps unsurprisingly, given the limited training on substance use issues that they receive and the difficult line they walk with respect to child protection, social workers were seen as a highly stigmatising group. Clearly, protecting children from harm is essential, but being part of a family is also important for a child's well-being, and not everyone who uses drugs or has used drugs in the past is necessarily a bad parent, in the same way as not everyone who has a drink is.

The desire to care properly for their children is a key reason for trying to overcome drug dependence for many drug users, so stigma from social workers is an area that can have a huge impact on help-seeking and recovery, to the detriment of the children, parents and wider family members alike. The key concerns expressed were about the way some social workers interpreted every action – such as being late for an appointment, which in other people would be considered irrelevant – as being related to drug use and a sign of continued drug problems.

The other main issue raised concerning social workers was the apparent reluctance by some 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. For example, as a participant in a Glasgow described:

I've been clean for over a year and still ... Every time six months goes by it will be another six months. ... I'm clean. I get urined [urine tested] all the time and all that, and they say "You're doing brilliant." I says "if I'm doing brilliant, what's happening?" "Oh, wait another six months." Glasgow focus group

Not surprisingly, this can lead to relapse and a self-fulfilling prophecy.

Employment and housing are other areas where stigma can have a huge impact on 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 and crack user, even if they were fit for the job (UKDPC, 2008), and in our current research former drug users reported having job offers withdrawn once their former drug using status became 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 CRB checks are being increasingly 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, as described by one rural focus group participant:

You get people ... that will actually phone up and inform on people, [telling] managers 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.

This occurs whether or not the person is in recovery or receiving treatment, as shown in the following example:

My anonymity was blown in a previous work situation which resulted in discrimination from senior management. I was in a management role and had been in recovery for a number of years. Attitudes changed overnight when they found out my previous background.

WS029

Family members of people with drug problems also reported problems at work. The expressed attitudes of work colleagues towards drug users makes it difficult for family members to disclose their situation and is painful for them to hear. Participants in our study described managers who were unsupportive and, for people working in some fields such as social work or probation, might lead to questions about fitness to practice. Many reported having given up their jobs or having avoided promotion for fear of having to disclose their situation or as a consequence of their treatment by work colleagues once they had; others maintained silence about their situation, but at a cost in terms of stress.

I went to work in ... another shop, I decided, listening to these people, you're not going to get any sympathy off these people. They don't give a monkey's about people who are drug addicts ... [they were saying] What kind of families do they come from? What kind of homes do they come from? And I thought if you only knew you're talking to me and you think everything is hunky dory in my life, you know. I never told them and I worked there for 12 years as well, and they never, ever knew. And I'm still friendly with a few of them, you know, go for a coffee and different things, and still you'll hear them saying "Oh, did you see that about junkies in the paper." Glasgow Families Group

The shortage of social housing, which makes obtaining suitable accommodation a problem for a wide range of marginal groups, is exacerbated for people with a history of drug use by stigma. For example, the assumption that people never recover from drug dependence can lead to exclusion from many properties in areas where drug use has been a problem. This same attitude can lead to continued stopping and searching by

police, even after a person has ceased illegal drug use. Such attention can be demoralising and lead to problems in maintaining recovery – for example, if such searches are made in front of employers or work colleagues.

White and Mojer-Torres (2010) emphasised the stigma against methadone as a treatment modality in a range of areas, including public discourse, the drug treatment sector and also within drug using communities in the USA. The same issues have been evidenced extensively in our research in Scotland. As one of the participants in the focus group in Aberdeen stated, people on methadone are seen as exactly the same as someone using 'street' heroin *"Never that you're trying to help yourself or get better"*. These attitudes are then reflected in services, as in the following description of attitudes at job centres:

As soon as you go in ... for an interview, you say "Aye, I'm on methadone" so straightaway they'll go ... they'll not try their hardest to find you a job, They'll automatically go through the motions and then send you away. I've not been on methadone and then I've been on it, so I know the difference of going in there and then going in a second time and you're on methadone. And ... they don't try for you.

Paisley focus group

The expansion in the availability of methadone treatment in the past may not always have been matched by an equal attention to provision of other necessary support services to enable recovery and reintegration or of alternative types of treatment provision. This perceived imbalance led to understandable calls for a greater focus on abstinence and more choice in treatment and support provision alongside negative media coverage of the use of medication such as methadone. It appears that this may have had the unfortunate side effect of stigmatising those for whom methadone works and makes an important contribution to recovery.

3. Attitudes to drug dependence in Scotland

The professionals and other individuals working with people with a history of drug problems are members of society and as such their attitudes are likely to reflect those held more generally. This chapter considers the results of the public attitudes survey derived from the sample of 566 people resident in Scotland and provides an overview of the attitudes of people in Scotland towards people with a history of drug dependence. The equivalent findings for the entire UK sample can be found in the main survey report (Singleton, 2010) with some limited comparisons shown in the tables in the Appendix to this report. Those items for which the result for Scotland differs significantly from that for the UK as a whole are highlighted in the text. Where appropriate, the results are also compared with those from the recent Scottish Social Attitudes Survey (Ormston et al., 2010), which considered attitudes to cannabis and heroin use as well as treatment and recovery.

EXPLANATION OF THE ANALYSIS

The Attitudes to Drug Dependence (ADD) survey included twenty-five attitude statements, with which respondents were asked to state their level of agreement on a five-point scale, from 'agree strongly' to 'disagree strongly'. Thirteen of these statements were the same as ones used in the Attitudes to Mental Illness (AMI) survey in England but with the terminology changed from 'mental illness' to 'drug dependence'. Four of the statements were very similar to those used in the AMI survey and eight of the statements were developed specifically for this research.

For analysis purposes, the twenty-five statements were grouped into six strands, each following a similar underlying theme. Four of the strands were established through a factor analysis. This is a statistical analysis that examines correlations between items in order to group the items into themes or factors. Four factors were identified during this analysis through a factor loading, a measure of the correlation between the statement and the factor which shows how important the statement is to the factor. Each statement was allocated to the factor on which it had the highest loading.

The remaining strands encompass two new themes in which we had a specific interest and which were not included in the AMI survey: recovery and families. These themes are key priorities for the Scottish drug strategy (Scottish Government, 2008).

The six strands were labelled based on the main themes of the statements:

- 1) Blame and intolerance of people with drug dependence
- 2) Sympathy and care towards people with drug dependence

- 3) Fear and exclusion of people with a history of drug dependence
- 4) Acceptance and integration of people with a history of drug dependence as part of the community
- 5) Recovery from drug dependence
- 6) Stigma towards the families of people with drug dependence.

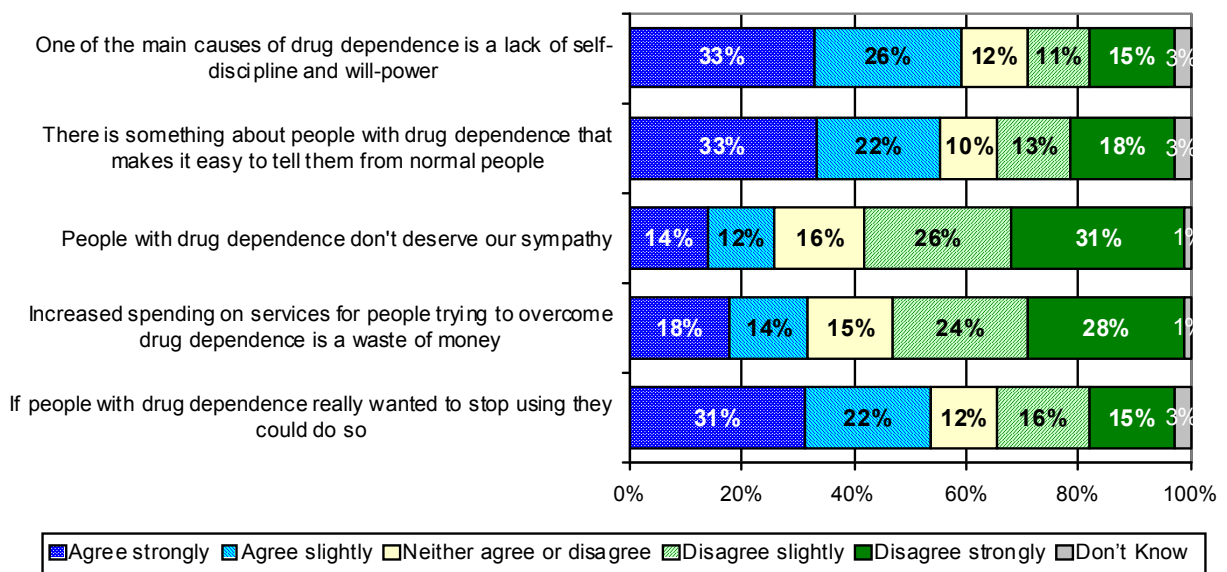
BLAME AND INTOLERANCE OF PEOPLE WITH DRUG DEPENDENCE

The first group of attitude statements identified through the factor analysis can be described as demonstrating blame and intolerance. They relate to beliefs that individuals with a history of drug dependence are to blame for their condition and to a lack of concern for their plight. The statements included in this group can all be considered to indicate negative attitudes towards people with drug dependence, and are as follows:

- One of the main causes of drug dependence is a lack of self-discipline and will-power.
- There is something about people with drug dependence that makes it easy to tell them from normal people.
- Increased spending on services for people trying to overcome drug dependence is a waste of money.
- People with drug dependence don't deserve our sympathy.
- If people with drug dependence really wanted to stop using they could do so.

A key reason for the stigmatisation of drug users identified by Lloyd (2010) was the idea that individuals with drug problems are to blame for their predicament because they have chosen to use and continue to use drugs.

Figure 3.1: Responses to questions reflecting blame and intolerance, Scotland, 2010



As can be seen from Figure 3.1 and Table A.1 (in the appendix), over half the respondents in Scotland (59%) agreed with the statement "One of the main causes of drug dependence is a lack of self-discipline and will-power"; about a quarter (26%) disagreed with the statement. Similarly, over half (53%) agreed that "If people with drug dependence really wanted to stop using they could do so", with almost a third (32%) disagreeing. Nevertheless, only about a quarter of respondents (26%) agreed with the statement that "People with drug dependence don't deserve our sympathy", with well over half (57%) of the respondents disagreeing.

Respondents in Scotland were more likely than those in the UK as a whole to agree that "There is something about people with drug dependence that makes it easy to tell them from normal people"; over half (56%) agreed compared with just over a third (37%) in the UK overall. Just under a third (31%) of Scottish respondents disagreed with the statement (compared with 40% in the UK as a whole).

Scottish respondents were also more likely than people in the UK as a whole to agree that "Increased spending on services for people trying to overcome drug dependence is a waste of money" (32% did so compared with only 24% in the UK as a whole).

SYMPATHY AND CARE TOWARDS PEOPLE WITH DRUG DEPENDENCE

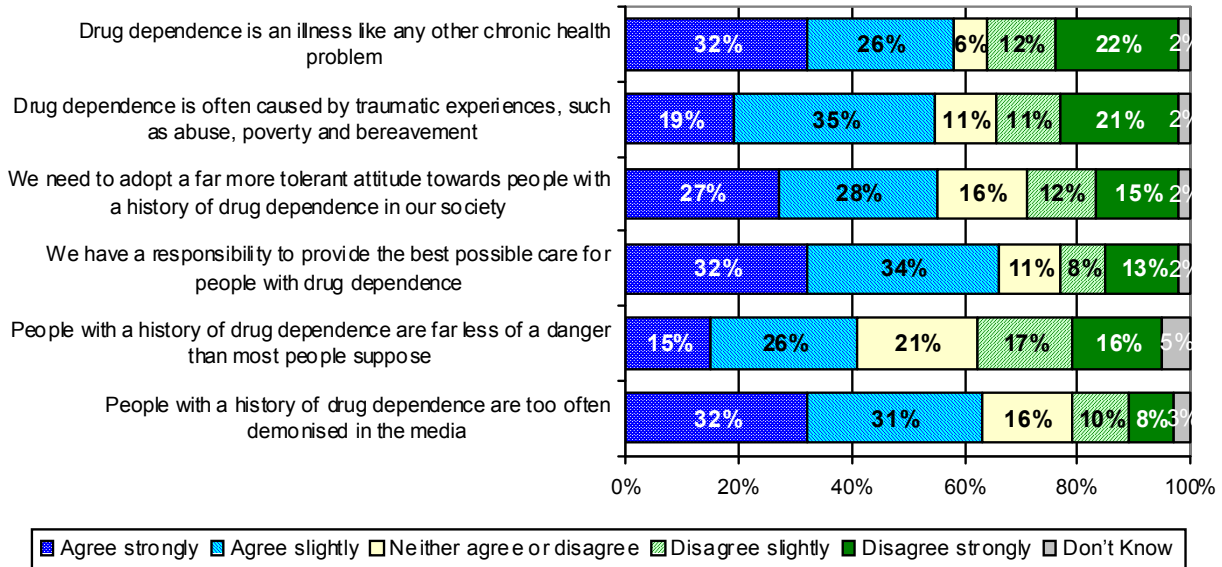
The next group of attitude statements represents a theme that can be described as insights into attitudes of sympathy and care. This group includes the following statements:

- Drug dependence is an illness like any other long-term chronic health problem.
- Drug dependence is often caused by traumatic experiences, such as abuse, poverty and bereavement.
- We need to adopt a far more tolerant attitude towards people with a history of drug dependence in our society.
- We have a responsibility to provide the best possible care for people with drug dependence.
- People with a history of drug dependence are far less of a danger than most people suppose.
- People with a history of drug dependence are too often demonised in the media.

This group therefore includes statements relating to the perception that drug dependence is like an illness and that it results from causes beyond the individual's control. These attitudes might suggest sympathy with drug dependent people and a sense of responsibility for their care.

Figure 3.2 and Table A.2 show the responses to these statements. Well over half of respondents agreed that "Drug dependence is an illness like any other chronic health problem" (58%) and that "Drug dependence is often caused by traumatic experiences, such as abuse, poverty and bereavement" (55%).

Figure 3.2: Responses to statements reflecting sympathy and care, Scotland, 2010



There was strong agreement with the statement “We have a responsibility to provide the best possible care for people with drug dependence”, with two-thirds of respondents (66%) agreeing (32% strongly agreed). Also, well over half of respondents agreed with the statements “Drug dependence is an illness like any other chronic health problem” (58%), “Drug dependence is often caused by traumatic experiences, such as abuse, poverty and bereavement” (55%), and “We need to adopt a far more tolerant attitude towards people with a history of drug dependence in our society” (55%). However, only 41% of respondents agreed that “People with a history of drug dependence are far less of a danger than most people suppose”, but 21% said they neither agreed nor disagreed, suggesting a level of uncertainty about the question.

A high proportion of respondents (63%) also agreed with the statement “People with a history of drug dependence are too often demonised in the media”.

These figures are similar to those found in the UK sample as a whole.

FEAR AND EXCLUSION OF PEOPLE WITH A HISTORY OF DRUG DEPENDENCE

The third group of attitude statements concerns the perceived fear of people with a history of drug dependence and the exclusion of such people from society. The statements in this group were as follows:

- People with a history of drug dependence are a burden on society.
- A person would be foolish to enter into a serious relationship with a person who has suffered from drug dependence, even if they seemed fully recovered.
- I would not want to live next door to someone who has been dependent on drugs.
- Anyone with a history of drug dependence should be excluded from taking public office.
- Most people who were once dependent on drugs can be trusted as babysitters.

- Residents have nothing to fear from people coming into their neighbourhood to obtain drug treatment services.

Figure 3.3: Responses to statements reflecting fear and exclusion, Scotland, 2010

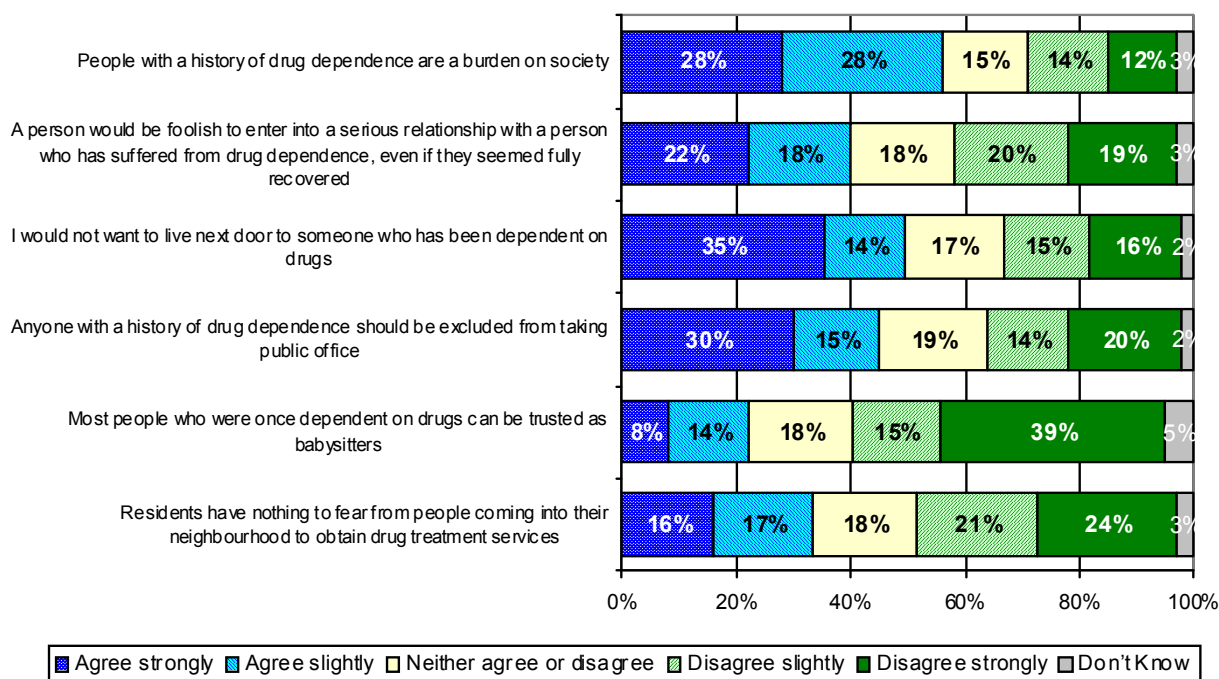


Figure 3.3 and Table A.3 show the results for this group of statements. Respondents in Scotland were more likely to report attitudes suggesting fear and intolerance in respect of five of the six statements in this group than respondents in England.

- Over half of respondents in Scotland (55%) agreed that “People with a history of drug dependence are a burden on society” (compared with 47% of people in the UK as a whole).
- Similarly, 49% agreed with the statement “I would not want to live next door to someone who has been dependent on drugs” (compared with 33% in the UK as a whole).
- 45% agreed that “Anyone with a history of drug dependence should be excluded from taking public office” (compared with 39% overall).
- 40% of respondents in Scotland agreed that “A person would be foolish to enter into a serious relationship with a person who has suffered from drug dependence, even if they seemed fully recovered” (33% in the overall UK sample agreed).
- Scottish residents were also more likely to disagree with the statement “Residents have nothing to fear from people coming into their neighbourhood to obtain drug treatment services” (46% disagreed, compared with 33% overall).

As was the case in the rest of the UK, over half of respondents in Scotland (55%) disagreed with the statement “Most people who were once dependent on drugs could be trusted as babysitters”, while only 22% agreed.

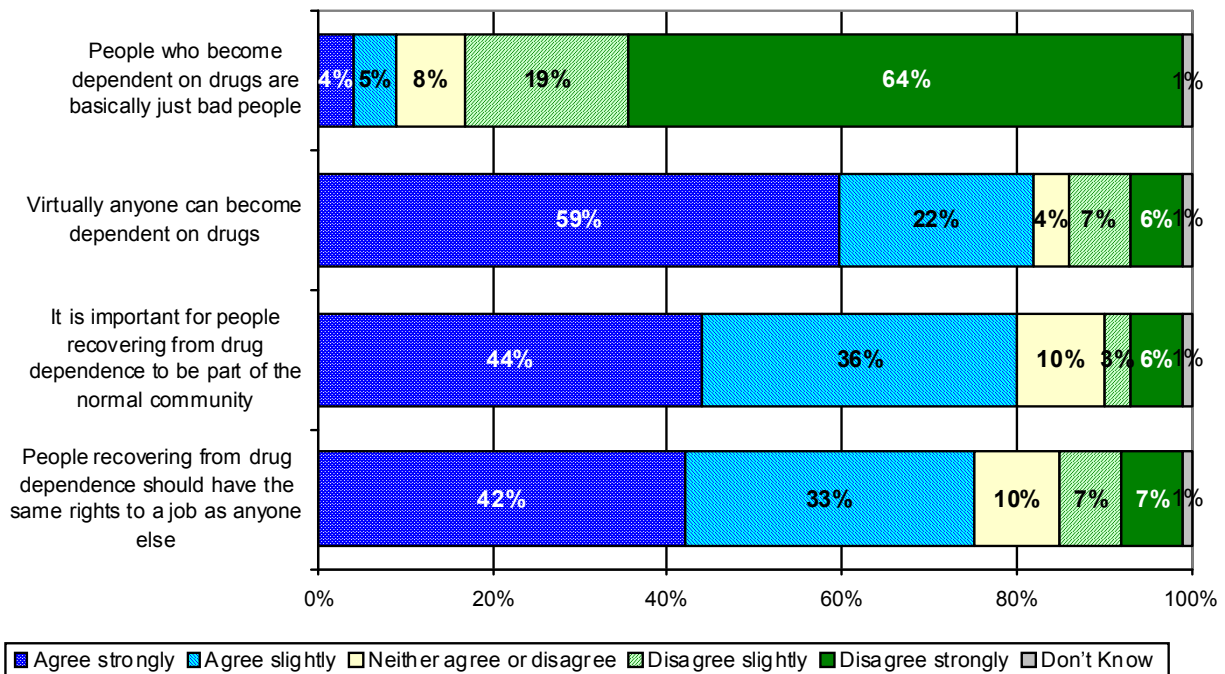
ACCEPTANCE AND INTEGRATION OF PEOPLE WITH A HISTORY OF DRUG DEPENDENCE

The fourth group of attitude statements relates to a theme that can be described as acceptance and integration. The statements in this group were as follows:

- People who become dependent on drugs are basically just bad people.
- Virtually anyone can become dependent on drugs.
- It is important for people recovering from drug dependence to be part of the normal community.
- People recovering from drug dependence should have the same rights to a job as anyone else.

As can be seen in Figure 3.4 and Table A.4, the vast majority of Scottish respondents to the survey (83%) rejected the statement “People who become dependent on drugs are basically just bad people”, with almost two-thirds disagreeing strongly. There was also a clear majority agreeing with the statement “Virtually anyone can become dependent on drugs” (82%). Most respondents also recognised the importance of integration into the community for recovery from drug dependence; 80% of respondents agreed that “It is important for people recovering from drug dependence to be part of the normal community” and 75% agreed that “People recovering from drug dependence should have the same rights to a job as everyone else”.

Figure 3.4: Responses to statements reflecting acceptance and integration, Scotland, 2010



The pattern of responses to these questions in Scotland was similar to that for the UK as a whole, with the only significant differences being that Scottish respondents were more likely to agree that “Virtually anyone can become dependent on drugs” (Scotland 82%,

compared with 77% overall) and a greater proportion strongly disagreed with the assertion that “People who become dependent on drugs are basically just bad people” (64% in Scotland, compared with 53% overall).

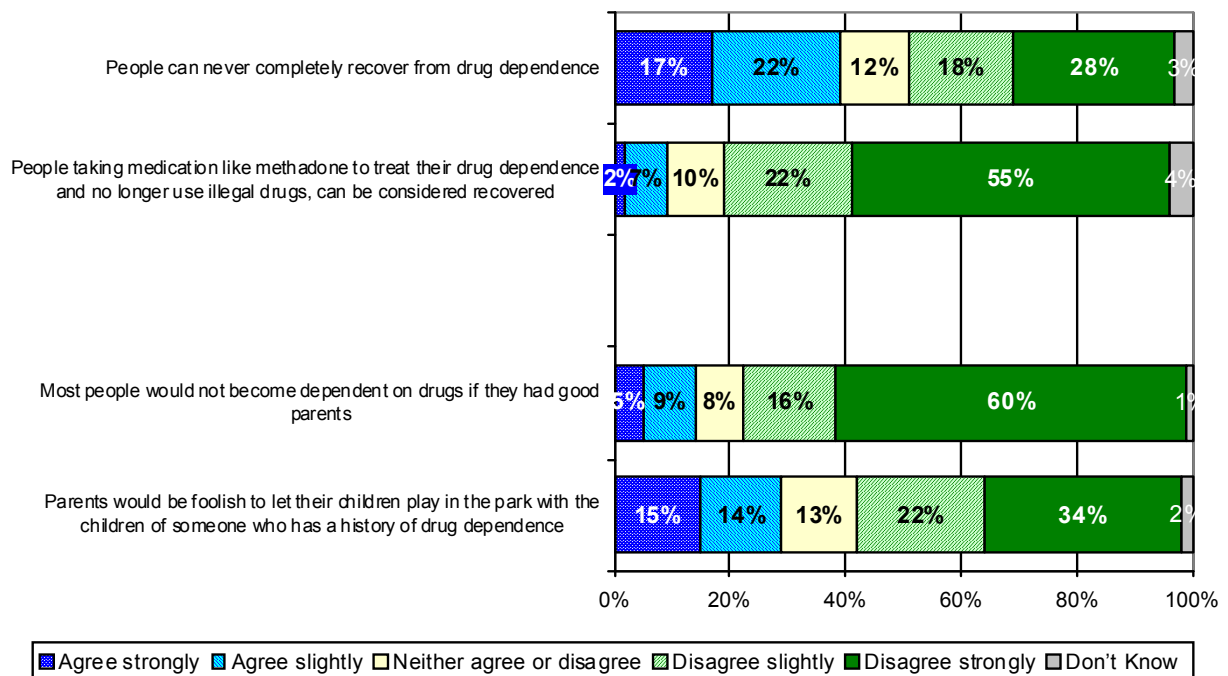
RECOVERY FROM DRUG DEPENDENCE

In addition to the two attitude statements in the previous group that related to recovery (based on questions in the AMI survey), two statements were included specifically to examine people’s beliefs about recovery from drug dependence. These were as follows:

- People can never completely recover from drug dependence.
- People taking medication like methadone to treat their drug dependence who no longer use illegal drugs, can be considered recovered.

As shown in Figure 3.5 and Table A.5, slightly more respondents disagreed with the statement “People can never completely recover from drug dependence” (46%) than agreed (38%). However, only a small proportion (9%) thought that people who have stopped using illicit drugs but are taking prescribed medication like methadone can be considered recovered – over three-quarters of respondents (77%) thought they could not. These attitudes towards medication-assisted recovery are more negative than for the UK as a whole (overall 15% agreed and 62% disagreed with the statement).

Figure 3.5: Responses to statements concerning recovery and family members of people with drug dependence, Scotland, 2010



ATTITUDES TOWARDS FAMILY MEMBERS OF PEOPLE WITH DRUG DEPENDENCE

Previous research (UKDPC, 2009) has shown that family members, such as parents, may blame themselves for not preventing their relative's drug dependence and may feel shame and embarrassment. Such feelings and the impact these have on family members' daily lives were confirmed and described in more detail in the previous chapter and in the overall report of the qualitative component of this research (Jones et al. (2010). Family members therefore tend to avoid other people and conceal their relative's situation for fear of negative reactions. The experience of stigma as a result of their relationship with or proximity to a stigmatised person is described by Goffman in his seminal work on stigma (Goffman, 1963) as 'courtesy' stigma. In order to identify the extent of such stigma towards family members of people with drug dependence, two attitude statements were added to the survey questionnaire:

- Most people would not become dependent on drugs if they had good parents.
- Parents would be foolish to let their children play in the park with children of someone who has a history of drug dependence.

Figure 3.5 above and Table A.6 show that over three-quarters of respondents (76%) disagreed with the statement "Most people would not become dependent on drugs if they had good parents", a significantly higher proportion than in the UK as a whole (overall 60% disagreed). Similarly, only about 1 in 7 people (15%) agreed with it, a significantly smaller proportion than the almost 1 in 4 (23%) in the UK as a whole, suggesting people in Scotland are less likely to blame parents for their children's drug problems.

Although a markedly higher proportion of Scottish respondents disagreed with the statement "Parents would be foolish to let their children play in the park with children of someone who has a history of drug dependence" (56%) than agreed with it (29%), it is still the case that over a quarter of respondents appear to hold attitudes that stigmatise the children of people with past drug dependence to some degree.

IMPLICATIONS OF THE FINDINGS

In his recent review of the literature relating to stigma and problem drug use, Lloyd (2010) 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 survey reported here tapped into these beliefs and revealed high levels of both blame and intolerance and of fear and exclusion of people with a history of drug dependence. In particular, respondents in Scotland were more likely than people in the UK as a whole to agree with statements suggesting that they would not want to live next door to someone with a history of drug dependence, that people would be foolish to enter into serious relationships with such a person and that such people should be excluded from public office. They were also more likely to disagree with the suggestion that residents have nothing to fear from people coming into the neighbourhood to use drug treatment services.

Conversely, significant proportions of people endorsed statements that show sympathy towards those with a history of drug problems and suggest they tend towards the view that drug dependence is an illness similar to other chronic conditions and are supportive of efforts to overcome it. For example, two-thirds of respondents agreed that we have a responsibility to provide the best possible care for people with drug dependence.

The Scottish public also strongly believe that those with drug problems should have the same opportunity as others to get a job and recognise the importance of being part of the community to recovery from drug dependence. There appears to be uncertainty but, on balance, people consider recovery from drug dependence to be possible – slightly more people disagreed with the statement “People can never completely recover from drug dependence” than agreed with it. However, only a small proportion, less than 1 in 10, think that people who have stopped using illicit drugs but are being prescribed medication such as methadone can be considered recovered – over three-quarters of respondents thought they could not. These attitudes towards medication-assisted recovery are more negative than for the UK as a whole. There has been a lot of debate in the media about methadone prescribing, which may have had an influence. It would be interesting to know whether people perceive those taking medication for other chronic health problems, such as insulin for diabetes or antidepressants for mental health problems, in the same way.

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 (see for example the report by the Academy of Medical Sciences (2008) *Brain science, addiction and drugs*). This calls into question the extent to which people should be blamed for their drug dependence and how easy it is for them to ‘just stop’.

The findings of this survey are similar to those in the recent Scottish Social Attitudes survey, which considered attitudes to cannabis and heroin use and to treatment and recovery (Ormston et al., 2010). That survey 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. It also highlights some of the potential difficulties associated with community-based treatment and the reintegration of heroin users into society, with relatively high proportions of people expressing discomfort with the idea of a recovering heroin user moving near to them.”

Another possible factor in the apparently contradictory responses is the difference between what we say and what we do, or between our perceptions of drug dependence as an abstracted social problem and as a more immediate personal issue. 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 may not want them as neighbours and are fearful of having support services in their neighbourhoods. Such attitudes are reflected in the campaigns that can often provide a significant barrier to the

establishment of drug treatment services.³ Although, as might be expected given the slightly higher rate of drug problems in Scotland than in the UK as a whole (UK Focal Point, 2010, p72), a higher proportion of Scottish respondents reported knowing someone who currently has or has in the past had a problem with drugs (58% mentioned someone compared with 51% for the UK as a whole). However, this means that a significant proportion of the sample (42%) did not know anyone with a history of drug dependence, and for a further 10% the person known was only an acquaintance, so quite often such fears are not based on personal experience. It is also worth noting that people who currently, or had in the past, lived, worked or were friends with someone with a history of drug dependence had less negative attitudes than people who had not.

The sample size for Scotland makes analysis of sub-groups difficult, but the UK-wide survey can provide an insight into variation in attitudes between different groups which are likely to also apply to Scotland. The survey as a whole demonstrated variation between people with different socio-demographic characteristics and by geographical area. Women held slightly less-negative attitudes towards those with a history of drug problems than did men. Both the youngest (16–29 years) and older (60+) adults had more negative attitudes towards those with drug problems than those in the middle age groups. Those in the AB social groups (professional/managerial occupations) had more positive attitudes towards those with histories of drug dependency. People living in Wales and, to a lesser extent, in Scotland had more negative attitudes, as did those living in urban compared with rural areas. However, it is important to note that these factors may well be interrelated, or related to whether or not people have had personal contact with someone with drug dependence. For example, older adults, who had more negative attitudes, may be less likely to have had contact with someone with drug dependence.

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, at least to begin with, they blame themselves). Our survey suggests that people in Scotland are less likely than those in the UK overall to blame parents for their children's drug problem, but nevertheless 1 in 7 agreed with the statement "Most people would not become dependent on drugs if they had good parents". That stigma also rubs off on the children of users is shown by the fact that a third of people agreed with the statement "Parents would be foolish to let their children play in the park with children of someone who has a history of drug dependence".

This survey has captured a snapshot of public attitudes to drug dependence in Scotland, and the UK as a whole, and provides a baseline against which change can be measured. It suggests that the issues of fear and blame are important aspects of negative attitudes and that these may hamper provision of services for treatment and rehabilitation.

³ See for example: <http://www.thecourier.co.uk/News/Angus/article/128/horrified-by-angus-drug-rehab-centre-plan.html> and <http://www.pressandjournal.co.uk/Article.aspx/1773855>

However, it appears that these attitudes are not based on personal experience, as those who have had personal contact with people with drug dependence have more positive attitudes. This suggests that education about the nature of drug dependence and increased opportunities to see and interact with people in recovery from drug dependence may be valuable in changing attitudes and reducing stigma. However, for such measures to be effective and suitably targeted, more research is needed into what underpins these attitudes and how public attitudes are formed.

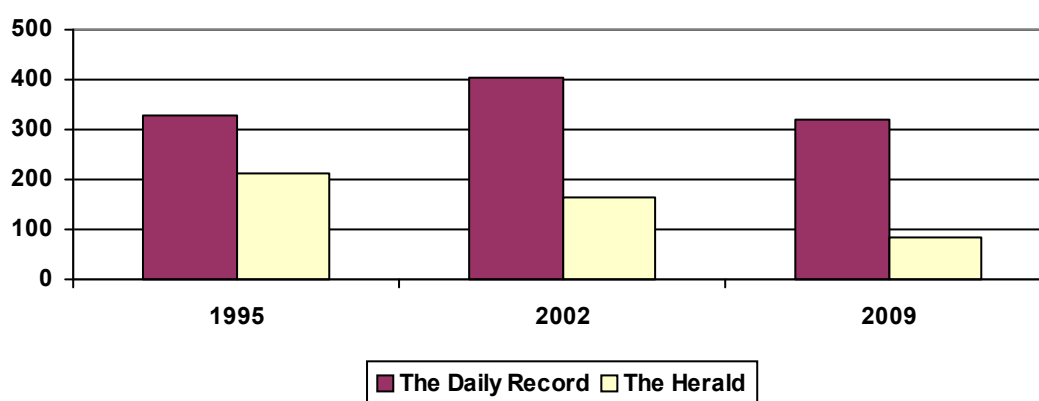
4. Portrayal of drug use and drug users in the media

Previous research has suggested that the media conveys a mainly negative impression which 'demonises' and 'marginalises' drugs users and misrepresents drugs users, drug use and its effects. Indeed in the public attitudes survey described in the previous chapter, nearly two-thirds (63%) of adults in Scotland agreed with the statement "People with a history of drug dependence are too often demonised in the media".

EXTENT AND NATURE OF COVERAGE

The UKDPC therefore commissioned the Loughborough Communications Research Centre (LCRC) to undertake a comprehensive and systematic study of the coverage of drug users and drug use in print media in the UK, to improve our understanding of the way drug users and drug use is represented in the British press. This research involved analysing all items (over 6,000 in total) referencing drug users or drug use in eight newspapers (representing national, regional, tabloid and broadsheet papers from across the UK) in each of three years: 1995, 2002 and 2009. Two Scottish papers, one broadsheet and one tabloid: *The Herald* and *The Daily Record*, were included in the study. It is worth noting that other UK national papers included in the sample will have significant circulation within Scotland and so may influence Scottish attitudes.

Figure 4.1: Number of news⁴ items on drug use or users in Scottish papers over time



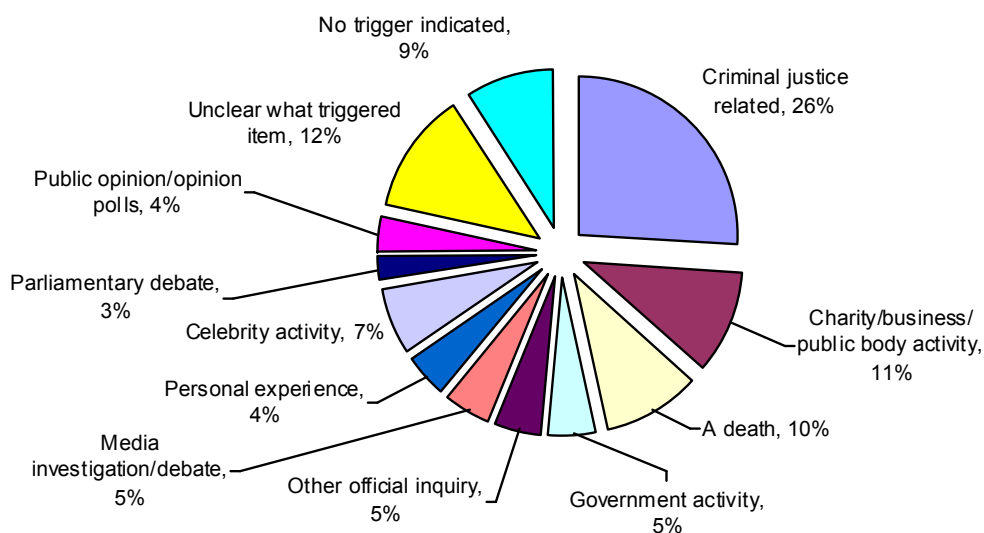
⁴ Throughout the report the term news item includes: news reports, editorials, columns, features, first-person pieces, diaries, readers letters, charts and graphs and interviews.

The full research report (LCRC, 2010) is available on the UKDPC website. In this chapter the key findings from the research as a whole and some of the findings for the Scottish papers specifically (based on a total of just over 1,500 items over the three years) are considered.

The study found no clear overall trend in the amount of coverage of drug use and drug users over time across all the UK newspapers included in the study. In 1995 there were 1,642 items, this rose to 2,759 in 2002 and then fell to 1,763 in 2009. The two Scottish papers showed different patterns, as can be seen in Figure 4.1. *The Daily Record* had twice as many items concerning drug use and drug users as *The Herald* (1,052 over the three years compared with 461 for *The Herald*). The amount of coverage in *The Daily Record* remained fairly stable over the three years, but was highest in 2002. In contrast, there was a marked decline in coverage of drug use and drug users in *The Herald* over the three year period. Overall, the majority of coverage (80%) was in news reports in all years, with feature pieces mentioning drug use or users being next most common (10%).

The study found a frequent association in reporting between drug use and crime. The most frequent trigger for a newspaper item that featured drug use (25% of items) was an event within the criminal justice system; for example, a reported court case or arrest. This was also the case in the Scottish papers included (26% of items were criminal justice related). Figure 4.2 shows the proportion of items in Scottish papers related to different triggers.

Figure 4.2: Proportions of items linked to different types of trigger in Scottish papers



The use of certain drugs was more frequently mentioned than others, although the pattern in Scotland differed slightly from the overall picture. In the Scottish press, heroin was the most frequently mentioned drug (in 22% of items), followed by cannabis (19%

of items), cocaine (18%), ecstasy (14%) and crack cocaine (3%). In the study as a whole, cannabis was most often mentioned (in 22% of items) followed by cocaine (20%) then heroin (19%), ecstasy (11%) and crack cocaine (5%). These differences probably reflect the different patterns of use in Scotland compared with the rest of the UK; for example, the higher prevalence of heroin dependence and lower prevalence of crack cocaine use in Scotland compared with England.

Compared with other drugs, coverage of ecstasy was much more commonly triggered by a death. Indeed, deaths were the most common triggering event for reports on ecstasy, in marked contrast to other drugs, for which triggers related to the criminal justice system were the most common. This is despite the fact that the number of drug-related deaths annually in which ecstasy is implicated is very small; for example, in 2009 there were only two (GROS, 2010). This supports the findings of Forsyth (2001), who found that deaths from drugs like ecstasy are more likely to be reported in the press than deaths from other drugs, such as opiates.

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, the individuals who featured as drug users in news items were most likely to be professionals of one kind or another, for example sports people; around a quarter (24%) of drug users were in this category. Young people were next most often featured as users, then celebrities/public figures, followed by offenders. However in the Scottish papers covered in the study, young people were most likely to feature in news items as users (24% did so), with professionals next, featuring in 18% of items.

In general, portrayals of professionals and celebrities as drug users were most often linked to cocaine use. Young people were most likely to be shown as cannabis and ecstasy users, while offenders and parents were most commonly portrayed as heroin users.

PORTRAYALS OF DRUG USE AND RECOVERY

Where the effects of drug use for either the community or the individual were mentioned in news items, these were overwhelmingly negative. The major negative impact raised for the individual was on health, with the next most significant consequence being crime. The results show some variation in the reported effects for individuals of using different drugs. Where the impact of heroin, cannabis or ecstasy use was mentioned it was mainly the impact on the individual's health, especially in the case of ecstasy. However, the main reported consequence of taking cocaine was on the individual's career, and in the case of crack cocaine on the individual's propensity to commit crime. News items that mentioned the health harms of heroin, ecstasy, cocaine or crack use focused on the impact of the drug on physical health. However, news items that mentioned the harm of cannabis use raised its mental health impacts more frequently.

Drug use rarely gets explained within newspaper coverage; reasons are only suggested in about one-third of items. In this study these were classified into six broad categories:

1. Environmental factors

That is, drug use seen as a product of the environment in which the subject lived, worked or socialised. News items in this category included stories about how membership of a youth subculture, such as clubbing, had led to an individual's use of drugs. Other stories blamed drug use on work-based socialising. Others examined drug use in a broader social context; for example, looking at how economic deprivation in a community impacted on drug use.

2. The influence of others

In these items drug use was explicitly linked to the influence of other people or groups. These might be a peer group or celebrities, or government ministers issuing different messages. In these news items those exerting influence were often clearly identified. For example, celebrities who used drugs were often claimed to be influencing the young and impressionable.

3. Price and availability of drugs

For example, items relating to falling drug prices making drugs cheaper and more accessible.

4. Emotional and personal issues

As when use was linked to abuse suffered by the user.

5. Individual choice

In some items, use was connected to individual choice; that is, no other factors were mentioned and use was explained in terms of decisions made by the individual.

6. Medical benefits

Use was sometimes linked to medical benefits. In these stories, mostly about cannabis, the use of drugs was related to the need of users to reduce pain or improve their lives.

Overall, where any cause was suggested, environmental factors were most often cited. There were no strong differences between the broadsheet press and the tabloid press in the ways in which drug use was explained. There was slightly greater emphasis on emotional and personal reasons in the Scottish press than overall. This may well be in part because there were some differences in the way all newspapers explained heroin and cocaine use. The reasons for heroin use were mainly personal and emotional issues and the influence of others while cocaine use tended to be explained in terms of lifestyle choice. In Scotland heroin was the drug most commonly mentioned in news items.

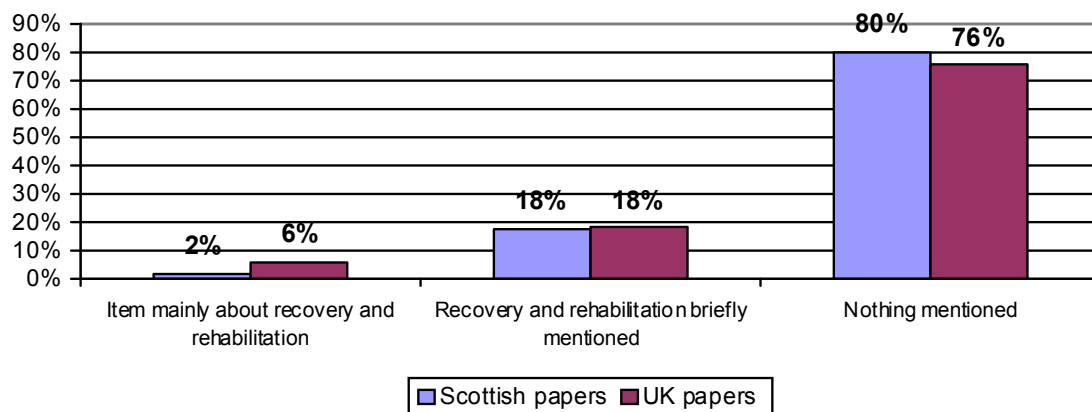
Over the sample period, stories that mainly focused on recovery and rehabilitation were few and far between. Overall less than a quarter of items (22%) made any mention of recovery or rehabilitation and very few items had a main focus on recovery or rehabilitation, less than 3% of all items sampled. When such items did appear they

mainly concerned the appropriateness of government proposals to rehabilitate heroin users.

Following publication of the Scottish Government’s drugs strategy *The Road to Recovery* in 2008, and other UK drug strategies that appeared subsequently, there has been an increased focus on recovery in drug policy and practice and it might have been expected that this would have led to greater coverage of recovery in the press. The proportion of news items that mainly focused on recovery increased over time but not by a very large amount, rising from 1.3% of items in 1995 to 3.4% in 2009. There was a bigger increase in the proportion of items that mentioned recovery and rehabilitation in passing, which rose from 13.2% in 1995 to 22.2% in 2002 but then decreased slightly to 19.5% in 2009.

The two Scottish papers included were no more likely to include stories mentioning recovery and rehabilitation than those in the rest of the UK, as shown in Figure 4.3.

Figure 4.3: Proportion of items mentioning recovery and rehabilitation, Scottish papers compared to the whole sample



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, while in the Scottish papers included in the study, 11% were condemnatory and 4% 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 in the whole sample, 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.

Drug users were more likely to be condemned than empathised with in all newspapers, but were most likely to be condemned in the tabloid press, where around one-fifth of users mentioned in articles, overall, were condemned. The most significant group of

users condemned in the tabloid press were offenders and parents who used drugs. Young people were least likely to be condemned.

Certain groups of users were more likely to be labelled as 'addicts' or 'junkies' than others. Celebrities, non-professionals, young people and professionals were least likely to be labelled 'addicts' or 'junkies', while offenders, parents and unspecified members of the public were most likely to be given the tag. Offenders were also more likely to attract negative descriptions, while young people and professionals were more likely to attract positive ones.

OVERVIEW AND IMPLICATIONS

The study as a whole shows that in the UK most of the reporting of drug use and drug users in the print media is in the form of brief news reports and that use of terms such as 'junkie' is thankfully fairly rare. While the analysis found some differences for the two Scottish papers included in the analysis, the overall picture was the same.

Coverage is heavily skewed towards items relating to celebrity drug use and reports relating to drug-related crime. Thus there is clearly the potential for an increased focus on informative content (e.g. features, editorials and comment pieces) about the causes of drug dependency and the routes and challenges for getting out of it.

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 (Philo et al., 2010) has shown how negative the television portrayals of people with mental health problems can be, further research to investigate if the same is true for people with drug problems would be beneficial. 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 and, in any case, was counterproductive in terms of seeking help and entering recovery. 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 (Kelly and Westerhoff, 2010).

5. What can be done to tackle stigma

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.

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 levels of fear and blame.

The findings from our survey and the recent Scottish Social Attitudes Survey (Ormston et al., 2010) indicate much uncertainty in public understanding about the complex and interrelated causes of drug dependency and the nature of drug treatment and recovery. The majority of people in our survey endorsed statements suggesting on the one hand that individuals with drug dependence had only themselves to blame and could stop if they really wanted to, and on the other hand that past trauma was often a cause of dependence and that people with drug dependence were *not* basically bad people. Similarly, most people agreed that people with a history of drug dependence deserved good treatment and services and needed employment and to be part of the community in order to recover, but conversely they also indicated that they were fearful of having such people within their own neighbourhood and community.

Coalitions and campaigns

In the mental health field, major campaigns and programmes such as the mental health coalition campaigns See Me (in Scotland) and Time to Change (in England) 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 more recently in attempts to challenge public reactions to people with facial disfigurement. The new structures set up to implement the Scottish Government's strategy, in particular the Scottish Drug Recovery Consortium and the local Alcohol and Drug Partnerships (ADPs), have a unique opportunity 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 people in recovery, government departments, drug treatment and service providers (both in the health service 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. The focus in the Scottish drug strategy on improving services and ensuring they focus on recovery outcomes and the, in some cases well-founded, criticism of the way services have undertaken methadone-prescribing appear to have led to very negative perceptions of medication-assisted recovery. However, there is very strong evidence for the importance and value of such drug treatment as part of recovery. It is therefore important that the general public, professionals and employers understand the place of medication in recovery pathways if services are to achieve the ambition set out in the drug strategy to radically increase the numbers of people in Scotland achieving recovery from drug dependence. In other arenas a coalition approach has proved effective and we believe that the Scottish Drugs Recovery Consortium, professional bodies (e.g. Royal Colleges), the Scottish Government, Health Boards, local authorities, Alcohol and Drug Partnerships, leading voluntary sector service providers and self-help, mutual aid 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 PCC 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" (Press Complaints Commission, 2009) – 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. The UKDPC will be working with the Society of Editors to develop guidance to clarify this.

In addition, newspapers and broadcast media could look to use informed feature items to help provide a balance to the regular crime and celebrity news. Bodies such as the Scottish Drug Strategy Delivery Commission and the Scottish Drugs Recovery Consortium should consider seeking to engage with key people in the Scottish media to consider ways in which the media can contribute to fostering a better understanding of drug dependence and recovery at all levels of society to provide an environment that supports government efforts to address Scotland's drug problem.

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 (Galvani and Forrester, 2008). 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 Scottish Government, in taking forward the workforce development process described in its recent statement "Supporting the Development of Scotland's Alcohol and Drug Workforce", 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 should ensure that the programme enables the workforce at all levels to develop competence, skills and expertise to challenge the stigma associated with drug and/or alcohol misuse.

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. The Scottish Government has led the way in refocusing drug policy towards recovery and, in setting up the Scottish Drugs Recovery Consortium with a remit to tackle stigma as part of the promotion of recovery, has demonstrated a clear recognition of the need to address stigma. It should consider how it might build on this in other areas and provide a model for others, for example by reviewing government practices in employment and contracting to identify and tackle any unwitting stigmatising practice (as discussed in more detail below).

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. The new alcohol and drug workforce development programme is potentially well situated 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.

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. The National Treatment Agency for Substance Misuse in England has recently published guidance for drug treatment workers on this subject⁵ and it would be helpful if similar guidance could be published in Scotland. 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, work by the crime reduction charity Nacro associated with its Change the Record campaign has shown that many employers are demanding CRB checks even where these are not lawful and as a result are excluding ex-offenders, whose offences are in fact spent under the Rehabilitation of Offenders Act.

⁵ Available at: [http://www.nta.nhs.uk/uploads/2yearrulenote2010\[0\].pdf](http://www.nta.nhs.uk/uploads/2yearrulenote2010[0].pdf)

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) 1995. 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 those people were not protected. This exclusion has been carried forward into the new Equality Act 2010. 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 Scottish Government might want to consider what it can do to bring this anomaly of the definition of addiction to the attention of the UK Government, and could also consider clarifying the position of people with drug and alcohol dependence within the provisions of the Adult Support and Protection (Scotland) Act 2007.

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.⁶ 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 Scottish Prison Service should examine how it can ensure access to such schemes and other ways 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.

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

⁶ See for example Bath, C. and Edgar, K. (2010).

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.

Through mutual aid, change and improvement can be made more visible, as the Scottish Drugs Recovery Consortium and many others, with support from the Scottish Government, are demonstrating. Throughout the UK, along with a long tradition of the open but 'quiet' AA (Alcoholics Anonymous) and NA (Narcotics Anonymous) movements and the growing 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 Alcohol and Drug Partnerships, 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, 'UK recovery walks' have been held in the North West of England and Scotland, in which recovering drug users have made their presence and commitment to self-improvement publicly visible. Having national leaders and figureheads supporting such marches and visibly joining this very marginalised group can go a long way in both encouraging those in recovery to 'stay with it' and helping to change public perceptions. It was notable that the Minister for Community Safety, Fergus Ewing MSP, launched and walked with those in recovery and their families at the recent UK Recovery Walk 2010 held in Glasgow.

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 WordsMatter⁷ could play a valuable part in helping those recovering from drug problems challenge some of the language and reporting about them.

⁷ An initiative currently being developed for a consortium of mental health organisations; see <http://wordsmatter.org.uk>.

5. Develop 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 walks already mentioned, there are other projects that seek to foster improved community relations through involvement in community; 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,⁸ 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 marked**

The mental health field has demonstrated how attitudes and, more importantly, behaviour can change. The See Me programme has begun to demonstrate reductions in the experience of stigma among mental health service users (McArthur and Dunion, undated). 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 over several years.

• **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 as part of their recovery. But, in return, society has to look at

⁸ See <http://www.camden.gov.uk/ccm/content/policing-and-public-safety/community-safety/camden-drug-action-team.en;jsessionid=AD49ABFAB042C4C101438A6F42943DB3>.

itself and begin to challenge the negative attitudes and barriers that can keep those with addictions and drug dependency problems locked into their problematic drug use and associated behaviours. 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.

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Appendix: Tables of results from the public attitude survey in Scotland, 2010

Table A.1: Percentages giving different responses to statements relating to the theme of blame and intolerance, Scotland, 2010

	Agree strongly	Agree slightly	Neither agree or disagree	Disagree slightly	Disagree strongly	Don't know	Scotland		UK overall	
							% agreeing (disagreeing)	% disagreeing (agreeing)	% agreeing (disagreeing)	% disagreeing (agreeing)
One of the main causes of drug dependence is a lack of self-discipline and will-power	33%	26%	12%	11%	15%	3%	59% (26%)	58% (23%)		
There is something about people with drug dependence that makes it easy to tell them from normal people	33%	22%	10%	13%	18%	3%	56% (31%)	37% (40%)		
People with drug dependence don't deserve our sympathy	14%	12%	16%	26%	31%	1%	26% (57%)	22% (60%)		
Increased spending on services for people trying to overcome drug dependence is a waste of money	18%	14%	15%	24%	28%	1%	32% (52%)	24% (58%)		
If people with drug dependence really wanted to stop using they could do so	31%	22%	12%	16%	15%	3%	53% (32%)	49% (32%)		

Notes:

Based on a sample of adults aged 16+ living in private households. Weighted to be representative of the population. Unweighted bases: Scotland = 566; UK overall = 2,945.

Percentages may not always add to overall totals or 100% due to rounding.

Table A.2: Percentages giving different responses to statements relating to the theme of sympathy and care, Scotland, 2010

	Agree strongly	Agree slightly	Neither agree or disagree	Disagree slightly	Disagree strongly	Don't know	Scotland		UK overall	
							% agreeing (disagreeing)	% disagreeing (agreeing)	% agreeing (disagreeing)	% disagreeing (agreeing)
Drug dependence is an illness like any other long-term chronic health problem	32%	26%	6%	12%	22%	2%	58% (34%)	59% (29%)		
Drug dependence is often caused by traumatic experiences, such as abuse, poverty and bereavement	19%	35%	11%	11%	21%	2%	55% (32%)	55% (26%)		
We need to adopt a far more tolerant attitude towards people with a history of drug dependence in our society	27%	28%	16%	12%	15%	2%	55% (27%)	57% (22%)		
We have a responsibility to provide the best possible care for people with drug dependence	32%	34%	11%	8%	13%	2%	66% (21%)	68% (16%)		
People with a history of drug dependence are far less of a danger than most people suppose	15%	26%	21%	17%	16%	5%	41% (34%)	40% (28%)		
People with a history of drug dependence are too often demonised in the media	32%	31%	16%	10%	8%	3%	63% (18%)	64% (15%)		

Notes:

Based on a sample of adults aged 16+ living in private households. Weighted to be representative of the population.

Unweighted bases: Scotland = 566; UK overall = 2,945.

Percentages may not always add to overall totals or 100% due to rounding.

Table A.3: Percentages giving different responses to statements relating to the theme of fear and exclusion, Scotland, 2010

	Agree strongly	Agree slightly	Neither agree or disagree	Disagree slightly	Disagree strongly	Don't know	Scotland		UK overall	
							% agreeing (disagreeing)	% agreeing (disagreeing)	% agreeing (disagreeing)	% agreeing (disagreeing)
People with a history of drug dependence are a burden on society	28%	28%	15%	14%	12%	3%	55% (27%)	47% (34%)		
A person would be foolish to enter into a serious relationship with a person who has suffered from drug dependence, even if they seemed fully recovered	22%	18%	18%	20%	19%	3%	40% (39%)	33% (41%)		
I would not want to live next door to someone who has been dependent on drugs	35%	14%	17%	15%	16%	2%	49% (32%)	43% (32%)		
Anyone with a history of drug dependence should be excluded from taking public office	30%	15%	19%	14%	20%	2%	45% (34%)	39% (41%)		
Most people who were once dependent on drugs can be trusted as babysitters	8%	14%	18%	15%	39%	5%	22% (55%)	21% (52%)		
Residents have nothing to fear from people coming into their neighbourhood to obtain drug treatment services	16%	17%	18%	21%	24%	3%	33% (46%)	42% (33%)		

Notes:

Based on a sample of adults aged 16+ living in private households. Weighted to be representative of the population.

Unweighted bases: Scotland = 566; UK overall = 2,945.

Percentages may not always add to overall totals or 100% due to rounding.

Table A.4: Percentages giving different responses to statements relating to the theme of acceptance and integration, Scotland, 2010

	Agree strongly	Agree slightly	Neither agree or disagree	Disagree slightly	Disagree strongly	Don't know	Scotland	UK overall
							% agreeing (disagreeing)	% agreeing (disagreeing)
People who become dependent on drugs are basically just bad people	4%	5%	8%	19%	64%	1%	8% (83%)	9% (80%)
Virtually anyone can become dependent on drugs	59%	22%	4%	7%	6%	1%	82% (13%)	77% (14%)
It is important for people recovering from drug dependence to be part of the normal community	44%	36%	10%	3%	6%	1%	80% (9%)	81% (7%)
People recovering from drug dependence should have the same rights to a job as anyone else	42%	33%	10%	7%	7%	1%	75% (14%)	73% (12%)

Notes:

Based on a sample of adults aged 16+ living in private households. Weighted to be representative of the population.

Unweighted bases: Scotland = 566; UK overall = 2,945.

Percentages may not always add to overall totals or 100% due to rounding.

Table A.5: Percentages giving different responses to statements relating to the theme of recovery, Scotland, 2010

	Agree strongly	Agree slightly	Neither agree or disagree	Disagree slightly	Disagree strongly	Don't know	Scotland		UK overall	
							% agreeing (disagreeing)	% disagreeing (agreeing)	% agreeing (disagreeing)	% disagreeing (agreeing)
People can never completely recover from drug dependence	17%	22%	12%	18%	28%	3%	38% (46%)	33% (44%)		
People taking medication like methadone to treat their drug dependence and no longer use illegal drugs, can be considered recovered	2%	7%	10%	22%	55%	4%	9% (77%)	15% (62%)		

Table A.6: Percentages giving different responses to statements concerning the theme of families of people with drug dependence, Scotland, 2010

	Agree strongly	Agree slightly	Neither agree or disagree	Disagree slightly	Disagree strongly	Don't know	Scotland		UK overall	
							% agreeing (disagreeing)	% disagreeing (agreeing)	% agreeing (disagreeing)	% disagreeing (agreeing)
Most people would not become dependent on drugs if they had good parents	5%	9%	8%	16%	60%	1%	15% (76%)	23% (60%)		
Parents would be foolish to let their children play in the park with the children of someone who has a history of drug dependence	15%	14%	13%	22%	34%	2%	29% (56%)	34% (46%)		

Notes to tables:

Based on a sample of adults aged 16+ living in private households. Weighted to be representative of the population.

Unweighted bases: Scotland = 566; UK overall = 2,945.

Percentages may not always add to overall totals or 100% due to rounding.

We are grateful to the Scottish Drugs Recovery Consortium, the Pilgrim Trust and the Esmée Fairbairn Foundation for their support for this research.

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ISBN 978-1-906246-30-3
This briefing is available at:
www.ukdpc.org.uk/publications.shtml#Stigma_reports