13

‘If I Wasn’t on Drugs or I Didn’t Take Anything, I Wouldn’t Be Here’: Mental Health ‘Problems’ as an Unfolding Dimension of Social Harm Generated by Stigma

Michelle Addison and Monique Lhussier

Introduction

This chapter discusses the impact of stigma on mental health as an unfolding dimension of social harm amongst people who use drugs (PWUD). In traditional models of Social Determinants of Health (SDoH) ‘social relations’ are often ignored in favour of a positivist world-view (Addison et al., 2023) yet they nevertheless constitute a messy ‘invisible reality’ that shapes a person’s experience in the world (Bourdieu, 1990). Drawing on Tyler’s concept of ‘mechanisms of stigma’ (2020), the chapter argues that stigmatising social relations work in synergy with social determinants of health, harming the mental health of already marginalised individuals.

M. Addison (✉)
Department of Sociology, Durham University, Durham, UK
e-mail: michelle.addison@durham.ac.uk

M. Lhussier
Department of Social Work, Education and Community Wellbeing, Northumbria University, Newcastle, UK

S. Weston and J. Trebilcock (eds.), *Mental Health, Crime and Justice*, Critical Criminological Perspectives, https://doi.org/10.1007/978-3-031-83390-8_13

The WHO describes mental health as 'a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community', and is a global priority (World Health Organization, 2023a). Research also shows that mental health is experienced differently depending on intersections of identity, social and environmental factors (Hill, 2016; Narendorf et al., 2023; Nematy et al., 2023) and is significantly exacerbated by inequality (World Health Organization, 2023a). Depression is the leading cause of disability and a leading cause of death amongst young people aged 15–29 years old worldwide (World Health Organization, 2023b). In 2019 the WHO aimed for universal health coverage for mental health to 'ensure access to quality and affordable care for mental health conditions in 12 priority countries to 100 million more people' (World Health Organization, 2023b) but this is still yet to be fully realised.

The '*Cost of Living Crisis*' has created a particularly harmful context in England and Wales for those experiencing mental health conditions, and where demand for mental health services has increased dramatically (Joseph Rowntree Foundation, 2024). The mental health of marginalised groups matters because these populations are the most likely to be impacted by co-occurring stressors and experience the greatest harm as a result of trying to cope (Clark & Wenham, 2022; Joseph Rowntree Foundation, 2016, 2024; Mustafa et al., 2020; Spencer et al., 2021). Between Sept and Oct 2022, 1 in 6 adults experienced moderate to severe depressive symptoms—this is a rise of 6% compared to pre-pandemic levels (Attwell et al., 2022). According to ONS—Crime Survey for England and Wales, in the year ending June 2022 (Jones, 2022) those who reported lower life satisfaction and feeling like things they do in their life were not worthwhile, were also more likely to have used illicit drugs in the last year. Further, 24% of PWUD aged 16–59 reported either high or very high levels of anxiety (Jones, 2022). Adding to this, data from the 2021 Census for England and Wales (Office for National Statistics, 2021) states that there were 5582 suicides indicating a slight increase from previous years (Camacho et al., 2024; Nasir et al., 2022), and prevalence of moderate to severe depression is much higher amongst marginalised and vulnerable groups such as

those who are unemployed because of long-term sickness, unpaid carers, disabled adults, people living in areas of high deprivation, young adults (16–29 years old) and women (Attwell et al., 2022).

Stigmatisation of Mental Health

The stigmatisation of mental health conditions can do significant harm and compound pre-existing issues. This can take the form of negative stereotyping, stigma by association, negative attitudes and behaviour towards another, as well as systemic stigma in mental health and wider services (Thornicroft et al., 2022). Research shows how stigma about mental health can negatively impact a person's help-seeking behaviours, their engagement with services, physical health and feelings of social inclusion (Thornicroft et al., 2022).

The NHS estimates that between 70 and 80% of people using drug and alcohol services have difficulties with their mental health (see NHS, 2023). It is common in health and justice settings to frame drug use as being the dominant reason a person's mental health is deteriorating and so other correlates, like poverty, domestic violence, housing, that are impacting mental health can be ostensibly overlooked (NHS Addictions Alliance, 2021). For PWUD, getting support for mental health is rarely straightforward because of the problems presented by having a 'dual diagnosis[1]'. This is often because a dual diagnosis of drug use and poor mental health makes treatment more complicated and access can be contingent on available resources (see NHS, 2023).

In England and Wales, the Mental Health Crisis Care Concordat sets out a national agreement regarding principles and good practice between services ranging from the NHS, the police and the Home Office to the third sector and charities (Department of Health and Social Care, 2014). This Concordat is intended to coordinate care and develop a better way of working that supports people experiencing acute mental crises, and secures better outcomes and equitable access to mental health services.

[1] Dual diagnosis refers to 'co-occurring mental health, alcohol and drugs'—i.e. COMHAD, and is further discussed in section three.

Although there is limited mention of stigma in the Concordat (a critical shortcoming of the agreement, also noted by Wiseman in her report to the Cabinet (Wiseman, 2021), police and practitioners are advised that they should avoid 'the stigmatising appearance that a mental health crisis is a crime, for example, police forces should consider using unmarked cars to travel to a property to enforce a warrant' (Department of Health and Social Care, 2014: 26). This is all set in the context of increased financial strain on services, increasing privatisation of health and social care, as well as parts of the criminal justice system, meaning resources are limited, workers are under pressure to secure outcome targets, and demand for mental health services has intensified (Joseph Rowntree Foundation, 2024).

The impact of mental health stigma has long been a concern and the *Lancet* Commission on ending stigma and discrimination in mental health highlights the toxic effects it has on already marginalised people, and how stigmatisation contravenes basic human rights (Thornicroft et al., 2022). Many studies detail anti-stigma campaigns and behaviour interventions aimed at reducing stigma about mental health conditions (Cook et al., 2014; Corrigan et al., 2012; Hatzenbuehler et al., 2013; Moore et al., 2023) to promote more inclusive services. Thornicroft et al. (2022), in particular, have developed a set of recommendations alongside targets and indicators to measure progress in these areas. However, Tyler and Slater (2018) are cautious about celebrating these approaches as 'successes' (see also (Bambra, 2018); they write that anti-stigma campaigns around mental health, although well meaning, can often divert attention away from the causes and beneficiaries of stigma, as well as widening structural inequalities.

Social inequality is pernicious and produces chronic stress (Bambra, 2016), and yet anti-stigma campaigns around mental health often overlook the determinants of health and neoliberal policies in 'actively promulgating mental distress' and legitimating stigma production (Tyler & Slater, 2018: 726). Tyler notes that it is the 'political project of austerity' and 'stigma craft' which 'destroys people's mental health' (Tyler, 2020: 199). Whilst the *Lancet* Commission maps stigma and discrimination *of* mental health with the aim of reducing negative attitudes and behaviours and making improvements to services, it does not address the

causes and beneficiaries of stigma mechanisms that do harm to a person's mental health. Neither does the Commission look closely at how intersections of identity alongside 'deviant' practices are stigmatised, and how this 'stigma craft' generates harms to mental health.

Further, stigma can be mobilised as part of behaviour change models, and this can inadvertently impact mental health. Dennis and Pienaar (2023) discuss how stigma can be used in behavioural interventions to reduce drug use (Dennis & Pienaar, 2023). The Scottish Parliament Cross Party Group on Poverty also reflected on the problems of a public health and criminal justice approach that used stigma in educational communication aimed at deterrence and 'recovery' (McLean, 2023). These policies and interventions can lead to an internalisation of shame and unintended harms to mental health, as a PWUD tries to make a 'liveable life' possible (Back, 2007; Bambra, 2018; Tyler & Slater, 2018).

Theorising Stigma

The concept of stigma has been widely theorised (Addison, 2023; Addison et al., 2022; Goffman, 1963; Hatzenbuehler et al., 2013; Link & Phelan, 2001; Pemberton et al., 2016; Tyler, 2020; Tyler & Slater, 2018; Yang et al., 2007). Goffman describes stigma as a 'deeply discrediting' attribute (Goffman, 1963). Cook et, al. state that stigma, 'occurs when a *label* associated with a *negative stereotype* is attached to a characteristic (e.g., skin color, sexual orientation, chronic illness), causing people with this characteristic to be seen as *separate* from and *lower status* than others and thus, as legitimate targets of *discrimination*' (emphasis in original, 2014: 101). Addison et, al. referred to stigma as 'a *verb*, something that is done to us in the everyday interactions between people' (Addison et al., 2022: 2). The Lancet Commission also details sites of multi-levels of stigma from the personal (inter-and intra-personal) to the structural (public and systemic) (Thornicroft et al., 2022).

Tyler has engaged extensively with the history of stigma to unveil its colonial roots in slavery and to question the power dynamics of stigma as serving the interests of the powerful and privileged (Tyler,

2013, 2018, 2020). She describes stigma as 'a site of social and political struggle over value' (2020: 180). Stigma mechanisms are 'techniques of social classification' through which 'inequalities are inscribed and materialised'—taken together as 'stigma craft' (Tyler, 2020: 89). These mechanisms specifically draw on intersections of identity (class, gender, race) and mobilise so-called 'deviant practices' (such as drug-taking) to produce, as Tyler describes, hierarchies of valued personhood. There is a great deal of evidence that shows how mental health conditions are stigmatised, how this can generate or exacerbate harms and can hinder help-seeking behaviours amongst PWUD (Corrigan, 2022; Corrigan et al., 2003, 2012; Hatzenbuehler et al., 2013; Phelan et al., 2008; Spencer et al., 2021; Thornicroft et al., 2022; Yang et al., 2007). Much less is known about how stigma functions in day-to-day interactions and harms a person's mental health (exceptions include Hatzenbuehler et al., 2013; Phelan et al., 2008; Tyler, 2020; Tyler & Slater, 2018)). Further, what is less often discussed is the phenomenological aspect of stigma and how this is harmful to the mental health of marginalised groups—often making pre-existing mental health conditions worse (Addison et al., 2023; Tyler, 2020; Tyler & Slater, 2018).

In this chapter we draw on a combination of these approaches to consider public stigma directed towards PWUD, as well as relational stigma between PWUD and practitioners. Throughout our discussions Tyler's concept of stigma mechanisms (i.e. ways that value is inscribed on the body or via practices) is utilised to help us to explore how social and health inequalities are perpetuated amongst PWUD. We are specifically interested here in harms to mental health that arise out of stigma from the public and in interactions with practitioners and service providers. We aim to show that the infliction of valuelessness on PWUD is a type of stigma craft that justifies disdain towards an already marginalised group of people. The weaponisation of stigma is harmful and in the remainder of our discussion we show how this can make ill mental health even worse amongst PWUD.

Methodology

The study presented in this chapter is qualitative in design and utilised semi-structured, in-depth interviews with n-24 people who use drugs (12 men, 11 women, 1 transgender; aged between 20 and 50 years old). Fieldwork occurred before and during the global Covid-19 (C-19) pandemic (2020–2021) meaning that a combination of face-to-face (n-12, before C-19) and online/telephone (n-12, during C-19) interviews were conducted to mitigate the risk of contamination. The interviews did not generally focus on C-19 in discussion. This research was located in the northeast of England, which has the highest number of drug-related deaths in England and Wales (Rae et al., 2022) and has a number of local authorities that fall into the lowest indices of multiple deprivations (Ministry of Housing Communities and Local Government, 2019).

We combined purposive and snowballing sampling to include a range of voices and inclusion criteria where participants used one of the following as a primary drug of choice: heroin, crack or crack cocaine, Spice (Novel Psychoactive Substance), although a range of frequency of drug use was acceptable. All participants were over 18 years old and the project was advertised via social media, leaflets, posters and 3rd sector organisations who acted as gatekeepers and helped to establish contact with interested persons.

Sound ethical practice (approved by Northumbria University ethics board—submission ref: 17304) was adhered to: participation in the study was voluntary and all interested persons were given the opportunity to look at an information leaflet about the study and ask questions. Participants were advised that all discussions would be anonymised and identifiers removed, all participants were assigned a pseudonym and were reminded that taking part would be treated as confidential. All participants were offered a £10 shopping voucher. Data was coded by MA using qualitative software (NVivo), organised into themes and discussed with ML in subsequent analysis meetings. A thematic analytical framework was developed using Braun and Clarke's approach (Braun & Clarke, 2006) and inferences were discussed and tested for credibility.

Findings and Discussion

Findings are organised into three core themes: i. Mechanisms of stigma ii. How stigma is harmful to mental health iii. Living with stigma.

Mechanisms of Stigma

In this section we look at how stigma operates through particular mechanisms at a personal and structural level (Tyler, 2020). We show that marginalised and vulnerabilised PWUD experience stigma from the public, as well as health and criminal justice services, and themselves because of devalued aspects of their identity and 'deviant practices'.

Pre-existing Mental Health Conditions

Many of our participants reported pre-existing mental health conditions ranging from schizophrenia and personality disorder to eating disorders and depression. They presented an array of complex needs and discussed challenges in their day-to-day lives, ranging from daily functioning to managing illicit and licit drug use, as well as accessing services.

> I'm diagnosed with schizophrenia, post-traumatic stress, personality disorder and acute psychosis. [RAVI, 42 YEARS]

> I mean, if you're not feeling mentally well, you can't work, you can't live a normal life because your emotions are all tied up. You don't know whether you're coming or going. [JACK, 43 YEARS]

Whilst not all PWUD experienced mental health challenges or conditions in this study, many did and made it clear that they did not want to be pathologised because of this. Several expressed that they wanted their experiences of mental health recognised and understood as a *'constant battle'*.

> I hear voices, which is even worse during stressful periods, so they're not very nice, they're horrible, they're nasty, vindictive, cruel, whatever […] So it's a constant battle with them. [BILLY, 47 YEARS]

The 'problem' of dual diagnosis was raised often by participants, as were challenges to navigating access to mental health support. Here, Wendy draws attention to simplistic assumptions about straightforward causality between drug use and mental health:

> my mental health's spiralled because of what I went through and it got progressively worse due to the alcohol consumption, so I do have mental health problems but they're not as a result of my drug and alcohol consumption. [WENDY, 42 YEARS]

She points to a more complex interrelationship between traumatic experiences, mental health and drug use, that is often not recognised in service provision. Indeed, the data showed that mental health was complexly bound up (but not limited to) past and present trauma, social, political and economic context, health inequalities and drug use.

In the next sections, we show how PWUD become exposed to mechanisms of stigma that operate at a personal and structural level, and how these are harmful to their mental health.

Public Stigma

PWUD felt stigmatised by members of the public for the way they looked, poverty and proximity to stigmatised locations (food banks, food kitchens).

> As soon as you walk out of here and you walk on the road like people drive past in cars and shout abuse at you and that […] I was coming out, what do you call it - the food kitchen, food bank place, and it's only daft young ones shouting and that but some still look down on you. […] It's all right if it's just me and them there, but when they shout [junkie] in front of people… [SARAH, 39 YEARS]

There was a sense from Sarah that stigma could come from anywhere and that she had to remain vigilant to unexpected aggressions and acts of violence. As Sam discusses, the marker of '*Smack Head*' can be used as a devalued signifier and conductor of value. It is used as a mechanism to stigmatise drug use and construct a particular kind of person lacking in value in a moral economy of worth (Muncan et al., 2020; Wakeman, 2016).

> I walk down the street the other night and a couple of lads called me a smack head because I didn't have a lighter on me to give them a light for a fag. And it wasn't that they knew, they didn't know, it's just that's something that people randomly can't get, and it's classed as something that's degrading. So, like they call you that to put you down. So, when the more people do that, the more starts getting here. And the more you start thinking right, well *that's what I am.* [emphasis from participant] So, that's how it is. [SAM, 36 YEARS]

Sam demonstrates the damaging impacts of exposure to acts of othering, when people intend to 'put you down'. Phelan et al. (2008) discuss this kind of stigmatisation as a means of keeping a person subservient in a social hierarchy—it is a means of establishing a power imbalance. This difference in power is legitimated by de-humanising an individual (labelling of 'smackhead' or 'junkie') as some 'thing' not worthy of human rights and decency. Sam draws attention to the cumulative effects of this kind of stigmatisation, and how it not only impacts mental health but also can be internalised as a 'stigma truth' (see also (Weston, 2021).

Relational Stigma

Stigma was experienced relationally between PWUD and staff at various health, care and criminal justice settings. PWUD reported feeling patronised and shamed because of how they presented themselves, how they talked and their drug using practices. Staff can unintentionally utilise tropes around class and other identity categories that end up stigmatising and framing the person as 'less than' or someone to look down on. Karla talks about a young man who was street homeless and how he was

kept waiting outside in freezing temperatures as he tried to access a drug treatment programme. From her perspective, his needs were not being met and he was positioned as a 'nobody' by the service.

> there was an addict outside waiting to be seen and it was freezing cold. It was before Christmas, this day was really freezing cold, and you could see this lad was in withdrawals and I stand and talk to them outside because… do you know what I mean, it was me a few months ago, and anyway, I was just talking to him and I could see he was just so cold to the bone and I know what that feels like, and honestly my heart went out to him, and he said he'd been waiting 45 minutes. […] I just think is that one of the things that not being tret (sic) equally […] just kept him waiting like a nobody […]. [KARLA, 49 YEARS]

Research shows that this kind of stigmatisation by service providers generates insidious harms to health and wellbeing and legitimates inequality (Addison, 2023; Weston, 2021; Wright & Klee, 2000)—and as Karla points out, it can feel like you are being deprioritised.

The kinds of interactions that take place in criminal justice and health and care settings can have a positive life affirming impact on the individual but they can also be detrimental to recovery and deleterious to mental health when these interactions are stigmatising. In this excerpt from Haven, they draw attention to the power imbalance between themselves as a young adult receiving mental health support and their psychiatrist. Haven felt shamed and was repeatedly accused of taking drugs; we could surmise here that a question from the psychiatrist kept recurring due to issues around dual diagnosis and mental health interventions. Nevertheless, Haven felt very stigmatised in this interaction receiving mental health treatment:

> I remember seeing this psychiatrist who every week when I went would repeatedly ask me, "Are you taking drugs, are you taking drugs?" and at that age, I wasn't and he obviously didn't believe me and wouldn't look at anything else. [HAVEN, 30 YEARS]

Criminal justice and care systems[2] are under huge amounts of pressure to manage PWUD with complex needs and reduce service demand and costs to the wider economy (HM Government, 2021). As the Scottish Parliament Cross Party Group on Poverty shows, stigma can problematically become part of public health messaging intended to be educational and prompt behaviour change amongst at-risk sub-populations (PWUD) but can unintentionally generate stigma-induced harms (McLean, 2023). Further, increased pressure on services and performance targets can mean that staff can unknowingly draw on stigmatising stereotypes because of fatigue or when a PWUD has a complex history of relapse. As such, careful consideration is needed regarding the development of and investment in services involved in health and social care provision, and criminal justice, as well as intervention design and implementation, to avoid stigma-induced harms that widen health inequalities.

Theo discusses feeling stigmatised by members of a crisis team because of his drug using practices and challenging mental health needs. His way of managing how he was feeling at the time was to write in marker pen on his body to remember things. Theo emphasises feeling judged and marked out as *'crazy'* by this mental health professional.

> …there was one person from the crisis team, she looked down at me. I had writing on my body just in marker pen, it started off with my arm and it ended up on my chest and things like that because I had no memory at the time, I was forgetting things because I was doing too much, and these were important things to me and she just looked at that as being *crazy*. I was praying quite a lot. […] that was classed as me being *crazy*, instead what she couldn't see was that was giving me strength to go through this process. [THEO, 39 YEARS]

Interactions between service providers and PWUD can have a detrimental impact on mental health, but they can also be extremely positive. Chelsea shares her experience of Mary, a case worker, who was 'brilliant' and 'supportive'; she felt these interactions were so successful because they were stigma free and humanising.

[2] We are referring here to services regarding drug and alcohol, mental health, primary care, housing and social work.

> like Mary, she's amazing, she's an absolutely brilliant worker, do you know what I mean? I was doing really well when I was with her. She was really supportive. [CHELSEA, 43 YEARS]

Chelsea contrasts her experience with Mary to her experiences with her doctor who would accuse her of lying. This felt combative and judgemental, and she felt provoked into anger and defensiveness. This method of 'refusal' to be stigmatised as a 'liar' can be both liberating to a PWUD but also costly as they try to navigate treatment services (Dennis & Pienaar, 2023).

> She didn't turn around and say, like the doctors say now, "You're just using an excuse, you've always got an excuse, you're a liar," like, he's got no right calling me a liar, who the f*ck does he think he is? […] and what does he expect, me to sit there and say nothing? He's seen me enough times to know that I'm not going to sit there and let him talk to me like that. Like, I know for a fact, he expected me to kick off that day, he knows me well enough to know that I was going to kick off for him saying that [CHELSEA, 43 YEARS]

Often, people accessing methadone treatment are expected to accept a stigmatised identity, show remorse and present the image of a deserving patient to successfully navigate treatment programmes (Harris & McElrath, 2012). In this way, stigma is institutionalised as part of the fabric of these systems and processes which expects PWUD to conform.

Internalised Stigma

Not everyone experiences the same harms from stigma. Some people resist and refuse the markers of stigmatisation, whilst others 'play the game' in a way that reinforces power differences between themselves and others (Bourdieu, 1990). This kind of *resistance* can be seen as an act of rebellion towards structures that expect deference and conformity (Harris & McElrath, 2012). The excerpt from Chelsea is an example of this kind of push-back, and a refusal to be treated in a denigrating way by a professional:

> I've sent an email to the X board about the abuse. I'm f**king fed up of it. I'm fed up of him, and I think if more people put in complaints instead of just whinging about him to other people, then maybe they'll do something about him. [CHELSEA, 43 YEARS]

Navigating stigma and managing presentation of 'self' requires effort; this labour became an unnecessary and painful burden for some PWUD. Participants like Sam internalised stigma narratives lack of worth. She describes the sum total of her identity as a 'druggy' who is located in a marginalised position in social hierarchy.

> I'm just back to being a druggy. Which isn't a good thing is it? Like everybody just classes druggies as like lower than them. [SAM, 36 YEARS]

Karla describes long periods of feeling worthless and alludes to the impact this has on her mental health:

> You self-loathe yourself and that's not a nice place to be for years and years [KARLA, 49 YEARS]

Stigma can get '*under the skin*' and affect how a person experiences the world (Addison et al., 2022; Tyler, 2020). In this short excerpt from Karla it is clear how stigmatisation can translate to harm:

> …it makes you mentally and emotionally and spiritually not well. It just deadens anything that's healthy really, any healthy thoughts, feeling anything, emotionally well about yourself and I think that's what it strips away from you [KARLA, 49 YEARS]

In this regard, we have tried to show how there is a complex interrelationship between stigma (structural, relational and internal), mental health and drug use. Stigma is harmful to a person's mental health. It can suffocate anything positive and healthy in a person's life until it becomes the overwhelming lens through which they see themselves and their place in

the world. In the next section, we discuss in more detail how stigma can amplify mental health issues and generate harms that are avoidable and unjust.

Stigma Is Harmful to Mental Health

We present the argument that stigma has a detrimental impact on a person's mental health, exacerbating existing conditions and generating harm. So far, we have shown how stigma mechanisms draw on aspects of identity and 'deviant' practices to signify and inscribe value and worth (Tyler, 2020). These stigma mechanisms can operate relationally, structurally and internally. In this section we focus on stigma harms to mental health, specifically examples of isolation, hopelessness and suicidal ideation.

Experiencing stigma can make it difficult to be around other people. It creates a heightened state of vigilance in which a person is attuned to the judgements of others, and this can generate anxiety about being in certain places and around certain people out of fear of stigma-induced harms. In essence, stigmatisation vulnerablises already marginalised people with mental health issues—exposing them to social and health harms in ways that may be invisible to practitioners and those who are not exposed to the same stigmas (Addison, et, al. 2025). In Jack's excerpt, he describes how negative judgements are damaging his confidence. He isolates as a form of protection from stigma harms, which starts to feel like a prison.

> I'm mentally ill with my emotions and depression and anxiety and panic attacks and all that and I get depressed […] and then people pass comment like as they do, and they don't realise how damaging that is. That's put me in… it's kind of imprisoned me. It took my confidence away from us and I didn't want… I don't want anything to do with people anymore [JACK, 43 YEARS]

Stigmatising interactions with healthcare professionals can make mental health worse. A decline in mental health can be misattributed to drug use or individualised pathology. Tyler describes this kind of reframing

of the problem through a lens of 'stigma-optics' which individualises problems of inequality as 'a consequence of people's poor behaviours, indiscipline and shamelessness' and legitimates a 'hardening' of staff and public feelings towards marginalised people (2020: 28). In our example, Jack talks about feeling utterly destroyed by comments and judgements from a mental health nurse:

> when I was about 22, 23 when I had the breakdown. Psychosis. I was in hospital […] the mental health nurse said I was f**ked. I went, "F**king hell." When someone says that in a mental health ward when you're trying to get better, it f**king just absolutely destroys you. It f**king does. It's like, "You b*stard". Do you know what I mean? [JACK, 43 YEARS]

Kev goes on to share how healthcare providers' attitudes can create a feeling of hopelessness and lack of self-worth:

> I mean sometimes it can make people feel really low and depressed. I mean they deal with the habit already and everything else and problems at home or whatever and then you've got the one place where you go to get that same thing each day and you know, you've got somebody looking at you like you're a piece of *shit*. [KEV, 41 YEARS]

Harms to mental health arising from stigma can be multiple and complex (Pemberton, 2016; Pemberton et al., 2016). At its most extreme, stigma can amplify feelings of suicidal ideation (Tyler, 2020). Hannah shares how she internalised shame and guilt:

> I think a lot of shame and guilt especially […] I wanted to escape reality I still want to… at times I know I didn't want to be here [HANNAH, 35 YEARS]

This stigma can coalesce on multiple levels, both structurally and internally, and can bring together multiple mechanisms based on identity and practices to create toxic conditions for a person's mental health. When stigma becomes intolerable for a person it can make a 'liveable life' literally seem impossible (Addison et al., 2023; Back, 2007).

Living with Stigma

In this final section we discuss how a marginalised person might live with stigma, and what coping strategies are used to try and mitigate harms to their mental health. We draw attention to help-seeking behaviours and the challenges some people experience trying to access support and the persistent problems presented by dual diagnosis.

Drug treatment programmes are often prioritised, often leaving a PWUD feeling exposed to the full gamut of problems arising from mental health.

> Mental health services wouldn't talk to me because I was using, the addiction services were like, "Well, we're not mental health service", and it felt like the only way I was going to get any help with my mental health was to stop using, but the only way I could cope with my mental health on a daily basis was to use as much as possible. So, there was that immediate clash between what I should be doing and what I felt like I had to be doing. [HAVEN, 30 YEARS]

Many PWUD we spoke to felt that dual diagnosis should be addressed in a holistic, person-centred way and were frustrated by systems which stigmatised them and controlled what treatment they could access, as Andy discusses:

> when I had discussions with the drug programmes it's always like, "Well, there's no point going down that route until you sort your addiction out." Well how do I stop my addiction out without any help? So, my genuine feeling and experience is that, unless you've got the money, then the support is really non-existent. [ANDY, 29 YEARS]

Andy felt that if you were affluent enough then different care pathways were open to you via private healthcare. To overcome barriers, Hannah talks about 'gaming' the system which stigmatises her—she uses deception to make her presentation congruent with health provider expectations.

> …obviously dual diagnosis, trying to get a dual diagnosis, so I had to 'get well' a bit and lie a little bit to get the medication I needed, and then once I got on that medication we started to have a bit lift off then, things started improving quite a bit… [HANNAH, 35 YEARS]

Being underheard or fearful of experiencing stigma led a number of people to disengage with services, or reluctant to access support. Jack discussed feeling like help and resources were unavailable and professionals were disinterested. Relational stigma made Jack feel more anxious and so drug use provided a way to cope.

> [Drugs] ruined me a long time ago and when I've spoke to professionals and that about it, they were like, "Yeah, I don't think we can help you," blah, blah, blah. So, I just put it off […] I use drugs, sorry, right, because people make me feel that insecure and that hurt and that alone is the only friend I've got. [JACK, 43 YEARS]

Andy draws attention to the stigmatisation he experienced built into systems that focus on targets. Short appointments and distracted professionals, at times when he was upset and vulnerable, made him feel unseen. These efficiencies stigmatise PWUD and are not conducive to creating conditions of care; as such, the danger here is that it can lead to further disengagement with support services and reduce help-seeking behaviours—shoring up problems related to dual diagnosis for the future.

> …in terms of seeking psychological help, I'd say I just feel like I went round in circles for years with the NHS. I didn't really get anywhere with them, you're out waiting at doctor's rooms and Crisis, crying my eyes out and they've got three and a half minutes to speak to you, if that, once they've typed your information into the system and left themselves time to write notes. I just never really thought, in fact, I still don't really feel that the care is there publicly [ANDY, 29 YEARS]

Some people need greater care from services, but this need can quickly translate to feeling like a burden—especially when attitudes of care and compassion appear scarce amongst the general public. This is often

the case in times of austerity and at the time of writing—our current 'cost of living crisis'. Wacquant writes about this as a public hardening of attitudes towards those who are stigmatised as 'undeserving' of care (Wacquant, 2008). Instead, some PWUD chose to continue or even escalate their drug use to make a 'liveable life' possible with stigma. Drug use was a way to manage the impacts of stigma that they experienced in social relations with other people. Haven describes feeling less than and using drugs to help:

> I knew they looked down on me, I knew they saw me as, "less than", and the only way that I could feel okay about that was by using something to fix it. [HAVEN, 30 YEARS]

Jack talks about using drugs to mitigate the harms arising out of stigma; he shows how he recognises stigmatisation in social relations and the corrosive impact this has on his mental health.

> I've self-medicated because of how fucking low and destroyed I've been… I've felt about people. The body language and the way they talk to us and the way they spoke to us. They really made us feel horrible and I don't deserve this. I'm not what you f**king see me as. [JACK, 43 YEARS]

Jack, 43 years resists this symbolic violence done to him and claims his own subjectivity by stating *'I'm not what you f**king see me as'.*

Discussion and Conclusion

In this chapter, we discuss the impact of stigma on mental health as an unfolding dimension of social harm amongst people who use drugs. We suggest that mental health is made worse by social relations that stigmatise individuals and their drug using practices. This chapter builds on Tyler's concepts of stigma mechanisms and stigma craft to show how social relations are synergistic to social determinants of health, harming the mental health of already marginalised individuals.

Mechanisms of stigma operated at multiple levels (structural, relational and personal) and had deleterious effects on mental health—especially for those who already had pre-existing mental health conditions. Whilst some people are able to subvert stigma, or even resist it, others in our study discussed internalising it which made mental health issues worse. However, concern about public stigma or structural stigma meant that they were reluctant to seek help. Instead, our research showed that stigma relations led to isolation, feelings of hopelessness, suicidal ideation and less access to support services.

PWUD experienced being treated with contempt due to a public and professional hardening of attitudes towards them and disinvestment in services. Tyler reminds us here to be cognisant of the social and political context that creates conditions of 'austerity' and a 'cost of living crisis', and not just individual experiences of stigma. The problem of 'stigma' is structural and its beneficiaries are out of sight. In this cost of living crisis resources feel scarce, and services are underfunded and understaffed (Addison, et, al. 2025; Tyler, 2020). This climate increases pressure on staff and necessitates efficiencies and cost-cutting within services—meaning that PWUD using these services can end up feeling dehumanised and stigmatised in interactions with service providers who are time and energy poor (Addison, et, al. 2025). This sociopolitical backdrop legitimates stigma relations imbued with contempt towards marginalised groups—these people become framed as the '*problem*' and a 'burden' through powerful 'stigma-optics'. Blaming and shaming PWUD, using stigma mechanisms, neatly diverts attention away from the causes and beneficiaries of structural inequalities (Addison, 2023). To this end, it is possible to see how stigma is weaponised and is deeply harmful to mental health and wellbeing (Pemberton et al., 2016; Scambler, 2018; Tyler, 2020).

Living with stigma and trying to mitigate harms to mental health is not easy. Participants in our study felt vigilant about the judgements of others (both from the public and practitioners) and were sensitive to mechanisms of stigma that made them feel 'less than' and 'looked down on'. Rather problematically, research shows how stigma can be used implicitly and explicitly as a 'nudging device' in public health and criminal justice policies and interventions to change behaviours aimed at

improving health and desistance (McLean, 2023; Tyler & Slater, 2018). Many of our participants were aware of this on some level, particularly when trying to access support for dual diagnosis, which was very difficult and exacerbated feelings of shame. This shows how services can have a compounding effect on stigmatisation because of the obstacles in getting help and maze-like complexity of the system. This structural stigma heightens the harms to mental health amongst PWUD with a dual diagnosis. Furthermore, coping with relational and structural stigma was cited as a reason for continuing or escalating drug use—a way of coping with stigma and trying to make a 'liveable life' possible (Back, 2007). As such, we argue that a greater awareness of stigma harms is urgently needed and should inform how health and justice interventions, policies and practices are designed and implemented so that they do not inadvertently induce more harm to mental health amongst already disadvantaged groups.

Finally, we wanted to show that social relations constitute a messy 'invisible reality' that shapes a person's experience in the world and what makes a life 'liveable' (Bourdieu, 1990). Stigma mechanisms and subsequent harms can be completely invisible to those of us who are not exposed to or made vulnerable by stigma (Addison, et, al. 2025). This means that we may inadvertently reproduce stigma mechanisms based on identity categories and practices without knowing it. Stigma can make someone feel *less than*, worthless and valueless. This state of *un*subjectivity and abjection can have devastating consequences to health and wellbeing. Stigma relations are often overlooked in discussions about the social determinants of health and this needs to change. In this regard, we have tried to show how stigma permeates social relations and needs to be recognised as an unfolding dimension of social harm that negatively impacts the mental health of PWUD.

Acknowledgements We would like to thank all the participants who took part in this research and shared their experiences with a view to helping others. We would like to thank the editors for their helpful comments on subsequent drafts of this chapter.

Funding This chapter is based on a research study titled: A qualitative pilot study exploring health inequalities amongst illicit substance users in the north-east of England. This research was funded in whole by the Wellcome Trust (Grant No. 214607/Z/18/Z) and MA was the recipient. For the purpose of Open Access, the authors have applied a CC BY public copyright licence to any Author Accepted Manuscript version arising from this submission.

Declarations

Conflict of Interest The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this chapter.

Ethical Approval This research acquired ethical approval from Northumbria University during the time that (MA) was employed by this institution, 16 August 2019 (Submission REF: 17304).

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