Understanding Drug-Related Stigma

Tools for Better Practice and Social Change

Curriculum Outline for Trainers

Developed by the Harm Reduction Coalition
for the New York State Department of Health AIDS Institute

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Acknowledgments

Produced by:

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About the Harm Reduction Coalition:
The Harm Reduction Coalition is a national advocacy and capacity-building organization that promotes the health and dignity of individuals and communities impacted by drug use. HRC advances policies and programs that help people address the adverse effects of drug use including overdose, HIV, hepatitis C, addiction, and incarceration. We recognize that the structures of social inequality impact the lives and options of affected communities differently, and work to uphold every individual's right to health and well-being, as well as in their competence to protect themselves, their loved ones, and their communities.

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Training Materials:

Participant Workbook

TRAINING RATIONALE AND OVERVIEW

Training Length

Half-day (3 hours)

Training Goal

This half day training will give participants a distinct set of knowledge and skills to help them understand and address drug-related stigma.

Training Objectives

Upon completion of this training, participants will:

- Recall the meaning of stigma, discrimination and related concepts, finding personal relevance in these terms through workshop discussion and activities.
- Identify the various ways in which drug users experience stigma through collective brainstorm and discussion.
- Explore key sources of pre-existing stigma and discrimination, including positive and negatives stereotypes of drug users.
- Identify consequences of drug-related stigma on drug users' willingness and ability to access services.
- Consider ways to address stigma at individual and agency levels.
- Gain conceptual and practical tools toward developing attitudes and environments that challenge stigma and support drug users' needs.

Training Rationale

For individuals who use or have a history of using drugs, the impact of stigma can permeate nearly every aspect of their life – including relationships with family, friends, employers and health care providers. While a great number of expectations are often placed on drug users to change their behaviors, the social context that creates and reinforces drug-related stigma is rarely explored or further - challenged. A greater understanding of ways in which internalized stigma can lead to harmful behaviors is valuable in working more effectively with drug using clients. In addition, through evaluation of one's own potential role in perpetuating drug-related stigma, providers can develop new strategies for building more authentic and more productive relationships with clients.

**** Key point ****

This training will highlight issues more often present among drug users who are disenfranchised or otherwise vulnerable (due to homelessness, economic status, etc). The writers in no way presume that there is a single drug user experience. While every effort was made to make overall themes broadly relevant, there may be examples or issues that do not apply to all drug users.

Prerequisite

There is no pre-requisite for this training, though familiarity with the principles of harm reduction perspective may be useful.

Audience

This training is relevant for community-based direct service staff, caseworkers, therapists, peer advocates, program administrators, medical providers, and all who are interested in understanding and addressing drug-related stigma.

Course Outline At-a-Glance – 3 hours

Module 1: Values Clarification and Introduction (40 minutes)

Values Clarification ***Activity****: Statement Evaluation – 10 minutes*
Participant and Trainer Introductions – 10 minutes
Goals, Expectations and Guidelines – 10 minutes
Quotes ***Activity*** *– 10 minutes*

Module 2: What is Stigma? (20 minutes)

Basic Principles
Stigma Definition
Activity*: Forms of Stigma*

- Recall the meaning of stigma, discrimination and related concepts, finding personal relevance in these terms through workshop discussion and activities.

Module 3: Understanding Drug-Related Stigma (30 minutes)

Elements of Drug-Related Stigma
Cycle and Reach of Drug-Related Stigma
Implications for Providers

- Identify the various ways in which drug users experience stigma through collective brainstorm and discussion.
- Explore key sources of pre-existing stigma and discrimination, including positive and negatives stereotypes of drug users.
- Identify consequences of drug-related stigma on drug users' willingness and ability to access services.

- 10 minute BREAK -

Module 4: Exploring Labels and Language (25 minutes)

Activity*: Video Critique*
Drug User Labels
Considering Language

- Explore key sources of pre-existing stigma and discrimination, including positive and negatives stereotypes of drug users.
- Consider ways to address stigma at individual and agency levels.

Module 5: Dynamics of Stigma (35 minutes)

3 *Functions of Stigma*
Activity*: 3Ds - Dynamics of Stigma*

- Explore three functions of stigma.
- Identify consequences of drug-related stigma on drug users' willingness and ability to access services.

Module 6: Challenging Stigma, Creating Change (10 minutes)

Individual-Level Change
Staff- and Community-Level Change

- Gain conceptual and practical tools toward the development of attitudes and environments that challenge stigma and support drug users' needs.

Module 7: Closing and Evaluations (10 minutes)

Learning review

Evaluations

Course Preparation

What is Harm Reduction?

Guiding Principles

Harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence. Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself.

Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction. However, HRC considers the following principles central to harm reduction practice.

- Accepts – for better and for worse – that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being--not necessarily cessation of all drug use--as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, homophobia, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

Key Issues for Trainers of *Understanding Drug-Related Stigma*

Creating a Positive Learning Environment

Learning takes place best in environments where people feel safe and relaxed. This workshop relies on active participation from workshop attendees; therefore it is important to create a comfortable space in which participants feel open to the process of learning and sharing.

Food is good for the mind and the body! If possible, provide snacks and/or coffee or soda, not only as a comfort, but also to provide energy and engagement. Participants also feel valued when they receive these kinds of offerings.

When deciding where to hold the workshop, choose a space that is comfortable – be mindful of issues such as accessibility, natural light, room size, room set-up (including table/chair arrangement), comfort of the chairs, temperature of the room, and other related issues. Welcome individual participants as they arrive, introducing yourself.

Establishing Guidelines

Given the time constraints of this training session, it is not possible to develop guidelines for the training as a group exercise; however, it can still be valuable to propose certain guideline and have the group agree upon (or challenge) them, and to give participants an opportunity to propose other guidelines.

Some suggested guidelines include, but are not limited to:

Step up, step back
- This refers to encouraging participants to be mindful that if they have a tendency to speak up more often, perhaps they step back, listen and give others a chance to speak, while those who may have a tendency to sit back and stay quiet, step up and challenge themselves to share and speak up.

Non-judgment and respect for ideas
- This refers to keeping an open mind and accepting that everyone's ideas and experiences are valid and have a place in the training, which is a safe place for people to share and grow their ideas.

There are no right or wrong answers.
- This again, refers to the safety to share any thoughts or ideas – encouraging brainstorm and participation with the knowledge that any contribution can be valuable and presents opportunity for learning.

Talk with each other not at each other.
- This refers to the idea that discussions, even about ideas that may be conflicting or challenging, be a respectful exchange of ideas that respects a mutual process of dialogue.

Confidentiality
- This refers to keeping personal information that is shared as part of the training to oneself. Trainings can and should be a safe place for people to share experiences, stories and thoughts and this can be compromised if people do not feel secure that their information will not be respected and kept private. Of course, many of the ideas and concepts in the training are meant to be shared widely; however, this is not the case with personal stories. This can be especially important when there are multiple people from the same agency or organization present.

Solicit Frequent Participant Feedback and Engagement

This curriculum relies on the trainer to create an environment that will promote participation, feedback and excitement from participants. Open-ended questions and probing statements are valuable tools for soliciting additional discussion. The trainer should be comfortable working with drug users and familiar with the issues discussed in the workshop. It is important that the trainer have the skills necessary to generate discussion and move conversations forward in small-to-larger group settings, even around issues that may be sensitive. It will also be necessary for the trainer to balance different perspectives and articulate main points in order to make the entire session useful for all participants. Trainers should be mindful of language and

comprehension throughout the session, avoiding complicated medical jargon or other terminology that may be difficult for everyone to understand.

Making workshops personally relevant

Thorough planning before a workshop is important in order to get a good grasp on the material covered in the training, as well as to connect with it personally. A good trainer is one that will be able to translate their own interest and investment in an issue to the audience, and who will also be able to effectively communicate why the information is relevant to training participants. Using case examples from one's own experience, or stories from people you know, can be a valuable tool in broadening participant understanding and investment in concepts and ideas explored in the session. *Take time before the session to think about as many examples as possible, understanding that while they may not all be used or shared, they will be available in your toolkit as another means of expressing ideas and explaining concepts.*

Using Power Point

Use slides as a guide, but speak about information that you understand.

The workshop is not scripted although suggestions are offered with regards to key points, communicating important information and general facilitation techniques.

Context is offered on main points to assist trainers in preparing for discussion. Trainers are encouraged to be creative in the presentation of material, using the text and notes offered in this guide as a reference. ***I***t is important to have explored the ideas thoroughly in advance to prepare for issues that may be more or less relevant to different participant groups. *People will have copies of the presentation – there is no need to read every word.*

Preparation and Supplies

Prepare the following materials for distribution to participants:

- Participant Workbook
- Training Evaluations

It will also be necessary to prepare for the various exercises in the workshop, including:

- **Quotes** – copied and cut into individual quotes ***(see page 53)***
- Labeled **flip chart paper** for group exercises
- Ensure access to a **DVD** player, internet and/or QuickTime for playing video

Module One: Values Clarification and Introductions

The goals of this module are to:

- Introduce participants to training goals and provide background on why the training was developed.
- Introduce training participants and trainers to one another.
- Encourage active participation and engage in values clarification.
- Develop a common harm reduction framework within which to frame the session.

Objectives

Upon completing this module, participants will be able to:

- Identify why the training was developed.
- Outline the goals and objectives for the training.
- Describe the range of participants taking part in the training.
- Understand some basic principles about drug use from a harm reduction perspective.

Time

40 minutes total

Materials

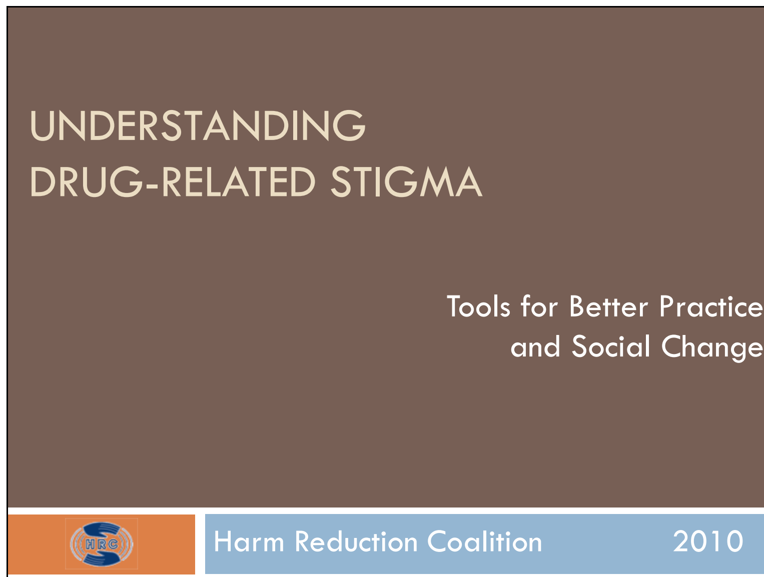
- ***Individual quotes for distribution***
- ***Participant Workbook***
- ***Sign-in sheet***
- Clock
- PowerPoint Slides
- Newsprint/flip chart/large paper
- Markers
- Tape for newsprint

PREPARATION: Setting up the room

1) *Make sure that each participant receives a participant workbook.*

2) *Place the sign-in sheet near the entrance to the room.*

3) *Place the individual quotes for the* ***Quotes exercise in a bowl or bag near the sign-in sheet*** ***(see page 15).***



Format: *Activity*

Slide Purpose: *To state the name of the training and provide a platform for welcoming participants.*

- Welcome the group and introduce yourself. Consider giving some details about your background and experience, why you wanted to do this training, etc.
- Ask everyone to sign the sign-in sheet and go over any training logistics.
- Ask if everyone received a quote (for the quote exercise on page 15). If not, pass the quotes around.
- Explain that you would like to ask participants do an exercise **first thing**, also letting people know that you will facilitate group introductions after the exercise.

<u>Anonymous Survey Exercise</u>

- Ask people to turn to **page 9** in their workbooks.
- This survey is to be used as a values clarification and to get people thinking about the issues.
- Ask people to silently reflect on each statement. Emphasize that there are no right or wrong answers, and that this is not a test. Explain that they can fill out the survey if they want to, or they can keep their responses/thoughts in their head. After people have had a few moments to read the statements, ask any or all of the following questions to probe additional discussion:

    a. How did it feel to think about the statements?
    b. Were there any statements that you got stuck on, or had a harder time with?

c. Were there statements that didn't make sense to you?
d. Were there statements that statements that were more (or less) meaningful for you?

- After a brief discussion, explain that this exercise was done to get people thinking about some of the ideas that will shape our discussion today, and about some of the values that can be pushed and pulled when it comes to discussions around drug use and health care. Take notes as needed on the newsprint.

  Thank the group for their participation.

ANONYMOUS SURVEY

Consider the following statement. Either in your head or on paper mark the box that most accurately reflects your response to the statements below.

Please do not put your name on this paper.
There are no right or wrong answers and these papers will not be collected.

Statement	***Strongly Agree***	***Agree***	***Disagree***	***Strongly Disagree***
Although I don't necessarily agree with them, sometimes I have prejudiced feelings (like gut reactions or spontaneous thoughts) toward drug users that I don't feel I can prevent.				
I understand the experience of being stigmatized as a drug user.				
Sometimes I am uncomfortable around people who are very different from me.				
It is not appropriate for me to talk about my drug and alcohol use with clients.				
I trust drug users just as much as I trust non-drug users.				
If a woman is pregnant, she has a responsibility to stop taking drugs.				
Drug users have a difficult time practicing safe sex consistently.				
Drug users have meaningful participation in developing policies and programs at my organization.				
I know how to avoid language that stigmatizes drug users.				
Although it is hard to admit, I sometimes judge people who cannot stop using drugs.				

Adapted from *Using Harm Reduction to Address Sexual Risk with Drug Users and Their Partners*,
HIV Education and Training Programs, NYSDOH AIDS Institute, by Joanna Berton Martinez, August 2009.

Some of the statements on this exercise were borrowed from Project Implicit and their Implicit Association Tests,
https://implicit.harvard.edu/implicit/

MODULE 1 — DISCUSSION – 10 MINUTES

Goals

- Identify and explore the reach of drug-related stigma.
- Name strategies for confronting drug-related stigma.
- Promote productive service provision that avoids stigmatizing drug users.

Slide purpose: *To provide participants with a broad overview of the goals of the session and what to expect.*

- Review the training goals. It is unnecessary to need to read every word; give people a sense of what they can expect overall from the day. Incorporate any expectations from participant intros, acknowledging what you may – and may not – aim to cover.

Training Guidelines

- Step up, Step Back
- Non-Judgment
- Talk *with* each other, not *at* each other
- Agree to disagree
- Confidentiality

Format: *Discussion*

Slide Purpose: *To establish a set of guidelines that will promote a respectful and productive learning environment for all training participants.*

- Next, introduce the list of proposed training guidelines. Review each bullet briefly to ensure that participants are clear on their meaning.
- Ask people if they can agree on this list and/or if there are any additional guidelines they feel are important and necessary.
- Thank the group for their help in creating a productive training environment.

Key point

The goal is not to "give answers" or to tell people what to do. We will provide a framework for thinking about stigma, and try to make it practical and tangible – but there are no easy answers when it comes to stigma.

Introductions and Quotes

- Name
- Organization
- How do you interact with drug users?

Slide Purpose: *To outline information being asked of participants during group introductions.*

- Next, facilitate participant **introductions**:
    - Introduction methods may vary depending on the size of the group.
    - Go around the room and have people say their name and any **organizational affiliation**.
    - Ask people what they are **expecting** from today's training.
        - Take not of participant responses; consider jotting them down on newsprint.
        - Address which expectations you will aim to meet during the training, and acknowledge any limitations or areas that will not be covered.
    - Ask people to state **how they interact with drug users**.
        - Encourage people to think outside of their professional experience (if they are comfortable).
        - This portion of the exercise gives information about the ways in which participants see their relationship to drug users.

<u>Quotes Exercise:</u>

- ***After everyone has introduced himself or herself,*** explain that everyone should have picked up a quote when they came in. If anyone does not have a quote, ensure that they get one.
- Ask if anyone would like to share their quote and explain why they like/dislike the quote and other thoughts they may have about it.
- Set a quote limit up front – for example, explain that we'll hear 3 quotes.
    - If introductions took more or less time, adjust the time spent on this exercise to compensate.
- Explain that the complete list of quotes can be found on **page 10** of the participant workbook.

MODULE TWO: WHAT IS STIGMA?

Goals

The goals of this module are:

- To explore the meaning of stigma, discrimination and related concepts
- To understand the many forms of stigma.
- To recognize the functions of stigma.

Objectives

Upon completing this module, participants will be able to:

- Define stigma and its consequences within a broad social framework.
- Name several forms of stigma, providing concrete examples of each.
- Describe various functions of stigma toward shaping social norms and practices.

Time

20 minutes total

Materials

- Clock
- PowerPoint Slides
- Newsprint/flip chart/large paper
- Markers
- Tape for newsprint

A few basic principles…

- Drug use exists along a continuum
  - *Abstinence is one of many possible goals*
  - *Meet people "where they are at"*
- Drug-related harm can not be assumed
  - *Drugs can meet important needs*
- Drug users are more than their drug use

Format: *Presentation*

Slide purpose: *To set a general tone for the training and to address stigmatizing ideas and generalizations about who is considered a "drug user".*

- Use this as an opportunity to set the tone. Rather than having a complete discussion about harm reduction, this slide pulls out some points from harm reduction that are particularly relevant to this session.
- Encourage people to think beyond one idea/definition of "drug use", "drug user" wherein drugs are placed in a "good/bad" dichotomy and to move away from presumptions that there is a single/definable drug user experience.
- Explain that when discussing stigma throughout training, we will highlight issues more often present among drug users who are disenfranchised or otherwise vulnerable (due to homelessness, economic status, etc).
- Note that some examples or issues explored during workshop will not apply to all drug users due the complexity of stigma & the varying experiences of drug users…will be explored further during workshop.

Key Point

This training will highlight issues more often present among drug users who are disenfranchised or otherwise vulnerable (due to homelessness, economic status, etc). The writers in no way presume that there is a single drug user experience. While every effort was made to make overall themes broadly relevant, there may be examples or issues that do not apply to all drug users.

What is stigma?

A **social process** which can reinforce relations of **power** and **control.**

Leads to **status loss** and **discrimination** for the stigmatized.

- Link and Phelan

Format: *Presentation + Participant Input*

Slide purpose: *To offer a common definition of stigma.*

- Ask the audience for a definition of stigma.
  - "What comes to mind when you think about the term stigma?"
  - Optional: Record responses on flip chart

- Acknowledge that in all likelihood, *each of us has at one point been stigmatized ourselves AND imposed stigma upon someone else.*
  - ***Encourage each person to take a moment, and in their minds, think about a time that they may have been stigmatized and when they may have imposed stigma on others.***
  - *This can be useful for people to use as a personal reference throughout the training.*

- It can be helpful also to ask participants to quickly name some examples of how stigma is imposed For example:
  - HIV/AIDS-related stigma
  - Weight-related stigma
  - Mental health-related stigma
  - Race/ethnicity-related stigma

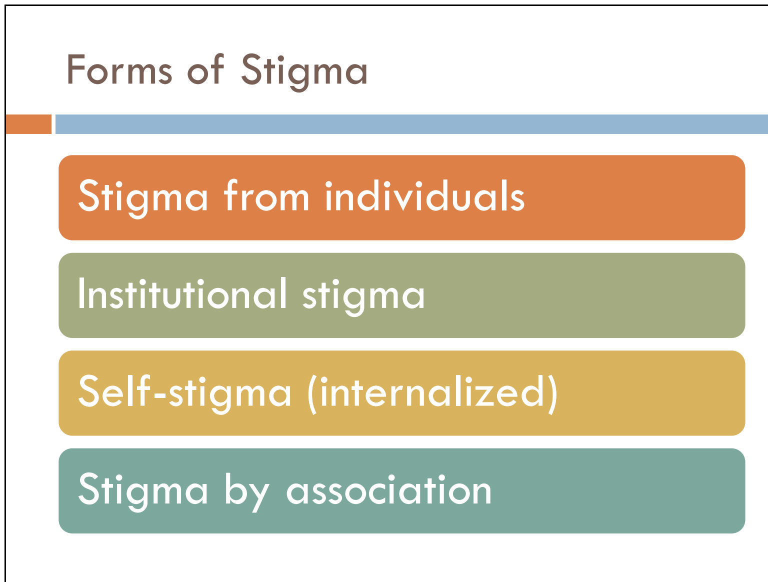
Context

- Stigma is a social process that is linked to power and control. It leads to stereotypes, labeling.
- Stigma originates from the Greek word meaning tattoo or puncture mark with a sharp object, which stems from the practice of branding slaves to ensure that their status was recognized.
- Stigma is different from discrimination, but it can be used to legitimize discrimination; discrimination is part of the process of stigma.
- Based on attributes (housing, race, class, etc) or behaviors (drug user, gay, mental health issues, etc).

- There are consequences for stigmatized (status loss, self-esteem, etc) and the stigmatizer (power/social, economic, political control).
    - So, even in cases where the stigma may be **understood,** it has serious consequences that are negative for the stigmatized and can have broader consequences for society (in an extreme example – stigma against axe-murderers, the stigmatized is cut out from normal society and isolated…leading to consequences that are negative and damaging for the individual. So, the axe-murderer will likely have a harder time receiving services to avoid such behaviors, etc.)
- Stigma can changes over time (smoking example, HIV).

Stigma through a Harm Reduction Lens:

- We accept that stigma is a part of the world.
- There are ways to manage & challenge stigma.
- Stigma intersects with other forms of marginalization & oppression.
- When challenging stigma, meet ***all*** people where they're at (even stigmatizers).
- Acknowledges that change is hard, values incremental change.



Format: *Activity*

Slide purpose: *To explore the different forms/expressions of stigma.*

- Stigma is expressed in several forms and there is often overlap between different forms of stigma.

- Briefly describe each form of stigma and offer an example – see context below for examples. Examples can pertain to drug use, or may be related to other forms of stigma.

ACTIVITY

- Post four newsprint pages around the room, one with each heading.

- Have participants count off by 4s. Assign each group to stand by one of the sheets of paper.

- Have each group brainstorm and write up examples of each kind of stigma.

    - It can be useful during this section to encourage participants to highlight examples of stigma that are *not* only about drug use. In this way, participants may be able to connect with the concepts in a different, perhaps more familiar way.

- After 2-3 minutes, have the groups rotate to the next sheet of paper.

    - Continue the rotation until each group has visited each kind of stigma.

- Conduct a group process by asking people to point out points or examples that were of particular interest or surprise to them.

- Be cautious to differentiate between stigma and discrimination here, wherein stigma is the belief and discrimination is the action.

Context

Stigma from Individuals: Occurs when individuals/the public develop and sustains negative stereotypes and assumptions about individuals; can be verbal or physical. Some examples:

Drug related - When people lock up their valuables when a drug user visits; calling people junkies; assumptions that health care providers make about drug users as aggressive or seeking drugs.
Non-Drug related – When people talk louder to blind people; not wanting touch people who are disabled or ill.

Institutional Stigma: Occurs when assumptions and stereotypes are translated into public policy, practice and funding decisions. Some examples:

Drug related – Treatment guidelines that exclude drug users (HCV); urine screening at methadone programs; hiring practices around drug use.
Non-Drug related – Laws that impose criminal penalties on spitting by people who are HIV+ ; laws that limit the rights of gay men and lesbians; bathroom policies that exclude transgender individuals.

Self-stigma (internalized): Occurs when individuals believe and adopt negative stereotypes and assumptions about themselves. Some examples:

Drug related – Drug users stigmatize themselves, feeling that they are "bad" people; that they don't "deserve" services or respect – often results in a "why bother" attitude; that people think of them as liars, so they might as well lie. Not being able to be honest with themselves about their own use because of what it means to be a drug user.
Non-Drug related – People with learning disabilities stigmatize themselves as less capable than others; people with HIV stigmatize themselves and blame themselves for their illness.

Stigma by association: Occurs when assumptions and stereotypes are made based on association with stigmatized individuals/groups. Some examples:

Drug related – Providers working with drug users are stigmatized; harm reduction providers are stigmatized by abstinence-based providers; people are stigmatized for going to a SAP; even wearing a harm reduction t-shirt; having a family-member who is a drug user.
Non-Drug related – Having a family member who is mentally ill; working with prisoners; Sister Helen Prejean (featured in the movie *Dead Man Walking*) for working with a man on death row.

Module Three: Understanding Drug-Related Stigma

Goals

The goals of this module are:

- Identify the various ways in which drug users experience.
- Explore key sources of pre-existing stigma and discrimination, including positive and negatives stereotypes of drug users.
- Identify consequences of drug-related stigma on drug users' willingness and ability to access services.

Objectives

Upon completing this module, participants will be able to:

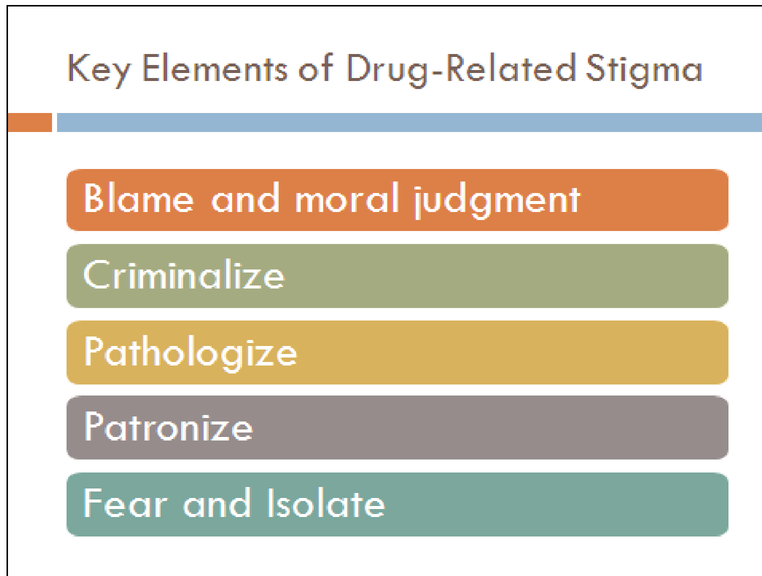
- Explain several key elements of drug-related stigma and the purpose each element serves.
- Describe the cycle of stigma and its impact on drug users.
- Identify specific ways in which drug users experience stigma.
- Name several steps providers can take to challenge stigma.

Time

30 minutes total

Materials

- Clock
- PowerPoint Slides
- Newsprint/flip chart/large paper
- Markers
- Tape for newsprint



Format: *Presentation + participant input*

Slide purpose: *To outline some key elements of drug-related stigma as they relate to the previous discussions on stigma; to highlight some of the ways in which drug-related stigma is unique.*

- Explain that now that we have a better understanding of what stigma is, as well as its forms and functions, we will look closer at drug-related stigma in particular.

- Briefly review each point, offering examples and context for each element.
    - Consider the function of each element
    - Consider the consequences on the drug user for each element
    - Consider why it is important to explore these elements more deeply

- If there is time, consider asking the group if they have any suggestions as to the key elements of drug-related stigma. Another option would be to offer the elements one-by-one, seeking feedback and examples on each.

Context

Blame and Moral Judgment

The belief that drug use, and problematic drug use at that, is purely a choice is a huge driver of drug-related stigma. It brings up many emotions including anger and frustration.

As opposed to some stigmas, drug users are blamed for bringing their conditions "upon themselves." Blame also in relation to HIV and HCV acquired through drug use.

Example: Someone who is born without a hand vs. someone who loses their hand because of an injection-related infection

Drug users are held accountable at the highest standard for the problems that are linked to drug use, despite the web of socially constructed barriers to opportunity and care. There is often little acknowledgment of the conditions which may lead people to problematic drug use, however, there is a great deal of judgment placed on individuals who struggle with drugs and drug use.

Moral judgment may also be tied to beliefs about drug use as a sin – wherein drug users are considered weak.

Impact on drug users: Fear to be identified as a drug user, shame, isolation, internalize judgment, lowered self-esteem.

Criminalize

The best example of the ways in which drug-related stigma relies on the element of criminalization is the "war on drugs" which is really a "war on drug users". Drug use is treated as a criminal matter as opposed to a public health issue.

By criminalizing drug users, poor treatment, labeling and judgment are all legitimized. Behavior deemed as criminal is already associated with stigma, and drug use magnifies this. Criminalizing drug users is cyclical because drug users who are caught up in the criminal justice system are likely to have diminished opportunities.

Further, by criminalizing the behavior, it pushes it underground – making it more taboo and stigmatized.

Important: There is an important intersection with race- and class-related stigma and racial profiling which increases the impact of stigma.

Effects of criminalizing drug use:

- More resources for incarceration, less for supportive services
- Increased stigma (external + internalized—"criminal")
- HCV/HIV rates increase
- Interruptions in services/treatment

Impact on drug users: Hide use; increased risk behaviors; identify themselves as criminal and therefore engage in additional criminal acts; fewer services available, shame, incarceration, etc.

Pathologize

Pathologizing drug users – or the diseasing of drug users – is an important part of drug-related stigma. *This is not the same as a public health approach to drug use – wherein drugs and drug-related harm are placed within a larger public health context.*
*** This may lead to a more in-depth discussion. We are not saying that the disease model is not helpful for some individuals and that it should never be used. We ARE saying that it is important to be critical of how discussions around addiction as a disease are framed in order to avoid stigma.*

Pathology implies that drug users are sick, diseased or otherwise cannot help themselves; can also imply a sickness of character. It can lead to patronizing behaviors and the belief that if drug users would just do XYZ – they could be healed or "better"; that generic treatments can work for anyone, and that "experts" know what to do to heal drug users.

Impact on drug users: Decreased sense of autonomy; frustration if unable to change behavior; lower self-esteem; fatalistic attitudes; different kind of accountability and responsibility for relationship to drug use.

Patronize

Drug users are often patronized, spoken down to or otherwise treated as though they are a lower class of individual. This comes through in language (ie, the way that information is communicated) as well as in presumptions about the needs, desires and experiences of drug users. Very often, there is a sentiment that others (be it service providers, friends, family members, treatment programs, etc) know what is best for drug users; people are very often telling drug users what they should do, or what they need, as opposed to seeking input and involving drug users in the decisions that matter most to them.

Fear and Isolate

Fear and isolation act in two capacities: fear of drug use itself (example: fear-based anti-drug campaigns, "this is your brain on drugs") and fear of drug users (ex. research shows that health care providers expect drug using patients to be aggressive and dangerous).

Impact on drug users: People are discouraged from talking about drug use and become isolated; find community in other drug users which can make behavior change more difficult; diminished job/education/health care opportunities.

Additional Context:

Drug-related stigma is largely normalized*:*

Pervasive ideas about drug users are rarely challenged. In the media, in our families, in our communities – negative stereotypes and labels of drug users are constant.

There is often a failure to recognize the complicated social condition in which drug use (in particular, problem drug use) takes place.

It is hard, often even among providers who are familiar with drug users and may work harder to counter some stigmas to recognize that drugs can be a lesser of evils – and/or can actually be helpful.

The argument can be made that drug-related stigma is often ***more damaging than the actual drugs.*** That is not to diminish that harms associated with drugs, however stigma means there is no honest dialogue about drugs, that drug users are forced to hide their use and feel shamed for struggling with use, that people are isolated and cut off from help, and that opportunities are denied.

Drug users (certain drug users in particular – HCV or HIV+, sex workers, IDU, crack smokers, etc) are bad.

Examples of normalization:

- Research shows that physicians expect drug users to be aggressive and difficult patients.
- Images of drug users in the media – consistently drug users are either artists or criminals.
- WHO study revealed drug addiction the most stigmatized behavior.

Impacts many aspects of user experience

As providers, we may focus on the impacts of drug-related stigma on services and health, etc. However, for drug users experiencing stigma, there is no way to separate these things out. For drug users – stigma affects their relationships with families, employers, educators, health care providers, housing and perhaps most deeply – themselves.

Of course, there is also the intersection of drug-related stigma with other stigmas and prejudices (race/ethnicity, sexual orientation, gender, class, HIV status, incarceration history, etc)

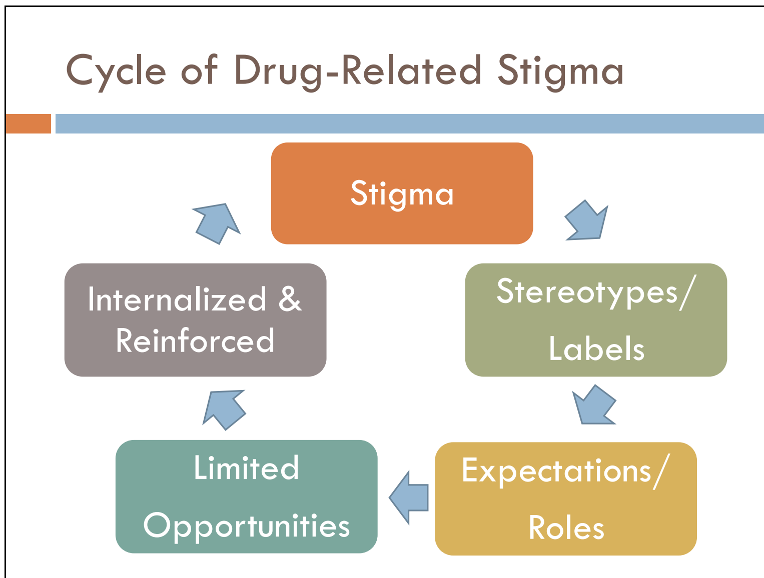
For example: Research suggests HIV-related stigma experienced more acutely by IDUs.

Exists despite actual behaviors

One doesn’t have to directly IMPOSE stigma for it to EXIST. Because of the internalization of stigma, consequences can occur simply from the anticipation of stigma and judgment.

For example - drug users may not feel able to be open about their drug use with health care providers simply because they have heard that health care providers do not treat drug users the same.

Another example – drug users may not feel able to disclose use after periods of abstinence out of fear that stigma will return.



Format: *Presentation*

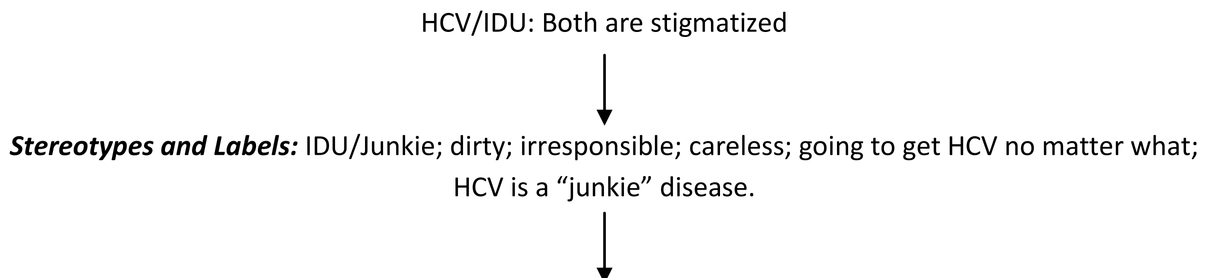
Slide purpose: *To explore the insidious nature of drug-related stigma, the difficulties many drug users have in escaping from the cycle of stigma and the longer-term consequences of stigma.*

- Use this slide as a visual representation of how stigma impacts the experience of drug users.
- Walk participants through each step giving examples of each step.
- Use the HCV example below, or a more general context.

Context

Important: *The impact of stigma remains after people make changes to drug use: "Once a junky, always a junky." Very difficult to break the cycle and regain status.* This may be particularly relevant Drug treatment says create new communities/social groups – however, the stigma towards drug users makes this very difficult.

HCV as an example:



Expectations/Roles: Expect people to share works; expect IDUs to get HCV; expect IDUs to use in risky situations; expect IDUs to take on the role of "transmitter" of disease

Individual takes on these expectations, roles and internalizes them. Although s/he knows better, s/he feels it is inevitable and shares injection equipment – subsequently feels dirty, ashamed, etc.

Limited Opportunities: It is more difficult to access treatment for HCV if an active drug/alcohol user; may be more difficult to access health care – depending on other conditions; opportunities may ***feel*** limited based on the stigma of "coming out" as an IDU with HCV; opportunities may also be limited due to the stigma of HCV/IDU in the funding world and subsequent lack of services overall.

Internalized and Reinforced: Once infected with HCV, user internalizes shame and guilt; "it was my fault, I was irresponsible, I should have known better, what's the point of seeking care HCV anyway, I'm not worth it", etc. People may also feel like they already have HCV, so what's the point of always using clean equipment, thereby self-selecting out of certain opportunities. Further, there could be additional guilt and shame if others were infected as a result of their having HCV.

STIGMA:

Drug users don't care about their health – Drug users will share equipment – Drug users don't want treatment for their HCV – Drug users are diseased, etc…

Implications for Providers

- Willingness to access services
- Relationships and trust
  - *Assumptions*
- Participant risk and behaviors
- Participant self-worth
- Funding

Format: *Presentation*

Slide purpose: *To connect the conceptual ideas discussed to the practical aspects of providing services with drug users; to make the conceptual ideas relevant to providers.*

- Introduce this slide as a way to connect the earlier ideas directly to provider practice.
- Acknowledge that there are more implications, and that this list represents some important considerations. Time permitting – give participants a chance to brainstorm additional implications.

Context

Willingness to access services

Drug-related stigma leads to fear/anticipation of mistreatment, which can keep drug users from accessing services. This can be applicable regardless of actual mistreatment.

Because of the pervasiveness of stigma, the common experience for most drug users is to remain guarded until trust is earned; this occurs for very real reasons given the potential consequences already discussed. If drug users do not want to disclose drug use or potentially be identified as a drug user by accessing certain services, it has an impact on the effectiveness of prevention, testing and treatment services.

Relationships and trust

Relationships are at the very core of effective service provision. Relationships can be severely hindered by stigmatizing behaviors and practices.

While some people may still access services despite stigmatizing language or behavior, the relationship may suffer if individuals feel stigmatized; stigma is not always overt – but can also be subtle. For example, policies that communicate distrust or disrespect for personal choice. One common example of this is policies against offering cash incentives for client participation in agency projects. The usual justification for not giving cash is the concern that drug users will use the money to purchase drugs; the underlying message is that the provider does not trust the client to spend the money productively. The truth is that it should not be up to the provider to decide how clients spend their money. Using cash incentives to buy drugs may in fact be harm reduction.

Stigma affects relationships because of providers' emotional response to client behavior which may be a response to internalized stigma (i.e. providers take things personally that don't have anything to do with them.)

> *Example: a client is "dishonest" about his/her drug use and the provider gets upset that the client does not trust them. However, in truth, the client is actually struggling to admit to themselves that they are using – he/she has so much shame about the use, and to talk about it would make it too "real".*

Assumptions and Expectations

Expectations of clients (for example, that someone will not make it to an appointment, or succeed with treatment, etc.) can translate into feeling stigmatized. In the same respect, positive expectations that oppose traditional ideas about drug users can counter stigma and have a positive impact on relationships.

It is important to avoid making assumptions about drug users based on the prevailing stigma. Service providers are only human – and at times, they may make assumptions about client behavior based on stereotypes and labels of drug users. However, it is important for providers to be mindful of when this occurs, be open to addressing the beliefs and to be willing to challenge these assumptions. It is not the responsibility of the client to manage these assumptions for the provider.

Participant risk and behaviors

Less likely to access prevention services (SEP), disclose drug use to medical providers/psych providers, discourages disclosure of HIV/HCV status
Ex: Increase risk for overdose if people use alone
Ex: 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

Client self-worth

Internalized stigma can easily diminish client self-worth and self-esteem. Subsequently, clients may have a more difficult time making changes to harmful behaviors or other positive changes. For example, clients may increase drug use as a way of coping with internalized stigma and to boost self-esteem. In addition, they may not feel like they deserve help or respect.

Funding

Stigma effects political will to provide adequate funding and programs for drug users. For example, look at funding discrepancies between funding for hepatitis prevention and HIV prevention; and even HIV prevention did not receive sufficient funding until Ryan White brought HIV to a different kind of public consciousness.

Stigma leads to beliefs such as, "if 'they' don't care about their health, why should we?"

Generally speaking, stigma legitimizes inadequate funding and budget cuts; drug users are not considered viable political constituents.

BREAK ***10 MINUTES***

Break!

- 10 minute break -

MODULE FOUR: EXPLORING LANGUAGE AND LABELS

Goals

The goals of this module are:

- To understand the impact of language in furthering and imposing stigma.
- To explore the impact of the media in shaping stigmatizing ideas about drug users.
- To deconstruct the messages and ideas promoted by drug-related stigma.

Objectives

Upon completing this module, participants will be able to:

- Identify elements of language that stigmatizes drug users.
- Deconstruct a media representation of drug users.
- Apply broad themes and manifestations of stigma to everyday practice with drug using clients.

Time

25 minutes total

Materials

- ***Video: CNN clip – DVD provided***

or *Online link to video clip:*
http://www.cnn.com/video/data/2.0/video/showbiz/2009/09/15/sbt.whitney.drugs.cnn.html
or
http://www.youtube.com/watch?v=Y3vyacojPN8&NR=1

- Clock
- PowerPoint Slides
- Newsprint/flip chart/large paper
- Markers
- Tape for newsprint

Video: Labels and Language

Purpose: *Explore labels and language associated with drugs/drug use and their relationship to stigma*

Pay attention to:

- *Labels & Language*
- *Themes that you see in your work with clients*

Format: *Activity*

Slide purpose: *To introduce the video exercise that will explore labels and language associated with drugs/drug user and their relationship to stigma.*

- This exercise presents a video clip from the CNN entertainment show "Showbiz Tonight". It presents a panel of three journalists talking about Whitney Houston's disclosure of drug use.

- The clip offers a look at media/social perception of drug use and drug users, as well as Whitney's self-reflection. Key points outlined below.

- Before the video, offer guidance of themes for people to pay attention to while they watch the video and encourage people to take notes. Ask people to be mindful of:
  - ***Language*** *used by panelists AND by Whitney that could be stigmatizing*
  - *Examples of* ***stereotypes, labels*** *and* ***generalizations*** *placed on drug users.*
  - ***Themes*** *that relate to the lives of* ***clients****.*
  - *Ways in which the situation may be* ***different*** *for clients (different standards based on status, fame, etc.)*

- ***It is essential to explain that we are not showing the video to focus on Whitney Houston!***

- Facilitate discussion well – it is important to make the exercise applicable to provider practice and their clients. Language and labels in the video can be tied directly to the elements of drug-related stigma discussed earlier: Judgment, criminalize, pathologize, patronize, fear and isolate.

- An option is to replay certain sections of the video and/or replay and stop at certain sections to highlight specific ideas.

Context

Language: There is a lot of stigmatizing language throughout the piece – some subtle and some more overt.

- Words like *"shocking…upsetting…disturbing"*
- *"Drug-filled…drug-crazed"*
- The language is primarily negative.
- The language represents a sort of ownership over what she does – which is partly tied to her celebrity, however this is a common theme with clients as well when it comes to certain measures of control that is exerted (syringe exchange caps, non-cash stipends, expectations of disclosure).

There is an overall theme that divides Whitney into the person who is loved (not using drugs) versus another Whitney who – it can be inferred – was not loved *("that is the 'addict' talking").* Also, the persistent nature of stigma is present when the panelists are talking about how Whitney will be forever "different" – marked because of her experience as a drug user.

The discussion about which is more shocking – that Whitney started using "so early" or that she started after becoming a mother brings up 2 important ideas:

- *Re: When she started using:* It was shocking because she had been using without public knowledge for a long period of time. There is an implication that for one, we have a right to know about other peoples' drug use and two, that it is surprising someone can be a "functional" drug user. There was a tone that suggested the journalists felt deceived or betrayed for not knowing sooner.
- *Re: Using as a mother*: One journalist suggests that it is shocking she would use after becoming a mother – representing the stigma related to parenting and drug use – while another journalist immediate writes this off as expected. She says, "once you go down that road" – implying that drug users don't care about anything, even parenting, and that it's to be expected of an "addict"." Overall, there is a tone of judgment about Whitney's parenting.

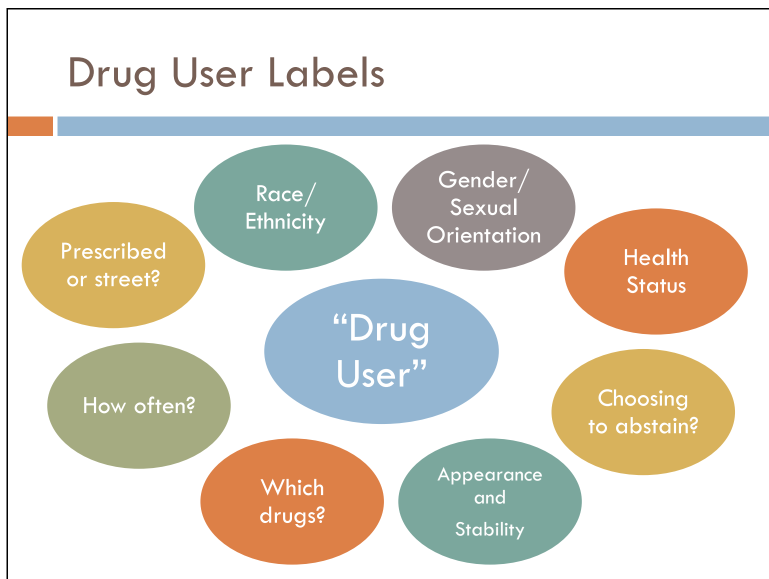
Disclosure: Disclosure is referenced at several points throughout the clip and overall, there is a theme that "we" have a right to the knowledge about her drug use. It is stated that she "has to reveal more and more" to be "set free" and that she has to "put everything out there."

Disclosure is expected and framed as within her best interests. So, at the same time that it is made clear how much drugs are disapproved of, there is still the expectation that people will be willing to talk about it freely.

In harm reduction practice, this speaks to the standards and expectations around disclosure that drug users face. Clients are asked to make themselves as vulnerable as possible, despite the risks involved with that. At the same time, providers are expected not to talk about drug use – which actually promotes stigma by suggesting that drug use is something that cannot or should not be openly discussed by all.

Levels of drug use: It is clear that Whitney knows the implications of smoking with a pipe (crack is a lower class drug with far more stigma attached to it), and is clear to separate herself from "those" drug users. This theme was also clear with the emphasis placed on the words "every single day" when the reporter was describing Whitney's use.

Patronize: The reporters are very comfortable making statements about what Whitney needed to do, and when and how she needed to do it. She is not given credit for her own role in changing her life, but instead it is her mother who "*intervened and got her daughter clean.*"



Format: *Discussion*

Slide purpose: *To follow-up on the discussion from the video exercise and explore labeling of drug users as a complex and multilayered social construct that has many variations.*

- This conversation will need to be facilitated well because of time limitations.
- This slide is animated to reveal each of the bubbles one-at-a-time. This will allow the facilitator to challenge participants to think about how a scenario will change as each of the elements is added/shifts.
- It may be helpful to use a specific scenario, or it can be kept vague. It is also possible to get the audience to develop the scenario – for example, ask the audience to picture a "drug user" - a response can be solicited from the audience. Then, reveal each bubble and ask the audience how the labels may change.
- Try to connect the examples back to the impact on service accessibility – continue to make the discussion relevant to providers (i.e. who has greater access to services, what is the quality of services, etc)

Context

Differentiation and labeling is a social process – it exists only because we create it. Although labels may at times be proven to be true – generalizations are dangerous, unhelpful, and are not accurate.

The linking of negative attributes to differentiated groups of individuals facilitates a sense of separation: "us" and "them". Individuals of the labeled group are fundamentally different which leads to stereotyping.

Labels leading to stereotypes: Once people identify and label your differences others will assume that is just how things are and the person will remain stigmatized until the stigmatizing attribute is undetected (if possible).

Language

Junkies, Dope Fiends
Crack-heads, Crack Babies
Drug Addicts, Drug Abusers
Drug Users, People Who Use Drugs
Drug Use, Drug Abuse, Drug Misuse
Clean and Dirty
Relapse vs. Lapse

Format: *Discussion*

Slide purpose: *To provide participants an opportunity to think specifically about the role of language in perpetrating stigma.*

- This section is not about giving "answers", but thinking critically about the power of language and the different sentiments it can communicate.

- It is important to acknowledge that some of this language may be upsetting to people. It is not meant to offend anyone, but to acknowledge the relationship between stigma and language.
    - If there is discomfort seeing some of the language, it is ok – and probably represents important information.

Context

Language is complicated. In some cases, language that is typically negative can be re-appropriated by members of the group the language refers to – for example, some users identify themselves as junkies or dope fiends.

- *Is it still stigmatizing if the person using it claims it as identity?*
- *What is the relationship to internalized stigma?*

Language extends beyond the labels placed on drug users; language used when talking about drug use in general and the process of change can be particularly "charged".

MODULE FIVE: DYNAMICS OF STIGMA

Goals

The goals of this module are:

- To develop a deeper understanding of what stigma means in the daily lives of drug users.
- To explore the ways in which social structures and institutions perpetuate stigma.
- To identify consequences of stigma.

Objectives

Upon completing this module, participants will be able to:

- Name specific consequences of stigma as it related to various institutions.
- Analyze the impact of stigmatizing behaviors on drug user access to services and opportunities.
- Apply theoretical concepts from throughout the session to day-to-day relationships between drug users and various institutions.

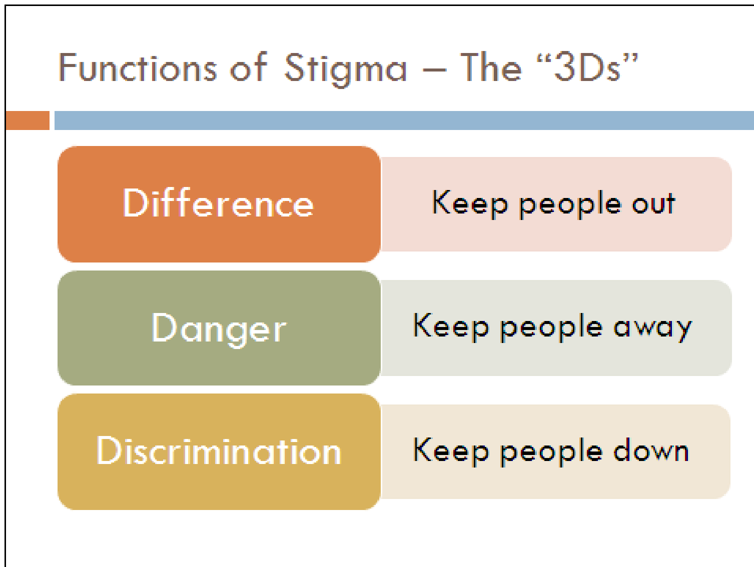
Time

35 minutes total

Materials

- Clock
- PowerPoint Slides
- Newsprint/flip chart/large paper
- Markers
- Tape for newsprint
- ***Pre-printed newsprint for group activities – see diagrams below***

Institution: Medical/Hospital	**Institution:** Law Enforcement/ Legal	**Institution:** Education/ Employment
Institution: Family/Friends/ Community	**Institution:** Harm Reduction Service Provider	**Institution:** Housing



Format: *Presentation*

Slide purpose: *To provide participants with a context for the 3D exercise by exploring functions of stigma.*

- Review the 3 functions of stigma quickly – just to provide context for the 3D exercise.

- Direct people to the article called "*Stigma and Prejudice: One Animal or Two?"* in their **participant workbooks.**
    - ***3Ds –*** *The 3 "D" words (Difference, Danger, and Discrimination) are used to simplify the concepts outlined in the article "Stigma and Prejudice: One Animal or Two?"*

- Looks at the functions of stigma, in general – not just drug-related stigma. Different functions are more directly linked to drug-related stigma, but each speaks to the roots of the behavior.

- Stigma exists and serves a function in our society – therefore, we need to be mindful of where stigma comes from. Although the consequences of stigma are largely negative, to some extent, stigma may simply be a learned behavior.

Context

3Ds – *The 3 "D" words (Difference, Danger, and Discrimination) are used to simplify the concepts outlined in the article "Stigma and Prejudice: One Animal or Two?"*

DIFFERENCE: Norm Enforcement, Keeping people out

Stigma as norm enforcement applies to behaviors seen as "voluntary".

This is the most common function of stigma as it applies to drugs and drug use. Stigma as norm enforcement is about setting the boundaries of acceptable behavior – creating an "in" group and "out" group. So, just as much as this type of stigma is about keeping "them" out, it is also about keeping people "inside" the boundaries of "normal". In this case, stigma can be seen as a deterrent to engaging in socially unacceptable behaviors.

This function of stigma is strongly linked to morals, values and social norms, emphasizing personal choice at the root – people who engage in certain behaviors bring related treatment upon themselves. There is a perception that XYZ is the product of personal choice: that one *chooses* to engage in "bad" behaviors that put one at risk and so it is "one's own fault".

Examples: Drug use, sex work, homosexuality (when seen as a choice); infidelity; pedophilia; unprotected sex/teenage pregnancy; etc.

NIMBY – don't want a SAP because it will bring "those" people
"This is your brain on drugs" – fear campaigns…"you don't want to turn out like this"

Linked to Disclosure because this type of stigma transforms an individual from a whole person to a tainted one; this can result in feeling different and devalued by others – isolating and a reason not to disclose use.

DANGER: Disease Avoidance, Keeping people Away

This function of stigma is largely historical – going back to evolutionary theories. However, it is still relevant, particularly in light of issues such as HIV and HCV, etc.

Stigma as disease avoidance can function in 2 ways – using stigma to keep people who are perceived as dangerous/infectious away and to discourage people from engaging in behaviors that could lead to disease.

Fear of contagion (HIV, HCV, TB)/association with behaviors that are either illegal or socially sensitive (e.g., sex work, drug use, sexual orientation, etc).

Examples: Quarantining HIV+ people, incarceration of drug users, arrest of homeless, isolation of people with illness/disability, etc.

DISCRIMINATION: Exploitation & Domination, Keeping people down

This function of stigma is clearly linked to the end goal of reducing power of others as a means of elevating the stigmatizers' position and power. This may be related to drug-related stigma in some ways – however there needs to be gain on the part of the stigmatizer.

Stigma is used to legitimize discrimination – there are some people that are just inferior to others and therefore do not deserve the same amount of power and opportunity.

Examples: Mass incarceration of individuals for non-violent drug-related offenses; As it relates to funding, there is a benefit to stigmatizing people with AIDS, drug users and others who may draw funding away from other constituencies; Immigrant labor and less desirable jobs (belief that immigrants don't deserve better jobs – have to earn their place in society).

Dynamics of Stigma: The 3-Ds

Purpose: *To explore different dynamics and consequences of stigma*

The 3-Ds:

- *Difference (Keeping people out)*
- *Danger (Keeping people away)*
- *Discrimination (Keeping people down)*

Slide purpose: *To introduce and outline the 3D exercise that will explore the dynamics and consequences of stigma.*

- Introduce the exercise as an activity that will be done in small groups.
- Depending on the number of people, have participants count off so that there are 4 or 5 people in each group (ex: 15 people: count off by 3s, 25 people: count off by 5s, ≥30 people: count off by 6s)
- Explain the purpose of the exercise: *To explore different dynamics and consequences of drug-related stigma.*
- Provide additional details on the exercise:
  - There will be **three rounds**, during which we will explore the experience of the **stigmatizer** and the **stigmatized**.
  - Each group will be assigned **an *institution***. This institution provides the perspective from which the group will be thinking throughout the exercise.
- Assign each group an institution and distribute the prepared flip-chart paper accordingly:
  - *Medical/Hospital*
  - *Legal/Law Enforcement*
  - *Education/Employment*
  - *Family/Friends (Community)*
  - *Harm Reduction Service Provider*
  - *Housing*

Round 1

Brainstorm ways that your institution stigmatizes drug users

Think about behaviors/actions

AND

Why it happens

(3Ds/Beliefs)

Slide purpose: *To introduce round 1 of the 3D exercise in which participants consider the role of those who stigmatize.*

- Introduce the first round of the group exercise.
- Ask participants to brainstorm different ways in which their assigned institutions may impose stigma upon drug users. Ask them to be mindful of the ***role of stigma*** versus the ***act of discrimination – encourage to think about the beliefs and the functions.***
- Encourage people to think about the elements of drug-related stigma discussed earlier.
- Ask if everyone understands the activity. If there are no questions, give the groups about 5-7 minutes to complete the first round.

Round 2

Brainstorm ways that drug users may respond to the stigmatizing behaviors from round 1

Name behaviors/actions

AND

Ways stigma may be internalized

Slide purpose: *To introduce round 2 of the 3D exercise.*

- Ask participants to brainstorm different ways in which drug users may respond to the different stigma and discrimination discussed in Round 1. Again, remind them to be mindful of the ***role of stigma*** versus the ***act of discrimination – encourage to think about the beliefs and the functions.***

- Encourage people to think about the elements of drug-related stigma discussed earlier.

- Ask if everyone understands the activity. If there are no questions, give the groups about 5-7 minutes to complete the second round.

Round 3

List 3 *strategies/alternatives* to challenge the stigmatizing behaviors you have discussed.

Either from the perspective of the institution

OR

As a provider helping a client

Slide purpose: *To introduce round 3 of the 3D exercise.*

- Ask participants to compile a list of 3 strategies or alternatives that they can use as providers, or that the institution could adopt, in order to challenge/confront stigma (3 is the total number – not for each behavior).

- Explain that the groups will be asked to share these strategies in a moment.

- Give the groups 5-7 minutes to come up with their strategies.

ACTIVITY DISCUSSION

- Ask each group if they have had enough time to finish coming up with their strategies.

- Ask each group to briefly present on their discussions.
    - Ask them to highlight points from rounds one and two - and to name the strategies that they came up with in round 3.

- After each group has had a chance to present, ask for any comments on the overall exercise:

- Probing questions include: *What stood out to you as new or unexpected? What was most challenging or surprising?*

Activity Context

The following are sample ideas that may come out of the brainstorms:

Legal/Law Enforcement

- Drug users are profiled. Syringe exchange programs are profiled. Neighborhoods/areas profiled based on ideas about who are drug users. The practice is based in ideas that drug users are always doing something wrong, that they are deceptive and that they can not be trusted.
- Searches/arrests are handled differently (more aggressive, questions about sharps). Based on the belief that drug users are dangerous and that others should be scared of them.
- Access to methadone (medication) may be cut off during processing – based on ideas that methadone is a drug not a medication (drug users only want to get high), or that drug users need to "be taught a lesson".
- Stop and frisks more happen more often; warrant checks without any violation. See bullet one for belief.
- Policies are created that limit access to services. Stigma towards drug users leads to limited opportunities.
- Drug users can never be perceived as victims in cases where they need assistance from the police/system. They are not given credibility of character.

Medical/Hospital

- Expectations about HIV/HCV status and disclosure. It is expected that
- People are denied service if they are high.
- Peoples' charts are "flagged" charts.
- Methadone programs place rules about loitering. Also, the way that methadone is regulated in general – tone is more criminal than medical.
- Medical providers place emphasis on drug use/abstinence.
- Language implies assumptions about behaviors and health investment.
- Poor trust from doctors.
- Insurance sees drug use as a liability. Other insurance inequalities.

Education/Employment

- Drug testing and screening.
- Disciplinary action or assumptions based on drug use not on performance.
- Hiring practices and opportunities that do not include or prioritize drug users.
- Lack of diverse education about drug use. Silencing of drug users in history.
- Placement in certain schools/programs based on experience with drug use/drug related criminal records.

Family/Friends/Community

- General distrust of family and friends who are drug users: hiding belongings when drug user comes around.
- Cutting people off based on drug use; ultimatums, isolation.
- Talk about drug users but don't talk to drug users.
- Patronize, tell people what they need to do; set goals for people instead of asking what is realistic or what will work for them.

Harm Reduction Service Provider

- Perpetuating the us vs. them dynamic through boundaries, language, and regulations.
- Providers are identified as experts instead of clients.
- Policies are created and imposed without client input
- Drug users are not hired, and if they are, they are given limited roles/authority.

Housing

- Policies are created that threaten housing for drug use.
- Neighbors will call the cops based on judgment.
- An overall monitoring of personal space – different standards, because many people can get high in their own homes without having to worry.
- Housing is isolated, and is not wanted in certain neighborhoods.
- Housing options are excluded to those where drug users already live – segregation.

MODULE SIX: CHALLENGING STIGMA, CREATING CHANGE

Goals

The goals of this module are:

- Consider ways to address stigma at individual and agency levels.
- Gain conceptual and practical tools toward the development of attitudes and environments that challenge stigma and support drug users' needs.
- Review strategies discussed throughout the workshop.

Objectives

Upon completing this module, participants will be able to:

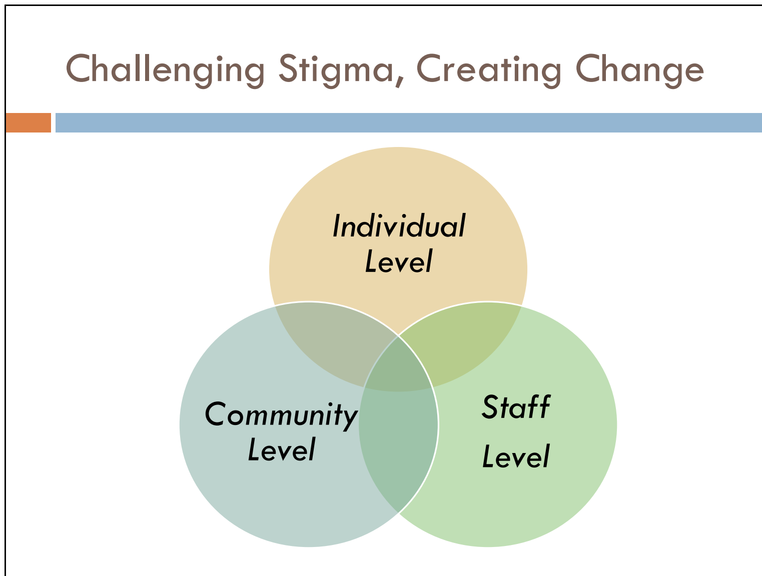
- Identify at least 3 strategies to be used at an individual level when confronting stigma.
- Name at least 2 strategies that can be used to confront stigma at both the staff and community level.

Time

10 minutes total

Materials

- Clock
- PowerPoint Slides
- Newsprint/flip chart/large paper
- Markers
- Tape for newsprint



Format: *Presentation*

Slide purpose: *This slide is meant to introduce the next module by identifying the 3 levels of change that will be discussed.*

- This slide is simply an overview of the 3 levels at which we will discuss challenging stigma.
- It offers a visual representation of the bigger picture, showing that there is overlap between the different levels.
- Do not spend much time on this slide – each component will be addressed in the following slides.
- Acknowledge that there will not be a lot of time to discuss each of these strategies in general. Hopefully, some of the material covered in this module was covered throughout the training, making this more of a review.
    - *If more time is available, expand this section to accommodate for more discussion.*

Context

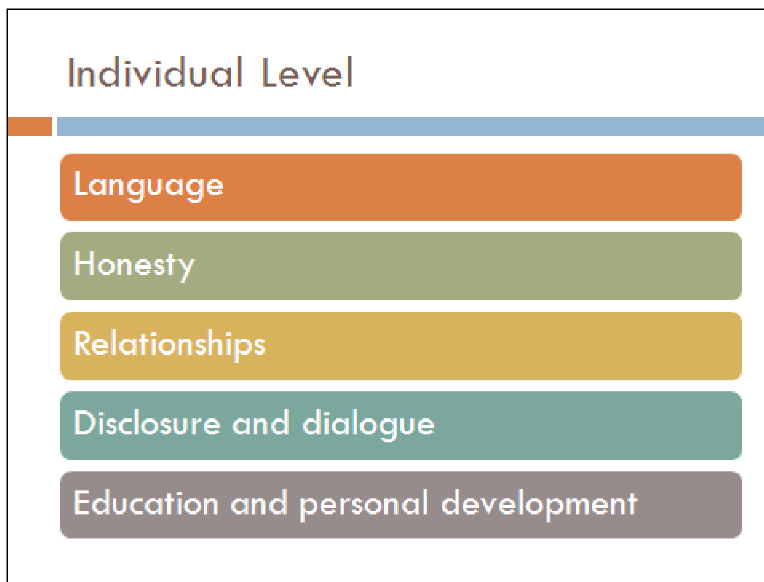
The following are examples of how the 3 levels may overlap:

Example: Consider a social service agency where individual providers have their individual practice strategies. The agency has a policy of hiring users and providing cultural competency training, and they also work with their local police department to educate about syringe access and occasionally organize lobbying trips.

Example: ACT UP – a handful of individuals formed a sub-committee to start providing syringes as a part of a larger campaign. Individually, the members learned and honed harm reduction practices. At the organizational level, involvement of drug users was prioritized and users therefore participated in advocacy around funding and policy change. The entire process was underlined by a commitment to shifting beliefs and reducing stigma.

Placing Stigma within a Harm Reduction Framework

- Harm reduction accepts that stigma is a part of the world
- There are ways to manage & challenge stigma
- Stigma intersects with other forms of marginalization & oppression
- When challenging stigma, meet ***all*** people where they're at
- Acknowledges that change is hard, values incremental change



Format: *Presentation*

Slide purpose: *To review individual-level strategies for challenging/confronting stigma from a provider perspective.*

- Briefly define each strategy, highlighting the ways in which they can contribute to confronting stigma.

- Whenever possible, offer clarifying examples. Draw on discussion from the rest of the training for examples.

- ***This section can be used for review to the extent that material was already covered.*** *Ex: Language*

Context

Language: Reflect back to earlier discussion for this point. There are few right or wrong answers when it comes to language, however it is critical to be mindful of what our language means, and the impact it can have. Also it is valuable to consider the ways in which language can set the tone for a relationship and/or bring up past stigma/trauma for individuals.

Explore drug use honestly: By giving clients room to talk about the good aspects of their drug use, as well as the negative, it may remove some potential judgment or perceived judgment. Honest conversations about drug use can promote shifts in the relationship between clients and providers and promote greater trust.

Authentic relationship-building: It is important to treat everyone as individuals – valuing their unique experiences and needs, and seeing them as more than simply their drug use. It can be helpful (though sometimes difficult) as providers to challenge "cookie-cutter" approach to service provision; in doing so, you begin to challenge the potential us v. them dynamic that is often present in service provision.

Explore Disclosure and dialogue*: This point refers to the value of providers talking their own experience (or lack of) with clients. Although it is essential to use personal disclosure in a purposeful way, when done thoughtfully, there is potential to challenge some drug-related stigma by removing the "taboo" around talking about use. Consider why it is ok to expect clients to disclose personal information about drug use, while it is assumed that providers should keep that information to themselves. Of course, boundaries are helpful and providers and clients have a right to set them as needed, however, we can begin to level the playing field by making drugs something that is ok for ANYONE to talk about honestly.

Education and personal development: This training is a part of that process – expanding our individual cultural competency about drugs, drug use and the lives and experiences of our clients.

Format: *Presentation*

Slide purpose: *To quickly review staff- and community-level strategies for challenging/confronting stigma.*

- Briefly define each strategy, highlighting the ways in which they can contribute to confronting stigma.

- Whenever possible, offer clarifying examples. Draw on discussion from the rest of the training for examples.

Context

Staff Level:

Training and education: Increase staff cultural competency through training and education. Training should extend to ALL staff levels from upper management to maintenance staff – anyone who interacts with drug users should receive training. A knowledgeable staff will hopefully be more competent and less stigmatizing.

Outlets for feedback: Does your agency have an outlet for discussing policies or behaviors that may be stigmatizing? The individual level strategies discussed above can also be useful when applied to inter-staff relationships. It is important for staff to be able to explore stigma honestly and openly – whether it related to client or staff-level policies.

Assessment of practices: Sometimes the policies that agencies adopt for administrative or other purposes can be inherently stigmatizing – even if it is subtle or easily overlooked. Frequent assessment of policies and procedures, preferable with feedback from clients and all staff can be vital.

Hiring Drug Users: (This may be a longer discussion, if time allows) Hiring drug users sends an important message to clients and other staff about respect for the experience and knowledge of drug users, and validates their capacity to be successful. Hiring drug users is an important issue for any organization working with and for drug users to take into serious consideration. Just as important as exploring the importance of hiring drug users can be to understand any meaning behind policies/beliefs *against* hiring active drug users.

Community Level:

Participant Advisory Boards: A PAB is an organized group of SAP participants and drug users who can offer feedback, guidance and recommendations regarding SAP policies and services. Although incredibly valuable, setting up a PAB, CAB or UAB may require a heightened level of organization, resources and commitment. IDU involvement in evaluation, through an advisory board or other vehicle, is recommended.

Awareness Campaigns: Just as we have discussed – it is possible for stigma to change, even on a broad community level. Awareness campaigns can be used to challenge stigma on a wide scale level – just as campaigns have been used to promote stigma (this is your brain on drugs). Agencies who work with drug users can use their relationships and knowledge to challenge stigma and promote more compassionate relationships to drugs and drug users. Awareness campaigns can also be very effective in challenging stigma among drug users themselves.

Policy and advocacy: Legislative advocacy can be a useful tool particularly when challenging institutional stigma. For example, campaigns are being waged against existing travel bans placed on drug users and sex workers.

Events: Community events can be a tool for unifying allies, and giving community members a chance to get to know drug users on a personal level. Engaging drug users to participate in, speak at and be part of organizing community events with other organizations, community boards, and even law enforcement can be a useful tool for challenging stigma. Research has shown that even having more contact with groups that are traditionally stigmatized can be an effective strategy for challenging beliefs and stereotypes.

Module Seven: Closing and Evaluations

Goals

The goals of this module are to:

- Summarize main themes of the training session.
- Allow participants to evaluate the session.

Objectives

Upon completing this module, participants will be able to:

- Identify main themes of the training session.
- Articulate strengths and weaknesses of the training.

Time

10 minutes total

Materials

- Clock
- PowerPoint Slides
- Newsprint/flip chart/large paper
- Markers
- Tape for newsprint
- ***Training Evaluation***

Release Campaign

Format: *Activity*

Slide purpose: *To provide participants with an example of a community level campaign put forth by the organization Release in the UK.*

- This slide is just offered to give participants one nice example of a community-level campaign.
- More images can be viewed at *http://www.release.org.uk/*:

From Release's website about the campaign:
Nice People Take Drugs is a campaign run by UK drugs organization Release. It started on 1st June 2009 with the slogan emblazoned across London buses and has been capturing the attention of the public and the media. The simple slogan was chosen to trigger a debate about UK drug policy that would then encourage politicians to engage properly with the subject too.

Learning Review

- Ask each participant to briefly share one thing that they will take away from the training today and apply to their work.
- ***Thank participants for their participation throughout the session.***

Evaluations

- Distribute the training evaluations and encourage people to complete them honestly. Instruct participants where to leave their completed evaluations.
- Distribute certificates, if available.

Anyway, no drug, not even alcohol, causes the fundamental ills of society. If we're looking for the source of our troubles, we shouldn't test people for drugs, we should test them for stupidity, ignorance, greed and love of power. P. J. O'Rourke, American political satirist, journalist, writer and author

I always got along with all types of people - popular people as well as drug addicts. - Amy Sedaris, American actress, author and comedian

I used to have a drug problem, now I make enough money.
David Lee Roth, American rock vocalist, songwriter, actor, author, and former radio personality, best known for Van Halen

Let me be clear about this. I don't have a drug problem. I have a police problem. - Keith Richards, English guitarist, songwriter, singer, record producer and a founding member of The Rolling Stones

People always want to ask me about my drug problem - I never had a drug problem; I had a self-esteem problem! - Gloria Gaynor, American singer, best-known for the disco era hits

"You cannot solve a problem from the same consciousness that created it. You must learn to see the world anew." -Albert Einstein, theoretical physicist, philosopher and author

It is no measure of health to be well adjusted to a profoundly sick society. Jiddu Krishnamurti, an Indian writer and speaker on philosophical and spiritual issues

Society has always seemed to demand a little more from human beings than it will get in practice. - George Orwell, an English author and journalist, best known for the novels Nineteen Eighty-Four and Animal Farm

All the people like us are we, and everyone else is They. - Rudyard Kipling, a British author and poet

A man is but the product of his thoughts what he thinks, he becomes. Mohandas Gandhi, pre-eminent political and spiritual leader of India during the Indian independence movement

There's so much talk about the drug generation and songs about drugs. That's stupid. They aren't songs about drugs; they're about life. - Cass Elliot, noted American singer, best remembered as Mama Cass of the pop quartet The Mamas & the Papas

The most potent weapon of the oppressor is the mind of the oppressed. - Steven Biko, a political activist and writer, is regarded as the father of the Black Consciousness movement in the Union of South Africa

"Marijuana is taken by '.....musicians. And I'm not speaking about good musicians, but the jazz type...' ~ Harry J. Anslinger, Federal Bureau of Narcotics, 1948

"All people have the right to beautful and radaint things" -Emma Goldman, an anarchist known for her political activism, writing and speeches

"Fear is a disease that eats away at logic and makes man inhuman." – Marion Anderson, an American contralto and one of the most celebrated singers of the twentieth century

"Prejudice is the child of ignorance." – William Hazlitt, an English writer, remembered for his humanistic essays and literary criticism, and as a grammarian and philosopher

No man is good enough to govern another man without that other's consent. - *Abraham Lincoln,* served as the 16th President of the United States

The trouble with people is not that they don't know, but that they know so much that ain't so. — *Josh Billings,* the pen name of humorist born Henry Wheeler Shaw

A junkie is someone who uses their body to tell society that something is wrong." ~ Stella Adler, an American actress and an acclaimed acting teacher

"Our national drug is alcohol. We tend to regard the use any other drug with special horror." ~ William S. Burroughs, an American novelist, poet, essayist, painter and spoken word performer

“Of course drugs were fun. And that's what's so stupid about anti-drug campaigns: they don't admit that. I can't say I feel particularly scarred or lessened by my experimentation with drugs. They've gotten a very bad name.”~ Anjelica Huston, an American actress

The basic thing nobody asks is why do people take drugs of any sort? Why do we have these accessories to normal living to live? I mean, is there something wrong with society that's making us so pressurized, that we cannot live without guarding ourselves against it? - John Lennon, an English singer-songwriter who rose to worldwide fame as one of the founding members of The Beatles

The more you can increase fear of drugs and crime, welfare mothers, immigrants and aliens, the more you control all the people. - Noam Chomsky, an American linguist, philosopher, cognitive scientist, and political activist

I think it's too bad that everybody's decided to turn on drugs, I don't think drugs are the problem. Crime is the problem. Cops are the problem. Money's the problem. But drugs are just drugs. - Jerry Garcia, an American musician best known for his lead guitar work, singing and songwriting with the band the Grateful Dead

Run for office? No. I've slept with too many women, I've done too many drugs, and I've been to too many parties. - George Clooney, an American actor, film director, producer, and screenwriter

As parents, we need to talk to young people about drugs and make sure they understand that drugs are dangerous, addictive substances that can ruin their lives and harm their communities. - John Walters, former Director of the White House Office of National Drug Control Policy (ONDCP)

I think hard drugs are disgusting. But I must say, I think marijuana is pretty lightweight. - Linda McCartney, an American photographer, musician and animal rights activist

If they took all the drugs, nicotine, alcohol and caffeine off the market for six days, they'd have to bring out the tanks to control you. - Dick Gregory, an American comedian, social activist, social critic, writer, and entrepreneur

It's so easy for a kid to join a gang, to do drugs... we should make it that easy to be involved in football and academics. - Snoop Dogg, an American entertainer, rapper, record producer and actor

Drugs made me feel more normal. - Carrie Fisher, an American novelist, screenwriter and actress

The purpose of random testing is not to catch, punish, or expose students who use drugs, but to save their lives and discover abuse problems early so that students can grow up and learn in a drug-free environment. - John Walters, former Director of the White House Office of National Drug Control Policy (ONDCP)

I'm in favor of legalizing drugs. According to my values system, if people want to kill themselves, they have every right to do so. Most of the harm that comes from drugs is because they are illegal. - Milton Friedman, an American economist, statistician, and a recipient of the Nobel Memorial Prize in Economics

There is only one reason why men become addicted to drugs - they are weak men. Only strong men are cured, and they cure themselves. Martin H. Fischer, was a German-born American physician and author

I'm already so ashamed of being a junkie. Now I have hep C, and I feel as if that announces to everyone that I'm a junkie. - Marcus R., from The First Year: Hepatitis C

In my hep C support group, people would talk about how they got the disease. There was this hierarchy in which people who got the disease through transfusion were 'good people' and people who got the disease through drugs were the 'bad people' who 'deserved' hep C. - Janice H., from The First Year: Hepatitis C

I am a successful guy. I have a great, well-paying job as a consultant. I am married with two kids. I have everything I've always wanted. I also have hep C. I messed around with drugs once or twice when I was younger. I wish I hadn't. Usually I lie about how I contracted hep C…say I don't know. I still feel like people are suspicious of me. As if I don't deserve everything I have now. - Bart M., from The First Year: Hepatitis C

QUOTES

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HARM REDUCTION COALITION
TRAINING EVALUATION

TRAINING:

DATE: ______________________________

TRAINER(S) NAME(S): ______________________________

____

Please circle the number that best indicates how you felt about the course.

	Strongly Disagree	Somewhat Disagree	Neither Agree	Somewhat Agree	Strongly Agree	Not Applicable
1. The training met its stated goals and objectives	1	2	3	4	5	
2. The handouts/materials were helpful.	1	2	3	4	5	
3. The training was well organized.	1	2	3	4	5	
4. Trainer 1 knew the course material.	1	2	3	4	5	N/A
Trainer 2 knew the course material.	1	2	3	4	5	
5. Trainer 1 listened and responded to questions well.	1	2	3	4	5	N/A
Trainer 2 listened and responded to questions well.	1	2	3	4	5	
6. Trainer 1 provided clear directions for group activities.	1	2	3	4	5	
Trainer 2 provided clear directions for group activities.	1	2	3	4	5	N/A
7. I had enough time to practice what I learned during the training.	1	2	3	4	5	N/A
8. This training will help me do my job better.	1	2	3	4	5	
9. I would recommend this training to my co-workers.	1	2	3	4	5	
10. Harm Reduction Coalition is an important resource in this region for training on HIV/AIDS.	1	2	3	4	5	
11. I was satisfied with the registration process for getting into this training.	1	2	3	4	5	

12. What did you like best about the training?

13. How could this training be improved?

14. Please write any other comments or suggestions you have about this training?

15. What other kinds of training would you like to take?

- ❒ Overview of Harm Reduction
- ❒ Motivational Interviewing
- ❒ Harm Reduction in African American Communities
- ❒ Opiate Overdose Prevention
- ❒ Boundary Issues for Service Providers
- ❒ Successfully Housing Substance Users
- ❒ Crystal Methamphetamine: Pharmacology, Patterns of use & HR Strategies
- ❒ Medical Complications & Drug Use
- ❒ Using Harm Reduction to Address Sexual Risk with Drug Users & their Partners
- ❒ Other ______________________________
- ❒ Other ______________________________