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Follow-up to the implementation at the national, regional and international levels of all commitments, as reflected in the Ministerial Declaration of 2019, to address and counter the world drug problem**Summary of the discussions of the informal technical consultation on promoting non-stigmatizing attitudes to ensure the availability of, access to and delivery of health, care and social services for drug users, 14–16 January 2020, Vienna, Austria****

1. This document presents a summary of the discussions during the informal technical consultation organized by UNODC in response to resolution 61/11 “Promoting non-stigmatizing attitudes to ensure the availability of, access to and delivery of health, care and social services for drug users”, calling UNODC “to integrate awareness of stigmatizing attitudes into existing training programmes for agencies with tasks in the areas of health, care and social services, and other relevant officials, ...”.
2. The participants of the informal technical consultation considered good practices in this field on the basis of their experiences and research. As a summary of the discussions, the document is limited to a synopsis of the studies and examples considered by the participants of the informal technical consultation, covering both an understanding of stigmatizing attitudes and the promotion of non-stigmatizing attitudes to ensure access to services. While recognizing that such studies and examples might not be universally relevant, they are presented in the spirit of sharing information and experiences that might inform comprehensive and balanced efforts to promote non-stigmatizing attitudes to ensure the availability of services taking into account national, legal, cultural and socioeconomic contexts, as well as to inform the integration of awareness of stigmatizing attitudes into existing training programmes for relevant agencies.
3. The conference room paper is made available to the Commission for its information only at its sixty-fifth session.

* E/CN.7/2022/1.

** This document has not been edited.



Summary of the discussions of the informal technical consultation on promoting non-stigmatizing attitudes to ensure the availability of, access to and delivery of health, care and social services for drug users,
14-16 January 2020, Vienna, Austria

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
HIV	Human Immunodeficiency Viruses
UNGASS	United Nations General Assembly Special Session
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Introduction

This document presents a summary of the discussions of the informal technical consultation organized by UNODC in response to resolution 61/11 “Promoting non-stigmatizing attitudes to ensure the availability of, access to and delivery of health, care and social services for drug user”, calling UNODC “to integrate awareness of stigmatizing attitudes into existing training programmes for agencies with tasks in the areas of health, care and social services, and other relevant officials...¹”.

The participants of the informal technical consultation considered good practices in this field on the basis of their experiences and research. UNODC extends its appreciation to all those who contributed their knowledge, insights and experience in the process.

As a summary of the discussions, the document is limited to a synopsis of the studies and examples considered by the participants of the informal technical consultation, covering both an understanding of stigmatizing attitudes and the promotion of non-stigmatizing attitudes to ensure access to services. While recognizing that such studies and examples might not be universally relevant, they are presented in the spirit of sharing information and experiences that might inform comprehensive and balanced efforts to promote non-stigmatizing attitudes to ensure the availability of services taking into account national, legal, cultural and socio-economic contexts, as well as inform the integration of awareness of stigmatizing attitudes into existing training programmes for relevant agencies.

To prepare the informal technical consultation, UNODC undertook a multi-phase process to collect scientific evidence, good practices and experiences.²

The process was presented for information at the 63rd session of the Commission on Narcotic Drugs in Conference Room Paper E/CN.7/2020/CRP.11 *Note of the Secretariat on the implementation of resolution 61/11 “Promoting non-stigmatizing attitudes to ensure the availability of, access to and delivery of health, care and social services* and comprised an overview of the scientific literature.

In the first phase, UNODC undertook an overview of the scientific literature and addressed a call to all Member States to identify experts who could serve as focal points for this process³.

¹ Resolution 61/11 - Promoting non-stigmatizing attitudes to ensure the availability of, access to and delivery of health, care and social services for drug users (https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_61/CND_res2018/CND_Resolution_61_11.pdf).

² UNODC acknowledges the financial support provided by the Government of Canada to this multi-phase process.

³ Note Verbale CU 2019/64/DO/DHB/PTRS

Twenty-eight Member States nominated 31 experts that were all requested to provide input, ideas, experiences and scientific information through an online consultation. The online consultation was also opened to all the members of the Vienna NGO Committee with a view to involving civil society stakeholders.⁴

The results of the overview of the literature and of the online consultation informed the second phase of the process that consisted in a face-to-face technical consultation hosted by UNODC on 14-16 January 2020. The nearly 50 participants included the experts nominated by Member States that had provided substantive input through the online consultations, four representatives nominated by the Vienna and the New York NGO Committees, as well as a limited number of researchers identified as particularly significant through the overview of scientific literature. In addition, in the interest of coordinating efforts with other relevant United Nations entities to support an increasing awareness of the negative effects of stigmatizing attitudes on the availability of, access to and delivery of health, care and social services for drug users, UNODC invited representatives from the World Health Organization and three other regional and international organizations. The list of participants is attached to this summary as Annex I.

The objectives of the meeting were to identify and collate information on good practices related to resolution 61/11 and specifically about:

- Increasing awareness of the negative effects of stigmatizing attitudes on the availability of, access to and delivery of health, care and social services for persons who use drugs;
- Promoting non-stigmatizing attitudes in the development and implementation of scientific evidence-based policies related to the availability of, access to and delivery of health, care and social services for persons who use drugs.

Throughout the multi-phase process, a commitment was made to welcome affected populations⁵ to contribute their experience of stigmatizing attitudes in relation to the availability of, access to and delivery of services. This commitment significantly contributed

⁴ E/CN.7/2020/CRP.11 Note of the Secretariat on the implementation of resolution 61/11 “Promoting non-stigmatizing attitudes to ensure the availability of, access to and delivery of health, care and social services” (https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_63/CRPs/ECN72020_CRP11_e_V2001458.pdf).

⁵ In the context of this summary of the discussions of the informal technical consultation on stigma, and purely for purposes of improving the readability of the text, the term affected populations is used to refer to people who use psychoactive substances, including the non-medical use of controlled substances, and people with substance use disorders, whether or not they are in contact with the treatment and health care system, and whether or not they have engaged in a path of recovery or are in recovery.

to a meaningful dialogue during the informal technical consultation that is herewith presented as a summary.

International framework

Resolution 61/11 of the Commission on Narcotic Drugs was endorsed in response to, and framed by, a number of commitments Member States have made in past years. One of the driving forces behind the need for this resolution was the Outcome Document of the 2016 United Nations General Assembly Special Session on the World Drug Problem⁶ in which Member States “reaffirmed their determination to address the world drug problem and to actively promote a society free of drug abuse in order to help ensure that all people can live in health, dignity and peace, with security and prosperity, as well as their determination to address public health, safety and social problems resulting from drug abuse”. Promoting non-stigmatizing attitudes to ensure health, care and social services is clearly linked to the framework of the UNGASS Outcome Document and operational recommendations on demand reduction and related measures, including prevention and treatment, as well as other health-related issues.

In the UNGASS Outcome Document Member States recognized “drug dependence as a complex, multifactorial health disorder characterized by a chronic and relapsing nature with social causes and consequences that can be prevented and treated”.⁷ Voluntary participation of persons with drug use disorders in treatment, rehabilitation and care programmes, with informed consent, is encouraged within all levels of health programming, as well as “outreach programmes and campaigns ... to prevent social marginalization and promote non-stigmatizing attitudes, as well as to encourage drug users to seek treatment and care and take measures to facilitate access to treatment and expand capacity.”⁸ The document goes on to discuss non-discriminatory access to a broad range of interventions to including but not limited to psychosocial, behavioural and medication assisted treatment modalities in line with national legislation. Particular attention is paid to the needs of persons in the criminal justice system, women, children and youth.

⁶ UNODC (2016), “Outcome Document of the 2016 United Nations General Assembly Special Session on the World Drug Problem, New York, 19-21 April 2016 - Our joint commitment to effectively addressing and countering the world drug problem”

(<https://www.unodc.org/documents/postungass2016//outcome/V1603301-E.pdf>).

⁷ *Ibid.*, page 6

⁸ *Ibid.*, page 6, paragraph (j)

The focus on the health and welfare of humankind is the very cornerstone of the three international drug control conventions⁹ and number of resolutions over the years have supported a strong drug demand reduction approach that is based on science and evidence of effectiveness. In particular, resolution 57/4 of the Commission recognized that efforts supporting recovery from drug use disorders needed to be consistent with human rights obligations and be within the framework of the international drug control conventions, and encouraged Member States to take measures to ensure non-stigmatizing attitudes towards those seeking help or in recovery, to help reduce marginalization and discrimination and to promote social reintegration, partnering with different levels of governmental authority and, where appropriate, with civil society and communities. This resolution also called on Member States to facilitate exchanges on developing a chronic-care approach to the treatment of drug use disorders similar to approaches for other chronic conditions, and to support and sustain recovery programmes, as appropriate, in schools, universities, workplaces, communities and other domains, calling for a comprehensive, integrated and balanced approach to drug demand reduction that promotes and protects the health and safety of individuals, families and communities, while promoting non-stigmatizing attitudes.

In resolution 61/11, the Member States recognize that marginalization, stigmatizing attitudes, discrimination and fear of social, employment-related or legal repercussions may dissuade many who need help from accessing it and lead those who are in stable long-term recovery from a drug use disorder to avoid disclosure of their status as a person in recovery from said disorder. Actions taken to reduce stigmatizing attitudes and discrimination must be done in conjunction with other existing human rights documents, ensuring persons who use drugs still have the same rights to quality health care and entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity as any other citizen, whether for drug use treatment or for other health conditions:

- Universal Declaration of Human Rights (UDHR)¹⁰
- Convention on the Rights of Persons with Disabilities¹¹
- Convention on the Rights of the Child¹²

⁹ UNODC (2013), The International Drug Control Conventions (https://www.unodc.org/documents/commissions/CND/Int_Drug_Control_Conventions/Ebook/The_International_Drug_Control_Conventions_E.pdf).

¹⁰ United Nations (1948), Universal Declaration of Human Rights (<https://www.un.org/en/universal-declaration-human-rights/index.html>).

¹¹ United Nations (2006), Convention on the Rights of Persons with Disabilities (<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>).

¹² United Nations (1989), Convention on the Rights of the Child (<https://www.unicef.org/child-rights-convention/convention-text#>).

- International Covenant on Economic, Social and Cultural Rights (ICESCR)¹³

Another relevant framework is the 2030 Agenda for Sustainable Development adopted by Member States in 2015 and serving as a blueprint to address seventeen Sustainable Development Goals (SDGs).¹⁴ SDG 3 ensures healthy lives and promote well-being for all at all ages. Promoting non-stigmatizing attitudes to ensure the availability of, access to and delivery of health, care and social services for all persons, including persons who use drugs will contribute to accomplishing SDG 3, and specifically Target 3.5 on strengthening prevention and treatment of substance and drug use disorders. Moreover, promoting non-stigmatizing attitudes can contribute to improved outcomes of other SDGs as well, and sustain changes that will aid in development agendas at the global and national level.

¹³ United Nations (1966), International Covenant on Economic, Social and Cultural Rights (<https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>).

¹⁴ United Nations (2015), Transforming our world: the 2030 Agenda for Sustainable Development (<https://sustainabledevelopment.un.org/sdgs>).

Understanding stigmatizing attitudes

The discussion about stigmatizing attitudes and stigma remains complex, poorly researched and includes a number of issues where consensus has not been achieved. These include issues with regard to policies that might contribute to stigma (e.g., in the health sector, in law enforcement, in the criminal justice sector, in the education sector, etc.), as well as with regard to the effects of stigma itself. These issues can be seen on a continuum with the information contained in this summary meant to inform and inspire ongoing discussions, by providing considerations on the nature of stigmatizing attitudes and stigma and on strategies to effectively reduce them as a barrier to health, care and social services for affected populations. In this context, the importance of voluntary interventions in all services should be highlighted, including effective, evidence-based drug prevention, treatment, rehabilitation, recovery support, care and low-threshold services.

In spite of international commitments and support to address the world drug problem, marginalization, stigmatizing attitudes, and discrimination remain obstacles for affected populations, including in relation to accessing health, care and social services. A systematic literature review found that negative attitudes towards patients with substance disorders were common among health professionals, who generally did not have sufficient education, training and support to serve these patients effectively with adequate knowledge, attitudes and beliefs. Health professionals' negative attitudes reduced patients' perceived empowerment and were associated with diminished empathy, a more detached and task-oriented approach to care, and poor treatment outcomes.¹⁵ A subsequent study by the same authors compared attitudes among drug prevention, treatment and care specialists, general medical practitioners, and the general public. The majorities or large percentages of all three groups were pessimistic about the likelihood that people with substance use disorders can achieve recovery, find a place to live, or maintain a normal job,¹⁶ despite scientific evidence that people can and do recover and that treatment for substance use disorders can be effective.

Stigmatizing attitudes towards affected populations is reflected in their routine labelling with terms which would be inappropriate in association with another physical or mental health

¹⁵ Leonieke C. van Boekel, Evelien P.M. Brouwers, Jaap van Weeghel, Henk F.L. Garretsen, Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review, *Drug and Alcohol Dependence*, Volume 131, Issues 1–2, 2013, Pages 23-35, ISSN 0376-8716, <https://doi.org/10.1016/j.drugalcdep.2013.02.018>.

¹⁶ Leonieke C. van Boekel, Evelien P.M. Brouwers, Jaap van Weeghel, Henk F.L. Garretsen, Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review, *Drug and Alcohol Dependence*, Volume 131, Issues 1–2, 2013, Pages 23-35, ISSN 0376-8716, <https://doi.org/10.1016/j.drugalcdep.2013.02.018>.

condition. This language is not benign in its impact. It not only reflects stigmatizing attitudes, but helps perpetuate and elicit them. Research suggests that its use in reference to affected populations impacts perceptions, judgements, and beliefs, even among highly qualified doctoral-level mental health and substance use disorders clinicians. One study found that such clinicians were more likely to assign blame to the subject of a clinical vignette and to concur with the need for punishment when randomly assigned to a vignette describing the subject as a “addict” when compared to a group responding to an identical vignette in which the individual was described as a “person with a substance use disorder.”¹⁷ Other studies have yielded similar findings across various populations.^{18 19 20 21 22}

There is broad expert consensus that stigmatizing attitudes have a range of negative impacts on affected populations and on efforts to address drug use and drug use disorders at the local, national and international levels. These include social exclusion and policies and practices that impede or prevent access to needed services as well as to safe, stable housing and employment. Stigmatizing attitudes also operates within affected populations and their families, resulting in self-blame, shame, guilt, and the belief that one cannot overcome one’s condition and that one’s identity is, to a greater or lesser degree, defined by one’s history of substance use disorders and its consequences. This can reinforce negative behavior patterns and dim the hope for a better future that is essential to navigating the changes needed to overcome substance use disorders.

Stigmatizing attitudes can exist across a number of life experiences and challenges. This summary focuses on the stigmatizing attitudes towards people who use drugs, noting that there are common elements and overlap with stigma experienced by persons who have mental health challenges. Both populations report being stereotyped, feeling prejudice and suffering discrimination. However, research consistently reports “that people labeled with

¹⁷ Kelly, J. F., and C. M. Westerhoff. "Does It Matter How We Refer to Individuals with Substance-Related Conditions? A Randomized Study of Two Commonly Used Terms." *Int J Drug Policy* 21, no. 3 (May 2010): 202-7.

¹⁸ Kelly, John F., Sarah J. Dow, and Cara Westerhoff. "Does Our Choice of Substance-Related Terms Influence Perceptions of Treatment Need? An Empirical Investigation with Two Commonly Used Terms." *Journal of Drug Issues* 40, no. 4 (2010): 805-18.

¹⁹ Ashford, R. D., A. M. Brown, J. McDaniel, and B. Curtis. "Biased Labels: An Experimental Study of Language and Stigma among Individuals in Recovery and Health Professionals." *Subst Use Misuse* 54, no. 8 (2019): 1376-84. <http://dx.doi.org/10.1080/10826084.2019.1581221>.

²⁰ Ashford, R. D., A. M. Brown, and B. Curtis. "The Language of Substance Use and Recovery: Novel Use of the Go/No-Go Association Task to Measure Implicit Bias." *Health Commun* 34, no. 11 (Oct 2019): 1296-302. <http://dx.doi.org/10.1080/10410236.2018.1481709>.

²¹ Ashford, R. D., A. M. Brown, and B. Curtis. "The Language of Substance Use and Recovery: Novel Use of the Go/No-Go Association Task to Measure Implicit Bias." *Health Commun* 34, no. 11 (Oct 2019): 1296-302. <http://dx.doi.org/10.1080/10410236.2018.1481709>.

²² Kennedy-Hendricks, A., C. L. Barry, S. E. Gollust, M. E. Ensminger, M. S. Chisolm, and E. E. McGinty. "Social Stigma toward Persons with Prescription Opioid Use Disorder: Associations with Public Support for Punitive and Public Health-Oriented Policies." *Psychiatr Serv* 68, no. 5 (May 1 2017): 462-69. <http://dx.doi.org/10.1176/appi.ps.201600056>.

drug addiction are viewed as more blameworthy and dangerous compared to individuals labeled with mental illness who, in turn, are viewed more harshly than those with physical disabilities.”²³ Research also suggests that people who use alcohol or drugs are more stigmatized than those who smoke cigarettes or are obese.²⁴

Untrained or poorly trained healthcare providers, when faced with people that use drugs, may shame them, may discredit their word or their description of their experiences, may blame them for having a drug use disorder, or may shorten or refuse care. Unfortunately, even well-meaning practitioners may perpetuate stigmatizing attitudes by segregating people with drug use disorders, using language that conveys explicit or implicit judgement of the person, and exhibiting reduced empathy for the patient, resulting in poorer health outcomes.²⁵ While drug use may have negative consequences for the individual, their family and the community, it should be remembered that, in cases of drug use disorders, the behaviours that cause harm are largely symptomatic of a chronic health condition. In 1946, the World Health Organization Constitution stated that: “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being...”, and the preamble defines health as: “... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”²⁶.

The dictionary definition of stigma reports: a) a mark of shame or discredit, b) an identifying mark or characteristic specifically: a specific diagnostic sign of a disease.²⁷ In one of the seminal works on the topic, sociologist Erving Goffman defined stigma as a “deeply discrediting” attribute that disqualifies one “from full social acceptance.” Indeed, Goffman went on to describe stigma as a “spoiled identity.”²⁸ Stigmatizing attitudes associated with affected populations often results in discrimination, which experienced when they seek services in healthcare settings.

Stigma can also be described as a compilation of negative thoughts, attitudes and labelling that serve to exclude or cause social separation from members of socially defined groups, harming members of the group. Likewise, discrimination can be summarized as the act of

²³ Corrigan, Patrick W., Sachiko A. Kuwabara, and John O'Shaughnessy. "The Public Stigma of Mental Illness and Drug Addiction: Findings from a Stratified Random Sample." *Journal of Social Work* 9, no. 2 (2009/04/01 2009): 139-47. Accessed 2018/06/20. <http://dx.doi.org/10.1177/1468017308101818>.

²⁴ Phillips, Lindsay A. and Autherine Shaw. "Substance Use More Stigmatized Than Smoking and Obesity." *Journal of Substance Use* 18, no. 4 (2013/08/01 2013): 247-53. <http://dx.doi.org/10.3109/14659891.2012.661516>.

²⁵ van Boekel LC, Brouwers EP, van Weeghel J, Garretsen HF. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. *Drug Alcohol Depend.* 2013 Jul 1;131(1-2):23-35. doi: 10.1016/j.drugalcdep.2013.02.018. Epub 2013 Mar 13. PMID: 23490450.

²⁶ WHO (1946), Constitution of the World Health Organization ([who_constitution_en.pdf](#)).

²⁷ <https://www.merriam-webster.com/dictionary/stigma>

²⁸ Goffman, Erving. *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon & Schuster. 1963.

treating someone who uses drugs differently from others based on these stigmatizing attitudes. Stigma as a construct can be associated with thoughts, perceptions, and judgements while discrimination is associated with actions. For affected populations the combination of stigma and discrimination work together to reduce healthcare seeking behaviour, and potentially reduce opportunities for quality health, care, social services²⁹ employment, and social inclusion. In addition, members of communities subject to such stigma may agree and apply these negative thoughts, attitudes and labels to themselves in a phenomenon known as self-stigma.

Historically, stigma relies on perceived and actual differences in social and individual identity. In some countries, stigma related to ethnicity, age, sexual orientation, disability, or other “markers” has been used to socially reject or discredit individuals.

Moreover, stigma and social status interact. Different social statuses (e.g., male or female, wealthy or poor) are viewed within a perceived social hierarchy but are seen as normal. Stigmatized characteristics, such as substance use, mental illness, or having a former conviction are not seen as normal, leading to uncertainty, strain and rejection in social interactions.³⁰

Research suggests that perceived social status can affect the extent to which stigmatizing attitudes are applied to individuals. For example, a U.S. study of how competing narratives effect the response to prescription opioid use disorders during pregnancy found that narratives depicting successfully treated prenatal opioid use disorders positively, affected public attitudes if the subject of the narrative was of high socio-economic status, but did not change attitudes if she was of low socio-economic status. Overall, individuals responding to a narrative about a woman of low socio-economic status expressed more negative attitudes toward the subject of the narrative than those randomized to read the narrative about the high socio-economic status pregnant woman, suggesting that stigma and social status interact. The study also found that narratives addressing the barriers to treatment a woman of low socio-economic status faced led to increased support for expanded coverage for drug use disorders treatment and reduced support for punitive policies.³¹ Thus, messaging strategies can be critically important for policymakers seeking to reduce the negative impacts of stigmatizing attitudes on affected populations.

²⁹ Corrigan P., et al, Developing a Research Agenda for Understanding the Stigma of Addictions Part I: Lessons From the Mental Health Stigma Literature. *The American Journal on Addictions*. 2016; XX:1-8.

³⁰ Phelan, Jo C., Jeffrey W. Lucas, Cecilia L. Ridgeway, and Catherine J. Taylor. "Stigma, Status, and Population Health." *Soc Sci Med* 103 (2014): 15-23. <http://dx.doi.org/10.1016/j.socscimed.2013.10.004>.

³¹ Kennedy-Hendricks, A., E. E. McGinty, and C. L. Barry. "Effects of Competing Narratives on Public Perceptions of Opioid Pain Reliever Addiction During Pregnancy." *J Health Polit Policy Law* 41, no. 5 (Oct 2016): 873-916. <http://dx.doi.org/10.1215/03616878-3632230>.

Some markers “associated with stigma”, such as skin colour or physical disability, may be visually observable. Others, such as an accent or speech impediment can be heard. Other markers of stigma, such as mental illness or substance use disorders, may not be readily apparent, except sometimes in cases of acute crisis or when markers of drug use or side effects of psychotropic medications are observed. These “hidden” types of stigma may manifest as labels that individuals are given based on their perceived membership in a class, assumptions about observed behaviour, or their diagnosis.³² Because these markers only become apparent to others when a person receives a diagnosis or seeks out treatment for the condition, the desire to avoid such a label can often be a powerful barrier to accessing treatment services.

Research literature on the stigma associated with mental illness is more substantial than that on the stigma associated with drug use and substance use disorders. However, the latter has been growing in recent years. Moreover, research consistently shows that the stigma associated with drug use disorders is greater than that associated with mental illness³³ and that stigma toward persons with drug use disorders is prevalent among health professionals, affecting care access, quality, and outcomes. The experience of discrimination among affected populations is also associated with poor health and behavioural health outcomes, while social alienation is associated with poor behavioural health in this group.³⁴

Further research is needed to explore the extent to which stigma against persons who use drugs may differ from that experienced by persons that meet the diagnostic criteria for drug use disorders. However, there is a growing body of research on factors such as framing and social status on the stigma associated with substance use disorders. Stigmatizing terms (such as “addict” or “junkie”) are associated with attribution of blame to the individual with substance use disorders and yield more highly stigmatizing responses than terms that portray substance use disorders as a disease or health condition.

In the discussion, participants referred to three types of stigma: 1) public or social stigma when a group identifies negative attitudes, labels, and stereotypes discriminating against others, 2) self-stigma when a person internalizes the label or stereotype that is assigned to them, and 3) structural stigma where the policies, regulations or structures in society are

³² Goffman E. *Stigma: Notes on the management of spoiled identity*. London: Penguin; 1963.

³³ Barry, Colleen L., Emma Elizabeth McGinty, Bernice Pescosolido, and Howard H. Goldman. "Stigma, Discrimination, Treatment Effectiveness and Policy Support: Comparing Public Views About Drug Addiction with Mental Illness." *Psychiatr Serv* 65, no. 10 (Oct 2014): 1269-72. <http://dx.doi.org/10.1176/appi.ps.201400140>.

³⁴ Ahern, J., J. Stuber, and S. Galea. "Stigma, Discrimination and the Health of Illicit Drug Users." *Drug Alcohol Depend* 88, no. 2-3 (May 11 2007): 188-96. <http://dx.doi.org/10.1016/j.drugalcdep.2006.10.014>.

informed by stigma, contribute to it, or serve, directly or indirectly, to stigmatize and discriminate.

Self-stigma emerges from the internalization of stereotypes and prejudices and their application to oneself. This complex dynamic deserves a significant amount of attention in future research. Currently much of the research around self-stigma is related to mental health. Corrigan et al. have worked on a four-stage model of self-stigma for mental health³⁵ that includes: 1) awareness of the public perception of mental health, 2) agreeing with or affirming the public perception regardless of actual experience, 3) applying the public perception of mental health to oneself, and finally, 4) reduced self-esteem from internalizing the negative public perception of mental illness, regardless of its accuracy.

In 2017, Matthews, Dwyer and Snoek published “Stigma and Self-Stigma in Addiction”³⁶ which discusses the relationship between public stigma and self-stigma as it pertains to substance use behaviours. They hypothesize that the negative stereotypes of substance use disorders become internalized and “loop” within the dynamics of the individual’s thoughts and behaviours. Their qualitative study with persons with substance use disorders describes a direct effect of public stigmatization contributing to a sense of shame and resulting in a pattern of consumption motivated by the need to forget, erase or avoid this sense of shame. The results of the qualitative study strongly support social policy and programmes that decrease language promoting stigmatizing attitudes and support inclusive social support structures. This is consistent with literature focused on schizophrenia that reviewed social and structural factors that contribute to a sense of social exclusion and to an internalization of social prejudices.³⁷

Structural stigma can be pervasive and difficult to recognize. It is the “societal-level conditions, cultural norms, and institutional practices that constrain the opportunities, resources, and well-being for stigmatized populations”.³⁸ Structural stigma also contributes to adverse health outcomes for members of the stigmatized group.³⁹

³⁵ Corrigan PW, Rafacz J, Rüsçh N. Examining a Progressive Model of Self-Stigma and its Impact on People with Serious Mental Illness. *Psychiatry research*. 2011;189(3):339–43. PMC3185170. PMID:21715017.

³⁶ Matthews, S., R. Dwyer, and A. Snoek. "Stigma and Self-Stigma in Addiction." *J Bioeth Inq* 14, no. 2 (Jun 2017): 275-86. <http://dx.doi.org/10.1007/s11673-017-9784-y>.

³⁷ Mora-Rios J, Ortega-Ortega M, Natera G. Subjective Experience and Resources for Coping With Stigma in People With a Diagnosis of Schizophrenia: An Intersectional Approach. *Qualitative Health Research*. 2016 Apr;26(5):697-711. DOI: 10.1177/1049732315570118.

³⁸ Hatzenbuehler ML, Bellatorre A, Lee Y, Finch BK, Muennig P, Fiscella K. Structural stigma and all-cause mortality in sexual minority populations [published correction appears in *Soc Sci Med*. 2017 Dec 11;:]. *Soc Sci Med*. 2014;103:33-41. doi:10.1016/j.socscimed.2013.06.005.

³⁹ Hatzenbuehler ML. Structural stigma: Research evidence and implications for psychological science. *Am Psychol*. 2016;71(8):742-751. doi:10.1037/amp0000068.

Structural stigma includes the system of regulations, policies, and laws that influence the design of or implementation of health, care and social services. Examples of structural stigma include laws, policies, and informal practices that prevent a person currently or formerly involved in the criminal justice system due to a drug use-related offence from obtaining a driver's licence, or securing gainful employment, or housing. In a broad sense, structural stigma encompasses the institution of policies and practices that marginalize affected populations, thereby impeding their access to health, care or social services. Another example of structural stigma is generally seen when affected populations are often not able to access the quality and quantity of health and social services that are typically available for other health conditions. Recognizing and changing institutional practices that marginalize any group has the potential to positively change cultural norms and allow greater access to health, care and social services.⁴⁰

⁴⁰ Link BG, Yang LH, Phelan JC, Collins PY *Schizophr Bull.* 2004; 30(3):511-41.

Case Study: Stigma Indicators Monitoring Project

The Center for Social Research in Health (CSRH) led by Scientia Professor Carla Treloar, undertakes behavioural and social research to increase understanding of the individual, social and structural factors that influence health-related behaviours, experiences and outcomes. They work closely with community, non-government and government partners, to ensure the research informs appropriate and effective policy and practice locally, nationally and at the international level.

Since 2015, the Australian Government Department of Health has provided funding to the CSRH to develop and implement the Stigma Indicators Monitoring project. The aim of this study is to develop an indicator of stigma among priority groups identified by the five national strategies addressing blood borne viruses and sexually transmissible infections, including men who have sex with men, people who inject drugs, people living with HIV, people living with viral hepatitis (B and C) and people who engage in sex work.

In Australia, there are currently five national strategies addressing HIV, viral hepatitis, and sexually transmissible infections. Each strategy contains its own set of objectives, with progress monitored via a set of related indicators. A clear objective exists within each of the five strategies to “eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people’s health”. The work of the Monitoring Project aims to identify indicators and ways to measure stigma and monitor the progress of these objectives. For example, in 2018, a stigma indicator included in an online survey of health workers determined if they would behave negatively towards other people because of certain attributes or if they had witnessed any other health workers behaving negatively towards others within the past 12 months because of those same attributes.

*The work of this Monitoring Project remains ongoing and has published reports that continue to inform the discussion around stigma such as, *Stigma Indicators Monitoring Project Summary: Health workers*, and *Stigma Indicators Monitoring Project Summary: People who inject drugs / Hepatitis C among people who inject drugs*. Additionally, there are a number of journal articles published by Broady and Brener which highlight the impact of stigma. All materials associated with the ‘Stigma Indicators Monitoring Project’ can be found at the website: <https://www.arts.unsw.edu.au/centre-social-research-health/our-projects/stigma-indicators-monitoring-project>.*

Promoting non-stigmatizing attitudes to ensure the availability of, access to and delivery of health, care and social services

Reducing stigma will improve access to health, care and social services for affected populations. In 2016, the American Journal on Addictions published an article entitled *Developing a Research Agenda for Reducing the Stigma of Addictions, Part II: Lessons from the Mental Health Stigma Literature*.⁴¹ It proposes that there are three distinct approaches for addressing stigma among different stakeholder groups with a role in perpetuating or reducing stigma: 1) a service approach that seeks to decrease stigma so people will be more likely to seek out services when needed, 2) a rights-based approach that focuses on replacing discrimination with opportunities, and 3) a self-worth approach that seeks to reduce shame and self-stigma. In the field of drug prevention, treatment and care, the self-worth approach is often anchored in mutual aid groups, peer recovery support services, advocacy, public events such as walks, rallies or social gatherings at which the community publicly celebrates recovery from drug use disorders and individuals in recovery share their stories publicly. The research highlights the need for policymakers, decision makers, strategic planners and other leaders, to consider all three approaches referenced above within a carefully planned, integrated, and comprehensive approach, that includes a mitigation strategy for potential unintended negative consequences referenced previously in this document.

Education interventions that raise awareness of the general public, policymakers, health and social service providers as well as civil society partners are among the most commonly adopted stigma reduction approaches. Education interventions raise awareness of stigma, its impact, how it is perpetuated, and steps that can be taken to reduce it. Additional research is needed to identify the educational approaches that are most effective in reducing and preventing stigmatizing attitudes against vulnerable populations including pregnant and breastfeeding women to promote and foster strong links with available childcare, employment, education, housing and other relevant services⁴². While increasing knowledge may change perceptions or attitudes among health professionals, there is limited evidence that this is linked to sustained changes in practice of healthcare. Further research is also needed to identify the best mechanisms for the delivery of educational interventions (e.g., traditional lecture, interactive participatory learning process, e-learning, or self-directed learning processes). It should be noted that education is often associated with changes in public stigma, but can also help reduce self-stigma.

⁴¹ Corrigan P., et al, *Developing a Research Agenda for Understanding the Stigma of Addictions Part II: Lessons From the Mental Health Stigma Literature*. The American Journal on Addictions. 2016; XX:1-8

⁴² WHO (2014), *Guidelines for the identification and management of substance use and substance use disorders in pregnancy*, p7
(https://apps.who.int/iris/bitstream/handle/10665/107130/9789241548731_eng.pdf).

Contact interventions, a facilitated and meaningful exchange with people with lived experience, are also very commonly adopted stigma reduction approaches. These can be particularly effective when they involve people in recovery from drug use disorders. A meta-analysis found that the reductions of stigma associated with contact interventions were attributable to at least three factors: (1) enhancing knowledge about the outgroup, (2) reducing anxiety about intergroup contact, and (3) increasing empathy and perspective taking. Among these three, increased knowledge appeared to have the smallest effect.⁴³ To address the stigma associated with drug use, Corrigan and colleagues suggest that models focusing on the rights and the self-worth of individuals in recovery as part of a contact model might be the most effective strategy for reducing the stigma associated with opioid use disorder.⁴⁴ One example includes pilot programmes in the United States, under initiatives such as the Recovery Community Support Program (later the Recovery Community Services Program)⁴⁵ which support people in recovery to drive a rights and worth agenda, such as framing National Recovery Month as an opportunity to celebrate recovery as a time of hope to those affected by a substance use disorder and their loved ones, showing that recovery is possible.

⁴³ Pettigrew TF, Tropp LR. How does intergroup contact reduce prejudice? Meta-analytic tests of three mediators. *European Journal of Social Psychology*. 38: 922-934. DOI: 10.1002/ejsp.504.

⁴⁴ Corrigan, P. W., & Nieweglowski, K. (2018). Stigma and the public health agenda for the opioid crisis in America. *International Journal of Drug Policy*, 59, 44-49. doi:<https://doi.org/10.1016/j.drugpo.2018.06.015>.

⁴⁵ Linda Kaplan MA, Catherine Nugent LPC, Marsha Baker LCSW, H. Westley Clark MD and JD and MPH and CAS and FASAM & Bonita M. Veysey PHD (2010) Introduction: The Recovery Community Services Program, *Alcoholism Treatment Quarterly*, 28:3, 244-255, DOI: 10.1080/07347324.2010.488522.

Case Study

Experiences in Stigma Reduction from The Mental Health Commission of Canada: How to Use Contact-based Education Effectively

In 2007, the Mental Health Commission of Canada (MHCC) was formed. A key part of its work has been to tackle the problem of mental illness-related stigma in Canadian society, expanding in recent years to include stigmatization towards people with opioid and other drug use problems, particularly as it manifests in various first response and health and social care settings. The approach taken by the MHCC is ground up, targeted, and evidence-based.

Results from MHCC evaluation studies suggest that contact-based education can be a highly effective tool in improving attitudes and caring orientation/helping behaviours. Contact-based education is an approach that uses the voices of people with lived experience of a substance use problem who are currently living in a state of recovery or wellness as a central feature of an educational intervention. In the most effective interventions, personal stories and experiences are tailored to reflect and reinforce the programme's main educational objectives. They also typically also include a combination of video-based and live social contact. In general, effective use of social contact is that which makes a positive personal connection and builds trust between the speaker and the audience, activates compassion and understanding, enhances belief in the reality of wellness and recovery for people with substance use problems, disconfirms negative stereotypes and common misperceptions about people with drug use problems and the nature of substance use disorders, and is supplemented with stigma-informed educational components that focus on improving language and positively shifting beliefs and behaviours towards people with substance use problems.^{46 47}

⁴⁶ Knaak S, Christie R, Mercer S, Stuart H. (2018). Stigma and the Opioid crisis: Final Report. Ottawa: Mental Health Commission of Canada.

⁴⁷ Knaak S, Kharpal K, Benes K, Bartram M. (2020). Reducing Opioid and Substance use Stigma in Healthcare and Other Direct Service Delivery Settings. Evaluation Results from Four Programs. Ottawa: Mental Health Commission of Canada.

UNODC, in conjunction with WHO has published two documents that promote health practices related to drug use, based on science and strong evidence of effective outcomes. Both the International Standards on Drug Use Prevention⁴⁸ and the International Standards for the Treatment of Drug Use Disorders⁴⁹ provide guidance for practitioners on effective health strategies and practices related to drug prevention, treatment and care. Well-informed, educated and trained healthcare providers can contribute to effective strategies that address the needs of affected populations.

Additionally, UNODC addresses the needs of key population with or at risks of acquiring HIV, hepatitis, tuberculosis and other communicable diseases: people who use drugs and people in prison settings. UNODC, UNAIDS and WHO developed evidence- and rights-based responses for people who use drugs^{50 51 52}, including a comprehensive package of interventions for the prevention, treatment and care of HIV among people who inject drugs which has been endorsed widely and includes:

1. Needle and syringe programmes (NSPs),
2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment,
3. HIV testing and counselling (HTC),
4. Antiretroviral therapy (ART),
5. Prevention and treatment of sexually transmitted infections (STIs),
6. Condom programmes for people who inject drugs and their partners,
7. Targeted information, education and communication (IEC) for people who inject drugs and their partners,
8. Prevention, vaccination, diagnosis and treatment for viral hepatitis,
9. Prevention, diagnosis and treatment of tuberculosis (TB), and
10. Overdose prevention.

⁴⁸ UNODC/WHO (2018), International Standards on Drug Use Prevention, Second revised edition (<https://www.unodc.org/unodc/en/prevention/prevention-standards.html>).

⁴⁹ UNODC/WHO (2020), International Standards for the Treatment of Drug Use Disorders (https://www.unodc.org/documents/International_Standards_2016_for_CND.pdf).

⁵⁰ WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision. ISBN 978 92 4 150437 9 (https://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/Target_setting_guide2012_eng.pdf).

⁵¹ UNODC (2019), HIV Prevention, Treatment, Care and Support for People Who Use Stimulant Drugs. UNODC, WHO, UNAIDS. Technical guide (https://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/19-04568_HIV_Prevention_Guide_ebook.pdf).

⁵² UNODC (2020), HIV prevention, treatment, care and support in prisons and other closed settings: a comprehensive package of interventions. UNODC, ILO, WHO, UNFPA, UNAIDS, UNDP Technical brief - 2020 Update (https://www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/20-06330_HIV_update_eBook.pdf).

Historically, this work is grounded in ensuring access to screening, testing and care for all persons including those who are most vulnerable and experience stigma and discrimination. It is important to recognize that civil society partners and advocates consistently involve the voices and perspectives of people who use drugs to increase awareness, reduce stigma and promote an inclusive response.

When promoted collectively as a continuum of health-centred services to address drug use, drug use disorders and their health and social consequences, the above package of interventions can be a strong foundation for Member States to promote non-stigmatizing attitudes to ensure the availability of, access to and delivery of health, care and social services for persons who use drugs.

Case Study

An Evaluation of the Co-Design of a CityWide Pilot Anti-Stigma Training Programme

In early 2018, CityWide launched the campaign “Stop the Stigma” to raise awareness and challenge drug-related stigma and the impact it has on people who use drugs. To address this issue, Citywide commissioned phase one of this research to develop a template for a training programme to be delivered to staff in the relevant public services, meaningfully involving people with experience of drug use in its eventual delivery. In phase two, the training programme was developed, and a pilot study was conducted in partnership with the SAOL Project, to evaluate the process, the roll out and impact of the anti-stigma training programme.

Participants’ expectations of the training programme were met as evidenced by the follow-up comments provided. These were understanding stigma, how to address the issue, learning more about their own stigma, how it affects their practice, the impact it has on service users and services, and increase their general knowledge on stigma. Further, the survey findings measured stigma across nine domains and results from the sample of participants from the pilot training, illustrating improvements in eight of the nine domains. Three of these improvements, namely attribution of blame, avoidance behaviour and segregation, were statistically significant despite the very small sample sizes. The work of CityWide Pilot is ongoing with further scaling up planned in future roll outs⁵³.

A cross-cutting theme between education interventions and contact interventions is the important issue of language promoting stigmatizing attitudes. Eliminating language promoting stigmatizing attitudes is a practical strategy that can be used in conversations at all levels: between individuals, within services and in discussion of national and international

⁵³Comiskey, C., Banka, S., McDonagh, D and Galligan, K. (2021) An evaluation of the co-design and roll out of an anti-stigma training programme. Report for CityWide. https://www.citywide.ie/assets/files/pdf/citywide_anti-stigma_training_report_final.pdf.

policy. A change in language contributes to changes in attitudes and ultimately actions. In the healthcare professions it is not uncommon to see a change in language over the years as the body of evidence in science and practice changes.

Researchers and professionals in the fields of drug use prevention, drug use disorders treatment, the organized recovery community, and a growing number of researchers on policy, communications, and stigma, have been calling to replace language promoting stigmatizing attitudes with more neutral and science-based terms. The call is typically for person-first language, such as the one used to describe people with mental health conditions, and people with chronic conditions or disabilities (e.g., “person with a substance use disorder” or “person in recovery” as opposed, to “addict,” “alcoholic,” or “reformed addict”). The promotion of neutral, science-based, and person-first language to replace stigmatizing terms has been widely supported by the medical and research communities.

Adopting neutral, science-based, and person-first language is critically important, even as it should be recognised that shifting or changing language alone is insufficient to reduce discrimination, especially when the latter is institutionalized in law, policy, or longstanding practice.

Moreover, shifting language requires an ongoing commitment, outreach to diverse stakeholder groups, and time. While language in some contexts may be amenable to relatively expeditious change, in other contexts, it will be a much slower process requiring perseverance (e.g., changing language in the context of international and national policies and statutes). Finally, achieving sustainable changes in attitude and behaviour requires contact, education, an understanding of the impact words have on people, and of the potentially transformative power of language.

Examples of good practices

The following is a list of examples of good practices in promoting non-stigmatizing attitudes and ensuring the availability of, access to and delivery of health, care and social services for affected populations, organized around four domains: education, meaningful contact, quality practice, and policy and research.

Education of policymakers, health and social service providers and the general public

- Ensuring that all persons who work in the field of health and social services are educated and well-trained in the nature of substance and drug use disorders, of stigmatizing attitudes towards affected populations, as well as in science-based and effective substance use prevention, treatment, health care, social protection and rehabilitation.
- Supporting the development and enforcement of ethical standards and codes of conducts for professionals.
- Institutionalizing modules or classes promoting non-stigmatizing attitudes into the higher education curriculum for physicians, nurses, mental health practitioners, emergency room staff, drug use disorders treatment centres and other health practitioners.
- Incorporating mandatory professional and licensing courses for all health and social care practitioners related to drug use and stigma.
- Supporting increased community awareness through public discourse and transparency about drug use via other discussion venues.
- Ensuring policymakers are regularly receiving updates and have the chance to hear the voices of affected populations, their families and close network of friends.
- Providing specific training and awareness-raising about language promoting stigmatizing attitudes, changing documents and direct communication with persons and other professionals.
- Focusing on skills-based training where the participants practise and teach strategies to promote non-stigmatizing attitudes in addition to the awareness-raising content-based lectures, including personal reflections to consider on one's own conscious and unconscious stigmatizing attitudes.
- Including a unit on the importance of addressing the harms that can come from self-stigma, as well as information related to trauma.
- Exploring a model similar to mental health in the field of sociology that seeks to develop stigma resistance similar to risk and protective factors.

- Increasing collaboration between the public safety and public health sectors around drug use.
- Underlining the responsibility of police officers and prison staff to not punish or harass persons and to respect the dignity and rights of people even when their conduct is not according to the law.
- Developing strategies to promote non-stigmatizing attitudes among public officials, law enforcement, other first-responders, and the broader criminal justice.
- Engaging local communities with the local law enforcement and public health sectors in joint efforts to address drug use and to build individual, family, and community resilience.

Facilitated and meaningful contact with affected populations

- Increasing the meaningful involvement, presence of and voices of affected populations in all levels of policy and strategic planning around drug and substance use prevention, treatment and continuing care.
- Integrating, as appropriate in the context of the therapeutic process and with adequate training and support, affected populations as staff members in treatment service and other health, care and social institutions.
- Actively seeking to include family members and close personal networks of the affected populations in community level policy level dialogues, and, for individuals voluntarily participating in a treatment programme, considering including family or caregivers in discussions about the person-based treatment plan with informed consent and when/ if beneficial.
- Identifying mechanisms to access meaningful experiences from the most marginalized populations such as those in prison settings or with severe psychiatric challenges.
- Ensuring affected populations are meaningfully engaged within an equal power structure, in intervention, policy development and implementation of programmes.
- Embracing a respect for all persons, including affected populations, with a focus on empowerment and appreciation.

Quality health and social services practice

- Taking a human-rights based approach with respect for the dignity and inclusion of all persons.

- Ensuring that, at every point on the continuum of care for affected populations, health and social services practices are based on science and evidence of effective care.
- Supporting informed and voluntary participation at any level of care for persons for affected populations.
- Integrating prevention of drug use, treatment and care of drug use disorders, as well as prevention of the health and social consequences of drug use (also called ‘harm reduction’ by some Member States), as per UNODC, WHO and UNAIDS technical documents.
- Promoting an equity-based lens where all persons receive the best healthcare available regardless of any stigmatizing element (e.g., substance or drug use, mental health, race, ethnicity, financial status, education level, gender, religion, sexual orientation, disabilities, etc.).
- Practicing quality healthcare that is no less than what would be provided to other persons in need of healthcare, including but not limited to confidentiality, diagnostic services, treatment planning that includes provision of medication when necessary and meaningful inclusion of the person in need of healthcare in decisions related to their own care.
- Ensuring that the physical settings where affected populations seek health services are held to the same high standards as other health conditions – clean, spacious, respectful of privacy, welcoming and of adequate construction.
- Ensuring that treatment and care service respond to the special treatment and care needs of population groups.

Policy development and research

- Advocating for promotion of non-stigmatizing attitudes on the access to services for affected populations in the design and production of any strategic instrument on drugs, considering the importance of stigma, and how it decisively affects the outcome of the policies and responses that are intended to be implemented.
- Investing time and resources into mapping available services and collecting accurate data related to experiences in a healthcare setting, particularly the experience of affected populations.
- Considering the issue of stigmatizing attitudes within a multi-component framework or system of policies and services that must be addressed in different settings, with different evidence-driven strategies for unique individuals.
- Considering Community-Based Participatory research models that address stigmatizing attitudes in specific groups, with scientists and policymakers working

together with affected populations to reflect also the interests, perspectives and priorities of that group, and create a sense of ownership.

- Supporting more comprehensive data collection to inform policy development, using consistent measures that allow for sharing experiences of shame, prejudice or discrimination.
- Supporting future research into best practices around stigmatizing attitudes, consequences that stigma cause for affected populations, especially with regard to their health and/or barriers to access to care and treatment, factors leading to an increase (or decrease) in stigmatizing attitudes, and how to implement practices that are respectful, change behaviour and practice.
- Adopting a recovery-oriented approach that begins with promoting language that does not promote stigmatizing attitudes and supports meaningful integration into families, employment and communities as aligned with the needs of affected populations.
- Promoting and facilitating treatment as an alternative to conviction and punishment for people who use drugs and people with drug use disorders in contact with the justice in accordance with domestic legislation and applicable international law.
- Developing a policy within healthcare systems which includes provisions that do not exclude or discriminate against affected populations or their families.
- Assessing current policies around employment of persons with a history of drug use to enact policies and regulations that ensure that affected populations can be gainfully employed and can access healthcare without the fear of losing employment.
- Conducting a cost analysis of the healthcare costs associated with persons who feel stigmatized and are less willing to access health, care and social services within a framework of prevention and who may suffer complications with a higher cost to the healthcare system as potential disease processes progress to a critical level.
- Supporting comprehensive and in-depth analysis of structural stigma and the impact on individuals, families and communities over multiple generations.

Conclusion

Questions remain about the nature and impact of stigmatizing attitudes on the availability of, access to and delivery of health, care and social services for affected populations, as well as about the best way of addressing such attitudes. However, promising research and good practice examples, including from the field of mental health, indicate that it is possible to promote non-stigmatizing attitudes; to ensure the availability of, access to and delivery of health, care and social services for affected populations; and most importantly to improve their health outcomes. Such examples centre around: education of policymakers, health and social service providers and the general public, including with regard to the use of non-stigmatizing and people-centred language; facilitated and meaningful contact with affected populations, including in planning and decision making; quality health and social services practice; and policy development and research. A global commitment to expanding and documenting the effectiveness of such strategies would significantly contribute to the health and well-being of affected populations, thus leaving no one behind.

Annex 1

List of participants to the informal technical consultation

(In alphabetical order of surname/ family name)

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