Stigmas and Stereotypes

Ontario Harm Reduction Conference
February 10-12, 2013
Goals and Objectives

• Gain a better understanding of the negative effects of stigma and stereotypes on people that use drugs and/or have HIV or Hep C.

• Reflect on the how stigma and stereotypes are generated.

• Examine ways in which access to and provision of services can be affected.

• Consider ways to reduce stigma and improve the well being of people that use drugs.

• To show some of the good work being done within harm reduction programs in Ontario.
“I had high regard for him... until he disclosed that he used drugs... this fact... it lessened him for me.”

We might come back to this quote...
What do you notice about these pictures?
Stereotypes, Stigma & Discrimination

• Stereotype
  – A thought about specific types of individuals or certain ways of doing things, which may or may not accurately reflect reality.

• Stigma
  – A belief that one does not deserve X/Y/Z...

• Discrimination
  – Being denied something (e.g., service or a job).
People Who Do “Drugs”

• Drug use is a powerful source of stigma and discrimination.

• The stigma attached to drug use may be reinforced by the fact that it is an illegal and covert activity, and that there is no legal protection available to people who use drugs.

• There are also stereotypes of drug users, such as “junkies” and “bad” when in fact many drug users are employed, bring up families, are financially stable, are good neighbours and good friends.

• Alcohol as a drug?
“Hierarchy” of use and stigma...

- Which drugs and which drug users are:
  - Most stigmatized?
  - Least stigmatized?
  - Why?
Judgments can be based on...

- Legality
- How they are taken (smoked; injected; snorted…)
- Frequency of use
- Class of people
- Impact on personal health
- Impact on social circles
- Personal experience
- Media
People Who Use Crack Cocaine

• People of all income levels use crack for a variety of personal and systemic reasons.

• Ongoing myths and misconceptions that characterize crack users as chaotic and dangerous, coupled with the realities of a powerful addiction that can be difficult to control, have contributed to the intense stigmatization and marginalization of people who use crack.
People Who Use Crack Cocaine

Homeless adults who use crack face discrimination and poor treatment from service providers.

• 50% of homeless adults who use crack said they had been judged unfairly or treated with disrespect by a health care provider in the past year.

• The most common reasons people felt they were discriminated against were because of their use of alcohol or drugs or because the health care provider thought they were drug-seeking.

• 24% of homeless adults who use crack reported having had at least one negative experience with hospital security, including being told to go away, verbally assaulted, physically removed or beaten up.

People Who Use Injection Drugs

• Discrimination against injecting drug users (IDUs) is widespread, especially within health care:
  – Some health professionals refuse to provide proper medical care or access to social services.

• IDUs are also likely to be discriminated against by the police, not just because of the illegality of drug use, but also because of their status as “second class citizens”.
People Who Use Injection Drugs

• Prejudice and discrimination against IDUs makes those not yet infected with HIV and HCV more vulnerable, facilitating the transmission of HIV and HCV infection.

• People who have acquired HIV through injecting drug use face a double stigma:
  – They are marginalized and discriminated against on the basis of their drug use, as well as their HIV status.
Stats on HIV Stigma

• 32% of people believe incorrectly that HIV can be transmitted through kissing.
• 29% believe incorrectly that HIV can be transmitted through a mosquito bite
• 49% feel uncomfortable using a restaurant drinking glass once used by a person living with HIV/AIDS.
• 26% would be very or somewhat uncomfortable working in an office where someone is known to be infected with HIV/AIDS.
• 26% feel uncomfortable even wearing a sweater once worn by a person living with HIV/AIDS.
• 20% do not believe in supporting the rights of people living with HIV/AIDS.

Stigma of People with HIV/AIDS

Fear of contagion coupled with negative, value-based assumptions about people who are infected leads to high levels of stigma surrounding HIV/AIDS. Factors that contribute to HIV/AIDS-related stigma:

• HIV/AIDS is a life-threatening disease.
• HIV infection is associated with behaviours (such as homosexuality, drug addiction, prostitution or promiscuity) that are already stigmatized in many societies.
• Most people become infected with HIV through sex. Sexually transmitted diseases are always highly stigmatized.
• There is a lot of inaccurate information about how HIV is transmitted.
• HIV infection is often thought to be the result of personal irresponsibility.
• Religious or moral beliefs lead some people to believe that being infected with HIV is the result of moral fault (such as promiscuity or 'deviant sex') that deserves to be punished.
Multiple Stigmas

- Country of Origin
- Race
- Culture
- Drug Use
- Mental Health
- Poverty
- Sex Work
- Incarceration
Forms of Stigma

*The next few slides are adapted from*
*The Harm Reduction Coalition (harmreduction.org)*

- Stigma from individuals/society
- Institutional stigma
- Self stigma (internalized)
- Stigma by association
Stigma from Individuals/Society

• Labeling and avoidance
  - People lock up their valuables when a drug user comes over.
  - The person on the street is called a “crack head”.
  - People assume “junkies” don’t care about their health.
  - Families / friends disown people or cut them off…
Toronto Drug Strategy Survey

• “My brother doesn’t want to talk to me because I’ve used [drugs].”

• “I’m outcast from the family because I’m an alcoholic.”

• “Your mom, your dad, your brother, your sister… they say you’re a worthless piece of crap, and they want nothing to do with you.”

• “My family, that’s where I get it all from. I’m a whore, I’m a thief, I run the streets, I’m a crackhead, I’m dirty, I’m no good.”
Institutional Stigma

• Employers believe drug users won’t be reliable.
• Landlords won’t rent to you.
• Healthcare providers:
  • Believe drug users aren’t reliable for treatment (re-infection; won’t comply with medications)
  • Emergency departments believe people are “just drug seeking”

• Stigma → Discrimination
“They won’t even give you a pain killer because they take one look in your eyes and say, “Oh, you’re a druggie.”

“When you have alcohol and drug problems, it’s hard to get housing…unless you can get it by doing paper work only – if they don’t see you.”

“I’ve been thrown out of the hospital. I’ve been thrown out in a hospital gown by security guards.”

“When I walk outside, the police jack me up because I’m a drug user. It’s not right.”
Self Stigma (internalized)

• Asking for help means admitting to themselves and others that they are one of those ‘hopeless addicts’ and acquiring that label and all that goes with it.

• It’s my fault, I’m diseased, bad, what’s the point of doing XYZ (housing, medical care, drug tx, etc.)?
Stigma by Association

- HCV+ = drug user
- Access needle exchange = drug user
- Go to HCV support group = drug user
- Working with drug users = stigma
- Drug user in the family = stigma
“Sometimes being black, you can’t be chillin’ with people on the street. ‘Cause on my street, if I’m seen chillin’ with certain white people the cops would just pull me aside and see if I’m selling crack or something.”

“I’m Native and they assume I have an alcohol problem. They figure I’m a drunken Indian, which is pretty awful.”
Key Elements of Drug Related Stigma

- Blame and make moral judgments
- Criminalize
- Pathologize
- Patronize
- Fear and Isolation
Key Elements of Drug Related Stigma

• Blame and moral judgment
  • “just say no”; your own fault for getting HIV / HCV; weak-willed; you don’t care

• Criminalize
  • drugs = bad → get tough → punish
  • Incarcerating drug users for non-violent crimes vs. resources for supportive services

• Pathologize
  • something is wrong with drug users; they can not help themselves…
Key Elements of Drug Related Stigma

- **Patronize**
  - Drug users often told what they should do, or what they need, as opposed to seeking input and involving them.

- **Fear and Isolation**
  - Drug users are “scary”;
  - Fear-based public education campaigns;
  - People afraid to talk about drug use; HIV; Hep C
  - People become isolated, hide their behaviour, or are not honest with families, friends or professionals, such as doctors or counsellors
"Once a junkie, always a junkie."

Cycle of Drug-Related Stigma

- Stereotypes/Labels
- Internalized & Reinforced
- Limited Opportunities
- Expectations/Roles
- Stigma

Julian Buchanan, Social Inclusion Unit, Glyndwr University, Wrexham, LL11 2AW
“Once they put it in your head so many times, you hear it over and over. It’s like a recording in your head that won’t stop. Like, “I’m a crackhead, I sell my body.” Once you keep hearing this recording over and over, this is what you start to believe. You start to believe this is what you are, and you’re worthless.”
Implications for Clients and Providers

- Willingness to access services
- Risk and behaviors
- Self-worth
- Relationships and trust
- Funding
Willingness to Access Services

- Discourages access to prevention, testing, case management, health care services.
- Feelings of shame and worthlessness also prevent people accessing treatment because they feel they are ‘not worth bothering with’.
- Don’t disclose drug use to health/social service providers; discourages disclosure of HIV/HCV status.
Risk and Behaviors

• Less likely to access prevention services; may not have equipment to keep them safer.
• Don’t get access to educational or other resources.
• Increases risk for overdose if people use alone.
• For people who can “pass”, the potential stigma means they may have even less access to services than people who are so stigmatized already that they “don’t have anything to lose”.
Self-Worth

- Less likely to make changes around reducing harmful behaviors, making other positive changes such as reducing use, finding housing or accessing medical care.
Relationships and Trust

• Assumptions are made by health and social service providers:
  – e.g., they won’t show for appointments; be adherent with treatment; follow through with referrals; abide by rules of agency

• These reinforce stigma, lower expectations, and present barriers to recovery and reintegration:
  – e.g., don’t call them back; hard to find a job
Funding

• Stigma effects political will to provide adequate funding and programs for people that use drugs, especially IDUs:
  – They’re getting HIV/HCV even with education; Shouldn’t they know better?; If they don’t care/why do we?
Drug Related Stigma

http://harmreduction.org/issues/drugs-drug-users/stigma-drug-use/
VIDEO

“Count the Costs Series: Promoting Sigma and Discrimination”

- Hungarian Civil Liberties Union

http://drogriporter.hu/en/stigma
Thinking about your own use.

- Take a few minutes by yourself to answer the following questions.
- Then discuss your responses with someone else.
- Remember to respect each other’s privacy and only share what you feel comfortable with.

Adapted from “Under the Influence”, Canadian AIDS Society, 1997
Thinking About Your Own Use

A. Working by yourself, answer the following:

1. Do you use substances? If so, where, how much, how often, for what reasons. If not, why not?

2. What did you learn about substance use when growing up?

3. What are your attitudes now about alcohol and drugs?

4. What do you experience when you see a man under the influence of a substance? A woman? Is there a difference?

5. Do you look negatively on substance users even if you have used on occasion?

6. How do you distinguish between social drinking, the use of alcohol in moderation and heavy drinking? Do others measure this differently?

B. With a partner, discuss your responses. Respect each other's privacy and share only what you feel comfortable with. Use the following questions as a guide:

1. What have you learned about your own attitudes, values and beliefs about substance use.
2. How did you feel responding to these questions?
3. How do you think your client might feel when asked questions about their substance use?
4. Have you identified any biases? If so, what can you do about them?
5. What are you most uncomfortable with?
6. Are you aware of what you do not want to share and why?
Working by yourself, answer these questions:

- Do you drink /use substances? If so, where, how much, how often, for what reasons? If not, why not?
- What did you learn about substance use when you were growing up?
- What are your attitudes now about substances?
- What do you experience when you see a man under the influence of a substance? A woman? Is there a difference?
- How do you distinguish between social drinking, the use of alcohol in moderation and heavy drinking? Do others have a different way of measuring?
• With a partner discuss your responses to part A. Respect each other’s privacy and share only what you feel comfortable with. Here are some questions to guide the discussion:
  – What have you learned about yourself regarding your attitudes, values and beliefs about substance use and sex?
  – How did you feel responding to these questions?
  – How do you think your client might feel when you ask questions about their substance use and sexuality?
  – Have you identified any biases? If yes, what can you do about them?
  – What are you most uncomfortable with?
  – Are you aware of what you do not want to share and why?
Reaching Out

Harm Reduction Programs are often the first or only contact “drug users” have with health or social service providers.
Recent Survey of IDU Programs in Ontario

• Interviews with service users of needle exchange Programs.
  – 64 individuals who access IDU outreach program services
    • Age range (teens – late 50s/60s)
  – 15 program sites across Ontario
    • (St. Catherines, Sudbury, Ottawa, Toronto, London, Kingston, Guelph, Hamilton, Brampton, Peterborough, Windsor, Thunder Bay)
      – Some communities have more than one site
Key Findings

Outreach workers:

• Listen to you
• Provide moral support
• Are someone to talk to
• Are treated like a friend
What makes the outreach program unique?

• The recurring theme of the personal relationship with outreach workers
  – Outreach workers treat you like a person
  – Outreach workers are trusted
  – Outreach workers are comfortable and friendly
Trust with outreach workers

“I am very open with xxx because he makes me feel comfortable, isn’t judgemental.”

“Family things and issues. You get a relationship going and it is easy to talk to them about anything.”

“With life problems – relationships, trouble with family, relapsing, staying clean, being stressed out, nightmares.”
Trust with outreach workers

“If I am having a rough day they get me through. Being able to talk to them. Shit [sic] doesn’t go your way. Just having them confirm and acknowledge my feelings that it is okay. You are ok. It is okay to feel how you are feeling. You are going to make it through. It is okay. Acknowledgement goes a long.”
“Other agencies I wouldn’t pour my heart out. I wouldn’t. I do feel comfortable. I can talk to them like a brother or something. I would not trust other agencies. I would be discreet.”

“If there is outreach workers, there is human contact. They will help you get better or feel better at least. They can help you change if you want it.”

“The moral support from the outreach workers [peers and staff], asking, “How are you?” and really meaning it. Your well-being. You do build a relationship. They are not judgemental. You begin to get some trust, some rapport with my outreach crew.”
“Making youth feel like people, not just trapped in drug-addicted world of poverty and depression and bring your spirits up a bit. Generally, the outreach workers, the people do that, and they come with the program.”

“You don’t have to feel ashamed that you do your drug that way. They don’t look down at you.”
Treating people with respect

“She [worker] will call/text if she [client] hasn’t been heard from in a few weeks to see if she needs anything. Nice to know that someone notices when you’re not around.”

“They are nice and open and genuinely trying to help me. Xxx enjoys talking to you and it raises your confidence. Makes you feel better and that you aren’t just a drug addict, not just a piece of shit[sic].”
Improved self-worth

“I have changed my view from looking at myself as someone who doesn’t have anything to contribute or isn’t worth anything. I see myself as someone who can put back into the community and can contribute to the community. I can look for jobs, I can find a job and contribute; even with my drug use I can still do things. It has given me back my life.”
How Does My Language Reflect My Values?

- “Drunks”, “Alcoholics” →
  - “Alcohol users”, “Individuals with Problematic Alcohol Use”
- “Drug Addicts”, “Junkies”, “Crack Heads” →
  - “People Who Use Drugs”, “Individuals Struggling with Drug Addiction”, “Active Substance Users”, “A Person Living with an Addiction”
- “Drug Abuse”, “Substance Abuse” →
  - “Drug Use”, “Problematic Substance Use”
- “Clean Needles”, “Dirty Needles”
  - “New”, “Used”
- “Hooker”, “Prostitute” →
  - “Sex Trade Worker”
Things we could do…

• Put a human face on the issue of substance use
• Train and educate professionals about substance use
• Educate the public about substance use
• Change our language
• Use art to reduce stigma
• Build on existing efforts

www.toronto.ca/health/drugstrategy/reportsandfactsheet.htm
That quote…

“I had high regard for him… until he disclosed that he used drugs… this fact… it lessened him for me.”
“The facilitator provided a great 2 days of info and, until he disclosed personal info that he himself used drugs, I had high regard for him. But I must say I do not think he needed to disclose this fact; it lessened him for me and others that I spoke to after the training felt the same way. I am glad you sent this [evaluation] out because there was many times I wanted to send an email to him letting him know this.”

- Social / Health Services worker providing feedback after a two-day workshop on HIV, Hep C, Substance Use and Harm Reduction.
Contact Us

Nick Boyce, Provincial Director
nboyce@ohsutp.ca

CC Sapp, Provincial Trainer
ccsapp@ohsutp.ca

490 Sherbourne St., 2nd Floor
Toronto, ON M4X 1K9
1-866-591-0347 (toll free)
416-703-7348 (t)
www.ohsutp.ca