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Template for a training programme on drug-related stigma for delivery to staff in public services

Developed by Citywide Drugs Crisis Campaign

and

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October 2019

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Introduction

Citywide Drugs Crisis Campaign is a national network of community activists and organisations involved in responding to issues of drug use. It works to develop local community capacity to respond to drugs issues, to support and network local groups working on drugs issues, to lobby on policy issues and play a representative role for the community sector on policy bodies, and to encourage an inter-agency and inter-sectoral response to drugs issues. It supports a community development response to drugs issues. (Crowley, 2017, p.6)

In February 2018 Citywide launched a campaign to highlight and challenge drug-related stigma and its impact on people who use drugs called *Stop the Stigma* http://stopthestigma.ie/. The goal of the campaign was to shift attitudes and to move towards a situation where people with experience of drug use are treated with respect and dignity.

A significant issue which emerged in the development of the campaign, was that people with experience of drug use experienced stigma when accessing public services. This finding is in line with a wealth of national and international research, as outlined in the literature review[1]. The participants in Citywide research for the campaign felt that their interactions with agencies could be significantly improved by providing training to increase knowledge and understanding of addiction and of the personal, social and economic situation in which the person with experience of drug use lives.

Five key areas of action were identified as part of the campaign and specific actions set out to address them. Action 2 related to the stigma experienced by people who use drugs when they are engaging with public services: Action 2) Challenge stigma in delivery of services, states:

'We can engage with health care and frontline staff to develop education and training programmes to challenge the stigma that people who use drugs can experience in public services.'

To address this action, Citywide commissioned research to develop a template for a training programme that is to be delivered to staff in the relevant public services and which would involve people with experience of drug use in its eventual delivery. The training programme aims to reduce drug-related stigma in public services so that people with lived experience of drug use can receive the services that they require with equal dignity and respect.

The objectives of the training programme are:

- To raise awareness of the nature of drug-related stigma and how it can be manifested in the delivery of services.
- To raise awareness of how this stigma impacts on people who use drugs and on the effective delivery of services.
- To identify specific aspects of service delivery that may require change and improvement.
- To reach agreement on how appropriate changes and improvements can be implemented.
- To assist staff in putting in place a plan for ongoing monitoring and review.

The training template sets out the core elements of the programme while allowing for its adaptation for use with different professional groups.

The research in this study addresses this action. This report provides the findings of research carried out by Citywide in conjunction with Trinity College Dublin, which involved engagement with healthcare and frontline staff, and people with experience of drug use, to develop a training template to challenge the stigma that people who use drugs can experience in public services.

Why is this work important?

> "…The stigma of being drug users and discrimination drive people who use drugs to the margins of society…The marginalization and stigmatization of people who regularly use drugs also have a negative impact on their employment opportunities and social relationships"

(UN system coordination Task Team on the Implementation of the UN System Common Position on drug-related matters, 2019)

Research has shown stigma experienced by people who use drugs can prevent them seeking help and support (Levy, 2011; Lloyd, 2010; O'Reilly, 2014). As part of Citywide's focus groups in 2018 for the Stop the Stigma campaign interviews with thirty-three participants found that 'experiencing shame through drug use and associated behaviours resulted in them withdrawing from family and community and becoming more and more isolated. This isolation was also associated with 'depression and suicide attempts' (Citywide, 2018, p. 9)

Perceived stigma, where people assume that attitudes towards them will be negative, can also inhibit people from seeking support. These perceptions are generally based on observations that society looks down on them, and the anticipation of being stigmatised can prevent people from reaching out. The people who participated in the Citywide focus groups said that the experience of stigma made them feel humiliated, worthless and degraded.

The need for this work is presented in Citywide's seven evidence-based key position statements, which are:

1. Drug-related stigma prevents people from seeking help and can make it extremely difficult for people to move beyond their addiction.
2. Societal views of people with drug dependency are hostile and negative.
3. Use of every day pejorative language has an eroding impact on people's self-esteem and leads to feelings of extremely low self-worth and often resignation that there is no point in looking for help or recovery.
4. Stigma is long-lasting. It destroys people's prospects and their chances to contribute to society.
5. Drug-Related problems affect communities, and whole areas are labelled.

6. If we are serious about achieving the goals of our new National Drugs Strategy, we have to acknowledge and tackle the damaging impacts of stigma on people who use drugs.
7. Damaging bias exists within policing and judicial institutions. This can add to feelings of injustice, alienation and stigmatisation, (Citywide, 2018, pp.5-10)

The 2018 Citywide Stop the Stigma Campaign was based on findings from four key research sources:

1. A qualitative exploration of the experience and impact of stigma on people who use drugs undertaken in collaboration with six community-based Drug Rehab Projects and their participants in the summer of 2017.

2. The results of a Red C poll conducted in 2016 on behalf of Citywide to assess public attitudes towards drug use and people who use drugs.

3. The summary of research evidence and expert findings of the UK Drug Policy Commission (UKDPC) stigma research 'Sinning and Sinned Against: The Stigmatisation of Problem Drug Users'.

4. Doctoral Thesis, Laura O'Reilly 'Stigma & Identity: an exploration of drug use in West Dublin, TCD 2014.

Link to Citywide Stop the Stigma Campaign resources: https://stopthestigma.ie/campaign-resources/

Link to Citywide Stop the Stigma Position paper: https://www.stopthestigma.ie/wp-content/uploads/2018/02/Position_Paper_web.pdf

Literature Review

Defining Stigma

The concept of stigma refers to negative stereotypes assigned to a people when their attributes are considered both different from or inferior to societal norms, (Buchanan, 2008). HIV Ireland defines stigma as 'an attitude or belief, a mark of disgrace associated with a particular circumstance, quality, or person', and link it to shame and morality (HIV Ireland, 2017, p 14)

Erving Goffman's seminal work on stigma helps explain some of the processes and practices involved in shaping how people with lived experiences of drug use are stigmatised (Goffman, 1963)

According to Goffman, stigmatised identity is lodged in the discrepancy between normative social expectations and actual identity, where these expectations cannot be met, and the individual is ***"reduced in our minds from a whole and usual person to a tainted and discredited one"*** (Goffman, 1963, p. 3).

Goffman suggests that stigma has three principal dimensions:

1. "Bodily abomination" (perceived disfigurement or physical impairment, for example);
2. "Character blemishes" (perceived problematic identity or lifestyle, for example);
3. "Tribal stigma" (perceived negative characteristics associated with a particular group).

These multiple practices of stigmatisation are often used to characterise and 'cast out' members of minority and excluded communities. We can see how LGBTI+ people, migrants, members of ethnic minorities, (including the Traveller Community), and people with disabilities and mental health conditions have long been stigmatised.

Stigma can be seen to operate in a public, visible manner**.** Foster, Dinitz and Reckless suggest that 'The labelling hypothesis maintains that being publicly identified as deviant results in a 'spoiled' public identity. It contends that being labelled 'deviant' results in a degree of social liability...which would not occur if the deviance were not made a matter of public knowledge' (Foster, Dinitz and Reckless, 1972)

Emphasising the importance of "the visual," Goffman indicates the vital role played by the body, as both biological and social index, in stigmatising practices, (Goffman, 1963, p.8). Writing about stigma, body image and young gay men Barron and Bradford posit that 'for young gay men…there is immanent potential and recurrent possibility of being stigmatised because of the visual (and transgressive) codes of camp and effeminacy that are identified in the complexity of everyday social interaction" (Barron and Bradford, 2007, p. 2).

In his report *Sinning and Sinned Against: The Stigmatisation of Problem Drug Users* (2010) Lloyd suggests that stigmatisation occurs when a person's status is one which makes that person less acceptable in other people's eyes and which affects their interactions with others. He suggests, "this phenomenon becomes much more serious when the stigma takes centre stage, to the obscuration of the rest of a person's identity: when it becomes a 'master status'". One such master status is 'problem drug user', (Lloyd, 2010, p. 7). He further states that stigma only occurs where there is an imbalance in power between the stigmatised [little power] and the stigmatiser [more power].

When seen in relation to power, stigma can be seen to operate in similar ways as oppression. According to Iris Young, oppression is structural, which means it is not caused by specific policies or individuals, but has its causes in "unquestioned norms, habits, and symbols, in the assumptions underlying institutional rules and the collective consequences of following those rules." Oppression is experienced by members of certain, less powerful social groups. It operates through systems and structures which, "inhibit the ability of members of such groups to develop and exercise their capacities and express their needs, thoughts, and feelings" (Young, 1990, p. 40).

According to Thompson (2005), the workings of oppression can be analysed using a model that examines three levels – 1) *personal (an individual's views), 2) cultural (shared values)*

and 3) *structural (where "*oppression is 'sewn into the fabric' of society through institutions that support both cultural norms and personal beliefs". (Thompson, 2005)

What is a drug-related stigma, and what is its effect?

People who use drugs are seen to be "deserving punishment rather than deserving health care" (Des Jarlais et al. 1995: 1579 in Levy, 2014 p.1)

Lloyd (2013), in a narrative literature review, states that stigma is an enduring mark of social disgrace for those who are stigmatised. His review found that stigmatising attitudes towards people who use drugs are commonplace, including amongst the public and professionals, and its impact can be devastating, including when it acts as a significant barrier to recovery. He also outlines the long-lasting effects of drug-related stigma on children, families and communities.

O' Reilly (2014) found, in her research in West Dublin, that 'experiencing shame through drug use and associated behaviours resulted in them [people who use drugs] withdrawing from family and community and becoming more and more isolated. This isolation was also associated with depression and suicide attempts.

According to Levy, "Stigma, in addition to criminalisation, serves to drive people who use drugs underground, acting as a disincentive to seek healthcare and service provision, and further isolating and alienating people who use drugs from normative society and reducing opportunities for education and outreach, thus again exacerbating harm to both people who use drugs and wider society" (Levy, 2014, p.9)

Stigma towards people with experience of drug use can manifest itself in terms of discrimination – including when accessing services and in other aspects of their daily lives (on the street, shopping, travelling on public transport). It can also increase people

vulnerability to experiencing violence and sexual violence and to HIV and sexually transmitted or blood-borne infections (Levy 2014 p. 9; Logie et al. 2011; WHO 2005b)

Stigma towards people with experience of drug use can be seen in its historical context. As far back as 1940 A. R. Lindesmith in his paper *Dope Fiend Mythology* wrote 'heroin addicts are labelled with an assortment of contradictory terms, e.g. Passive psychopath, aggressive psychopath, narcissistic, dependent, childlike, sociopath, constitutionally immoral, hysterical, neurasthenic, weak character and will, self- indulgent, introspective, extroverted, pseudo-psychopathic delinquent'. Although not using the language of stigma, here Lindesmith speaks to core elements of stigma – including bias, fear and lack of factual information.

Drug-related stigma, socio-economic conditions and marginalised communities.

The links between what is often described as 'problem drug use' (as distinct from drug use) and of socio-economic conditions - such as poverty, unemployment, educational disadvantage, social exclusion and housing problems are long-established.

Again, as far back as 1940 in the United States, Lindesmith maintained that "To call addiction a disease when applied to the wealthy, and a vice when referring to the [poor] addict is nothing short of criminal, and such distinction serves but to becloud the situation and to interfere with the ultimate solution of the problem. At present, a poor addict is an underworld addict. ... We, as physicians have no right to refuse treatment to the poor addict. Similarly, hospitals have no right to refuse such people treatment, and we, the general public, are entirely to blame if by forcing the addict to take treatment in a penal institution, we make of him a criminal-and that is exactly what we are doing" (Lindesmith, 1940, p. 203)

In 1975 John Helmer linked stigma towards certain people who use drugs with class and racial stereotypes, "and mythologies that promote minority oppression within a given

society". He further states that the "perceived characteristics of the drug abuser reflect the attitudes towards stigmatized racial and socioeconomic groups and constitute class conflicts, especially in times of economic crisis, (Helmer, 1975).

The link between socio-economic conditions and the needs of people with experience of drug use was first recognised by the Irish government over 20 years ago when the first report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs concluded:

"in view of the link between economic and social deprivation and drug misuse, strategies to deal with the problem need to be focused on these areas. (p.28).

Citywide has identified that issues for individuals with experience of drug use are often compounded in communities by:

- Availability and range of drug use (poly drug use) including alcohol;
- Visibility/ public buying and selling of drugs;
- Social nuisance/community spaces being used for buying and selling drugs;
- Community safety/intimidation of the local community;
- Community pride/image/social networks disintegrating;
- Lack of resources to respond. (Citywide, 2018)

O' Gorman and colleagues in a 2016 Clondalkin study, noted that transitioning from childhood to adulthood for many young people in the area brought with it an increased multitude of risks and challenges. They also noted, significantly, that such young people had to negotiate this transition with a decreasing level of resources to address their needs – notably in relation to educational, social development and psychological difficulties. (O'Gorman et al., 2016, p. 7).

It is significant to note that drug-related stigma intersects with many other stigmas. According to Faden et al. (1991), 'Stigma can be compounded and intersected, with drug use becoming a double, triple or quadruple stigma in the context of (perceived or assumed) sex

work, HIV status, and LGBTQ status'. Logie et al. (2011) highlight how multilevel forms of stigma and discrimination are 'representative of an intersectional model of stigma and discrimination.'

The power of language

Levy (2014), draws attention to the power contained in everyday language, and its ability to turn subjective biases towards certain social groups into taken-for-granted reality. He states,

"Where we give metaphorical and/or analogous meaning in order to understand, however, the resultant meaning can be a powerful, political, and moralistic (or, at least, not an objective) one, where people may be defined using metaphor, assumption, social construction, and presupposition (Sontag 1989), people made to conform to language instead of language merely describing people" (Levy 2014 p 10)

Also speaking of the power of language to stigmatise and therefore put people who use drugs lives at risk Michael Botticelli, former director of the US Office of National Drug Control Policy under President Obama stated clearly:

"21 million Americans have a substance use disorder, and unfortunately, a very small percentage — about 10 per cent of those people — actually get treatment. And when you look at the reasons that people cite of why they don't seek treatment, the No. 1 answer that comes up for many people is stigma: They don't want their neighbors finding out, they don't want friends finding out. And one of the contributory factors to that stigma is our language that we use. So, this is not just a polite thing to do. These are issues, and these are words that have a dramatic impact on both clinical care and about how medical professionals actually see and treat people with addiction".

Citywide have clearly pointed out that the 'use of every day pejorative language has an eroding impact on people's self-esteem and leads to feelings of extremely low self-worth

and often resignation that there's no point in looking for help or recovery' and have called stakeholders and society to:

- Build upon the engagement between the Press Ombudsman and representatives of people who use drugs and other civil society organisations to develop an effective collaboration with journalists/editors to develop guidelines for the media on stigma.
- As a society, we need to stop calling people disrespectful, belittling and dehumanising names. We need to use more positive language about people who use drugs (Citywide, 2018, p.12)

Negative societal views

Red C research, commissioned by Citywide in 2016, shows that while there is some softening in public attitudes towards people who use drugs over the past 15 years, the majority opinion in Ireland is still very unfavourable. It found that nearly two thirds (64%) of the Irish population said that it would bother them to live near somebody who has a drug dependency. Just over half of the population said that they felt "scared" of people with a drug dependency. Nearly 90% believe that drug-related crime is a significant problem in Ireland. This negative societal attitude transcends the way people act, often unconsciously, when they pass or see a person with a drug dependency.

This research also found that the issue of blame is central to the stigma that surrounds drug use and that people who are viewed as being "responsible" for their situation are often most discriminated against".

A little over half of RED C respondents still believe that society is too tolerant towards people who use drugs, and nearly half of those polled thought that people who end up with drug problems have only themselves to blame. (Citywide, 2016)

Criminal / Addict

Scholars have considered how framing people with experience of drug use as either (or both) criminals and/or subjected to the disease of addiction perpetuates dangerous stigma (Keane 2002; Stevens 2012; Larkin et al. 2006; Levy 2014)

Drucker, E. (2000) 'In an environment frightened with powerful moral and legal reactions to the use of drugs, the stigma attached to drugs may come to be a more important factor than the biology of addiction. The demonization of drugs and the criminalization of the drug user (i.e. the war on drugs) could be more damaging to the individual and society than drug use or addiction' (p.31)

Keane argues that the addiction as diseases model results in people with experience of drug use being "infantilised and pathologised by the presumption of powerlessness" (Keane 2002: 191).

Levy argues that this, "discourse has facilitated a marginalisation and silencing of the voices of people who use drugs themselves, especially those who do not wish to conformingly identify as passive, pathological 'victims', thus serving to exclude narratives that threaten to destabilise and muddy crude assumptions and understandings of drug users as mentally unstable and inept people lacking agency and/or as dangerous criminals".

Moving away from stigma: people with experience of drug use at the centre of the discussion.

Human Rights

In September 2015 the United Nations High Commissioner for Human Rights presented a report to the Human Rights Council on the "impact of the world drug problem on the enjoyment of human rights, and recommendations on respect for and the protection and

promotion of human rights in the context of the world drug problem, with particular consideration for the needs of persons affected and persons in vulnerable situations"[1].

This report discusses how globally people are denied access to medical treatment on the grounds of prior drug use when evidence does not support such denial. It also outlined the value of outreach, information and education programmes and the risks inherent in the denial of such programmes which it says is not compatible with the right to health because it hinders individuals' ability to make informed choices about their health.[2]. The report further highlights the particular impact of criminalisation of drug use on ethnic minorities and women (p.13).

Amongst its recommendations are:

- "The right to health should be protected by ensuring that persons who use drugs have access to health-related information and treatment on a non-discriminatory basis. Harm reduction programmes, in particular, opioid substitution therapy should be available and offered to persons who are drug dependent, especially those in prisons and other custodial settings. Consideration should be given to removing obstacles to the right to health, including by decriminalizing the personal use and possession of drugs; moreover, public health programmes should be increased.
- Ethnic minorities and women who possess or use drugs, or who are "microdistributors", should be protected against discrimination.

In March 2019, the UN system coordination Task Team on the Implementation of the UN System Common Position on drug-related matters published the *report What we have learned over the last ten years: A summary of knowledge acquired and produced by the UN system on drug-related matters*[3]

[1] Full report here: https://www.unodc.org/documents/ungass2016/Contributions/UN/Human_Rights_Council/Panel_Drugs_HRC_31_45_Eng.pdf

[2] Submission of the Special Rapporteur to the Committee against Torture (19 October 2012), p. 6.

[3] UN system coordination Task Team on the Implementation of the UN System Common Position on drug-related matters: *What we have learned over the last ten years: A summary of knowledge acquired and produced by the UN system on drug-related matters*. Full report:

Significantly the report speaks in detail about the harmful effects of stigma and exclusion when it comes to the lived experience of people who use drugs. It draws attention to the interplay between drug use and marginalisation, stating:

"Marginalization can be viewed as contributing to illicit drug use, just as drug use can be viewed as contributing to the marginalization of some users: drug use can cause a deterioration in living conditions, while processes of social marginalization can be a reason for initiating drug use" (p.37).

It further speaks about linked risk factors, including unemployment, homelessness, incarceration, sex work and vulnerable youth (such as young victims of family abuse and violence).

People with lived experience of drug use as educators to combat stigma

"The slogan "nothing about us without us", first adopted by the disability rights movement, has been taken on by drug user rights organisations (Jürgens 2008), emphasising the importance of their contribution and inclusion" (Levy, 2014 p. 19)

The involvement of 'service users' in training for health care professionals, such as social workers, is a well-established (Loughran and Broderick, 2017; Foreman and Quinlan 2008)

Livingston et al. (2012) provide a review of research which has empirically evaluated interventions aimed at reducing stigma 'related to substance use disorders'. Their study reviewed interventions aimed at, 1) people with experience of drug use, 2) the general public, and most relevant to this study, 3) medical students and other professionals. They found that the involvement of people with lived experience of drug use in the delivery of anti-stigma programmes to professionals "are likely to decrease their stigmatizing attitudes and increase comfort levels towards working with this population" (p. 46). They further suggest that anti-stigma interventions involving people with experience of drug use "can

https://www.unodc.org/documents/commissions/CND/2019/Contributions/UN_Entities/What_we_have_learned_over_the_last_ten_years_-_14_March_2019_-_w_signature.pdf

maximize their effectiveness by targeting implicit-automatic processes underlying stigma (e.g. subconscious biases)" and "as such, it would be prudent to integrate this knowledge into anti-stigma interventions" and concluded that "for changing stigma at a structural level, contact-based training and education programs targeting medical students and professionals (e.g. police, counsellors) are effective" (p.46).

Kieron Hatton (2017) presents a creative framework for the involvement of service users in social work education, suggesting this allows such involvement to 'move beyond tokenism' and to empower social work students to promote social justice and social change.

Loughran & Broderick, (2017) richly describe a two-year process whereby service users from the SAOL Project, (a drugs rehabilitation centre for women), in Dublin worked in partnership with the management of the centre, and University College Dublin (UCD), to develop a curriculum and assessment method for a Masters of Social Work programme. In evaluating the programme, the authors found that service users were motivated to influence how social workers carried out their assessment, and in turn student social workers were influenced by their views and the experience of the training and assessment.

Other key findings, which are of particular significance for this training template are:

- Trust and confidence born of the long-standing relationship between the university lecture and the service provider were vital.
- The role of the service provider in supporting service users, through key working and ongoing programme was vital.
- Standards attached to gaining ethical approval for including service-users in the research provided an invaluable guide.
- In addition to increasing content about drug and alcohol use on such programmes, it is also vital to place further emphasis on core skills of relationship-building.

- Service users benefited from the experience and emphasised the value in influencing how social workers of the future would meet and engage with their peers in better ways.
- ‘A strong motivator in all this work for service users is that the groups that go to talk to students are seen as ambassadors for the other women in similar situations who do not have the opportunity to be heard’, (Loughran and Broderick, 2019, p. 14)
- “The research supports the view that when appropriately engaged, this service-user group have much to contribute to social work education. They can demonstrate to student social workers the importance of listening to parents, a critical factor in building trusting relationships”.

Models of anti-stigma training in Ireland, UK and internationally

CityWide has stated that five key actions can reduce stigma towards people with experience of drug use.

These are:

1. Change our language, stop using the word junkie and be aware of the language we use

2. Develop education and training programmes in collaboration with healthcare staff.

3. Support stronger community drug programmes

4. Understand more about the complexity of addiction

5. End the criminalisation of people who use drugs

In-line with these actions and in light of the literature review above, the following anti-stigma training courses have influenced the development of this template.

In-person anti-stigma training

Ireland

BeLonG To and HSE's LGBTI+ Safe and Supportive Services

The LGBTI+ Safe and Supportive Services model was developed to help create services that are inclusive of LGBTI+ young people. The model intends to empower services to tackle homophobic and transphobic stigma and involves a whole organisation community approach. It has been evaluated and adapted through six years of delivery. It supports organisations to take actions in 6 key areas:

1. Policy and planning
2. Programmes/ Curriculum
3. Safe and supportive environment
4. Community partnership
5. Direct support to young people
6. Staff training and development

As part of becoming an LGBTI+ Safe and Supportive Services programme, BeLonG To, and the Health Service Executive, (which is the state body that provides all of Ireland's public health services in hospitals and communities), developed a 'Rapid Assessment Tool' to help organisations in the process of creating an LGBTI+ Safe and Supportive Environment.

The evaluation of the project concluded that "This innovative project…has had a dramatic and positive impact on school staff. The outcome analyses suggest that the project increased their understanding of LGBT issues and ability to effectively respond to homophobic and transphobic bullying. The enduring nature of this change, as evidenced by the maintenance of positive effects at 9-month follow-up, is particularly noteworthy" (Sarma and Barron, 2016, p. 17)

HIV Ireland: Let's Talk About HIV, Stigma and Discrimination

This training provides participants with an understanding of HIV, living with HIV and HIV-related stigma and discrimination.

It is designed for people working across a range of sectors and professions who want to learn more about the impact of an HIV diagnoses, the law and HIV-related discrimination, where to seek support and how to challenge HIV-related stigma.

Content:

- Overview of HIV: transmission, prevention, testing and treatment.
- Living with HIV: impact of an HIV diagnosis, the impact of HIV-related stigma.
- Research: findings from the People Living with HIV Stigma Survey 2017.
- HIV and the Law: discrimination, transmission, and disclosure.
- HIV Ireland experiences and case studies of HIV-related discrimination.
- Challenging HIV-related stigma.
- Services and Resources.

Length of Training:

This is a half-day education and training programme, approx. 4 hours in duration

UK

Scottish Drug Forum: Understanding Stigma – Promoting Inclusive Attitudes and Practice

This training aims to support service providers to challenge drug-related stigma so as to make their services more accessible to people with experience of drug use.

Learning Outcomes - By the end of the session, participants should be able to:

- Recognise the meaning of stigma and the theory relating to stigma
- Identify and understand the specific stigma attached to people who use substances, people in treatment or recovery from substance use
- Describe the consequences of the cycle of stigma
- Identify our attitudes and beliefs towards treatment options and treatment outcomes for substances
- Identify language and practice which de-stigmatise people affected by substance use
- Challenge stigma attached to people who use substances, people in treatment or recovery from substance use.

This training is aimed at staff and management working with problem drug users, drug workers, housing/ homelessness workers, social workers, GPs, nurses and mental health workers. Free within Scotland and bespoke costs for elsewhere.

Training duration: one day.

USA

Harm Reduction Coalition for the New York State Department of Health AIDS Institute: Understanding Drug-Related Stigma Tools for Better Practice and Social Change.

This half-day training aims to provide participants with knowledge and skills to help them understand and address drug-related stigma, including internalised stigma. It aims to support participants to examine their own potential role in perpetuating drug-related stigma and to develop new ways of working in light of these.

Learning outcomes – on completing the organisers indicate that participants should be able to:

- 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 stereotypes and labels placed on 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 promoting attitudes and environments that challenge stigma and support drug users' needs.

This training is aimed at 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.

Training Duration: Half-day

Link: https://harmreduction.org/wp-content/uploads/2012/02/stigma-facilitators.pdf

Online anti-stigma training resources

The Australian Injecting and Illicit Drug Users League (AIVL): The Normal Day

Online training module that aims to improve communication between health professionals and people who use illicit drugs. The Normal Day module features podcast conversations between people who use drugs and health professionals about the challenges that arise during clinical interactions and provides resources for health professionals to improve their practice with people who use drugs.

Links:
http://aivl.org.au/project/stigma-and-discrimination/
https://vimeo.com/251587836

Centre for Addiction and Mental Health Canada: Understanding Stigma

Understanding Stigma is an online course designed for healthcare providers. Learning objectives include:

- Explaining stigma and its causes and identify what stigma looks like in the healthcare setting.
- Describing the impact of stigma on people with lived experience and why it is important for people with lived experiences to share their stories.
- Describe the relationship between stigma, mental illness and addiction.
- Identify common misperceptions about mental illness and addiction.

Links:
https://www.camh.ca/en/education/continuing-education-programs-and-courses/continuing-education-directory/understanding-stigma

Having reviewed the literature in the area of drug related stigma and training modules to combat it, the next section outline the research methodology used in the development of this resource.

Methodology

Citywide, in 2018, established recommendations to challenge drug related stigma in the delivery of public services. One of these recommendations was to engage with *health care and frontline staff* to develop education and training interventions to challenge the stigma that people who use drugs can experience.

In light of this, Citywide commissioned for research in relation to the development of a training template to take place. This research was undertaken by Trinity College Dublin, in conjunction with Citywide. Prior to any research being undertaken a full ethical approval process was conducted and the study design, methodology and all documentation and processes received ethical approval from the legally constituted Faculty of Health Sciences Ethics Committee at Trinity College Dublin, the University of Dublin.

Aims and objectives

Aim

The overarching aim of the research to develop education and training template was two-fold.

1. To explore the evidence base relating to stigma in substance use services
2. Secondly to use this evidence to inform the development of a training programme template.

Objectives

To enable the exploration of the evidence on stigma the objectives of the research were to

1. To perform a narrative literature review identifying relevant models of anti-stigma training that have been developed in Ireland, the UK and internationally.

2. To interview key professional informants, i.e., people with expertise of work with people who are drug users and who have experience of working on initiatives to combat stigma.
3. To conduct two focus groups with people with experiences of drug use at two Community Drug Projects in Dublin

The required objectives of the anti-stigma training template for professionals as stated by Citywide are that the template needs:

1. To raise awareness of the nature of drug-related stigma and how it can manifest in the delivery of services.

2. To raise awareness of how this stigma impacts on people who use drugs and on the effective delivery of services.

3. To identify specific aspects of service delivery that may require change and improvement.

4. To reach agreement on how appropriate changes and improvements can be implemented.

5. To assist staff in putting in place a plan for ongoing monitoring and review.

Design:

A multiple methods study design was used to reflect the research objectives.

Methods:

The methods below reflect the objectives:

1. A narrative review based on a desk top literature review

2. A series of qualitative interviews with professionals with expertise in working with people who are drug users and who have experience of working on initiatives to combat stigma
3. Focus groups with two groups of people with lived experience of drug use and two sites at community drugs projects in Dublin.

Sampling and sample method

Service provider interviews

Five key informant professionals were identified by the commissioning organisation Citywide to take part in this study. These included those who work in the area with expertise of work with people who are drug users and who have experience of working on initiatives to combat stigma. The Citywide Co-ordinator and Citywide Manager, selected the five key-informants and were jointly the gatekeepers for contacting them.

These five key professional informants:

1) Advocate for policy improvements in relation to drug users,

2) Work in a youth focused community drugs project,

3) Developed a major anti-stigma campaign in relation to HIV positive people

4) Coordinate a community drugs project focused on women

5) Coordinate a project that advocates for the rights of people who have experiences of drug use

Accessing sample

The Co-ordinator of City Wide facilitated access to potential participants for the researchers. Following this, the researchers initiated contact with the potential participants to establish their interest in taking part in the study. The professionals with expertise of working with people who have lived experience of drug use and who have experience of working on initiatives to combat stigma selected were contacted by email by the research team to inform them of the study, and to ask if they would like to take part in an interview. This

email included an information leaflet and a copy of the consent form. Follow up emails were sent one week after initial email to establish interest. Interviews were arranged at a time and date that suited participants. Consent was taken at the time of the interview. Interviews examined the development of a template for a training programme that is to be delivered to staff in the relevant public services and will also involve people with experience of drug use in its eventual delivery.

Interview questions

Participants were asked, from their own experience, in what ways do people who have experience of drug use experience stigma in general, and within public services, what information do health service providers need in order to make their services more welcoming and sensitive to the needs of people who have experience of drug use, what helps people understand the stigma they may be demonstrating to others, what kinds of training helps reduce stigma towards excluded people and finally what should such a template include. Thematic analysis was conducted on the data according to the established methods (ref?)

Service users: Focus groups

The research team worked with two community organisations – SAOL Project and TURAS Training, two community based supports for people with experiences of drug use, to organise focus groups with service users. SAOL, established in 1995, is a community based educational and rehabilitation day programme for women in treatment for drug addiction, based in Dublin's North Inner City. SAOL believes that education is the key to escaping poverty and addiction. Turas Training is a comprehensive day programme supporting individuals in recovery from addiction, funded by the Health Service Executive and the Department of Social Protection to provide education, training and specialist one-to-one services.

Accessing sample

As above for the service provider interviews, permission to access potential participants in SAOL and TURAS training services, was provided by the Directors of SAOL and of Turas Training service.

For the focus groups, the recruitment process began with an information session at the first Project and at the Training Project – two community-based supports for people with experiences of drug use. This information session was provided by the research team who informed the potential participants of the study. Potential participants were advised that they had a week to review the information material in order to provide sufficient time to consider whether or not they would like to participate.

Over the following week the researchers worked with the community projects to organise a focus group at a time that was convenient for members who wished to participate. Both focus groups took place with full written consent of all participants, completed on the day of the focus group.

A total of 2 focus groups took place, one with 16 participants and one with 6 participants. Both focus groups were carried out to best practice standards with a facilitator and an observer present from the research team.

Interview questions

Participants were asked their opinions on their lived experience of stigma, and stigma within public and health services. Following this, they were asked about what information service providers need in order to make their services more welcoming and sensitive to the needs of people who have lived experience of drug use, what they feel a training template to address stigma in services should include, and finally, questions in relation to their lived experience of stigma at different stages of drug use, and gender related issues. Thematic analysis was conducted on the data.

Summary of the findings

This research found that stigma towards people with experience of drug use is so common that it is experienced across many aspects of their lives on a daily basis. This includes while walking down the street, in shops and in health and public services. Language is a key driver

of such stigma with degrading words being used in the media and in everyday discussion. Stigma manifests itself in public and health services in a number of practices. These include the labeling of files in medical services and in people with experience of drug use not being given their files in the same manner as other services users (both practices publicly mark them out, a key component of stigma). In focus groups people with experience of drug use spoke about being made feel like unfit parents and about a lack of understanding of their personal and social circumstances. Other participants spoke about not being included in decisions around their own medication – an experience which can be seen to infantilise people.

Participants spoke about the impact of stigma as being extreme, and indeed potentially life threatening. This included people with experience of drug use not receiving emergency medical care when needed. It further included serious mental health conditions and suicidality as a result of feeling uncared for, cast out and hopeless. Interviewees also spoke about how stigma acts as a deterrent from seeking public and health services which in turn can perpetuate a cycle of chaotic drug use.

All interviewees spoke about the link between drug-related stigma and stigma towards people living in poverty. In line with the literature above a strong distinction was made between 'problem drug use' amongst people living in poverty and drug use amongst other people. This served to create a 'them' and 'us' in how drug use is seen and frames the regular use of certain drugs, for example alcohol, as socially more acceptable and less stigmatised.

Interviewees stated that public and health service providers need to better understand what stigma is and the impact it has. A number of participants stated that because stigma is so embedded in the 'everyday' that people may not be aware that their behviour is stigmatising. With that in mind, this research found that providing experiential and reflective learning opportunities is important. Such learning allows participants to experience how stigma feels through reflection on their own lives and experiences of being both stigmatised and stigmatising others.

Participants spoke about the importance of relationships in the provision of services and of the need for people with experience of drug use being centrally involved in the development and delivery of training.

Participants discussed a number of approaches to anti-stigma training. These included focusing on participants values, knowledge and skills, on anti-oppression frameworks and on discussing the lives of people with experience of drug use within the human rights framework.

Finally, the research found that service providers need support in putting learning from training into action and that as such training modules should include a focus on 'taking action' both personally and organisationally.

In conclusion

The details of the proposed training template outlined below draws upon the literature review detailed within this report, the existing international programs outlined and the findings from our research with people who use and people who deliver services.

Part Two: The Training Template

Introduction and template overview

The details within the template draw on the literature outlined earlier and it is expected that the trainer delivering the program would use this literature and the details within this report as a resource in the delivery of each section.

Duration: One day (10.00 – 17.00)

Objectives of training template

1. To raise awareness of the nature of drug-related stigma and how it can be manifested in the delivery of services.
2. To raise awareness of how this stigma impacts on people who use drugs and on the effective delivery of services.

3. To identify specific aspects of service delivery that may require change and improvement.
4. To reach agreement on how appropriate changes and improvements can be implemented.
5. To assist staff in putting in place a plan for ongoing monitoring and review.

Areas covered in training template:

- An awareness of stigma.
- An awareness of drug related stigma.
- An awareness of drug related stigma and its impact on people accessing services.
- An awareness of drug related stigma and poverty.
- An awareness of drug related stigma as it interacts with other stigmas, e.g., gender, race, sexuality.
- An awareness of the power of language in stigmatising people and approaches to changing this.
- An awareness of how services can change to become anti-stigma services.
- A framework in which such changes can be made and monitored.

Principled Approaches to this training template:

The approaches outlined here are based on themes which emerged from the primary research for this programme. In the research to develop this template both people with experience of drug use and professionals working in this area highlighted the importance of acknowledging the deep impacts of stigma on services users, many of whom have experienced trauma in their lives. As such, the need to create 'safe spaces' for discussing the issues is important, as is allowing participants space for reflection on their own experiences and values.

The importance of positive relationships was also highlighted by research participants, which further emphasises the need for training to be experiential and reflective. This further

demonstrates the importance of people with experience of drug use in the delivery of anti-stigma training.

Experiential and self-reflective:

Providing safe space for participants to explore their own experiences of stigma.
Providing safe space for participants to explore their own values and relationships.
Providing safe space for participants to reflect on stigma within their own services, and actions that can be taken to address it.

Service user facilitated:

Providing safe space for people with experience of drug use to discuss their experiences of stigma when accessing services and to allow for exchanges with participants.

Factual and myth-busting:

Drug-related stigma is often premised on morality-based misinformation which everyone has internalised due to its overwhelming presence in the media and in day-today conversation. Providing accurate up to date information is key to tackling drug-related stigma. This accurate information is in relation to the lives of people with experience of drug use, the impacts of stigma.

Practical and supportive of change

It is important to acknowledge that people working in services who interact with people with experience of drug use want to provide a good and supportive service. It is often the case that due to lack of training and information that they find this a difficult task. This training takes this position as a starting point and aims to provide service providers with support, space and practical tools to create the anti-stigma services they are committed to developing.

Socio-economic conditions and intersectional stigmas

The training acknowledges that people with living experience of drug use who are urgently in need of health care are disproportionately living in poverty, a reality which multiplies the stigma they experience. Additionally, it acknowledges that they very often live in the

intersections of discriminations on the basis of gender, race, disability, civil status, family status, sexual orientation, religion, age and membership of the Travelling Community and housing assistance.

Human Rights and Equality Focused

"All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood." (Article 1 of the Universal Declaration of Human Rights, 1948)

Every person is entitled to enjoy human rights by virtue of being human. They are universal rights and freedoms that belong to every person in the world**.** This training takes a human rights based approach which acknowledges the right of people with experience of drug use – including to access public and health services.

Training Template - Step by Step

Unit 1: Establishing a welcoming and safe learning space which promotes equality and respect. (40 minutes)

10.00-10.20 Check-in and overview of the training

[Objectives: Creating safe learning space – based on values, knowledge, skills]

What: Participants and trainers have opportunity to introduce themselves. Trainer provides brief overview of the training module – it's purpose and content.

Goal: All participants introduce themselves and are welcomed into the training, the participatory nature of the day is established from the start, participants get an overall sense of the day ahead.

Sources: SAOL Project check-in resource - https://saolproject.ie/checkincheckoutcards.php

Materials: Digital presentation, labels and markers

Introduction:

This training template is designed to promote participating and active shared learning. This first exercise is important as it helps set the tone for the day. It also acts as a fun 'energiser' which encourages engagement and equality of input (all participants and trainers take part).

To promote a safe learning space, it is also important that participants are aware of the outline of the training, its purpose and methodology. Knowing this from the beginning can reduce worry

Exercise

There are many check-in energizing exercises, here are just two examples from The SAOL Project:

1. Trainers invite each participant to tell the group their name, where they work and three things they would take to a desert island.
2. Trainers invite each participant to tell the group their name, where they work and one quality they like to see others exhibit.

Trainers description of the training

Key points to relay:

- This training template was designed because in 2018 Citywide launched a campaign to highlight and challenge drug-related stigma and its impact on people who use drugs called *Stop the Stigma.* The goal of the campaign was to shift attitudes and to move towards a situation where people with experience of drug use are treated with respect and dignity. A significant issue which emerged in the development of the campaign was the stigma experience by people when accessing public and health services. It was felt that interactions with agencies could be significantly improved by providing training to increase knowledge and understanding of addiction and of the personal, social and economic situation in which the person with experience of drug use lives.

- It is research and evidence-based.
- It acknowledges participants expertise and their desire to provide the best services to people with experience of drug use.
- It is largely experiential and reflective in nature.
- It encourages participant involvement and shared learning throughout.
- There is however no compulsion on anyone to share, and participants can input at their own pace – it is important that everyone is comfortable.
- The group will develop a group agreement.

10.20-10.40 Establishing a positive respectful learning space.

What: Establishing a respectful supportive learning space.

Goal: All participants feel safe, supported and respected throughout the training so that they can share experiences and opinions, to reflect on their own practices and to maximise their learning.

Sources: Patricia Prendiville (2004) Developing Facilitation Skills A Handbook for Group Facilitators (Combat Poverty Agency, Dublin)

Materials: Flipchart and markers / digital presentation to record

Introduction:

This training template takes as a starting point, that participants are committed to providing supportive services to people with experience of drug use. It acknowledges that participants are dedicated and expert in their areas, and that due to the scarcity of training and the nature of stigma itself, it can be challenging to provide anti-stigma work environments. The fact that participants are in the room is an indication of their commitment.

Stigma and discrimination towards people with experience of drug use is deeply embedded in our society and all of us have internalised it. Because of that, this training template is

designed to be experiential and reflective. It invites participants to share their own experiences and to challenge their own assumptions – this can be a very personal process. As such it is vital that the group of participants, facilitated by the trainers, create a safe space for discussion. This should be introduced at the start (through a group agreement) which should be revisited throughout the day.

Exercise: Developing a principles-based group agreement for a safe and supportive learning space.

Such principles can include:

- Listening: group members, including trainers, agree to listen to each other.
- Confidentiality: group members, including trainers, agree to honour what each participate contributes and to not report it outside of the group.
- Respect: each participate commits to according each other respect throughout the training.
- Equality: each participate has an equal right to contribute to the training and each member commits to valuing each other's participation and life experiences.
- Creating a safe space: group members commit to developing a learning space where everyone feels safe to share and learn.
- Assuming that participants are present to learn: group agrees that everyone involved is there because they want to provide the best possible supports, and want to develop their knowledge and skills.

At the end of each session the trainer can check back in with the group to see if the group agreement is being followed. This can remind participates of the principles and provide an opportunity to clarify and make additions.

Unit 2: What is Stigma? (1 hour)

Note to trainers: Please see section one of literature review for research to support you in delivering this module.

10.40 – 11.40

[Objective: raise awareness of nature of stigma - based on values and knowledge]

What: Developing an understanding of stigma.

Goal: To raise awareness of the nature of stigma. This includes participates engaging with their own personal experiences of stigma, to connect with how it 'feels' and to examine models for understanding how stigma operates personally, socially and structurally.

Sources: The CHANGE project – Understanding and Challenging HIV Stigma: Toolkit for Action – https://www.icrw.org/wp-content/uploads/2016/10/Understanding-and-Challenging-HIV-Stigma-Toolkit-for-Action.pdf

Materials: Pens and paper (for participants), flipchart and markers, digital presentation

Introduction (why this is important):
This section provides participants with experiential learning opportunities to engage with stigma. The research for this template highlights the importance of 'feeling' the impact of stigma on individuals and breaking down the 'us' vs 'them' dichotomy which is a core tenant of stigma. By facilitating professional participants to draw on their own experiences of exclusion this section aims to empower participants to personally connect with the impact of stigma.

This section also acknowledges that similarly to most people, participants have stigmatised others – consciously or unconsciously. This section supports them to reflect on this, and the impact it has had, and build towards developing anti-stigma work practices.

Finally this section presents a number of models for understanding stigma and its position within people's personal life, community and within broader structures.

Trainer presentation content

Defining stigma, (pp. 6-8 above), key points:

- Stigma is a mark or sign of disgrace. It distinguishes someone from others in society and acts to diminishes their worth as a person.
- It refers to negative stereotypes
- It is linked to shame and morality
- It involves public shaming
- When stigma takes centre stage in how someone is viewed by society it becomes how they are defined and this is hard to change.
- Stigma operates on a personal level (how people see others and themselves), on a cultural level (how communities view people) and on a structural level (how it is institutionalised, for example through legal systems and education systems)
- Stigma is complex and involves attitudes, feelings and behaviours.
- Fear and lack of accurate information contribute to stigma

Stigma is made up of two major parts:

1. Negative attitudes.
2. Negative behaviours that result from those attitudes – which includes discrimination.

Exercise 1: My own experiences of being stigmatised.

Goal: For participants to connect with the <u>feeling</u> of stigma by reflecting on their own living experience.

Exercise

1. Ask participants to individually think about a time when they felt rejected or isolated because of being perceived as different. Ask them to think about what was happening in this situation, how it felt and the impact it had on them.
2. Ask participants to discuss their memories in pairs, sharing as much as they feel comfortable with.
3. Invite participants to feed back to the full group if comfortable. Record key shared feelings from the group on a flipchart so that they can be seen by all throughout the training

Exercise 2: My own experience of stigmatising others.

Goal: For participants to reflect on their own experiencing of rejecting and isolating others and to connect with the feeling.

Exercise

1. Ask participants to individually think about a time when they rejected or isolated someone because they perceived them to be different. Ask them to think about what was happening in this situation, what were they thinking at the time and how did they behave?
2. Ask participants to write down any words they associate with this experience and with stigma.
3. Invite participants to feed back some of these words to the full group. Record these in a visible place for reference throughout the training.

Outcome: At the end of this exercise the group will have had time to reflect on how stigma feels and some agreed language to describe these feelings.

Exercise 3: Models for understanding stigma

Goals: For participants to develop an understanding of existing models of stigma and to see their own position in relation to these models.

Exercise:

Presentation on stigma, drawing on definitions outline in the literature above, including Goffman (stigma), Thompson (discrimination), Young (oppression) (pp. 6-8 above)

Trainer presentation content

Note to trainers: Please refer to models for understanding stigma, discrimination, oppression, (pp. 6-8 above), key points:

Goffman's model:

Stigma results in an individual being ***"reduced in our minds from a whole and usual person to a tainted and discredited one"***

Three principal dimensions:

1. "Bodily abomination" (perceived disfigurement or physical impairment, for example);
2. "Character blemishes" (perceived problematic identity or lifestyle, for example);
3. "Tribal stigma" (perceived negative characteristics associated with a particular group).

These multiple practices of stigmatisation are often used to characterise and 'cast out' members of minority and excluded communities. We can see how LGBTI+ people, migrants, members of ethnic minorities, (including the Traveller Community), and people with disabilities and mental health conditions have long been stigmatised.

Thompson's PCS Model

Stigmatising attitudes result in discriminatory behaviours which can become institutionalised. Thompson's PCS model offers a framework for teaching and learning in this area. The model recognises that such discrimination operates at three separate but interrelated levels:

1. The personal – how people see and treat each other
2. The cultural – how societies develop shared discriminatory views and practices

3. The structural – how these views and practices are ‘sewn into the fabric’ of society through institutions.

Iris Young’s five faces of oppression model

When seen in relation to power, stigma can be seen to operate in similar ways as oppression. According to Iris Young, oppression is structural, which means it is not caused by specific policies or individuals, but has its causes in "unquestioned norms, habits, and symbols, in the assumptions underlying institutional rules and the collective consequences of following those rules."

Oppression is experienced by members of certain, less powerful social groups. It operates through systems and structures which, “inhibit the ability of members of such groups to develop and exercise their capacities and express their needs, thoughts, and feelings”.

Participants discuss the presentation in pairs, reflecting on the previous exercises about how stigma feels. Participants are invited to feedback to the full group

Small group discussion, feedback, presentation of models for understanding stigma, e.g., Goffman (stigma), Thompson (oppression)

Unit 3: What is drug-related stigma and what are its impacts? (1 hour and 30 minutes)

Note to trainers: please see pages 8 to 10 above for information for this section.

11.40 – 12.40

This module should be lead by people with experience of drug use. There are a number of options for how this could be delivered which include:

1. This section centres around a series of real-life testimonies from people with experience of drug use delivered in person. Advantage: real life personal stories of stigma have a strong impact on trainees. Disadvantage: there is a risk of people feeling vulnerable and overly exposed, particularly when stories recount their trauma.

2. This section centres around a series of 'compost' stories delivered in person by people with experience of drug use who created the stories the with support from the community project they are connected to. This model has been developed by the SAOL Project, is outlined in Loughran & Broderick, (2017) and referred to on pages 16-17 above. Advantage: the people delivering the stories take on an important role in representing others, which research demonstrates is empowering and impactful. Disadvantage: the approach is somewhat less personal.

3. This section is delivered through a series of pre-recorded videos, which could incorporate both option 1 and 2 above. Advantage: practically it may be more possible to deliver this approach on a large scale throughout the country. Disadvantage: trainees do not have the opportunity to spend a day with people with experience of drug use – the very experience of which should be de-stigmatising itself.

What is drug-related stigma?

11.40 - 12.25

[Objectives: raise awareness of nature of stigma – based on values, knowledge]

What: Drug-related stigma

Goal: For participants to be able to recognise stigma towards people with experience of drug use, how it connects with poverty and intersects with other stigmas. For participants to also be able to recognise it in their own work environments.

Sources: 1. Citywide Stop the Stigma campaign materials. 2. SAOL training materials. 3.

Materials: Digital and video presentation, scenarios developed by people with experience of drug use.

Introduction:

The section provides participants with experiential learning opportunities directly from people with experience of drug use. As discussed on page 15 above the involvement of people with lived experience of drug use in the delivery of anti-stigma programmes to professionals “are likely to decrease their stigmatizing attitudes and increase comfort levels towards working with this population” (Livingston, 2012, p. 46)

Trainer presentation content

What is drug-related stigma, (pp. 8-10 above), key points:

- People who use drugs are seen to be "deserving punishment rather than deserving health care" (Des Jarlais et al. 1995: 1579 in Levy, 2014 p.1)
- Stigma towards people with experience of drug use is often based on a morality which sees drug use as an immoral choice and doesn’t see people who use drugs as deserving of support and empathy.
- Stigma towards people with experience of drug use can manifest itself in terms of discrimination – including when accessing services and in other aspects of their daily lives (on the street, shopping, travelling on public transport).
- It can also increase people vulnerability to experiencing violence and sexual violence and to HIV and sexually transmitted or blood-borne infections (Levy 2014 p. 9; Logie et al. 2011; WHO 2005b)

- Stigma towards people with experience of drug use can be seen in an historical context.
- Stigmatising messages about towards people with experience of drug use are often contradictory (e.g., passive vs aggressive; dangerous vs childlike) and have a basis in fear and lack of factual information.

How stigma manifests itself in public and health services, examples include:

- People with experience of drug use not receiving their medical files when others do at clinics.
- People with experience of drug use having to queue differently to others, including having different entrances.
- People with experience of drug use not being seen in accident and emergency hospitals.
- Professionals expressing discriminatory attitudes

Exercises:

A series of scenarios of drug-related stigma are presented to the group by people with experience of drug use. These scenarios may include some of the following issues:

- Drug related stigma and socio-economic conditions.
- Drug related stigma towards women.
- Drug related stigma as experienced in public and health services.
- Drug related stigma as it intersects with other stigmas.

Participants are asked to consider each scenario in small groups, feeding back to main group for discussion on identifying drug-related stigma.

Trainers present key issues, drawing on literature, own experiences with reference what the group feedback.

What are the impacts of drug-related stigma?

12.25 – 13.10

[objectives: raise awareness of nature of impact of stigma – values, knowledge]

What: Understanding the impact of stigma on people with experience of drug use

Goal: For participants to be able to recognise the impact of drug-related stigma and to connect with the experiences of people with experience of drug use.

Sources: Citywide Stop the Stigma campaign materials, SAOL and UCD materials

Introduction:

In this section, participants continue to learn directly from people with experience of drug use. It moves on from identifying drug related stigma to developing an understanding of the serious impacts it has on people's lives.

Notes to trainer (please refer to pp 8-10 above). Key points:

Stigma towards people with experience of drug use has extremely damaging impacts on their lives. These include:

- Low self-worth
- Avoidance of treatment and poorer quality of care when treatment is sought
- Decreased employment, housing and educational opportunities
- Experiencing shame through drug use and associated behaviours can result in people withdrawing from family and community and becoming more and more isolated
- Self-stigma, created when someone internalises the negative messages towards them, can be devastating and can be associated with a range of mental health conditions and suicidal ideation.

Exercises:

A series of scenarios of drug-related stigma are presented to the group by people with experience of drug use. These scenarios may include some of the following issues:

- Drug related stigma resulting in lack of engagement with vital health and public services.
- Drug related stigma being internalised and resulting in poor mental health.
- Drug related stigma resulting in serious risk to health, e.g., people not being treated for medical conditions because of service providers being unable to see beyond 'drug user' label.
- Drug related stigma towards families, including children, and its impact on access to education and services.

Participants are asked to consider each scenario in small groups, feeding back to main group for discussion on the serious impact of drug-related stigma.

Trainers present key issues, drawing on literature, own experiences with reference what the group feedback.

13.15 – 14.00– Lunch

Unit 4: Language matters, challenging and changing stigmatising language (45 minutes)

14.00 – 14.45

[Objectives: to raise awareness of the impact of stigma and aspects of service that can be improved – values, knowledge, skills]

What: Understanding the central role which language plays in stigma towards people with experience of drug use.

Goal: For participants to develop a clear understanding of how stigmatising language is and to become equipped with an alternative non-stigmatising vocabulary

Sources: Citywide Stop the Stigma Campaign Materials

Introduction:

The research for this template demonstrates that stigmatising language is commonplace - on the street, in the media and within services. Addressing this language is central to creating anti-stigma services.

Notes to trainer (please refer to pages 11-12 above). Key points:

- Language plays a central and powerful role in stigma towards people with experience of drug use.
- Stigmatising language towards people with experience of drug use is embedded in our society – including in the media and in the everyday way in which people are described.
- The use of every day pejorative language has an eroding impact on people's self-esteem and leads to feelings of extremely low self-worth and often resignation that there's no point in looking for help or recovery (Citywide 2016).
- Changing stigmatising language towards marginalised groups is an important, effective and concrete way to create anti-stigma services.

Challenging Stigmatising Statements

*Materials: S*tigmatizing statements written on flipcharts or cards and prepared alternatives

Activities:

In small groups ask participants to list the stigmatising language they have heard.

Invite them to consider:

- What the words really mean.
- Where they heard them
- Where they originate from

Ask participants to consider alternative words and descriptions that are less stigmatising. Examples include:

USE	Don't Use
Person who uses drugs.	Drug user.
Person with non-problematic drug use.	Recreational, casual or experimental users.
Person with drug dependence; person with problematic drug use; person with substance use disorder; person who uses drugs (when use is not problematic).	Addict; drug/substance abuser; junkie; dope head, pothead, smackhead, crackhead etc.; druggie; stoner.
Substance use disorder. Problematic drug use.	Drug habit.
Has an X use disorder.	Addicted to X.
Abstinent: Person who has stopped using drugs.	Clean.
Actively uses drugs; positive for substance use.	Dirty (as in "dirty screen").
Respond, programme, address, manage.	Fight, counter, combat drugs and other combatant language.
Safe consumption facility.	Fix rooms.
Person in recovery, person in long-term recovery.	Former addicts; reformed addicts.
Person who injects drugs.	Injecting drug user.
Opioid substitution therapy.	Opioid replacement therapy.

Additional exercise option - Hot Seat Exercise – Challenging Stigmatising language

Invite participants, in small groups, to take turns sitting in the "Hot Seat". The person in the hot seat is expected to improvise challenges to statements which are presented one at a time. See list of statements below.

Examples:

e.g. you deserve to be sick if you behave badly, you deserve to lose custody of your children if you are a drug user, medical professionals are right not to want to treat you if you have a disease

Add other common statements relevant to the group

Strategies for changing attitudes:

Then discuss “What methods work best for challenging stigma? Be specific.”

Summary:

The most powerful responses are those which make people stop and think, rather than attacking responses which make the stigmatizer defensive. Examples of strong responses:

- You (or someone you know) may be in the same boat in a years time so you should be more compassionate.
- All of us are drug users
- My sister has problems with her drug use and those statements affect our whole family

Unit 5: Building anti-stigma plans (1 hour 45 minutes)

14.45 – 16.30

[Objective: awareness of aspects of service that require change, improvements that can be made, monitoring progress – based on values, knowledge, skills]

What: Building personal and organisational plans to create anti-stigma services

Goal: Participants recognise how stigma manifests itself in the services they work in and build both personal and organisational plans to change this.

Sources: The CHANGE project – Understanding and Challenging HIV Stigma: Toolkit for Action – https://www.icrw.org/wp-content/uploads/2016/10/Understanding-and-Challenging-HIV-Stigma-Toolkit-for-Action.pdf and BeLonG To LGBT Safe and Supportive model

Introduction:
Core to this training template is empowering participants to work to affect change in their services. As such this section supports them to consider how to plan for change and how to develop anti-stigma services.

Notes to trainer (please refer to pp 13-21 above). Key points:

- It is possible to challenge stigma and create anti-stigma services.
- There are very good Irish and international examples of such work.
- Placing people with experience of drug use at the centre of work to challenge stigma is vital and it works.
- Building organisation wide plans to create anti-stigma services is key.
- Building plans step-by-step – with immediate, medium terms and long term actions is important
- This section aims to provide participants with tools to do this.

Exercises:

1. Finding solutions in different contexts

14.45 – 15.30

Goals: Participants will be able to: develop practical strategies for stigma in their own work contexts

Preparation: Put up signs (in different parts of the room) for meeting spaces for different task groups. For instance: clinic, home based care, youth, counseling, health care, hospitals, schools.

Activities

Group division

Ask participants to "vote with their feet." to join the group of their own choice.

Task Group Discussion

Ask groups to develop concrete action plans:

- What forms of stigma do you see in your service?
- What is the biggest stigma problem in your service?
- What is the source of this problem?
- What are some possible solutions to this problem?
- Identify 2-3 specific new things you would like to do to stamp out stigma in this context.

Ask groups to be concrete, "Think big. Start small. Act now!"

Report back

Ask each group to give a report then quick comments.

2. 10 Steps for moving to Action

15.30-16.30

Goals: Participants will be able to work out a strategy for taking action against stigma

Exercise

Action Planning

Divide into small groups (2-4 members) for this exercise. After

each step get a quick report back and then move to the next step.

Situational Analysis:

Ask ."What is the current situation in your service (and community?) regarding drug related stigma? What forms of stigma are common in your service (and community?)? What are some of the background factors?."

Examples:

- Lots of secrecy and silence – people find it difficult to talk
- Common use of stigmatising language
- Affected people are the target for insults, exclusion and discrimination
- High levels of fear, fatalism and hopelessness
- Low knowledge of stigma
- High levels of poverty and unemployment

Vision

Ask "What will the situation in our service look like in two years time after our anti-stigma programme?"

Examples

- More openness in talking about drug use
- Staff members helping each other in being inclusive of people with experience of drug use.
- No stigmatising language
- More hope. Less feeling of fatalism amongst service users

- More trust in and use of health and public services.
- Changes in service acts as catalyst for change in connected services.

Activities

Ask “What activities will you carry out to reach that goal?”

Examples

- More training for health, public and community projects.
- Equality-based policy and procedures reviewed to be cognisant of the rights of people with experience of drug use.
- Needs analysis – work with people with experience of drug use to ascertain the changes they would like to see in your service
- Community participatory education on new facts about drug use so as to remain up to date.
- Further develop relationships with community based drug support services.
- Development of whole service anti-stigma action plans
- Participate in campaigns aimed to reduce stigma
- Community visits and greater understanding of affected households

Priority Activities and timelining

Ask – What activities are most important?

Ask – record actions as: 1. Immediate 2. Medium term 3. Long term

Resources

Ask – What resources do we need to do these activities

Examples

- Funds and materials for training
- Support in policy development
- Awareness materials
- Full organisation buy-in

Obstacles

Ask - What things might block our activities?

Examples

- Resistance from services which are very stretched.
- People not understanding that they are being stigmatising
- Apathy and sense of fatalism —people feeling they cannot do anything

Indicators:

Ask - What things show we have been successful?

Examples:

- Ongoing needs analysis with service users with experience of drug use.
- Carrying out service evaluations – see section below.
- Service participates in community based events
- Services develops closer partnership with community projects
- Noticeable decrease in stigmatising language
- Colleagues have participated in training.

TEN STEPS FOR MOVING TO ACTION	
1 Where are you now? (Situational analysis)	This helps you to look at what is happening at the moment around stigma. You can ask "How have things been in the past?" and "How are they now?" "Where is the stigma in the community or workplace?"
2 Where do you want to be? (Vision)	How would things look if you could really make a difference? Make a 'vision' of the future with reduced stigma.
3 How will you get there? (Activities)	What kind of activities can you do to help reduce stigma? Brainstorm all your ideas - practical, new actions to solve the problem.
4 Where will you start? (Prioritize)	What are the most feasible actions to start doing? What is the most important action?
5 What do you need? (Resources)	Identify any resources, skills or training that will help with your action—and any partners who can help. Don't stop at this point—don't think you can't do anything because you have no funds.
6 What might get in the way? (Obstacles)	Identify any obstacles that might prevent your action from being successful. Try to make plans or strategies on how to overcome these obstacles.
7 How will you know that you are successful? (Indicators)	Decide how you will measure your success. Identify "indicators" or signs that will show you that stigma is reducing. (Are more people talking openly about testing HIV positive?)
8 Action	Start the activities you have planned. Assign tasks to specific people
9 Monitoring	Check how you are doing and whether anything is changing.
10 Replan	Make changes to your plans based on what you learn from the monitoring.

Unit 6 Questions and Answers, drawing the day together, check-outs, evaluation and tools (30 minutes)

16.30 – 17.00

What: Allow time for outstanding questions, recap on day and learning, administer evaluation, provide links and tools, allow participants to 'check out' of what will have been a challenging and emotional day.

Goal: Participants can recall what they have learned, feel appreciated for their participation and feel empowered to take action.

Sources: SAOL Project checkins and checkouts - https://saolproject.ie/checkincheckoutcards.php; Patricia Prendiville (2004) Developing Facilitation Skills A Handbook for Group Facilitators (Combat Poverty Agency, Dublin)

Introduction:

The principled approaches to this training template (as outlined on pages 30 and 31) and central to its delivery. These include positive regard for all participants, promoting equality of participation and creating a safe learning space for all. As with the opening session it is important to close the training in a manner that all involved feel they have been heard, have learned together and are motivated to act.

Note to trainers:

- Remember to briefly recap on each of the modules.
- Ensure that participants have had questions answered, or where this is not possible that you signpost them to where they will find additional information.
- The training day will most likely have been emotional for participants. It's important to acknowledge that.
- A main purpose of the training is to motivate participants to create anti-stigma services – it's important that they leave feeling positive and equipped to take action.

Exercises:

1. **Recap on the day:** using the training outline and materials produced by participants the trainers recount the day step by step and remind participants of the learning in each module.

2. **Outstanding questions/ comments:** Participants are invited to ask any questions which they haven't had an opportunity to during the training.

3. **Participant recap and plans and checkout:** Participants are asked to briefly describe (e.g., in one word) their experience of the day and their feelings for taking actions.

4. **Evaluation:** In line with evaluation developed through framework below.

Take away tools

- Evaluation materials – developed in-line with evaluation framework, page 53, below.
- Citywide (2018) Stop the Stigma Campaign https://www.citywide.ie/download/pdf/stop_the_stigma_position_paper_feb_2018.pdf
- Citywide (2018) Stop the Stigma Campaign - Five Things we can do https://www.citywide.ie/download/pdf/citywide_a5leaflet.pdf
- Citywide and Red C Polling (2016) Citywide – Attitude to Drugs & Drug Users. Dublin: Citywide https://www.citywide.ie/download/pdf/citywide_red_c_.pdf
- Thompson PCS model for understanding stigma as a personal, cultural and structural level: http://youthworkcentral.tripod.com/aop_pcs.htm

To consider:

Online training programme and service self-assessment tools

This has proven helpful in a number of cases, in particular - CAMH - Canada/Ontario. Centre for Addiction and Mental Health, and BeLonG To LGBT Safe and Supportive Rapid Assessment Toolkit.

- A self-assessment ‘test’ such as the BeLonG To rapid assessment, which will allow service providers to evaluate their own weaknesses or strengths with regards to drug related stigma. This assessment can then be used to teach, with the correct answers being revealed at the end of each section of the test. This was used in CAMH Canada/Ontario Centre for Addiction and Mental Health.

- Online videos with personal testimonies. In the Camh online training the self-assessment test featured many personal stories which helps to put a personal and human face to the people experiencing stigma. There were also a number of reenactments depicting situations where a person experiences stigma, with four various dramatic recreations of the responses one might give. As part of the test question, people are asked to choose the correct response.

Potential Training Evaluation Framework

The objectives of the training programme are:

- To raise awareness of the nature of drug-related stigma and how it can be manifested in the delivery of services.
- To raise awareness of how this stigma impacts on people who use drugs and on the effective delivery of services.
- To identify specific aspects of service delivery that may require change and improvement.
- To reach agreement on how appropriate changes and improvements can be implemented.
- **To assist staff in putting in place a plan for ongoing monitoring and review.**

In order to address the final objective- *To assist staff in putting in place a plan for ongoing monitoring and review*, we recommend an implementation process and impact evaluation. The implementation-science framework will enable the objective identification of barriers and enablers to the delivery of the programme. This evaluation framework is cognisant not only of the training templates code of governance but also of the resource context within which the training template is situated.

A process evaluation will provide information on the service-delivery and governance aspects of the programme, while the impact evaluation can provide objective evidence supporting the eight objectives of the programme. The evaluation plan will need to draw on the implementation-science literature of Burke and colleagues (Burke, Morris, & McGarrigle, 2012) and Fixsen and colleagues (Fixsen, Naoom, Blase, & Friedman, 2005).

A logic model for the training template should be developed in order to provide a clear and well-defined description of the aims, objectives and scope of the training.

In terms of the impact evaluation, it will be important to determine at what level you expect change to take place as a result of your training – the level of the individual, the service level, the community level?. The design of a logic model will facilitate the process of articulating the expected outcomes of the training.

Possible Training Evaluation Models

Kirkpatrick Four Level Model (Kirkpatrick 1996)

In terms of an evaluation framework for the impact of the training, the Kirkpatrick model may be of interest. The Kirkpatrick Model is probably the best known model for analyzing and evaluating the results of training and educational programs. It takes into account any style of training, both informal or formal, to determine aptitude based on four levels criteria.

Level 1 Reaction measures how participants react to the training (e.g., satisfaction?).

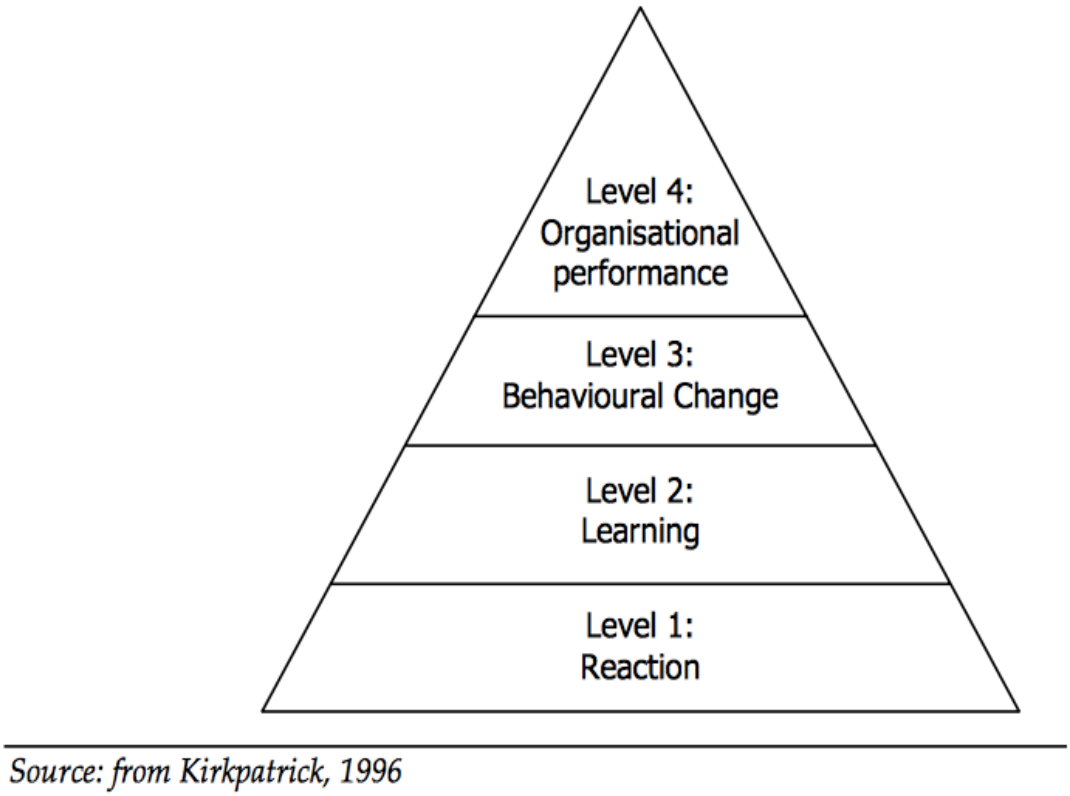
Level 2 Learning analyzes if they truly understood the training (e.g., increase in knowledge, skills or experience?).

Level 3 Behavior looks at if they are utilizing what they learned at work (e.g., change in behaviors?), and

Level 4 Results determines if the material had a positive impact on the organization.

As outlined by this system, evaluation needs to start with *level one*, after which as time and resources will allow, should proceed in order through *levels two*, three, and four. Data from all of the previous levels can be used as a foundation for the following levels' analysis. As a result, each subsequent level provides an even more accurate measurement of the usefulness of the training course, yet simultaneously calls for a significantly more time-consuming and demanding evaluation.

Undoubtedly, the most widely used and in-demand method for the assessment of training nowadays is Kirkpatrick's system based around the four levels as guidelines. The Kirkpatrick model has been used for over 30 years by many different types of companies as the major system for training evaluations. It is evident that Kirkpatrick's vision has made a positive impact to the overall practice of training evaluation.



The Kirkpatrick Model

Listed below is an in-depth look into the four levels of the Kirkpatrick Model:

Level 1 Evaluation – Reaction

In what ways participants liked a particular program / training? How participants feel?

The objective for this level is straightforward, it evaluates how individuals react to the training model by asking questions that establishes the trainees' thoughts. Questions will figure out if the participant enjoyed their experience and if they found the material in the program useful for their work. This particular form of evaluation is typically referred to as a "smile sheet."

As outlined by Kirkpatrick, each program needs to be assessed at this level to help improve the model for future use. On top of that, the participants' responses is essential for determining how invested they will be in learning the next level. Even though an optimistic

reaction does not ensure learning, an unfavorable one definitely makes it less likely that the user will pay attention to the training.

Examples of resources and techniques for level one:

- Online assessment that can be graded by delegates/evaluators.
- Interviews
- Can be done immediately after the training ends.
- Are the participants happy with the instructor(s)?
- Did the training meet the participant's needs?
- Are the attendee's happy with the educational tools employed (e.g., PowerPoint, handouts etc)
- Printed or oral reports provided by delegates/evaluators to supervisors at the participants' organizations.
- "Smile sheets".
- Comment forms determined by subjective individual reaction to the training course.
- Post-training program questionnaires.
- Verbal responses that can be taken into consideration and considered.
- Especially encourage written comments
- Try to get honest responses and feedbacks

Level 2 Evaluation – Learning

New skills / knowledge / attitudes? What was learned? and What was not learned?

Evaluating at this level is meant to gauge the level participants have developed in expertise, knowledge, or mindset. Exploration at this level is far more challenging and time-consuming compared to level one.

Techniques vary from informal to formal tests and self-assessment to team assessment. If at all possible, individuals take the test or evaluation prior to the training (*pre-test*) and following training (*post-test*) to figure out how much the participant comprehended.

Examples of tools and procedures for level two:

- Measurement and evaluation is simple and straightforward for any group size.
- You may use a control group to compare.
- Exams, interviews or assessments prior to and immediately after the training.
- Observations by peers and instructors
- Strategies for assessment should be relevant to the goals of the training program.
- A distinct clear scoring process needs to be determined in order to reduce the possibility of inconsistent evaluation reports.
- Interview, printed, or electronic type examinations can be carried out.
- An interview can be carried out before and after the assessment, though this is time-consuming and unreliable.

Level 3 Evaluation – Transfer

Was the leaning being applied by the attendees?

This level analyzes the differences in the participant's behavior at work after completing the program. Assessing the change makes it possible to figure out if the knowledge, mindset, or skills the program taught are being used the workplace.

For the majority of individuals this level offers the truest evaluation of a program's usefulness. Having said that, testing at this level is challenging since it is generally impossible to anticipate when a person will start to properly utilize what they've learned from the program, making it more difficult to determine when, how often, and exactly how to evaluate a participant post-assessment.

This level starts 3–6 months after training.

Examples of assessment resources and techniques for level three:

- This can be carried out through observations and interviews.
- Evaluations have to be subtle until change is noticeable, after which a more thorough examination tool can be used.
- Were the learned knowledge and gained skills used?

- Surveys and close observation after some time are necessary to evaluate significant change, importance of change, and how long this change will last.
- Online evaluations tend to be more challenging to integrate. Examinations are usually more successful when incorporated within present management and training methods at the participant's workplace.
- Quick examinations done immediately following the program are not going to be reliable since individuals change in various ways at different times.
- 360-degree feedback is a tool that many orgnaistions use, but is not necessary before starting the training program. It is much better utilized after training since participants will be able to figure out on their own what they need to do different. After changes have been observed over time then the individual's performance can be reviewed by others for proper assessment.

- Assessments can be developed around applicable scenarios and distinct key efficiency indicators or requirements relevant to the participant's job.
- Observations should be made to minimize opinion-based views of the interviewer as this factor is far too variable, which can affect consistency and dependability of assessments.
- Taking into consideration the opinion of the participant can also be too variable of a factor as it makes evaluation very unreliable, so it is essential that assessments focus more defined factors such as results at work rather than opinions.
- Self-assessment can be handy, but only with an extensively designed set of guidelines.

Level 4 Evaluation – Results

What are the final results of the training?

Commonly regarded as the primary goal of the program, level four determines the overall success of the training model by measuring factors such as lowered spending, higher returns on investments, improved quality of products, less accidents in the workplace, more efficient production times, and a higher quantity of sales.

From a business standpoint, the factors above are the main reason for the model, even so level four results are not usually considered. Figuring out whether or not the results of the training program can be linked to better finances is hard to accurately determine.

Types of assessment strategies and tools used for level four:

- It should be discussed with the participant exactly what is going to be measured throughout and after the training program so that they know what to expect and to fully grasp what is being assessed.
- Use a control group
- Allow enough time to measure / evaluate
- No final results can be found unless a positive change takes place.
- Improper observations and the inability to make a connection with training input type will make it harder to see how the training program has made a difference in the workplace.
- The process is to determine which methods and how these procedures are relevant to the participant's feedback.
- For senior individuals in particular, yearly evaluations and regular arrangements of key business targets are essential in order to accurately evaluate business results that are because of the training program.

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