Reducing stigma and discrimination associated with substance use

Brief literature scan, May 2022

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PO Box 108-244, Symonds St, Auckland, New Zealand
Web: www.tepou.co.nz
Email: info@tepou.co.nz

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Executive summary

Background

Stigma is a complex phenomenon that is conceptualised in various ways depending on the context in which it has been explored (Lancaster et al., 2017). However, it is essentially any attitude, belief or behaviour that discriminates against people. There are three key forms of stigma which operate at multiple levels – self stigma, social stigma, and structural stigma. Stigma is a fundamental social cause of health inequalities and is especially prevalent for people who use substances and have substance use disorders. The World Health Organization (WHO) states that substance use disorders are the most stigmatised conditions overall, among which alcohol use disorder alone is fourth (Room et al., 2001).

Stigma is identified as a barrier to seeking help for people who use substances (Ministry of Health, 2015). *Te Rau Hinengaro: the New Zealand Mental Health Survey* (Oakley Browne et al., 2006) indicates that about 3.5 percent of adults meet diagnostic criteria for a substance use disorder each year. In 2013, the National Committee on Addiction Treatment estimated this reflected up to 150,000 people (NCAT & Platform Trust, 2013). However, less than one-third of people seek help. This means that up to 100,000 people do not seek help each year. Stigma has been identified as a barrier to seeking help for people who use substances (Ministry of Health, 2015). Therefore, it is essential we fully understand and comprehend the impact of stigma on people and their whānau and reduce the harm. We also need to work with the people directly affected to ensure stigma associated with substance use and substance use disorders is not.

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (2018) identifies a pathway for improving Aotearoa New Zealand's approach to addressing substance use. This requires a shift in the national mindset away from stigmatising substance use towards viewing it as a health issue. *Kia Manawanui Aotearoa: Long-term Pathway to Mental Wellbeing* builds on the themes and recommendations from *He Ara Oranga* by outlining sequenced actions for the next ten years that provide a national-level view of long-term priorities (Ministry of Health, 2021). Currently there has been a limited examination of stigma associated with substance use in Aotearoa New Zealand.

Aim and objectives

This literature review aims to develop a better understanding of the extent and impact of stigma and discrimination in relation to substance use and substance use disorders, including alcohol use.

Specific objectives in relation to substance use and substance use disorders are to summarise or identify:

- evidence on the prevalence of stigma and discrimination
- factors contributing to stigma and discrimination
- evidence of the impact of stigma and discrimination on people
- key national and international policies and documents on stigma and discrimination
- national and international initiatives undertaken to reduce stigma and discrimination
- workforce development options to challenge and reduce stigma and discrimination.

Method

This literature review is based on an exploration of published and unpublished grey literature, primarily over the last 10 years.

Key findings

The literature indicates that stigma and discrimination is prevalent throughout the population, the media, within our healthcare, social services, and criminal justice systems. While substance use within Aotearoa New Zealand is relatively common, stigmatising beliefs and attitudes toward substance use is prevalent. There are various factors which contribute towards stigma, such as personal attitudes and beliefs; the language we use; the media; existing policies and laws; a lack of education about or contact with people who use substances; historical and social contexts; and different cultural perspectives and world views.

Stigma and discrimination associated with substance use have a pervasive effect on people. At the structural and social levels, stigma perpetuates social, economic and health inequities, and communicates that people with problematic substance use are not worthy of protection or opportunities to address their issues (Smith et al., 2016). At the individual level, stigma can manifest internally, impact on people's sense of self, and lead to depression, low self-efficacy and self-esteem (Ashford, Brown, Canode, et al., 2019). Self-stigma can reduce help-seeking behaviours and cause more substance use harms (Kulesza et al., 2014). Most importantly, stigma can act as a barrier to healthcare and treatment and have detrimental effects on people's health and wellbeing.

Several key national policies and documents reference stigma in Aotearoa New Zealand. These vary from early work that introduced the concept of stigma in a broad manner, such as *Te Kokiri: The Mental Health and Addiction Plan* and *Research into Knowledge and Attitudes to Illegal Drugs* (Ministry of Health, 2006; UMR & Acqumen, 2009). More recent documents identify aspects of stigma operating in society and consistently call for action to address stigma. *He Ara Oranga* (2018) is a significant recent document that identifies stigma associated with mental health and substance use as a barrier to help seeking. It also highlights how stigma is embedded in our laws, shapes attitudes, and influences how services are structured and delivered. *He Ara Oranga* calls for a shift in the national mindset away from stigmatising substance use.

Other documents that discuss stigma are outlined below.

- *The National Drug Policy 2015 – 2020* (Ministry of Health, 2015).
- *Monitoring and Advocacy Report in Aotearoa New Zealand's Mental Health and Addiction Services* (Mental Health Commissioner, 2020).
- *Scoping of a Destigmatisation Programme on Drug Use and Drug Dependence* (New Zealand Drug Foundation, 2015).
- *New Zealand Drug Foundation Submission on the Mental Health and Addiction Inquiry* (New Zealand Drug Foundation, 2018).
- *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012 -2017* (Ministry of Health, 2012).
- *Kia Kaha, Kia Māia, Kia Ora Aotearoa: Psychosocial and Mental Wellbeing Plan* (Ministry of Health, 2020).

- *Kia Manawanui Aotearoa: Long-term Pathway to Mental Wellbeing* (Ministry of Health, 2021).

In line with *He Ara Oranga*, recent international documents and policies on stigma focus on shifting the perception of substance use from a criminal and punitive issue towards a health-based issue. A key outcome document from the 2016 United Nations General Assembly Special Session on the World Drug Problem is *The World Drug Perception Problem – Countering prejudices about people who use drugs* (The Global Commission on Drug Policy, 2017). Relevant language resources include *Overcoming Stigma Through Language* from Canada and *Moving Beyond People-First Language – A glossary of contested terms in substance use* from Scotland.

In Aotearoa New Zealand there has been no nationally coordinated programme of work to address stigma and discrimination associated with substance use to date. Instead, there have been government funded programmes and community actions taken to reduce stigma and discrimination for other health issues, including mental health challenges, disability, and HIV/Aids. An example of this is the long running national Like Minds, Like Mine anti-stigma campaign, which now has an increased focus on equity. Internationally, initiatives range from media campaigns like Support Don't Punish to multi-dimensional projects like Stigma Ends with Me. The literature identifies interventions potentially effective in addressing stigma at the structural, social, and individual levels. These interventions can be used to guide workforce development activities and include educational programs, training in communication and delivery of programmes that includes contact with people with lived experience, changing language, advocating for people, motivational interviewing, cognitive behaviour therapy, and acceptance and commitment therapy which is a relatively new and emerging intervention (Livingston et al., 2012).

Considerations

Based on the findings of this literature review, considerations for everyone, and in particular those working in health, to address the stigma associated with substance use and substance use disorders are outlined below.

1. Work alongside people with lived experience to examine the current practices of health workers and addiction practitioners in Aotearoa New Zealand to better understand what improvements or actions are required to eliminate stigma and discrimination.
2. Within organisations, promote and foster values and attitudes that actively work against stigma and discrimination towards people who use substance as reflected in *Let's get real*.
3. Review and adapt curriculum across relevant courses, programmes, and educational providers and encourage co-facilitation of stigma and discrimination training by people with lived experience.
4. Ensure language and practice does not reinforce stigma. People need to engage with communities affected by substance-related stigma and discrimination to guide use of terminology. Consider adopting people-first language and avoid use of labels, slang, and idioms.
5. Encourage and support the launch of a nationwide destigmatisation campaign. This may look like what was set out in the 'destigmatisation programme on drug use and drug dependence' by the New Zealand Drug Foundation (2015).

6. Advocate for drug policy reform that treats substance use as a personal choice and problematic substance use as a health issue and not a criminal issue.

Background

What is stigma?

A standard definition of stigma is a mark of long-lasting social disgrace connected to a quality of a person that results in the person being devalued, discriminated against, and labelled as deviant (Lloyd, 2013). Stigma is a complex phenomenon that has been conceptualised in many ways depending on the context it has been explored in, meaning there is considerable variation among definitions in the literature (Lancaster et al., 2017). However, stigma is essentially any attitude, belief or behavior that discriminates against people (Canadian Centre on Substance Use and Addiction, 2019). It is generally based on assumptions or misconceptions and often emerges in the form of derogatory language that shames and belittles people. Those who experience stigma are often seen as less than others, and this has a profound effect on the interactions between those who are stigmatised and the unstigmatised. Stigma can be cultivated in a multitude of ways, and is continually reinforced with the words we choose, how we treat others and view ourselves. There are three key forms of stigma – structural, social, and self-stigma or personal stigma (Livingston et al., 2012; New Zealand Drug Foundation, 2015). These aspects of stigma operate at multiple levels and domains and are not limited to negative or discriminatory interpersonal interactions.

Structural stigma is created by the policies and practices of organisations and institutions towards stigmatised groups that restricts their rights or opportunities. This reduces the likelihood of these people receiving quality non-judgmental services or having access to the same treatment and opportunities received by non-stigmatised groups of people (New Zealand Drug Foundation, 2015).

Social stigma is caused by the attitudes and beliefs of the general public, whānau, and friends based on negative stereotypes resulting in social exclusion and isolation from communities (New Zealand Drug Foundation, 2015). This stigma is reinforced through social interactions and the media. It can be prevalent throughout society from our personal relationships to various stakeholders such as healthcare providers, police officers and others.

For social stigma to arise several interrelated components occur (Link & Phelan, 2001).

1. Labelling which identifies the differentness of people.
2. Construction of negative stereotypes.
3. The separation of labelled people into distinct categories.
4. The status loss of labelled people.

These interrelated components result in the disapproval, rejection, exclusion, and discrimination of stigmatised people. These processes can only happen if there is access to social, cultural, economic, and political power that can facilitate it (Link & Phelan, 2001).

Self-stigma is the internalisation of negative thoughts, feelings, attitudes, and stereotypes that emerge from identifying with a stigmatised group. It results in shame and the expectation of negative social reactions. It negatively impacts behaviour and shapes an

individual's sense of self. This is a barrier to seeking help as people see their stigma as a personal failing and that they are not worthy of receiving support (Livingston et al., 2012).

These types of stigma are experienced in either a 'felt' or 'enacted' way. If a stigma is 'felt' then a person has a "real or imagined fear of societal attitudes and potential discrimination arising from a particular undesirable attribute, disease (such as HIV), or association with a particular group or behaviour" (for example, problematic substance use), whereas 'enacted' stigma refers to "the real experience of discrimination" (such as where disclosure leads to the loss of a job or social exclusion) (Brown, et al., 2003, p.50).

Interestingly, even stigma terminology is contested in some spaces. Some people with lived experience do not feel that 'stigma' adequately conveys the harshness of its impact, and many prefer the term 'discrimination' instead (Pescosolido & Martin, 2015). In this context, discrimination relates to the structural patterns of power and social inequality – it is the lived effects of stigma. Within Aotearoa New Zealand, a recent nationwide anti-stigma programme called Nōku te Ao, Like Minds uses the terminology of prejudice and discrimination when discussing stigma against people with experience of mental health challenges. Throughout this literature review, we recognise this discussion and use both terms.

Stigma & substance use

Stigma is a fundamental social cause of health inequalities, and it is especially prevalent in relation to substance use and substance use disorders. The World Health Organization (WHO) found that substance use disorders are the most stigmatised condition and alcohol use disorder the fourth (Room et al., 2001). There are a range of reasons why substance use is frequently associated with stigma and discrimination. The main reason is the belief that people's behaviour is immoral, illegal, dangerous, or deviant. For people that use substances, their behaviors become inseparable from them as a person, and they are labelled as "alcoholics", "drug users" or "addicts" (Link & Phelan, 2001). Substance use can then either be thought of as a health disorder, or more commonly a moralised and derogated category. This moral attachment leads people to believe that as it was the person's choice to use substances, they are responsible for the onset and cessation of their illness and ultimately it is their failing, rather than a normal bio-psycho-social response to deprivation, stress, trauma, and other adverse childhood experiences (ACEs). People with a history of trauma have a higher likelihood of substance use, particularly those who have experienced greater trauma (Rosenberg, 2011). People may engage in substance use as a coping mechanism to deal with untreated trauma. It is therefore important to use a trauma-informed approaches when working with people who use substances.

Stigma can be experienced in a multitude of ways by people who use substances including public attitudes; the attitudes of health professionals, within addiction treatment services, and health-care settings; and in our laws and drug policies (Lancaster et al., 2017; Lloyd, 2013). These experiences were also highlighted in *He Ara Oranga* (2018), which recommended the need to shift the national mindset away from stigmatising substance use towards viewing it as a potential health issue that requires care and support.

It is important to recognise the intersectionality of stigma, and how the effects can be compounded as a result of multiple intersecting inequities or experiences of marginalisation that stigmatised people face (Knaak et al., 2020). Within Aotearoa New Zealand, this is particularly prevalent for Māori and Pacifika peoples who already experience health

inequities. Furthermore, the stigma associated with substance use can be compounded by other stigma, such as that associated with mental health challenges, certain health conditions such as hepatitis C or HIV/AIDS, and having criminal charges (Lancaster et al., 2017; Oakley Browne et al., 2006). It is common for people who use substances to face multiple layers of stigma.

Aims & objectives

This literature review aims to develop a better understanding of the extent and impact of stigma and discrimination in relation to substance use and initiatives that have or can be taken to reduce this, including areas for workforce development.

Specific objectives in relation to stigma and discrimination associated with substance use and substance use disorders, including alcohol use, are outlined below.

- Summarise national and international evidence on the prevalence of stigma and discrimination in the general population, mental health, and health workforces (including primary care).
- Identify factors contributing to stigma and discrimination, including systemic, structural, individual, and cultural issues.
- Summarise national and international evidence on the impact of stigma and discrimination associated with substance use, including individual stigma, health care utilisation (including primary and secondary care services), outcomes and recovery, including Māori and Pacifika peoples.
- Identify key national and international policies and documents, including human rights and the perspectives of people with lived experience of problematic substance use about stigma and discrimination.
- Describe national and international initiatives undertaken to reduce substance use stigma and discrimination at national, regional, and local levels.
- Identify workforce development activities that can be taken to reduce substance use stigma and discrimination related to substance use in the future.

Method

A literature search was undertaken through Google, Google Scholar and EBSCO. The key words used in the search included:

- stigma, discrimination, attitudes, stereotypes, social stigma, self-stigma, structural stigma AND
- substance use, alcohol, drug, intravenous, nicotine, vaping, opiates, injecting drugs AND
- prevalence, impact, initiatives, strategies, interventions, treatment, approaches, legislation, policy AND
- population, Māori, Pacific, Pasifika, community, workforce, doctors, nurses.

The search involved relevant national and international literature, policy documents and grey literature primarily within the last 10 years. Where possible the searches included a focus on Aotearoa New Zealand, Australia, the UK, and US. Both quantitative and qualitative data were included in the review. Accessible information was obtained and reviewed in relation to the key aims.

The five key domains of workforce development outlined in Figure 1 are used to summarise relevant activities to reduce stigma and discrimination.

Figure 1 Getting it Right workforce development approach *(Te Pou, 2017)*

Language

The language we use matters and if used incorrectly can have a negative impact on the way society perceives substance use and those who are affected by it. For these reasons, we have chosen to use strengths-based language, which is preferred by people with lived experience, depending on the context. As part of this, we prefer to use people-first language when discussing 'people who use substances' or 'people with a substance use disorder'. This is important because it shows respect and acknowledges that a person's condition, illness or behaviour is not that person's defining characteristic (Broyles et al., 2014). We also use recovery-oriented language which conveys optimism, supports recovery, and respects a person's autonomy.

Findings

This literature review aims to develop a better understanding of the extent and impact of stigma and discrimination in relation to substance use. Firstly, we describe findings related to the prevalence of stigma and discrimination then the factors that contribute to stigma, such as personal attitudes, language, policies, and laws. We then move to discuss the findings related to the impact of stigma and relevant national and international policies and documents. Finally, we describe findings of initiatives taken to reduce stigma and discrimination and areas for workforce development.

Prevalence of stigma and discrimination

From the literature, it is evident stigma associated with substance use and substance use disorders is prevalent throughout the public and media, and within health and criminal justice systems.

The public

Substance use within Aotearoa New Zealand is common, with 93 percent of the population trying alcohol and 44 percent other substances at some point in their lives (Ministry of Health, 2015). Substance use and its harms can be seen on a continuum from no use/low risk use to more moderate and severe disorders (see Figure 2 below). It is suggested that stigma impacts people with moderate to severe disorders the most, which is estimated to be up to 150,000 people here in Aotearoa New Zealand (New Zealand Drug Foundation, 2015). The prevalence of stigma can depend on the legality of the substance, type of substance used, and presence of other compounding factors such as unemployment or a criminal record (Lancaster et al., 2017). With these considerations, the prevalence of stigma and addressing stigma should be a priority area. However, within Aotearoa New Zealand, little research has been done examining public stigma towards people who use substances or in recovery from problematic substance use.

No Use or Gambling	Moderate Use or Gambling	Problematic Use or Gambling	Hazardous Use or Gambling	Harmful Use or Gambling	Moderate to Severe Disorder
	Using substances or gambling without problems	There are some occasional negative consequences	There is a risk of future physical , social and or mental health damage	There is some apparent physical , social and or mental health damage	Loss of ability to control use or gambling despite significant consequences

Figure 2 Continuum of substance use and gambling adapted from Matua Raki (2014)

In Aotearoa New Zealand, there has been a greater focus on stigma towards mental health challenges. For example, while a Health Promotion Agency survey in 2018 found 22 percent of adults were treated unfairly due to a mental illness, there have been no public surveys focused on stigma associated with substance use (Health Promotion Agency, 2016). In 2009, the Ministry of Health commissioned research into the knowledge and attitudes of illegal drugs and found various stigmatising beliefs among the public. People who use substances were characterised as making the wrong choices, being less connected to other

people and reality, and experiencing cognitive and behavioural effects including mood swings and lacking an ability to focus and hold long conversations (UMR & Acqumen, 2009). The 2016 Perceptions of Crime survey also provides some information on public stigma. The survey found substance use was perceived as a major cause of crime. “Drugs and alcohol” were perceived by 86 percent and 77 percent of people respectively as a major cause of crime. These findings indicate that being labelled as a person who uses substances confers negative stereotypes and that stigma exists within the general public of Aotearoa New Zealand.

International literature suggests substance disorders are perceived by the public as among the most dangerous mental health challenges (Janulis et al., 2013). Public stereotypes such as being aggressive, causing disturbances and neglecting one-self are commonly associated with people who use substances (van Boekel et al., 2015). People with substance use disorders are thought of as having a choice and being more blameworthy, unpredictable and dangerous than people who experience other mental health challenges (Corrigan et al., 2009; Merrill & Monti, 2015). These views lead to feelings of anger and fear and the belief that people with substance use disorders are more responsible for the onset and cessation of their ‘illness’. With these views, substance use disorder tends to be viewed more as a result of a moral failing than a biological failing (Merrill & Monti, 2015). This contributes to negative attitudes towards people who use substances and impacts how they are treated. For example, Barry and colleagues (2014) found people held more negative views towards people with substance use disorders compared to other mental health challenges. These negative views include being unwilling to have a person with a substance use disorder marry into their whānau or work closely with them; a greater acceptance of discriminatory practices towards people with substance use disorders; skepticism about the effectiveness of treatments; and being more likely to oppose policies aimed at helping people with substance use disorders. Schomerus et al. (2011) drew similar conclusions when reviewing population surveys from Aotearoa New Zealand, Europe, North America, Brazil, and Ethiopia. They found that compared with people living with other mental health challenges, people experiencing problematic alcohol use were highly stigmatised. They were less frequently regarded as being mentally ill, more likely to be held responsible for their own condition, to provoke social rejection and negativity and were at special risk for structural discrimination.

Factors such as education, political affiliation, ‘folk explanations’ of behaviour, support for punitive drug policies, knowledge about substances, health literacy, and personal familiarity with people who use substances all influence the public’s attribution of substance use (Sumnall et al., 2021). The underlying negative attitudes about personal responsibility for substance use explain public intentions to impose discriminatory restrictions on people who use substances, such as exclusion and loss of status. There is also an element of anger and fear towards problematic substance use by the public, as well as an ‘othering’ that occurs when people cannot relate or sympathise with a certain group. Attribution theory also comes into play, as when a health condition, such as substance use disorder, appears to be under an individual’s control, the reaction is to condemn or neglect rather than to help the person (Kennedy-Hendricks et al., 2017). It is important to note that public attitudes towards substance use disorder can be complex and at times contradictory. Many people simultaneously blame people who use substances whilst also believing they come from difficult or disadvantaged backgrounds. Health campaigns that work to reduce substance use through fear inducing messages can also contribute to people’s beliefs and attitudes (Peng et al., 2020). These campaigns work to reinforce the negative connotations associated with substance use, and by doing so produce affective stigma. Public attitudes

are susceptible to change over time however, and may not necessarily stay constant as societal, cultural, and political conditions of the time shift.

The media

The media is another setting in which stigma is prevalent. This is particularly concerning as the media act as a key source of information sharing and play a significant role in shaping stigmatising attitudes including those towards substance use. The media often depict people with substance use disorders in a negative light through the language used and framing the issue by emphasising individual responsibility. Furthermore, the media often portray substance use as a psychological and moral flaw and use terms that act to dehumanise and set people apart from society as inferior and flawed. For example, McGinty and colleagues (2019) explored US news media coverage of the 'opioid crisis' and found nearly half (49 percent) of news stories about the 'opioid epidemic' mentioned stigmatising terms and only 2 percent of articles opted for less-stigmatising alternatives. In Aotearoa, the *New Zealand Drug Foundation Submission on the Mental Health and Addiction Inquiry* identified how negative and stigmatising language is commonly used in news articles when talking about people who use substances or experience a disorder (New Zealand Drug Foundation, 2018). Some examples described in the submission include:

> *"Tragically, she has the spectral visage of a meth head."*
>
> *"P babies prove problem kids who cause chaos at school."*
>
> *"Death of transient drug addict could have been prevented."*

Health settings

Paradoxically stigma about substance use has been surprisingly evident in health services. People who use substances report experiencing discrimination when accessing both specialist and primary health services, even at sites promoting harm reduction at times (Knaak et al., 2020; Lloyd, 2013; Paquette et al., 2018). For example, a focus group held by Counties Manukau AOD Provider Collaborative (2014) with 23 Pacifika people accessing services and their whānau identified structural stigma as an issue. A range of factors that contributed to structural stigma were identified, such as the location of the service, its name, the language used to describe people accessing services, and the attitudes of practitioners. Some of the focus group participants identified that services are often located in low socioeconomic areas which could be stigmatising. When services are highly visible and delivered in a stand-alone buildings this can also draw attention to people using these services. People felt like others knew they were there to access the service. Additionally, treatment service names can include negative words, like detox or dependence, which can increase self-stigma as it indicates something is wrong with the person. Focus group participants also shared terms used that can be stigmatising, such as 'clean' time which implies that before people became clean, they were 'dirty' and had done something wrong. While it was often unintentional, the stigma made the experiences of treatment more alienating and dehumanisng as people felt they were an issue rather than a person.

While stigma can be inherent within institutional processes and structures of health care providers, this is often beyond the control of health workers. However, the predominant site of stigma in health services is within the beliefs, attitudes, and practices of health workers. This often stems from a lack of contact with or education around people who use substances. This can result in health workers treating people who use substances and

people with substance use disorder differently, and often in stigmatising ways. Several studies have consistently found that many health workers hold negative attitudes towards people who use substances (Gilchrist et al., 2011; Lawrence et al., 2013; van Boekel et al., 2015). The regard for people who use substances is lower compared to other groups (van Boekel et al., 2013). Health workers often attribute substance use to individuals, whereas other mental health challenges are often seen as having a biological basis leading health workers to hold different and stigmatising beliefs about substance use disorders (Jury et al., 2018).

Stigmatising beliefs held by some health workers include the inability or unwillingness to empathise with or show compassion towards people who use illicit substances; the attribution that substance use disorder is a consequence of someone's weakness; and the belief that people with a substance use disorder tend to be aggressive, self-neglecting and untrustworthy (van Boekel et al., 2013, 2015). Findings from a small study in Northern Ireland by McLaughlin and colleagues (2006) also suggest health and social care professions prefer support for people who use substances to be provided solely by addiction providers as they unable or unwilling to empathise with this group. People who inject substances face additional levels of stigma, with a belief held by some doctors that treating people who inject substances would be 'futile' and a preference not to treat this group (Lloyd, 2013).

Stigmatised attitudes appear to differ for different health professions. One comparative study found physicians who didn't work in specialised addiction services had the lowest regard towards people with substance use disorders, whereas those working in addiction services reported a higher regard (Gilchrist et al., 2011). These findings are echoed in similar studies with nurses, primary care providers, anesthesiologists, first responders, internists and hospital staff (Lawrence et al., 2013; Paquette et al., 2018; Soh et al., 2019; van Boekel et al., 2013; Wakeman et al., 2016). Health workers who have contact with people who use substances tend to have more positive attitudes and beliefs. Interestingly Masedo and colleagues (2021) found these differences were also evident within health science university programmes. Students within medical and nursing programmes showed more negative attitudes around perceptions of dangerousness, uncomfortability and discriminatory behaviour than psychology and occupational therapy students. The attitudes taught or learned throughout these formative years in university can have negative effects on the future practice of health workers.

Internationally, pharmacies have been identified as a key site of discrimination (Lloyd, 2013). As pharmacies are key to delivering various harm reduction programmes, stigma can be evident in these interactions. Luty and colleagues (2010) found one-third of the independent pharmacies surveyed in the UK chose not to dispense methadone to people with opioid dependence, demonstrating stigma within some pharmacies. Among others, pharmacy staff have often been found to hold negative attitudes towards people who use substances, such as concerns about disruption, theft, and shoplifting (Lloyd, 2013). Some pharmacies have introduced systems to separate people who use substances away from others and often prioritise customers not collecting opioid agonist medication or injecting equipment.

Criminal justice system

Stigma and discrimination is common within the criminal justice system, with overseas research finding that people who use substances commonly have experiences of public shame in interactions with police (Lloyd, 2013). For example, Lister and Wincup (2007) found interactions with police were often adversarial, people felt targeted by unwanted police

attention and they were defined in terms of their substance use. Another US study of over 600 police officers by Murphy and Russell (2021) examined their view of drug use and the impact on attitudes toward drug policies. They found 'addiction' frameworks were strongly related to attitudes about drug policies. Those with a stronger biological framework for understanding substance use were more likely to support policies that expand treatment, decrease punishment, and increase access to opioid agonist medication. Those with a stronger moralistic framework were less likely to support such policies and more likely to hold stigmatising attitudes towards people who use substances. The extent of stigma within the criminal justice system is important to consider because police officers often act as entry points into treatment for people who use substances, and therefore the way they choose to treat substance use (as either a criminal or health issue) has a significant impact for people.

Factors contributing to stigma and discrimination

As illustrated above, personal attitudes and beliefs are a significant factor that contributes to stigma and discrimination. Various other factors contribute to stigma, such as the use of language; the media; existing policies and laws; a lack of education on or contact with people who use substances; historical and social contexts; and different cultural worldviews.

Language

The language and terminology used to describe social issues and health conditions influences and reflects people's attitudes. Language intentionally and unintentionally propagates stigma: the mark of dishonour, disgrace, and difference that depersonalises people, depriving them of individual or personal qualities and personal identity (Broyles et al., 2014). When it comes to substance use, the language used is particularly important as certain terms can perpetuate stigmatising attitudes and enable discrimination. For these reasons, the language used by the public, the media, and health workers is important. Language frames what the public thinks about substance use and recovery and can affect how individuals think about themselves and their ability to change.

Kelly and colleagues (2016) suggest stigma is influenced by two main factors – cause and controllability. The cause refers to the extent people believe an individual is responsible for the attribute, behaviour, or condition; and controllability refers to the extent that people believe that the attribute, behaviour, or condition is beyond the individual person's control. Certain language contributes to perception held by the public that substance use and therefore substance use disorder is a 'choice' and that people can control it. Additionally, once one holds this perception of substance use, these stigmatising beliefs regarding cause and controllability give rise to specific ways of describing people with substance use disorders.

Link and Phelan (2001) suggest the formation of stigma involves two primary components – a label and a stereotype. The label (such as addict) links the person to a set of undesirable characteristics that work to form the stereotype. The link between this label and the stereotype creates a negative reaction towards the labeled person which in turn leads to a desire for more social distance, discriminatory actions, and the support of potentially harmful activities towards the stereotyped individual. These labels or certain terms can exacerbate or diminish stigma, even when we are unaware of it, and also invokes both implicit and explicit bias towards people with substance use disorder (Ashford et al., 2018; Kelly et al., 2016).

Ashford et al. (2018) examined the implicit and explicit bias elicited from multiple stigmatising terms. They found the terms “substance abuser”, “opioid addict”, “addict”, “relapse”, and “alcoholic” were strongly associated with negative bias, whereas “person with a substance use disorder” and “person with an opioid use disorder” elicited less bias and a more positive response from the public. Another study by Kelly and Westerhoff (2010) focused on the responses and implicit biases of mental health and addiction clinicians. In this study clinicians were randomly assigned to a vignette that described an individual in legal trouble due to substance use, as either “a substance abuser” or “having a substance use disorder”. Those exposed to the “substance abuser” term were more likely to judge the person as deserving of blame and punishment than the same person described as “having a substance use disorder”. In another study by Kelly and colleagues (2010) the same terms were tested in a general population sample and an even stronger relationship between negative and punitive judgements and the “abuser” term emerged. Both studies indicate that exposure to terms like “abuser” creates an implicit cognitive bias, by both trained professionals and the general public, that results in punitive judgements that may perpetuate stigmatising attitudes towards people. Other research has found negative words or phrases such as “junkie”, “crackhead”, “drunk”, “rock bottom”, and ”dope fiend” commonly elicit stigmatising beliefs and attitudes (Ashford, Brown, & Curtis, 2019).

The language used to talk about substance use harms is not consistent with other mental health and medical language and standards (Kelly et al., 2016). For example, people with eating-related problems are often described as “having an eating disorder” not as “food abusers”. Also, when describing urine toxicology screening results, people receiving treatment for substance use disorders are often described as having “dirty” or “clean” results instead of “positive” or “negative”. These language choices may evoke more negative and punitive implicit cognitions.

Policies and laws

Room (2005, pp. 147–149) argues that stigma around substance use stems from three main sources:

- intimate processes of social control and censure among family and friends
- decisions by social agents and agencies, which tend to focus attention on the most problematic cases and to amplify their marginalisation
- policy decisions at the local or national level which result in marginalisation.

Many other researchers have drawn attention to the important role of policy and law in relation to stigma (Lancaster et al., 2017; Sumnall et al., 2021). Laws can produce and perpetuate stigma through processes of labelling and categorisation, for example by classifying certain practices as deviant or illegal. The law can also protect people from stigma, for example laws that prohibit discrimination against particular groups or behaviours. Ultimately the law articulates the values and norms for a society and has the potential to prevent or protect against stigma, create or enforce stigma, and a role in structuring individual resistance to stigma (Burris, 2006).

Within Aotearoa New Zealand the criminalisation of substance use via the Misuse of Drugs Act 1975 contributes significantly to stigma for people who use substances. These laws and regulations target behaviour that is perceived as ‘deviant’ or ‘risky’. The New Zealand Drug Foundation reported in 2020 that almost 6,000 people were charged and 4,500 convicted of drug offences (New Zealand Drug Foundation, 2020). Over two-thirds (68 percent) of convictions were for ‘low-level’ charges, such as personal use, possession and use, or possession of a drug utensil. Treating substance use as a crime to be punished, rather than

a potential health issue requiring assessment and possibly treatment reinforces stigma and negative stereotypes of people who use substances as criminals. There are significant long-term consequences for people who have a criminal record due to substance use that can reduce the ability to find a job or travel.

A lack of education and contact

Both a lack of education on substance use and contact with people who have used substances directly contribute to stigma and discrimination (Lloyd, 2013). Health workers with no training about substance use tend to have more stigmatising attitudes and beliefs. The lack of training and education often stems from poor coverage in medical and nursing schools. A lack of contact with people who use substances can also cause more stigmatising beliefs. A frequent finding across studies is that the more personal or work experience that health workers have with people with experiences of substance use and substance related harm, the more positive their attitudes were towards this group (Merrill & Monti, 2015; Soh et al., 2019).

Different cultural worldviews

Stigma is a socio-cultural process. The dominant national culture and society which one lives in are factors that contribute towards stigma for people who use substances. For example, Simha and colleagues (2021) found people living in collectivistic societies, such as South Korea and China, perceived people with a substance use disorder as being counterproductive to group cohesion and group goals. Similarly, assertive societies, like Uzbekistan and Armenia, openly display their disapproval (Simha et al., 2021). Due to the beliefs in these societies, stigma would be more greatly felt and enacted. Alternatively, societies that have high levels of power distance, or behaviours that facilitate obedience to authority, such as Germany and Cyprus, tend to have lower rates of stigma towards people who use substances. This may be due to perceptions of people in high-power positions maintaining patterns of regular substance use. Earlier studies echo these findings and suggest that familial structures, which are largely based on the society one lives in, influence how people view those who use substances, how people seek treatment, and where stigma is attached to substance use in their society it will act as a treatment barrier (Chang et al., 2017).

Stigma has unique cultural elements, and racial and ethnic minority groups often face higher levels of stigma (Misra et al., 2021). While it is evident that Māori and Pasifika peoples encounter stigma associated with substance use, their views on substance use can be broad (Ebbett & Clarke, 2010). Some argue that Māori should abstain from alcohol because it was a destructive tool used in colonisation and has no traditional value (Te Puni Kokiri, 1995). It is argued that alcohol, and substances more broadly, has contributed to the deterioration of familial social structures and disconnection from tikanga (customary practices) and wairuatanga (spirituality) (Henare, 1988; Hutt & Andrews, 1999). However, generally the consumption of alcohol is welcomed in social situations as it encourages social contact and the sharing of a collective experience (Durie, 2001). Alcohol consumption can become stigmatising when one drinks alone though, as a survey of Pasifika and Māori peoples found that respondents viewed drinking alone as problematic (Alcohol Advisory Council of New Zealand, 1997). Māori, like other ethnic groupings, are not homogenous regarding a definitive stance on stigma and alcohol consumption. Stigma that could come from a more ‘traditional’ leaning has long given way to an urbanized collective consciousness that, along with the wider Kiwi culture, has normalized the consumption of alcohol (Henare, 1988; Hutt & Andrews, 1999).

In Aotearoa New Zealand evidence also indicates Asian populations have low levels of access to addiction services, and it is believed that one of the barriers causing this low access is stigma around substance use and problematic substance use. For Asian populations, traditional perceptions of substances affect the use of substances, and the social context can influence whether a substance is accepted or stigmatised (Cheung et al., 2004). Substance misuse is considered a taboo issue however, particularly if it affects the functioning of the family. As a result, Asian people tend to seek professional help as a last resort, partly due to strong family values and a wish to avoid family shame.

Overall, a range of factors influence stigma experienced by people who use substances, including the personal attitudes and beliefs held by various groups in society; the language we use; the policies and laws in place; a lack of education and contact with substance use; and differing cultural worldviews.

Impact of stigma and discrimination

Stigma has a pervasive effect on people who use substances and people with substance use disorders. At the structural and social levels, stigma perpetuates social, economic and health inequities, as well as communicating to people with substance use disorders they are not worthy of protection or opportunities to address this (Smith et al., 2016). At the individual level, stigma can manifest internally and impact on people's sense of self and lead to lower self-esteem, self-efficacy and depression (Ashford, Brown, & Curtis, 2019). Self-stigma can also reduce help-seeking behaviours while causing more substance use related harms (Kulesza et al., 2014).

People who use substances generally have high health needs compared to other populations. Stigma can act as a barrier to healthcare and treatment and detrimentally impact on the wellbeing of those who use substances. The delivery of healthcare can be negatively affected by the stigmatising attitudes of health care providers, leading to poor communication between health workers and people as well as a diminished therapeutic alliance (van Boekel et al., 2013). People with substance use disorders experience greater physical health inequities, as healthcare providers often only see the person as their substance use diagnosis and tend to misattribute physical illness symptoms to substance use problems (Lockett et al., 2021). This is referred to as diagnostic overshadowing and can cause a delay in health screening, care, and treatment, and in some cases this care can be missed altogether. Stigma can also reduce the willingness of providers in non-specialty settings to screen for and address substance use problems if it is not obvious (Yang et al., 2017). Additionally, lower levels of care can be seen when it comes to pain management, and the physical pain experienced by people who use substances is often not taken seriously (Morley et al., 2015; Soh et al., 2019).

The attitudes of health workers have the potential to influence the diagnosis, treatment, and rehabilitation of people with substance use disorders (van Boekel et al., 2013). These attitudes can be both positive and negative. Negative attitudes by health workers can result in treatment avoidance or dropout. One study confirmed that when people who use substances report greater perceived discrimination by health workers and dissatisfaction with treatment, they were less likely to complete treatment (Brener et al., 2010). These negative attitudes can negatively impact on the empowerment of people and treatment outcomes.

Self-stigma also impacts on people's treatment and outcomes. Luoma and colleagues (2014) found that people with higher self-stigma tend to have a heightened fear of being stigmatised and therefore retreat into more protected settings such as residential care. This results in higher treatment costs as people with higher levels of self-stigma often have longer stays in residential treatment settings.

Due to perceived stigmatising attitudes of health workers, some people who use substances report adopting various strategies to navigate access and receipt of healthcare (Chan Carusone et al., 2019). These strategies consist of self-advocacy or falling into the role of an 'easy patient'. Help seeking strategies are also often influenced by the nature of the substances used – with illegal substances causing greater avoidance. Surprisingly however, while many people who use substances are not entirely satisfied with the healthcare they receive, they are also not necessarily dissatisfied either. This could be because stigma has shaped their experiences in a way that has led people who use substances to believe that a basic level care is exceptional care (Farrugia et al., 2021).

Stigma reinforces discrimination and creates public biases and misconceptions about people who use substances. As previously discussed, negative attitudes and beliefs held by the public around substance use contribute to stigma, and this continuous stigma can both maintain these beliefs while also reinforcing new ones. When these beliefs become established in society, they can impact on many opportunities for people who use substances. This creates discrimination and marginalisation which manifests as structural stigma and results in exclusion from school, housing opportunities, employment, insurance, and other social opportunities (Hatzenbuehler et al., 2013).

Another way in which stigma impacts on people who use substances is through the support, or lack thereof, for policies relating to substance use. Stigma reduces the willingness of policymakers to allocate resources for substance use treatment or harms and also decreases public support for various substance related policies (Yang et al., 2017). For example, stigmatising attitudes are correlated with lower support for evidence-based public health policies such as expanding access to pharmacological treatment and establishing safe consumption sites (McGinty et al., 2019). At the same time, stigmatising attitudes are correlated with higher support for punitive policies, such as prosecuting people who obtain multiple opioid prescriptions from different doctors (Kennedy-Hendricks et al., 2017). These findings suggest the public is unlikely to support policies to benefit highly stigmatised groups, and instead prefer a punishment approach. Stigma impacts on people's beliefs and attitudes, and as a result the policies that are supported by the public can mean less access and care for people who use substances.

The 'war on drugs' is another example of the impact of stigma for people who use substances (Buchanan, 2004). The language used in the 'war on drugs' discourse is stigmatising and results in those who use or ever have used, being framed as dirty, dishonest, or evil. This results in a separation of us vs them, an increase in the incidence of social stigma in the community, and a hardening and greater support for policies that further perpetuate stigma and marginalisation for people who use substances.

Research from Aotearoa New Zealand on stigma for substance use is relatively limited, especially when examining the impact of stigma and discrimination for Māori and Pacifika peoples. A major impact of stigma for Māori people is that it acts as a barrier to help seeking. The current drug laws in Aotearoa New Zealand treat drug use primarily as a criminal rather than health issue (New Zealand Drug Foundation, 2020). This adds further stigma to

substance use and creates barriers to accessing help. Some Māori can then be afraid to seek help for their substance use in case they get treated in a punitive way (New Zealand Drug Foundation, 2018). This is a justified worry for Māori as they tend to face greater scrutiny and harsher judgement from police, and have more convictions for low-level drug offences than other ethnic groups (Ministry of Justice, 2020). One study by Winter and colleagues (2019) indicates the association between Māori ethnicity and hazardous drinking in Aotearoa New Zealand may be partially mediated by experiences of discrimination. This suggests that stigma and discrimination may influence Māori substance use patterns and may result in more hazardous drinking patterns.

Key national and international policies and documents

Recent studies indicate greater worldwide attention to the negative impact of stigma. Drug policy reform is higher on the international agenda than it has ever been (Bielenberg et al., 2021; New Zealand Drug Foundation, 2015). There has been a shift both nationally and internationally in the policy context away from a focus on crime and punishment towards a health model that is supportive of removing barriers created by stigma for help and recovery. The 2016 United Nations General Assembly Special Session (UNGASS) on the World Drug Problem was instrumental in changing this mindset. The outcome document of this special session (UNGASS, 2016), which was unanimously approved by all 193 member states, recognises that substance use is not the result of moral failure or criminal behaviour, and instead…

> drug dependence is a complex multifactorial health disorder characterized by chronic and relapsing nature with social causes and consequences that can be prevented and treated through, inter alia, effective scientific evidence-based drug treatment, care, and rehabilitation programmes, including community-based programmes. (p. 6)

Within Aotearoa New Zealand there has been minimal research done on stigma associated with substance use, but there is a growing body of national policy and documents that are beginning to recognise the harmful effects of stigma (see Figure 3 below for a timeline of this). Some of the older relevant national documents, such as *Te Kokiri: The Mental Health and Addiction Plan 2006 – 2015*, note that it is critical to understand mental health and addiction issues in the general public in order to reduce stigma and discrimination (Ministry of Health, 2006). However, the subsequent narrow focus has been on the stigma associated with mental health challenges, rather than substance use. The Ministry of Health also commissioned research in 2009 - *Research into Knowledge and Attitudes to Illegal Drugs* to provide an evidence base for a social marketing campaign and drug demand reduction programme. It found through telephone surveys and interviews that the general public had a high level of concern around drug use, focused more on the harms, and that stigmatising beliefs and attitudes were prevalent in society (UMR & Acqumen, 2009).

In 2012, the Ministry of Health released *Rising to the Challenge – the Mental Health and Addiction Service Development Plan 2012 – 2017*. This plan set out the direction for mental health and addiction service delivery across the health sector until 2017. While a great deal of focus was placed on calling out stigma and discrimination for mental health challenges, there was not much specifically given to problematic substance use. The plan did suggest that to enhance social inclusion opportunities and reduce stigma the Like Minds, Like Mine

programme should be continued and refreshed, with consideration given to incorporating addiction into the programme.

In more recent national policies and documents, stigma associated with substance use is increasingly being referred to. *He Ara Oranga* (2018) is perhaps one of the most significant recent documents. It identifies stigma surrounding mental health challenges and substance use as a barrier to seeking help. It recognises how it is also embedded in our laws, shapes attitudes, and influences how services are structured and delivered. *He Ara Oranga* calls for a shift in the national mindset away from stigmatising substance use issues.

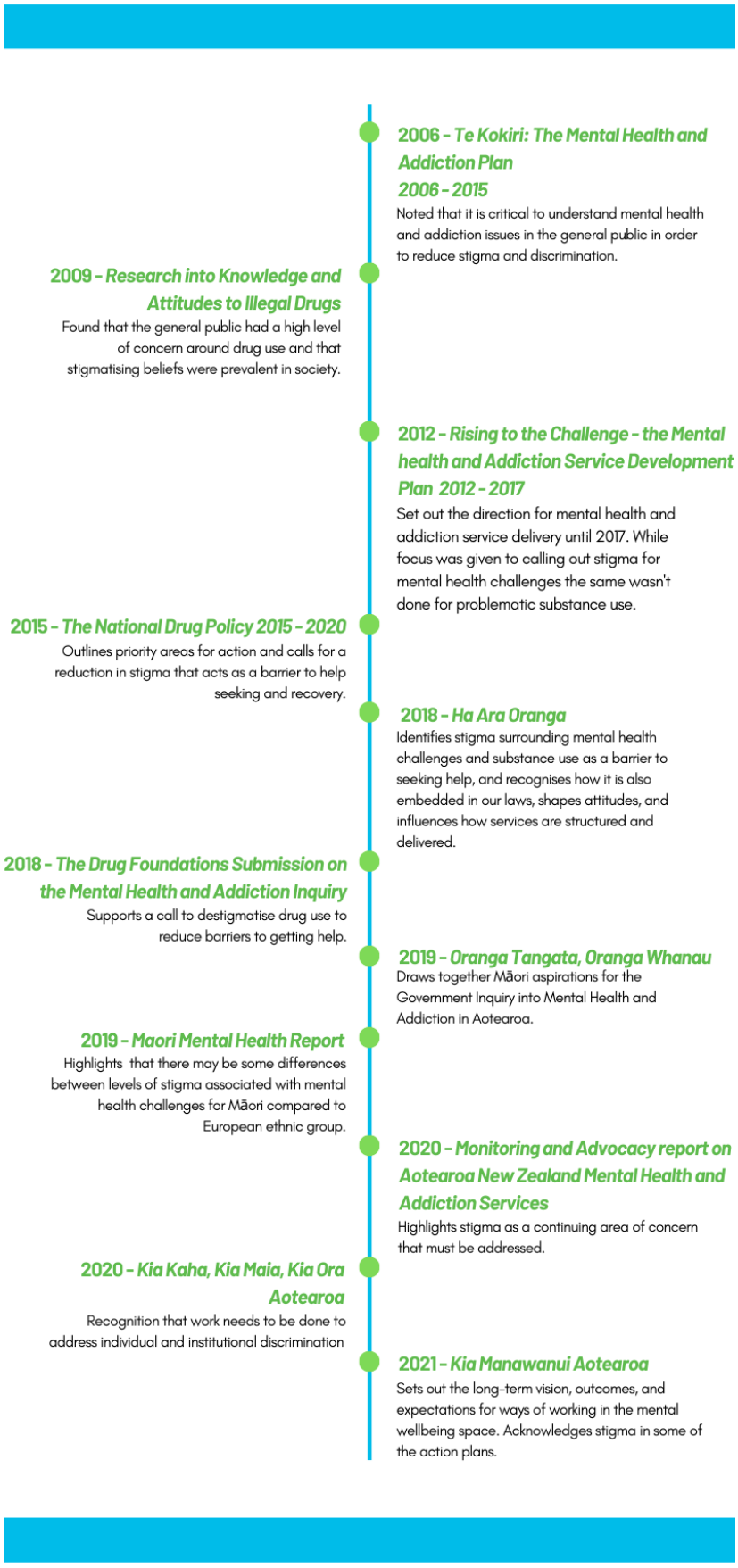

Figure 3 Timeline of key policies and documents

The *National Drug Policy 2015 – 2020* outlines priority areas for action and the Minister's foreword highlights the need for compassion, calling for stigma that acts as a barrier to help seeking and recovery to be reduced (Ministry of Health, 2015). The strategy identifies and highlights the need to:

- address factors that impact on people's ability to access treatment and support, including destigmatising help-seeking
- building on existing substance use-related public education campaigns to shift substance use culture, promote help-seeking and address stigma.

In the June 2020 *Monitoring and Advocacy Report on Aotearoa New Zealand's Mental Health and Addiction Services* the Mental Health Commissioner (2020) highlights stigma as a continuing area of concern that must be addressed. He states that it is an area that requires ongoing attention and quality improvement…

> ensuring that the distinct needs of people who are experiencing harm from their substance use is not lost within a broader focus on wellbeing, and that the stigma surrounding addiction is specifically addressed to encourage help-seeking and celebrate and support recovery. (p. 7)

The stigma associated with substance use is given significantly more attention in the June 2020 report than in other documents, with a call that Aotearoa New Zealand needs to act. The Mental Health Commissioner reaffirms that all three forms of stigma are currently an issue for people in Aotearoa New Zealand experiencing harm from substance use and recommends that a concerted and multi-faceted effort is required to address these issues. Specifically, the Mental Health Commissioner notes that to date, activities within the alcohol and drugs space have primarily focused on messages to reduce alcohol-related harm and that a destigmatisation campaign aimed at substance use and substance use disorders was previously scoped, but the findings and proposals were not implemented.

The destigmatisation campaign previously scoped was created by the New Zealand Drug Foundation to help the Ministry of Health decide whether Aotearoa New Zealand would benefit from a government funded programme to reduce stigma associated with substance use (New Zealand Drug Foundation, 2015). As part of the scoping for the destigmatisation programme, a consultation session workshop was run with the Matua Raki Consumer Leadership Group. This allowed the voices of people with lived experiences of stigma and discrimination to be heard, to better understand the settings in which stigma occurs, and where the most meaningful change can be made. Interestingly, the participants noted that it was common for them to experience stigma within the addiction sector as a consumer advisor, with less value given to lived experience over clinical knowledge. However, they did agree that there has been some improvement in this over time as the consumer profession grew. Overall, the workshop confirmed that stigma can be experienced all three levels (personal, structural and social) before, during and after treatment as well as in a broad range of settings with various drivers (New Zealand Drug Foundation, 2015).

The Drug Foundation's Submission on the Mental Health and Addiction Inquiry (2018) is another document that supports a call to destigmatise drug use to reduce barriers to getting help. In their submission, the Drug Foundation reiterate how substance use is highly stigmatised in Aotearoa New Zealand, with stigma towards people who use substances

existing at all levels in society and high levels of social and legal discrimination because of stigma. They go on to discuss how stigma stops people seeking help and influences the quality of help they receive. Finally, they urge the Ministry of Health to fund a destigmatisation campaign to reduce barriers to help-seeking and receiving quality treatment.

Due to COVID-19, most other recent health documents in Aotearoa, such as *Kia Kaha, Kia Māia, Kia Ora Aotearoa: Psychosocial and Mental Wellbeing Recovery Plan*, and other resources from the Ministry of Health's mental wellbeing long-term plan tend to focus more on mental health challenges and substance use harms from the pandemic. Within some of the principles and focus areas of *Kia Kaha, Kia Māia, Kia Ora Aotearoa* there is some recognition that work needs to be done to address individual and institutional discrimination and that by building knowledge and encouraging openness about mental health and substance use, stigma can be reduced and access to support improved (Ministry of Health, 2020).

A very recent document, *Kia Manawanui Aotearoa* sets out the long-term vision, outcomes, and expectations for ways of working in the mental wellbeing space (Ministry of Health, 2021). The document builds on the themes and recommendations from *He Ara Oranga* by outlining sequenced actions for the next 10 years that provide a national-level view of long-term priorities. One action planned is to strengthen investment in promoting mental wellbeing, and this will involve promoting societal-level awareness, behaviour change, and reduced discrimination and stigma related to mental health and addiction issues and help-seeking. Other actions set out that may help address stigma include plans to strengthen a public health approach to regulation and enforcement in relation to substance use; a review of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 and amendments to the Misuse of Drugs Act 1975 which are laws that often further stigmatise people who use substances; raising addiction literacy at the population level; and transforming the addiction workforce by engaging in sustained efforts to reduce discrimination. Finally, in *Kia Manawanui* there is an emphasis on valuing lived experience and the experiences of specific cultures. This is highlighted in many of the action plans, but one specific action that could help reduce stigma is the plan to enable tikanga Māori approaches alongside Māori clinical approaches in mental health and addiction services and supports. This will help reduce cultural barriers when Māori seek treatment.

Although there are few documents or policies specifically focused on Māori and substance use stigma, there are some key documents that include a focus on mental health and substance use among Māori and some conclusions can be drawn from this work. The first document is *Oranga Tāngata, Oranga Whānau* which draws together Māori aspirations for the Government Inquiry into Mental Health and Addiction in Aotearoa (Inquiry into Mental Health and Addiction, 2019). In this report they discuss how trauma and adversity is a root cause of addiction issues, and how a considerable amount of trauma is experienced by whānau due to colonisation, racial discrimination, and the lack of recognition of matauranga, tikanga and te reo Māori. They also mention, in relation to mental health, that stigma is a major deterrent to seeking help for Māori, and that there is a persistent stigma attached to mental health challenges. For whānau, stigma and racism are intertwined concepts, which can cause a layering effect on people. By recognising the racism that already exists for Māori with substance use disorders, we can acknowledge that they would additively experience stigma for their use as well. The potential of decriminalisation to reduce stigma is also brought up in this report, and as Māori are unfairly represented in low-level drug offences and the negative consequences of substance use fall heavily and

disproportionately on tāngata whenua, decriminalisation could significantly reduce the stigma Māori face and potentially improve mental health and substance use outcomes (Inquiry into Mental Health and Addiction, 2019; New Zealand Drug Foundation, 2020).

Another key document to examine is the *Māori Mental Health* report commissioned by the Waitangi Tribunal for the Wai 2575 Health Services and Outcomes Kaupapa Inquiry (Gassin, 2019). This document gives an outline of contemporary mental health services and significant historical developments, while paying specific attention to the disparities in outcomes, access, responsiveness, and effectiveness for Māori (Gassin, 2019). They highlight the results of the *2014 Health and Lifestyles Survey* by the Health Promotion Agency which indicates there may be some differences between levels of stigma associated with mental health challenges for Māori compared to European ethnic groups. This was determined through the willingness to have a community mental health center open in their suburb, with Māori less likely to want this. Furthermore, within the *Māori Mental Health* report they discuss how Māori ways of working are secondary to the dominant Western model and there are various cultural barriers when engaging in this system (Gassin, 2019). This would contribute to the 'othering' that happens when stigma forms, and thus these difficulties compound for Māori. This can then act as a barrier to seeking help as some Māori may feel like they will be stigmatised and treated differently in a system not designed for them.

Internationally, one key document is *The World Drug Perception Problem – Countering prejudices about people who use drugs* by the Global Commission on Drug Policy (2017). This report, while fully acknowledging the negative impact that problematic drug use often has on people's lives, focuses on how current perceptions of drugs and people who use them feed into and off prohibitionist policies (The Global Commission on Drug Policy, 2017). It emphasises that what should be factual discussions around drug policy reforms are frequently treated as moral debates. The report analyses the most common perceptions and fears and contrasts them with available evidence on drugs and the people who use them. It recommends changes that can be enacted to support reforms toward more effective drug policies. Some of these changes include encouraging policy makers to provide only reliable and consistent information, pushing opinion leaders to promote the use of non-stigmatising and non-discriminatory language and urging ordinary citizens to keep governments, the media, and health and social workers accountable. By doing so, they hope to shift the current narrative and perceptions around substance use to reduce stigma and gain greater support for health-based drug policies.

The *International Guidelines on Human Rights and Drug Policy* positions stigma as a human rights issue and an obstacle to the right to the highest attainable standard of health (International Centre on Human Rights and Drug Policy et al., 2019). They state that "responding to the harms associated with drug use and the illicit drug trade is one of the greatest social policy challenges of our time. All aspects of this challenge have human rights implications" (International Centre on Human Rights and Drug Policy et al., 2019, p. 4). As part of their guidelines, they call upon all country member states to address the social and economic determinants that support or hinder positive health outcomes related to drug use, such as stigma and discrimination against people who use drugs. The guidelines also call for specific measures, including training for health service providers regarding stigma and discrimination.

Initiatives to reduce stigma and discrimination

To date, there have been no clear nationwide campaigns about substance use stigma in Aotearoa New Zealand. Instead, there have been government funded programmes and community action to reduce stigma and discrimination for other health issues, including mental health challenges, disability, and HIV. Some elements from these campaigns could be relevant for a substance use anti-stigma initiative.

An example of one of these campaigns is the Like Minds, Like Mine programme which was designed to reduce stigma and discrimination associated with mental health challenges (Ministry of Health & Health Promotion Agency, 2014). As one of the longest running national campaigns, it is underpinned by the social model of disability, the power of contact and a human rights approach to disabilities. It draws on a multifaceted approach, including social marketing, community development, community action, adult education, consumer leadership and policy development. The target audience is people who have the potential to exclude others based on mental health, particularly in workplace and community settings. To assess the perceived impact of this campaign, Thornicroft and colleagues (2014) investigated the nature and degree of anticipated and experienced discrimination reported by people with mental health challenges, and their views on whether the campaign was contributing to reductions in stigma and discrimination. They found that whānau, friendship, and social life were the most common areas of discrimination reported by people with mental health challenges (see Figure 4 below); however, many believed the overall level of discrimination had reduced over the previous 5 years. Specifically, over half of participants reported improvement in discrimination over the previous 5 years, and nearly half thought that the Like Minds, Like Mine programme had assisted in reducing discrimination “moderately” or “a lot”. These findings are important to consider, as they suggest that if the government were to invest in a campaign to reduce stigma associated with substance use, there is a good chance it will have a meaningful impact.

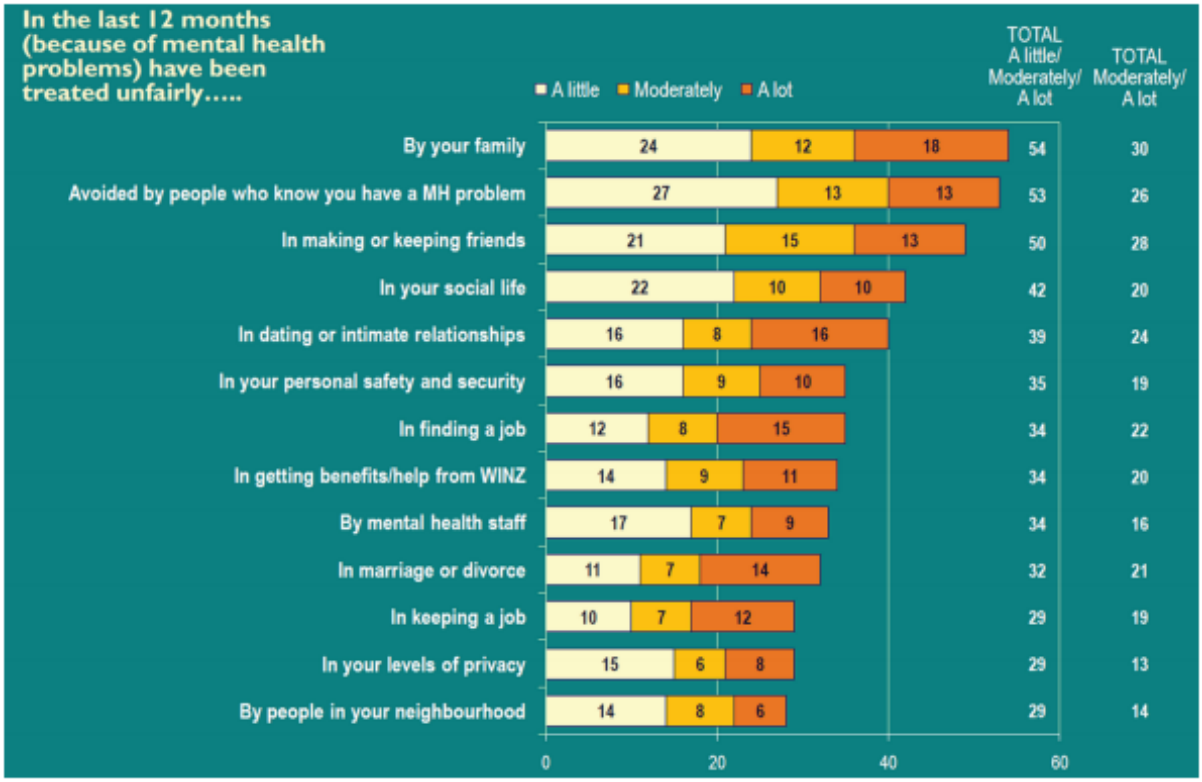

Figure 4 Experienced discrimination in personal life (Thornicroft et al., 2014, p. 365)

Although there are no government funded stigma focused initiatives, there are some small grassroots organisations in Aotearoa New Zealand that are working to reduce stigma. One example is Health not Handcuffs which is an organisation that is working with communities to change our drug laws away from prohibition (Health not Handcuffs, 2019). This movement promotes the belief that people with substance use disorder need a 'cloak of support and care, not punishment and stigma'. They believe stigma can be reduced by changing the drug laws so that health and social assistance is offered instead of punitive measures.

Another example of a smaller local initiative taken in Aotearoa New Zealand is Te Ara Oranga in Northland (Northland DHB, 2021). This initiative is a methamphetamine harm reduction initiative that involves the Northland District Health Board (DHB), police and non-government agencies working closely together to minimise the harm caused by methamphetamine. Figure 5 summarises recent outcomes from this programme. The way in which this community is dealing with substance related harms also simultaneously targets stigma, with police referring people who use substances on to treatment, rather than placing criminal charges. This is demonstrated in the graphic below on police action, which shows that over the last 3 years the police have made 686 referrals to treatment rather than charging people with methamphetamine related charges. Some of the various health actions that have taken place through this initiative are also highlighted in Figure 5, such as intervention options and employment possibilities.

Another grassroots community action is P Pull which is a national, community-driven movement supporting people and whānau to reduce the negative impacts of methamphetamine (New Zealand "P" Pull, 2021). Through a Facebook group, they provide knowledge, lived/learned experiences, practical advice, and support to people who use methamphetamine and their whānau. With a goal to educate and raise awareness, this community action initiative works to reduce stigma by challenging the stigmatising attitudes and beliefs people hold around methamphetamine use.

Police Action

Prevention		
3 Years (Sept 2017- Sept 2020)	July-Sept 2021	Total (Sept 2020-Sept 2021)
686 Referrals to Treatment: - 659 People referred to DHB for treatment options - 27 Whānau referred to Whānau group for support.	**56** Referrals to Treatment: - 56 People referred to DHB for treatment options - 2 Whānau referred to Whānau group for support.	**911** Referrals to Treatment: - 858 People referred to DHB for treatment options - 53 Whānau referred to Whānau group for support.
49 Reports of Concern for **111** children	**0** Reports of Concern for **0** children	**56** Reports of Concern for **126** children

Health Action

Treatment			
	3 Years (Sept 2017- Sept 2020)	July-Sept 2021	Total (Sept 2020-Sept 2021)
Treatment cases	2,134	723	2,857
Screening and Brief Intervention			
People screened	10,594	2,099	12,693
Self-reported methamphetamine use in previous 3 months representing 2.6% of those screened.	271	60	331
Users consented to a referral for support/treatment	103	20	123
Referral for meth use support/treatment	65	16	81
Agreed to a referral to address other substance use	38	4	42
Choice (One-day Brief Intervention Programmes)			
Referrals to Choice	876	185	1,061
Pou Whānau Connectors			
Clients and their whānau members supported	793	199	992
Employment			
Total Referrals	229	68	297
New Employment	105	24	129
Education/Work Skills	47	13	60
Job Retention	11	2	13

Figure 5 Te Ara Oranga outcomes July - September2021 (Northland DHB, 2021)

Aside from these grassroots initiatives in Aotearoa New Zealand, a range of workforce development resources have been developed that help reduce stigma. Te Pou have a raft of resources. This includes for example, the Asian language resources[1] containing substance use related information in Chinese – traditional and simplified. These resources raise awareness about substance use and substance use disorder and assist in destigmatising substance use for Asian communities by breaking down information and language barriers to seeking help. The *Real People Share Their Recovery Stories* resource created by Matua Raki[2] also shares a collection of people's different stories of their journeys to recovery from

[1] https://www.tepou.co.nz/initiatives/asian-language-resources
[2] https://www.tepou.co.nz/resources/real-people-share-their-recovery-stories

problematic substance use. These stories are also available in a different Asian languages, such as Japanese, Thai and Vietnamese. The series of resources reduces stigma by raising awareness that everyone can be affected by problematic substance use, and communicating that people are not alone, and there are options for help and support if you want it.

International initiatives to reduce stigma are summarised in Table 1.

Table 1 Summary of some International Initiatives

Name & Location	Description & Campaign Elements
Rethink Addiction (Australia)	This is an independent campaign representing a collaborative industry effort to rethink addiction through evidence-based information and linkages to support (Rethink Addiction, 2021). They acknowledge that addiction is misunderstood, and that stigma is damaging – real change is possible but to achieve it we need to Rethink Addiction. On their website they have a range of resources, real stories and a petition to join their campaign. Signing the petition means you are supporting the campaigns objectives. 1. To establish treating addiction as a national priority. 2. To convene a summit for meaningful knowledge exchange between addiction experts. 3. To draft a national plan and roadmap to address addiction. 4. To establish a dedicated research fund to improve treatment outcomes and service pathways.
Bringing Addiction Stigma to an End #QuitStigmaNow (Global – Dianova)	Dianova is a non-government organisation dedicated to the development of people, communities, and organisations. They operate in 19 countries over 4 continents. They develop advocacy activities that echo the UN 2030 Agenda (Dianova, n.d). The campaign's objective is to reduce the stigma attached to people with substance-related disorders and to promote treatment and prevention services that are more respectful of their rights. Through various images and messages, the target audience is invited to follow a series of recommendations geared toward combating stigma. Likewise, they are encouraged to share this material with third parties through their own channels. It is mainly a social media-based campaign that is also user led so depends on how interactive people want to be. It also relies on the power of social media sharing.
Nice People Take Drugs (UK – Release UK)	Release is the national centre of expertise on drugs and drugs law. The organisation is an independent and registered charity that takes the experience of their clients and issues they raise to organise campaigns (Release, 2013). This public campaign communicates a simple message via online messages and advertisements as well as wearable messages. The message was printed on London's red buses, on clothing and on posters.
Support Don't Punish (Global)	This is a global grassroots-centered initiative in support of harm reduction and drug policies that prioritise public health and

	human rights. The campaign seeks to put harm reduction on the political agenda by strengthening the mobilisation capacity of communities targeted by the "war on drugs" and their allies, opening dialogue with policy makers, and raising awareness among the media and the public (Support Don't Punish, 2019). Part of the campaign is the Global Day of Action which takes place on, or around, the 26th June. The campaign's Global Day of Action seeks to reclaim and shift that day's narrative, from a day that has been historically used by governments to showcase their drug control 'achievements' in coercive terms. And so, every year, an increasing number of activists in dozens of cities all over the world join this unique and multifaceted show of force for reform and harm reduction. Like Dianova's campaign it is mainly a social media-based campaign that is also user led so depends on how interactive people want to be. It also relies on the power of social media sharing.
A Movement to End Addiction Stigma (US – Shatter Proof)	Shatter Proof is a US organisation committed to ending the addiction crisis in the US. They challenge stigma to affect behaviour change, host a range of events from fundraisers to city wide challenges, partner with Major League Baseball teams to advance their message and work with lawmakers to draft and pass legislation (Shatter Proof, 2020). Their new movement aims to significantly reduce the four types of stigma associated with substance use disorder, with an immediate emphasis on opioid use disorder given its widespread impact in the US. They plan to do this in six steps. 1. Identify key stakeholders – the six systems that have the largest impact on people with substance use disorder, those seeking treatment and those in recovery were identified. 2. The creation of materials that enable individuals and organisations to take action – this includes action plans and resources on education, language and changing policies. 3. Build a national coalition. 4. Create an Addiction Stigma Index – this will be an annual measurement system measure the knowledge, attitudes, and behaviours of the general public, those within our six targeted systems, and those with substance use disorder. 5. Stakeholder certification – this will mean organisations will be publicly recognised as 'allies' for implementing actions. 6. Promote the movement – national and local media will be used to promote the movement, its progress and impact.
Stigma Ends with Me Impact Story (Canada - CCSA)	This is a multi-dimensional project with the goal of improving wellness and reducing harms for those with lived and living experiences of substance use (Canadian Centre on Substance Use and Addiction, 2020). The project has achieved impact through a combination of workshops, targeted training, social media campaigns and online resources. Together, these activities have raised awareness and enhanced understanding about stigma and substance use by education and providing resources and tools to individuals and organisations.
Stop Stigma, Save Lives	This project shares the words through short videos of 12 people with first-hand or whānau experiences of drug use (Northern Health, 2017). Through these stories, they hope to build

(Canada – Northern Health).	compassion, encourage empathy, and contribute to a community that treats all people with dignity and respect. The communication channels of this campaign are limited to the website.

Language

Other international initiatives have concentrated on producing documents that focus on changing the language used by people when discussing substance use and substance use disorder. One example is a primer produced by the Canadian Center on Substance Use and Addiction (2019) called *Overcoming Stigma Through Language*. The document was designed to increase understanding of the devastating stigma associated with substance use and the impact on the wellbeing of people touched by this issue. To increase recognition of the problem, the primer highlights stigmatising language, attitudes, and behaviours and includes practical language tips to help reduce stigma one conversation at a time.

Moving Beyond People-First Language – a glossary of contested terms in substance use by the Scottish Drugs Forum [SDF] (2020) is another document with a similar focus on language. In this document they recognise that some of the terms which have become key terms within the drugs field involve specialist knowledge to fully understand and often the language can be contentious or misunderstood. The SDF decided to publish their own glossary with the aim of improving communication and shared understanding across the drugs field in Scotland. The glossary increases understanding of the language used both in everyday conversation and discussion of drug issues in more specialist environments. One particular strength of this resource is the recognition that language is evolving, and the commitment they make to revising and updating the glossary resources.

Here in Aotearoa New Zealand, Matua Raki, the national addiction workforce development organisation within Te Pou at the time, developed a 'language matters' poster to help guide people on what language to use when discussing substance use[3]. This poster stresses that language is powerful, and that stigmatising language perpetuates negative stereotypes.

Workforce development

Within the literature, some seemingly effective interventions have been studied to address stigma at the structural, social, and self-level. These interventions include educational programs, contact-based training, changing the language used, advocacy, motivational interviewing, acceptance and commitment therapy, and communication training (Livingston et al., 2012). The targeted audience for these interventions includes health workers, medical students, other professional groups (such as the police), the general public, and people who use substances. It is based on some of these studies and findings that options for workforce development are made. In addition, trauma-informed practice and the values and attitudes of the workforce are important.

Educational interventions are commonly used to reduce stigma by targeting groups or professionals that are likely to encounter people who use substances or with substance use disorder. It has been suggested that knowledge gaps may contribute to stigmatising attitudes

[3] https://www.tepou.co.nz/resources/language-matters

and reluctance to engage with people who use substances. Therefore, developing educational programmes that address these gaps and raise awareness of substance use related stigma can be beneficial. These educational interventions can be delivered either online or in-person, and then supplemented with peer activities, discussion forums, and role playing. For example, Clair et al. (2019) reviewed an intervention focused on peer- and mentor-enhanced web-based training about substance use disorders. The training content included informing participants on substance use services and screening, the stigma associated with substance use, and interventions for substance use disorders and common comorbidities. This was delivered as a free web-based intervention that included peer and mentor-assigned activities, discussions, and role-play. They observed that after this intervention the participants had decreased stigma for tobacco and other substance use disorders yet not for alcohol use disorders. These types of interventions, particularly those delivered online, can be very cost-effective and feasible in low-resourced settings.

Blueprint for Learning's Addiction 101, which is a one-day addiction literacy program funded by the Ministry of Health, is another local example of an educational intervention that aims to increase awareness and reduce the stigma associated with addiction (Te Pou, 2021). The workshops are designed for people in organisations and communities and are also suitable for anyone without training or qualifications in the sector who is interested in learning about addiction and recovery. They are delivered using a co-facilitation model, meaning that one facilitator has lived experience while the other has clinical experience. A recent evaluation of this programme found that participants were positive about the workshop and agreed they would recommend it to others. One of the key findings was that most people felt that the learning from Addiction 101 has been useful for both the workplace (84%) and their personal life (67%), and almost all participants (90%) felt more confident talking about addiction and recovery (Te Pou, 2021).

While educational interventions can be helpful in attitudinal change, contact with people in recovery and with lived and living experience of substance use needs to be a vital component of interventions to have lasting effects (Bielenberg et al., 2021). Based on the relationship between knowledge, attitudes and practice, there is a strong need for health workers to have experiential education that includes psychosocial aspects of care with increased opportunities for practice (Rao et al., 2020). For example, Khenti and colleagues (2019) assessed an intervention which included contact-based training, an anti-stigma awareness campaign and a recovery-based workshop series. The training was formatted as a symposium with anti-stigma and recovery-based workshops, as well as an awareness campaign and policy analysis. They found, after this intervention there were significant improvements in attitudes towards people with substance use disorder.

It is important to note that educational interventions need to be implemented within services with the support of organisational leaders. One-off education programmes do see short-to-medium term gains in practitioners' attitudes and behavioural intentions; however, they need to be sustained and reinforced through wide and comprehensive implementation if they have any hope of effecting cultural change (Knaak et al., 2020). The culture within services is a key driver of structural stigma and health workers, as well as policymakers, need to be aware of this structural stigma to reshape the way health services are provided to people with lived experience. Structural stigma that exists within the policies, practices, rules, and institutional norms can both intentionally and unintentionally restrict access of support for groups of people. Therefore, in terms of interventions, research indicates that traditional educational strategies to reduce stigma in health care settings are unlikely to be as effective

when implemented alone, without an awareness of these structural issues and attempts to review commonly accepted practices (Paterson et al., 2013).

As stigma is reproduced through language, it is important health workers are aware of the importance of language and use non stigmatising language in practice. People-first language needs to be adopted and labels, slang and idioms are to be avoided. Instead, language should be used that reflects the medical nature of substance use disorders. At a minimum health workers should invite the people they see to guide them on which terminology they prefer (Northern Health, 2017). It is important that health workers prioritise lived experience, education, and advocacy. Aside from language, all people need to be treated with dignity and respect. A person should be seen for who they are and not what substance they use. Judgement should be withheld when working with people, and negative assumptions about people who use substances should be replaced with evidence-based facts. It is key to building trust between health workers and those who use substances (Treloar et al., 2016). Health workers also need to be aware of the structural stigma that exists within health settings, as this can influence the health and quality-of-life outcomes of people who use substances. It can also change the way health services are provided to people (Knaak et al., 2020).

In Aotearoa New Zealand, *Let's get real: Real Skills for working with people and whanau with mental health and addiction needs* (Te Pou and Ministry of Health, 2018) describes the values, attitudes, knowledge, and skills required for working effectively with people and whānau experiencing mental health and addiction needs[4]. The values and attitudes that underpin *Let's get real* can inform a way of practicing that does not further stigmatise against people who use substances and people with problematic substance use. One of the *Let's get real* seven Real Skills, aimed at reducing stigma and discrimination, is the Real Skill: Challenging discrimination. At the essential level these skills apply to everyone working in health, regardless of role, profession, or organisation. The *Let's get real* framework also incorporates a trauma-informed approach[5], the foundation of which is understanding what has happened to a person and their whānau, rather than focusing on what is wrong with a person. People who access mental health and addiction services are more likely to have experienced trauma than those in the general population. By using this approach, people with problematic substance use can be treated with compassion and care rather than discriminated against based on their substance use.

For self-stigma, health workers can help people challenge these beliefs using therapeutic interventions. While motivational interviewing and cognitive behavioural therapy are commonly seen as the main effective interventions, a recent study by Gul and Aqeel (2021) found greater reductions in stigma and shame for participants who received acceptance and commitment therapy (ACT) compared to those who received standard treatment for substance use disorders. Although this was a relatively small study (including 65 people) it does present a promising approach to addressing self-stigma. Those that work closely with people who have substance use disorders, such as practitioners, could consider combining ACT that focuses on stigma and shame with standard treatment. This ties in with ideas around mindfulness research, which shows increases in mindfulness facilitates acceptance, self-compassion and non-judgment while also reducing shame (Woods & Proeve, 2014).

[4] https://www.tepou.co.nz/initiatives/lets-get-real

[5] https://www.tepou.co.nz/initiatives/lets-get-real/trauma-informed-approaches

On a broader level, we need to push for health system policy changes that ensure all people who use substances and with substance use disorders have the ability to preserve their dignity (Adams & Volkow, 2020). Beyond health system policies, we need to evaluate the place of current drug policies. The criminalisation of many substances acts as a significant contributor to stigma, and in our work, we need to advocate for people who use substances and with substance use disorders. Advocacy for, and by, marginalised populations has historically functioned as a counterbalance to stigma and to promote policy change (Ashford, Brown, Canode, et al., 2019). In terms of drug law reforms, it is essential that we listen to the voices of those with living and lived experience, as well as priority populations such as Māori. These are the groups who are most effected by drug policies, as well as stigma, and to achieve true and enduring justice, their voices need to be heard.

Discussion

The literature review aimed to develop a better understanding of the extent and impact of stigma and discrimination in relation to substance use. Specifically, evidence was gathered on the prevalence of stigma, the factors contributing to this and its impact, as well as key national and international policies and documents and initiatives that have been undertaken to reduce stigma. Looking at both the national and international literature some of the key findings and their implications are discussed below.

Experiences of stigma and discrimination are common in the everyday lives of people who use substances and with substance use disorders. These experiences make people feel judged, looked down upon, excluded and most importantly they create inequitable barriers for people in the most fundamental aspects of their lives (Lancaster et al., 2017). Stigma is prevalent across a range of settings, such as healthcare, treatment, the media, criminal justice system, and society at large. It is within these settings that the inequitable barriers occur, such as barriers to whānau connection, employment opportunities, housing and community belonging. Potentially one of the most concerning barriers created by stigma is access to health services and treatment, which can occur at times when people need support the most. As a population with high healthcare needs, people who use substances should not face more barriers to accessing and receiving support due to stigma and discrimination than others. Stigma also acts as a barrier to help-seeking behaviours and experiences of stigma and discrimination at the moment of help-seeking can discourage people from seeking help again. As a result, people who use substances and with substance use disorders tend to have inequitable physical health outcomes and lower medical support (Lockett et al., 2021).

Another important finding is the significant influence that personal attitudes, beliefs, and language have on stigma. Factors such as education, political affiliation, 'folk explanations' of behaviour, knowledge about substances, health literacy, and personal familiarity with people who use substances all influence people's attitudes and beliefs around substance use (Sumnall et al., 2021). This can then impact the way people treat and interact with people who use substances, reinforce discrimination, create public biases and misconceptions, and influence the policies that are supported about substance use. Stigmatising attitudes and beliefs of health workers can influence the diagnosis, treatment, and rehabilitation of people with substance use disorders (van Boekel et al., 2013). Overall, stigmatising personal attitudes and beliefs can have a pervasive impact on the lives of people who use substances. The language used also has a pervasive impact, as it reflects our attitudes and approaches to substance use. The use of certain terms can perpetuate stigmatising attitudes and enable discrimination. Changing our language is a simple and easy first step that can be taken to reduce stigma and discrimination.

Aotearoa New Zealand's current drug policy, the criminalisation of many drugs and its role in producing stigma is crucial to consider. Our current drug laws are outdated, they stop people from seeking help, create stigma which impacts on the support people receive, leave people with convictions which negatively impact on their lives, and diverts funding from health into enforcement (New Zealand Drug Foundation, 2018). The Misuse of Drugs Act 1975 criminalises people who struggle with a substance use disorder instead of supporting them and this further stigmatises and alienates people by reinforcing idea that the individual person is to blame and the notion of choice to engage in illegal activities. Certain populations are more significantly impacted by this, with Māori being disproportionately represented in conviction and imprisonment rates which creates further barriers to getting help.

Furthermore, while many key national documents are starting to recognise the importance of addressing stigma, more research is need in in this area in Aotearoa New Zealand. We have a unique population, and it is essential that we have access to information which helps us understand how prevalent stigma is, how it works within our society, and the impact for our priority populations.

Finally, there is frequently the pairing, or nesting, of substance use disorder within considerations of mental health challenges. While the prevalence of coexisting substance use issues and mental health challenges is common it is important that substance use concerns have their own area of focus and considerations within policies and documents as it is broader, deeper, and wider than just simply a part of mental health (Lee & Allsop, 2020). The stigma towards mental health challenges has been reduced through considerable effort by the mental health sector, and while this is admirable the same consideration has not been as evident for substance use and addiction. It is essential that the stigma and discrimination experienced by people who use substances and with substance use disorders is specifically addressed. Due to the illegal nature of many substances, people who use substances face greater stigma. Even people who use legal substances, such as prescribed opioids and other pharmaceuticals, can face considerable discrimination due to the assumption they are 'drug-seeking' for non-therapeutic purposes. This stems from the view that substance use problems are not 'real' health problems and people have 'brought it on themselves' for choosing to use drugs. We are starting to see less blaming of individual people for mental health challenges, and this should be the case for substance use disorders as well (Jury et al., 2018).

Considerations

Based on the findings of this literature review, considerations for everyone, and in particular those working in health, to address the stigma associated with substance use and substance use disorders are outlined below.

1. Work alongside people with lived experience to examine the current practices of health workers and addiction practitioners in Aotearoa New Zealand to better understand what improvements or actions are required to eliminate stigma and discrimination.
2. Within organisations, promote and foster values and attitudes that actively work against stigma and discrimination towards people who use substance as reflected in *Let's get real*.
3. Review and adapt curriculum across relevant courses, programmes, and educational providers and encourage co-facilitation of stigma and discrimination training by people with lived experience.
4. Ensure language and practice does not reinforce stigma. People need to engage with communities affected by substance-related stigma and discrimination to guide use of terminology. Consider adopting people-first language and avoid use of labels, slang, and idioms.
5. Encourage and support the launch of a nationwide destigmatisation campaign. This may look like what was set out in the 'destigmatisation programme on drug use and drug dependence' by the New Zealand Drug Foundation (2015).
6. Advocate for drug policy reform that treats substance use as a personal choice and problematic substance use as a health issue and not a criminal issue.

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