Injecting drug users: A stigmatised and stigmatising population

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Abstract

Background: This paper considers the way that social stigma impacts both on injecting drug user (IDU) populations and operates within them and the consequences this has for prevention and harm reduction amongst IDUs.

Methods: The research from which this paper is drawn was a city case study, itself part of a larger national study to evaluate the efficacy of needle exchanges throughout England and Wales. Not initially part of the issues being explored, the interviews consistently pointed to concerns of stigma, and in this sense the theme was emergent from the qualitative process itself.

Results: The primary findings relating to this issue were: IDUs concern for being recognised or ‘seen’ as IDUs affected service uptake and/or their interaction with services; ‘normal’ IDUs moreover tended to stigmatise those IDUs they believed to be ‘worse’ than them – primarily the homeless – despite the fact that their own behaviour was often less than ‘responsible’ itself. In these ways ‘stigma’, whether being accepted or expressed by these different groups militated against the ‘harm reductive’ goals of Safer Injecting Services.

Conclusion: It is concluded that much can be done to reduce stigma related to IDU and drug use in general and that this may result in improved service efficacy and a reduction in associated drug related harms. It is also concluded that many IDUs seek to enhance their own self-esteem and reinforce their own sense as ‘responsible members of society’ rather than the outsiders they often feel themselves to be by attributing stigmatised behaviours on other ‘lesser’ IDUs. This practice may also contribute to them militating against their own guilt regarding their own risky behaviours, however in so doing the goal of harm reduction may be further undermined.

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Keywords: Stigma; IDU; Needle exchange; Harm reduction

Background

In recent years ‘stigma’ has been discussed in relation to various groups including those experiencing mental health problems (Angermeyer & Matschinger, 1994; Corrigan & Penn, 1999; Phelan, Link, Stueve, & Pescosolido, 2000), disability (Green, Davis, Karshmer, Marsh, & Straight, 2005) and a recorded criminal past (Cooke, 2004). As regards illicit drug use, injecting drug users and those experiencing HIV and Hepatitis it has been suggested that the attribution of, and internalisation of stigma can reduce the effectiveness of prevention and harm reduction activities: that the stigmatisation of client populations affects how they are treated and that the internalisation of stigma by the client (or potential client populations) prevents them from accessing or fully utilising the services on offer (Fitzgerald, McDonald, & Klugman, 2004; National Aids Trust, 2003).

Traditional concepts of stigma were concerned with those considered to have a ‘spoiled’ public identity (Foster, 1971) and, via the ‘looking glass self’ (Cooley, 1964, p. 184) how those stigmatised tended to internalise aspects of that spoiled identity. Stigma for Goffman (1963) relates to ‘an attribute that is deeply discrediting’ to the individual; and similarly for Schur (1971) it is a label that is applied (and accepted) that signifies that the individual deviates from that which society has deemed to be ‘normal’. Society thus responds to the attribute with ‘... interpersonal or collective reactions that serve to ‘isolate’ ‘treat’, ‘correct’, or ‘punish’ individuals engaged in such behaviour’ (Schur, 1971, p. 24). Stigma is also a means of exerting ‘social control’ (Lemert, 1972) and/or reinforcing one’s own more righteous, or less discrediting position over those undergoing stigmatisation. Stigma
does not ‘sit alone’ in its discrimination and Jones et al. (1984) for example argued that the drug use of those of low socio-economic status is more likely to be stigmatised than that of the rich and famous. Historical examples of working class drug use and the development of drug control appears to bear this out (along with that of ethnicity) to some extent (Bean, 1974; Berridge & Edwards, 1987; Coomber, 2006; Musto, 1987).

Although traditional views on stigma continue to influence current thinking (albeit often without the ‘baggage’ of social control theory) more recent discussions reinforce the dynamic nature of the process/es of stigmatisation (Link & Phelan, 2001) through a combination of labelling, stereotyping, separation, status loss and discrimination. Stigma, and the extent to which it is successfully attributed and accepted, should be understood from the unequal (social) power relations from within the context it operates. Link and Phelan note how earlier approaches viewed stigma as a mark or attribution within the person which focused attention upon the stigmatised individual. By considering stigma as ‘discrimination’ the focus is directed at those who produce rejection and exclusion (Sayce, 1998). The incorporation and use of terms such as discrimination when discussing stigma can then lead to different understandings of who is responsible for the problem of stigma, and the actions that may be taken (Sayce, 1998).

Herek (1986), Herek and Capitanio (1998) and Herek, Capitanio, and Widaman (2002) discuss stigma as being both instrumental and symbolic; possibly at one and the same time. Instrumental stigma concerns an evaluation of a given situation whereby individuals may refuse to shake the hand of an HIV/AIDS sufferer in order to protect him/herself from harm or to protect community resources. More recently Herek, Widaman, and Capitanio (2005) discuss how this stigma may be instrumentally attached to those who are assumed to present a risk to society by virtue of lifestyle; for example gay men. They may then be discriminated against.

Stigma may also be symbolic, as in when a moral judgement is made. For example HIV/AIDS suffers may be viewed as blameworthy as IDUs, unlike those ‘innocently infected’ by blood transfusions (Herek & Capitanio, 1998). Individuals then affirm their own self-concept by being able to distance themselves from ‘the problem’ and feeling justified in treating the blameworthy less advantageously.

The effects of stigma on drug users

The effects of stigma can be wide-ranging. In the public policy and health sphere the stigmatisation of specific populations may also result in the view that certain populations are less ‘worthy’ and therefore ‘less eligible’ or less ‘deserving’ of services than other groups. Fitzgerald et al. (2004) for example discuss how pain limitation for IDUs is less of a priority or indeed support services when there are other more deserving groups within the context of scarce resources. After all IDUs may be judged as having ‘chosen’ or voluntarily succumbed to the ill-effects of drug use.

The work of Fitzgerald et al. (2004) on stigma as applied to injecting drug users has particular resonance with our work, producing strong parallels as shall become evident later. In their study of how social stigma affects young drug users (IDUs) in small town Australia, Fitzgerald et al. (2004) considered the impact of drug use upon a young person’s identity. In this small town context, drug users (IDUs) quickly become ‘known’ as such. They underwent a ‘social transformation’; an extreme identity transformation, whereby they become publicly acknowledged as users (IDUs). One outcome of this process is their acceptance into using networks. Once ‘known’ as a user; many become excluded from broader social worlds, including employment opportunities (Fitzgerald et al., 2004). In contrast Fitzgerald et al. report that some users in larger places manage to maintain a dual existence, maintaining separate friendship groups amongst users and non-users. However it was much harder to conceal one’s identity in the smaller towns and new users had to quickly choose which world they wished to inhabit.

One important outcome highlighted by Fitzgerald et al. was how stigmatisation appeared to increase the likelihood of IDUs rejecting services such as Safer Injecting Services, even where this was provided by an outreach van that provided a relatively secure means of protecting their identity. Users in these circumstances reported being reluctant to arrange for the outreach service to call to their homes. They were reluctant also to buy needles from a local pharmacy as pharmacists were viewed with high levels of suspicion and as part of a network of surveillance. Indeed one recommendation that Fitzgerald et al. make (point 3.3) (2004, p. 56) is the review of practices whereby pharmacists assemble databases on IDUs’ consumption of over the counter remedies and so perform a ‘policing role’ (Sheridan et al., 2000).

Social stigma is ubiquitous (Dovidio, Kawakami, & Gaertner, 2000). Its almost universal existence suggests a ‘functional’ value or utility for the stigmatising individual him/herself, for the group from which he or she comes, for the society, or for all of these (Crocker, Major, & Steele, 1998, p. 508). Stigma can enhance the self-esteem of the stigmatising individual through processes of ‘downward comparison’ (Wills, 1981). In the ‘active’ state stigmatisers ‘create’ the disadvantage of others through discrimination (Dovidio et al., 2000). Stigmatisation may motivate inter-group comparisons. The stigmatiser, who views him/herself belonging to the in-group may feel a raised sense of self-esteem (Tajfel & Turner, 1985). In this way the development of a positive social identity (Tajfel & Turner, 1979) rests upon a process of stereotyping other groups who are judged by the attributes that the ‘in-group’ value.

Such work has resonance with a further important issue raised by Fitzgerald et al. (2004)—that of stigmatisation within the injecting drug user population. In their study they noted how non infected IDUs often passed moral judgements
upon those with Hepatitis C, viewing them as ‘not caring’, having ‘less morals’ and for being ‘irresponsible’ (48). In this case the in-group was made up of those without Hepatitis C.

That stigmatisation operates within drug using groups was commented on as early as the 1950s and 1960s where researchers referred to what they saw as the ‘propensity by drug users [sic] to derogate other drug users [sic]’ (Garfinkel, 1956, p. 420), in an attempt to raise their own status. Other early research by Sutter (1966) identified a hierarchy of injectors, facilitating one group’s ability to feel superior to another. More recently it has been noted that it is not uncommon for heroin addicted individuals to distinguish themselves from the ‘out of control dope fiend’; distancing themselves in order to remove themselves from a stigmatised category (Furst, Johnson, Dunlap, & Curtis, 1999).

Methodology

This paper is based upon research undertaken in 2005, on the barriers to effective provision of Safer Injecting Services (SIS) in a city in the far South West of England. The research was a case study off-shoot from a national needs assessment of SIS facilities in the UK, undertaken by the National Treatment Agency (NTA). The primary method of data collection used a qualitative interview for both SIS providers (community pharmacists) and injecting drug users using the service, as well as for other key persons involved with the delivery and organisation of services within the city and beyond.

SIS in the city consisted of 13 pharmacy outlets—many of which were little more than conventional ‘needle-exchanges’ (providing little more than free needles to those registered and greater/lesser degrees of flexibility around the exchange element). A primary ‘hub’ SIS provided a comprehensive Safer Injecting Service and a mobile (call-out) outreach service. Safer Injecting Services of the type provided by the ‘hub’ studied in this research include the provision of injecting support and advice; the provision of other ‘paraphernalia’ such as citric acid, swabs and the like; health checks and the return of used needles.

Interviews were undertaken with all 12 pharmacists providing needles (one pharmacist owned two outlets). Four respondents had also provided other injecting paraphernalia, with a fifth reporting that whilst she had done so in the past, she was no longer supportive of this. Four Key Personnel were interviewed. These included members of the local Drug and Alcohol Action Team, the manager of the primary ‘hub’ SIS, and the manager of the mobile (call out) outreach service.

Ninety-one injecting drug users were interviewed in total. Six IDUs were users of the outreach service as they lived in outlying (rural towns) areas. Four IDUs were steroid injectors recruited from gyms within the city; they used the hub service. At the time of the research there were approximately 2000 IDUs in Plymouth; however of these only 850 were registered with the SIS. On an average week some 450 IDUs use the SIS; however this figure may be subject to both over and undercounting as our research uncovered.

Recruitment

Seventeen (19%) IDUs were recruited from the hub SIS (including the 4 steroid injectors); 6 from the outreach service and 68 (75%) from the 13 participating pharmacies. The hub service provided researchers with rooms for interviewing, and staff approached IDUs initially to ask if they were willing to take part in the research. Outreach staff asked users beforehand if they would be willing to be interviewed and interviews took place ‘on location’. In pharmacies researchers were allowed to attend on days when pharmacists believed there would be more IDU ‘traffic’. After being introduced to the IDU (either by the receptionist/assistant or the pharmacist) and gaining agreement to be interviewed, the researcher either used an available room at the pharmacy for private interviews, used other local premises, or, very occasionally the researcher’s car. Very few IDUs declined the opportunity to take part in the research and all respondents received a £5 reciprocal payment for their time.

Sample characteristics

The mean age of IDUs interviewed was 32 years. Sixteen percent were between 18 and 25 years of age. Fifty percent were between 26 and 34 and 33% were over 35 years of age. Almost three quarters of the sample was male (73%). The sample reflected the largely White English population resident in the West of England with 96% (87) self-referring as ‘White British’. Three IDUs referred themselves as being ‘White Irish’, ‘White Scottish’ and of ‘dual heritage’, respectively.

The sample was a relatively experienced one, as injecting drug users and in using needle exchanges/SISs. The mean length of time that the main sample had used a needle exchange was 7.7 years whilst those using the outreach service had on average 10 years service use and the steroid users only 3 years.

A minority of the sample reported being in employment: nine (10%) IDUs said they were employed full time and two part-time. Three of the four steroid injectors were employed. Six IDUs (7%) reported being homeless, although it was clear that more lived in relatively unstable conditions.

Emergent themes

We did not specifically question pharmacists or drug users about the issue of ‘stigma’. However, in talking to pharmacists, comments that we interpreted as ‘stigma’ arose when we asked whether their staff or the local community opposed the running of needle exchanges. We also found that some
pharmacists stigmatised IDUs en masse, assuming them to be intent upon shoplifting for example. This occurred when we asked for their perceptions of problems that may arise for them in running a needle exchange.

When we talked to IDUs the issue of stigma arose, or comments that we interpreted as such, when we asked for their perceptions of problems arising for them in using the needle exchange; whether initially or at the time of the research. This was a common point at which IDUs, if they were going to talk about feeling stigmatised, actually did so.

Not all IDUs expressed feelings of being judged negatively by pharmacists, their staff and the community at large. Clearly, it may be that some users either were not sensitive to judgements being made or if they were they could not verbalise their sensitivity.

We found also that IDUs stigmatised others within the IDU population. This occurred when IDUs were asked whether they themselves shared needles or knew people who shared. In these ways the issue of stigma flowed from the more open ended responses that were made by both pharmacists and IDUs, and from the thematic analysis and ongoing reflective process that we, as researchers, engaged in as the study developed.

Findings

Stigma from the needle exchanges: what pharmacists had to say

A number of community SIS (three pharmacies) were provided by ‘independent’ pharmacists, that is those who owned their own businesses; however the majority were part of a regional or national chain (‘non-independent’). We found ‘independent’ pharmacists to be more unconditionally supportive of the goal of harm reduction; that is they saw the benefits of providing the SIS even though difficulties arose in so doing. They tended to view the needs of IDUs as no less than the ‘ordinary’ customer and were less likely to stigmatise IDUs, tending to offer a professional but friendly service, for example calling users by name and/or offering medical advice.

In ‘non-independent’ venues pharmacists were more likely to be ‘conditionally’ supportive of harm reduction; for example they did not wish to go beyond providing the bare essentials (clean needles versus other drug using paraphernalia) and providing IDUs ‘behaved’ themselves. In addition this approach tended to trickle down to shopfloor staff. In these pharmacies shopfloor staff were also likely to be less tolerant and less supportive of harm reduction per se. Thus in one venue, shopfloor staff questioned IDUs’ eligibility for support given their ‘welfare dependence’. They also called for a ‘three strikes and you’re out’ approach to users viewed as abusing treatment programmes by continuing to use street drugs. This resonated with the earlier controlling/policing role that community pharmacists had adopted (Matheson, Bond, & Mollinson, 1999; Sheridan et al., 2000) and indicates more limited support for harm reduction.

However, pharmacists and their staff did not always fall neatly into groupings of those who were more or less tolerant. Pharmacists who appeared ‘less tolerant’ were not consistently so, whilst those initially perceived by researchers as fully supportive of IDUs and ‘harm reduction’ were at times negative and stigmatising.

Some pharmacists viewed IDUs as ‘undesirable, scary and undeserving’ and likely to be ‘dodgy’ and/or shoplifters. They feared losing ‘general customers’ who may be frightened by IDUs, viewing the former’s needs as legitimate and as ‘priority’. IDUs were viewed as overly demanding if they requested other drugs paraphernalia such as citric acid or sterile swabs, thus notions of ‘less eligibility’ arose (Fitzgerald et al., 2004). They also discussed pharmacists who chose not to run SIS, assuming this was a moral stance or a rational judgement given their own customers’ reactions to IDUs. The extent to which such stigmatisation was discriminatory was raised, a point which Link and Phelan (2001) discuss.

Even where pharmacists appreciated the embarrassment and fear of recognition that IDUs experienced (Fitzgerald et al., 2004), they still expressed negative views. They discussed their staff feeling ‘threatened’, ‘scared’, morally judgemental and resentful of wasting resources on the undeserving. They also discussed staff fears concerning potential infection. Even where pharmacists themselves were supportive of SIS, their staff may not share those views, or indeed locums who from time to time support local pharmacies.

Stigma from needle exchanges: what IDUs had to say

Clearly, in talking to IDUs it became obvious that they did pick up on stigma from pharmacists and their support staff.

... you know they think you’re a thief and you know you can see sometimes when people notice and like people working in chemists ... you know it was like a look of shock as if to say ... they keep an eye on you, you know, embarrassing. (41-year-old male IDU)

This type of comment mirrors evidence collected from pharmacists. In addition, users said that it was not always the pharmacists themselves who stigmatised them, but their staff. This was clearly a community pharmacy issue as it did not occur within the dedicated drugs agency operating in the area. IDUs spoke of stigma arising in both urban and rural pharmacies, with the fear of stigma being greater for those living in smaller communities. Even in the city, some users would not use particular pharmacies where they felt too uncomfortable, fearing a lack of discretion on the part of staff.

... they don’t smile at you or nothing, know what I mean, ... if you’re in there with other people and that, customers,
you don’t know what they’re going to say and you feel uncomfortable. (24-year-old female IDU)

However one IDU noted how on using the SIS a few times, that the sense of stigma reduced.

... once they’ve seen your face a few times, they’re more relaxed and you can have a general chat about the day and it’s not a problem. (33-year-old male IDU)

The hub SIS and its outreach service was viewed as being non-judgemental, in contrast to community pharmacies where ‘helpfulness’ was concerned.

I’d say that there’s people in the outreach that are basically a lot more understanding and helpful. It seems more of a chore for the people in the chemist. (37-year-old male IDU)

Stigma: from other health and related professionals

IDUs identified stigma from other professionals, such as Social Services. One young female IDU felt judged as being a bad mother. She felt the need to ‘prove herself’ in order to displace the label and regain custody of her children. This labelling of women as ‘bad’ mothers’ resonates with Thetford’s (2004) work on mothers with Hepatitis C.

Two IDUs felt stigmatised by the National Health Service.

... I’ve even tried A & E at weekends. They won’t give them to you. They ostracise you because you are a junkie. (36-year-old male IDU)

Steroid users recognised the potential for stigma in using anabolic steroids. They were sceptical about developments for gyms locally to provide clean needles.

... there would be a lot of gyms that won’t want to do that because big fitness health clubs are not going to advertise the fact they allow steroid people to use their gyms but a lot of smaller ones would ... (25-year-old male ISU)

Stigma: from the community

A number of pharmacists explained how local residents were opposed to needle exchanges, and how they complained.

Oh people come in and ask to see me quietly and say that I’m encouraging drug use ... that the exchange doesn’t work ... and they are going to report me to the police ... the local councillor. (Pharmacist 10)

Both pharmacists and IDUs described stigma from general pharmacy customers. Pharmacists felt customers resented IDUs being given needles freely, when those suffering from diabetes are charged. Users were viewed as less deserving because their need resulted from ‘addictive life choices’ rather than the perils of ‘random’ health failure. Approximately half of the pharmacists (7 out of 12) stated that ‘general’ customers did not like IDUs using the pharmacy.

Some can get verbal about it ... they actually talk in the shop ... you get some people that you can tell they are not happy with the situation. (Pharmacist 3)

IDUs were aware of stigma from general customers and the lack of privacy when using the SIS was a problem. Users were concerned about being labelled as criminals and being ostracised by their local community, and effectively moved on.

... you should be able to go get them [clean needles] without people knowing because some people are malicious and they like, will try and get you kicked out of your property or something. (24-year-old female IDU)

Users often devised coping strategies, such as waiting until the pharmacy was empty.

Yeah, yeah I go out the shop and have a fag ... (26-year-old female IDU)

Stigma within the IDU population

Here we discuss IDUs’ own sense of stigma, resulting from their feelings of ‘wrong-doing’ or ‘deviance’, and from the verbal and non-verbal judgements of other customers and staff. The sense of stigma was particularly evident for injecting users of anabolic steroids, and for IDUs living in outlying areas. For both groups, being recognised was a particular problem, as it was anyway for those living in the urban environment. This research therefore challenges the commonsense view of IDUs as people who have little regard for what others may think about their behaviour.

Approximately half of the sample (41 out of 85 transcribed interviews) felt stigmatised when using SIS, particularly for the first time. For some, this sense of stigma continues.

The general sense of stigma and fear of recognition

A substantial theme was the general sense of stigma, shame or embarrassment at being an injecting drug user and in accessing SIS. Steroid injectors were particularly concerned at what others may think of them, they did not wish to be ‘mistaken’ for example as a ‘junkie’.

The fear of being recognised was particularly worrying for IDUs living in outlying areas, as communities tend to be closer knit. This resonated with Fitzgerald et al., 2004). The outreach services users who we spoke to were extremely reluctant to use pharmacies in their own areas, even if SIS provision were to be made available.
... I wouldn’t like to use the chemist out here. It’d be around the village in no time... It’s bad enough me going in there for my prescription. ... I just like to keep my anonymity and you can do that in a big place. (31-year-old female IDU)

**Stigma: hierarchies within the IDU population**

Here we discuss how stigma flows hierarchically through the IDU population. We do this by looking at the perceived behaviour of particular types of IDU. Thus users who perceive themselves to behave ‘responsibly’, judge and stigmatise those who they perceive do not, drawing upon the notion of attribution (Baskind & Birbeck, 2005).

**Responsible vs. irresponsible behaviour**

The homeless IDU was viewed as being at the bottom of the pile due to ‘irresponsibly’ sharing and disposing of needles. The main reason ‘responsible’ IDUs gave for sharing needles was laziness; or users not caring enough about themselves to access clean needles and feeling ‘worthless’. The implication was that this would lead to risky behaviour. By implication, those who claimed not to share experienced a greater sense of self-esteem which was underpinned by passing such judgements.

It’s either laziness or yeah... or it’s just... not being able to wait and when we walk half a mile to get some more. If it was a choice of a like use a dirty needle and have the drug now or wait half an hour and walk half a mile. A lot of people don’t wait. (33-year-old male IDU)

Sharing was viewed as something that is done by ‘dirty’, lazy people who had ‘given up’—nothing like themselves. Again, homeless people were identified as more likely to share or dispose of needles irresponsibly.

... if they are off the drugs they’re going to want a dig there and then do you know what I mean? Like if it’s not clean they don’t care and I need my drugs kind of thing... (32-year-old male IDU)

... they’ll [the homeless] inject on the streets and they’ll just won’t even bother to pack up their pin and throw it on the floor. (19-year-old female IDU)

This judgement was based upon a view of ‘what homeless people are like’, with no account taken of the barriers they face in using SIS. For those resident in hostels, ownership of any drug paraphernalia, including the Sharps Bins used for the safe return of used needles to the SIS, was grounds for eviction. Pharmacists were also reluctant to receive used needles that were not contained in this way (Coomber & Simmonds, 2005), again with little awareness for the obstacles that homeless people face. In addition, a number of homeless IDUs thought they were more likely to be stopped by the police anyway, and so were wary of the evidential implications of being found in possession of a Sharps Bin, or ‘sin bin’ as they are more colloquially known.

Negative judgements of the homeless were promoted, even though respondents may themselves have shared needles at an earlier stage, or indeed continued to do so in some form or another (irregularly or accidentally since). For some, sharing with a partner was not considered as ‘real’ sharing. IDUs reporting sharing with a current partner (albeit occasionally) still castigated those who share, particularly the homeless who ‘don’t care’.

One user, who herself had been quick to judge homeless people as more likely to behave irresponsibly, realised that the system for re-using needles which she and her partner had adopted was potentially flawed.

... that’ll be right underneath the tin and I’ll choose one of the top ones. You know when they say How did you realise? Actually I was stupid with it all really. It’s only when you actually say it out loud that you think, because in your head you think Oh it’s alright, it’s OK, well I know that’s mine – but when you’re explaining to someone like if someone was explaining to me I’d think I’d sit there like ah what you doing, you know, it’ll raise our awareness of it, what we’re doing like... (32-year-old female IDU)

We found evidence that being homeless was not necessarily a function of sharing or of disposing of needles irresponsibly.

... well every time I use a needle I’ll always clean it after I’ve used it so if I ever run out I’ll just go back and use one of the ones that I have used before. (36-year-old homeless male IDU)

The respondent was scathing of users who shared needles. Another homeless IDU told us how he always returned his dirty needles, even though he was living in a car park.

I’ve been given a sin bin by... so I fill that up and take it back. (29-year-old male IDU)

IDUs admitted disposing of needles in an unsafe manner, even though they were not homeless. One IDU was reluctant to return needles to the pharmacy. He described how he disposed of them, but also noted how pharmacies in other areas encouraged returns.

... every person I know that uses that needle exchange I have never seen one bring any needles back and I’m not going to be the first one to ask... I get rid of them on my own. I put them in – I don’t know if I am doing wrong – the recycle plastic – but it’s got a danger thing on the actual sin bin... but in London you can not get any needles without...
bringing your old ones along. And I think that’s a good idea. (35-year-old male IDU)

Although ‘normal’ (non-sharers and/or non-homeless) IDUs were judgemental towards sharers and/or homeless IDUs, this did not mean that they themselves always behaved responsibly. Some admitted to sharing needles in both the past and present. This was the case for steroid injectors who were particularly keen to distance themselves from IDUs who use street drugs such as heroin.

**Steroid users vs. ‘junkies’**

Two broad issues were clear in talking to steroid users. Firstly they feel ‘different’ from other injecting drug users and are anxious not to be misconstrued as a ‘junkie’, either by health professionals or their non-injecting peers. Secondly they view the drugs they use as creating this difference. They do not experience ‘dependence’ and ‘withdrawal’, unlike heroin users; thus, in their view they are not driven to share needles or to commit crime to feed their habit. In these ways steroid users were able to resist the label of junkie, perceiving themselves to be ‘ordinary’ or ‘normal’ people’. In this sense they managed a ‘dual existence’, as Fitzgerald et al. (2004) discussed in their study of IDUs in small town Australia.

I was actually quite chuffed when they asked are you here for steroids are you a steroid user by any chance, so that kind of cheered me up a bit that he knew I was there for steroids. . . . I thought he knows that I’m doing that then and I’m not a smackhead or anything. . . . I wanted him to know . . . know that I was just an ordinary normal person and haven’t got problems. (29-year-old male ISU)

Steroid users felt quite different because of the type of drug involved. They would not therefore need to share needles.

I don’t think anybody who does steroids shares needles. . . . when you’re a completely high druggie, you’ll share anything because you don’t care. But steroid users they just want the injection they are quite happy to wait an extra day if they have to. . . . If you are a hard drug user who’s injecting heroin, you probably couldn’t give two shits whether or not you are going to use the same needle . . . because you’re on a high and you’re just having another fix . . . (25-year-old male ISU)

**Discussion**

This research reports the real effects of stigma from professionals and the public, in terms of service uptake and IDUs ‘qualitative’ experience. However an equally important finding, in our view, was that IDUs stigmatised other (in their view) ‘lesser’ IDUs. Although this was evident from the steroid injecting drug user who chose to separate their behaviour from that of the ‘junkie’ heroin IDU, in terms of an aggregated impact on risky behaviour, it is the ‘normal’ IDU who looked down on the homeless and other ‘lesser’ IDUs that presented the most problematic form of stigma. Here, supposedly responsible IDUs (not engaging in risky behaviours such as needle sharing) condemned risky behaviour as likely to be carried out by lesser ‘others’—the lazy, the homeless and those that simply ‘don’t care’. The real issue here is that stigma is being used as a mechanism (as it often is) to displace acknowledgement of their own risky behaviour (which was evident) by focussing on the behaviour of others—others not like them but worse in definable ways (Wills, 1981). By doing this they often ignored the risky behaviour they themselves practised because there were IDUs ‘out there’ who were far worse, doing far worse things—in comparison they had little or less to be concerned about! The operationalisation of stigma against other IDUs was thus, ironically, working against this population in the sense that they could be less scrupulous about their own behaviour and thus put themselves at greater risk.

This research then shows how stigma operates negatively and impacts both against and within the IDU population. Further, our findings concerning this phenomenon support (albeit in a different context) what others (e.g. Fitzgerald et al., 2004) have also reported in relation to injecting drug users.

We found that some IDUs were able to maintain a dual existence in hiding their drug use from their local community (Fitzgerald et al., 2004). Those with young families viewed this as imperative. They didn’t want their children to be exposed to drug use in daily life, or by the research process. Steroid users particularly maintained dual lives as ‘normal’ guys who are also injecting drug users. Their drive to reject any label as to being a ‘junkie’ or ‘smackhead’ was very strong (Monaghan, 1999; Monaghan, Bloor, Dobash, & Dobash, 2000).

The embarrassment and shame that IDUs reported drew strong parallels with Cooley’s (1964) conception of the looking glass self; respondents sensed negative judgements from pharmacists and other customers which they tended to accept (or internalise). Even steroid users experienced this on beginning to inject, viewing injecting as ‘something that hard drug users do’. We also discovered the double jeopardy that certain drug users face; mothers who use, or homeless people who use drugs. Indeed the latter have little means by which to hide either their homeless or drug injecting identities.

Homeless people were at an unfortunate disadvantage in relation to being stigmatised, not only by professionals but by other IDUs. They were less likely to be able to return their needles to pharmacies and, by virtue of dress standards, were more likely to be thought of as ‘homeless and up to no good’. They were also more likely to be identified as ‘irresponsible’ by other IDUs, for example sharing and discarding needles unsafely. This was so even though non-homeless respondents had often—at some point—shared needles and certainly other paraphernalia. IDUs perceiving themselves to be responsible (the non-homeless/non-sharers), were also found to dispose
of needles unsafely, some quite regularly. This attribution was used by those who perceived themselves to be responsible (supposed non-sharers and safe disposers of needles) as a means of distancing themselves from ‘the irresponsible’ (Furst et al., 1999).

We also view this as their way of minimising the extent of their deviancy or difference by removing themselves from a heavily stigmatised category (Furst et al., 1999) and they were therefore at pains to deny being a needle sharer and the connotations that this may hold. The stigma attributed may also draw upon the notion of ingroups and outgroups (Tajfel & Turner, 1979), such that non-homeless and steroid users could feel an enhanced sense of self-esteem, both individually and collectively (Dovidio et al., 2000) at the cost of those they stigmatise.

Stigma raises a range of negative implications for individuals and their sense of well being, in terms of low self-esteem and motivation. Indeed we would also strongly suspect that receiving a continually negative judgement, one that does not separate the whole person from activities in which they engage, cannot aid or drive an individual away from drug use. In addition it may increase the risk environment in which they are located (Rhodes, Singer, Bourgois, Friedman, & Stratthdee, 2005).

Stigma therefore holds very real negative implications for harm reduction policy, as IDUs may feel too embarrassed to use the needle exchange service due to the reactions of professionals and the public. They may completely reject the service; delay using or as Scambler (1989) noted, take steps to avoid enactments of stigma. At worst this may mean not accessing clean needles with the greater likelihood of risky sharing ensuing. We were concerned that IDUs in outlying areas felt even more at risk of such stigma, within smaller, close knit communities. Even if a service had been available, they may still be reluctant to use them. At the same time they were sensitive to the stigma expressed towards them within city centre pharmacies.

The effects of stigma on IDU populations are sufficiently far-reaching for health care providers and others whose remit it is to reduce the harms emanating from injecting drug use, to seriously consider its impact, its production and how best to address the problems it causes. This research has shown that stigma has many facets and can impact upon individuals and groups differentially. Those types of stigma that fit with conventional understanding of the concept – where so-called ‘normal’ members of society look down on others – were found to be prevalent, to varying degrees, amongst most of the pharmacy outlets but absent from the hub service whose very raison d’être is harm reduction.

The relatively independent community pharmacy services often employed staff who lived locally and who often had little, if any, sympathy with harm reduction philosophy and practice. Even where pharmacists were more wedded to harm reduction activity, when it came to IDUs they often felt that the provision of other injecting paraphernalia was a ‘step too far’ for this ‘undeserving’ population. The outcomes of this felt stigma, in real terms for IDUs, was for many an initial delay in accessing the service; the tendency to move between service providers (and thus interruption in provision); a belief (borne out by our outreach sample) that non-service users avoided needle exchanges through fear of being recognised and the (negative) consequences that could follow-on from this in their community. Each of these issues was in turn exacerbated by the structural conditions within which the pharmacies (as opposed to the hub and outreach service) operated their needle exchanges: usually sited in full view of the public and other IDUs.

What can be done?

Reducing some types and levels of stigma for SIS users may not be as difficult as first appears. One of the findings from the original research (Coomber & Simmonds, 2005) was that IDUs found using the same shopfloor as general pharmacy customers embarrassing. This was particularly true for those based in outlying (e.g. small town) areas. The hub service by contrast suffered from relatively few problems regarding user fear of recognition or labelling.

A preferred situation would be for the hub service to have many more small satellite SIS bases spread around in relatively discrete accommodation. IDUs would not meet other members of the public, but would also avoid other IDUs as well. Given the resource driven nature of this proposal, a more practical response – at least in the short term – would be for some pharmacies to be encouraged to alter their premises/activities. IDUs could be accommodated with little contact with other customers/IDUs. Some pharmacies in the UK for example have one door for SIS customers and the ‘normal’ shop door for everyone else. This is a start, although for pharmacies on busy streets the use of separate entrances may signal even more clearly who is an IDU. In the longer run, thought (and resources) are required to provide accessible SISs that address both the structural–physical setting (buildings; location; procedures for giving needles and other injecting paraphernalia and receiving needles, etc.) that encourage stigma as well as the psycho-social environment (staff attitudes; restrictive policies determined by pharmacy/staff prejudice).

The attitudes of staff and pharmacists can be addressed – in part at least – by more training to promote the realisation that harm reduction activity is not primarily about the IDU, but that it is a broader Public Health issue. Indeed an encouraging attitude towards IDUs has a wider pay-off for them, their families and their community. Most pharmacists have rudimentary training in such issues, with little training for staff. Training such as this could highlight the danger of age old judgements as to ‘eligibility’ (Fitzgerald et al., 2004), particularly relating to supplying other drug paraphernalia or viewing IDUs’ need for their service as illegitimate in contrast to those who are ‘really ill’. Staff who are resistant should, in the medium term, be asked to re-assess their commitment to
the pharmacy. Alternatively the hub service or the DAAT may consider relocating the SIS. Progressive pharmacy SISs also need to seek ways to communicate to IDUs that they were welcome and will not be treated poorly. In areas where there is little pharmacy uptake and/or where it is combined with a less than welcoming attitude the strategic aim for the local DAAT should be the establishment of appropriate services rather than simply accepting that some areas are ‘difficult’. A further alternative to hub satellites is an increase of confidential outreach activity and possibly the provision of vending machines to supply injecting equipment/paraphernalia in secure areas, giving 24/7 availability.

More ‘specialist groups’ such as steroid users perceive stigma from non-injectors such as the other gym users (Monaghan, 1999). They also fear being recognised when using the SIS, indeed none of our sample used community pharmacies and were fairly reticent about attending the dedicated Safer Injecting Service where we interviewed them. The idea of gyms providing more by way of a needle exchange has been mooted, and perhaps the time is ripe for this to be driven forward.

Reducing stigma from ‘normal’ IDUs onto ‘lessor’ IDUs is less necessary (though desirable) to help moderate risky behaviour that is otherwise being ignored as falling outside or peripheral to (that which is perceived as) the more serious risk of straight-forward needle sharing. Harm reduction intervention needs to focus—and be successful in getting its message across that sharing of paraphernalia; allowing access to stick bins; sharing with partners, however occasionally, all represent serious, short and long term, risky behaviour that cannot be separated from more overt forms of needle sharing.

The IDUs interviewed testified to feeling stigmatised by professionals and the public alike, resulting in their involvement in risky behaviour. The fact that they did not pick up on judgements from within the injecting population, for example homeless IDUs, reinforces the view that stigma is located within power relations (Link & Phelan, 2001). How-ever whilst the more explicitly expressed stigma is dangerous, so is that which operates less visibly (that is from IDU to IDU). The stigma reported in this research, from whatever source, has negative implications for IDUs themselves but also, as noted, for the community as a whole.


