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

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This document has not been formally edited

Contents

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CND	Commission on Narcotic Drugs
CSRH	Center for Social Research in Health
HIV	Human Immunodeficiency Virus
MHCC	Mental Health Commission of Canada
SDG	Sustainable Development Goal
UNGASS	United Nations General Assembly Special Session
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Introduction

This document summarizes the discussions of an informal technical consultation organized by UNODC on 14-16 January 2020 in Vienna, 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". The resolution called on 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.

As a summary of the discussions, the document is limited to a synopsis of the studies and examples considered by the participants, covering both an understanding of stigmatizing attitudes and the promotion of non-stigmatizing attitudes to ensure access to services. Recognizing that such studies and examples may not be universally relevant, they are presented in the spirit of sharing information and experiences that may 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. The examples in this document may also inform efforts to integrate an awareness of stigmatizing attitudes into 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] This 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"*.

In the first phase of the process, 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 process.[3] Twenty-eight Member States nominated 31 experts, who were all asked to provide input, ideas, experiences and scientific information through an online consultation. The online consultation was also opened to all members of the Vienna NGO Committee in

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[1] Commission on Narcotic Drugs (2020), 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.

order to involve civil society stakeholders.[4]

The results of the overview of the literature and of the online consultation informed the second phase of the process, a face-to-face informal technical consultation hosted by UNODC on 14-16 January 2020. The nearly 50 participants included the experts nominated by Member States who had provided substantive input through the online consultations, four representatives nominated by the Vienna and 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 (WHO) and three other regional and international organizations. The list of participants is attached to this summary as an Annex.

The objectives of the informal technical consultation 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 people 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 people who use drugs.

Throughout the multi-phase process, a commitment was made to welcome affected populations[5] to contribute their experiences of stigmatizing attitudes in relation to the availability of, access to and delivery of services. This commitment significantly contributed to a meaningful dialogue during the informal technical consultation.

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[4] Commission on Narcotic Drugs (2020), 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 document, and purely to improve the readability of the text, the term "affected populations" refers 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.

International framework

Resolution 61/11 of the Commission on Narcotic Drugs (CND) was endorsed in response to, and framed by, a number of commitments made by Member States 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 Problem[6] (UNGASS), 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 people 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, 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 people in the criminal justice system, women, children and youth.

The focus on the health and welfare of humankind is the cornerstone of the three international drug control conventions,[9] and a number of resolutions over the years have supported a strong drug demand reduction approach that is based on science and on evidence of effectiveness. In particular, resolution 57/4 of the CND recognized that efforts supporting recovery from drug use disorders need to be consistent with human rights

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[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).
[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).

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. Resolution 57/4 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. The resolution called 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. Actions taken to reduce stigmatizing attitudes and discrimination must be done in conjunction with other existing human rights documents, ensuring that people who use drugs have the same rights as any other citizen to high-quality health care, whether for drug use treatment or for other health conditions, and that they are equally entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The relevant human rights documents are:

- Universal Declaration of Human Rights[10]
- Convention on the Rights of Persons with Disabilities[11]
- Convention on the Rights of the Child[12]
- International Covenant on Economic, Social and Cultural Rights[13]

Another relevant framework is the 2030 Agenda for Sustainable Development adopted by Member States in 2015 and serving as a blueprint to address the 17 Sustainable Development Goals (SDGs).[14] SDG 3 ensures healthy lives and promotes well-being for all people at all ages. Promoting non-stigmatizing attitudes to ensure the availability of, access to and delivery of

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[10] United Nations (1948), Universal Declaration of Human Rights (https://www.un.org/en/about-us/universal-declaration-of-human-rights).
[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#).
[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).

health, care and social services for all people, including people 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 global and national levels.

Understanding stigmatizing attitudes

The discussion about stigmatizing attitudes and stigma remains complex and poorly researched, and it includes a number of issues where consensus has not been achieved. These issues relate both 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.), and 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 presenting considerations on the nature of stigmatizing attitudes and stigma, and on effective strategies to 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 use disorders were common among health professionals, who generally had neither sufficient education, training and support, nor adequate knowledge, attitudes and beliefs, to serve these patients effectively. Health professionals' negative attitudes reduced patients' perceived empowerment and were associated with diminished empathy and a more detached and task-oriented approach to care on the part of providers, and poor treatment outcomes for patients.[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 majority 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

[15] van Boekel, L. C., Brouwers E. P. M., van Weeghel, J., and H. F. L. Garretsen (2013), Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. Drug and Alcohol Dependence. 131(1-2):23-35
(http://dx.doi.org/10.1016/j.drugalcdep.2013.02.018).
[16] van Boekel, L. C., Brouwers E. P. M., van Weeghel, J., and H. F. L. Garretsen (2015), Comparing stigmatising attitudes towards people with substance use disorders between the general public, GPs, mental health and addiction specialists and clients. International Journal of Social Psychiatry. 61(6):539-49

that treatment for substance use disorders can be effective.

Stigmatizing attitudes towards affected populations are reflected in their routine labelling with terms which would be inappropriate in association with other physical or mental health conditions. 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 disorder 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 an "addict", compared with 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]

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 negative impacts 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 operate 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 behaviour 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 stigmatizing attitudes towards people who use drugs, noting that there

(https://doi.org/10.1177/0020764014562051).

[17] Kelly, J. F., and C. M. Westerhoff (2010), Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. International Journal of Drug Policy. 21(3):202-7 (https://doi.org/10.1016/j.drugpo.2009.10.010).

[18] Kelly, J. F., Dow, S. J., and C. Westerhoff (2010), 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(4):805-18 (https://doi.org/10.1177/002204261004000403).

[19] Ashford, R. D., Brown, A. M., McDaniel, J., and B. Curtis (2019), Biased labels: An experimental study of language and stigma among individuals in recovery and health professionals. Substance Use and Misuse. 54(8): 1376-84 (http://dx.doi.org/10.1080/10826084.2019.1581221).

[20] Ashford, R. D., Brown, A. M., and B. Curtis (2019), The language of substance use and recovery: Novel use of the go/no-go association task to measure implicit bias. Health Communication. 34(11):1296-302 (http://dx.doi.org/10.1080/10410236.2018.1481709).

[21] Kennedy-Hendricks, A., Barry, C. L., Gullust, S. E., Ensminger, M. E., Chisholm, M. S., and E. E. McGinty (2017), Social stigma toward persons with prescription opioid use disorder: Associations with public support for punitive and public health-oriented policies. Psychiatric Services.68(5):462-9 (http://dx.doi.org/10.1176/appi.ps.201600056).

are common elements and overlap with stigma experienced by people who have mental health challenges. Both populations report being stereotyped, feeling prejudice and suffering discrimination. However, research consistently reports that "people labeled with 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."[22] Research also suggests that people who use alcohol or drugs are more stigmatized than those who smoke cigarettes or are obese.[23]

Untrained or poorly trained health-care providers, upon encountering a person who uses drugs, may shame them, discredit their word or their description of their experiences, blame them for having a drug use disorder, or 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.[24] 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 its preamble defines health as: "... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[25]

The dictionary definition of stigma is of "a mark of shame or discredit", and the plural form "stigmata" is defined as "an identifying mark or characteristic, specifically: a specific diagnostic sign of a disease".[26] 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".[27] Stigmatizing attitudes associated with affected populations often result in discrimination, which is experienced when they seek services in health-care settings.

Stigma can also be described as a compilation of negative thoughts, attitudes and labelling that serves to exclude or cause social separation from members of socially defined groups,

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[22] Corrigan, P. W., Kuwabara, S. A., and J. O'Shaughnessy (2009), The public stigma of mental illness and drug addiction: Findings from a stratified random sample. Journal of Social Work. 9(2):139-47 (http://dx.doi.org/10.1177/1468017308101818).

[23] Phillips, L. A., and A. Shaw (2013), Substance use more stigmatized than smoking and obesity. Journal of Substance Use. 18(4):247-53 (http://dx.doi.org/10.3109/14659891.2012.661516).

[24] van Boekel, L. C., Brouwers E. P. M., van Weeghel, J., and H. F. L. Garretsen (2013), Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. Drug and Alcohol Dependence. 131(1-2):23-35 (http://dx.doi.org/10.1016/j.drugalcdep.2013.02.018).

[25] WHO (1946), Constitution of the World Health Organization (https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf).

[26] https://www.merriam-webster.com/dictionary/stigma

[27] Goffman, E. (1963), Stigma: Notes on the Management of Spoiled Identity. New York: Simon & Schuster.

harming members of the group. Likewise, discrimination can be summarized as the act of 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, stigma and discrimination work together to reduce health-care-seeking behaviour, and potentially reduce opportunities for quality health, care, social services,[28] 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. While 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 seen as abnormal, leading to uncertainty, strain and rejection in social interactions.[29]

Research suggests that perceived social status can affect the extent to which stigmatizing attitudes are applied to individuals. For example, a study in the United States of America found that narratives depicting successful treatment of prescription-opioid use disorders during pregnancy positively affected public attitudes if the subject of the narrative was of high socioeconomic status. By contrast, the narrative did not change attitudes if she was of low socioeconomic status, suggesting that stigma and social status interact.[30] However, the study also found that narratives addressing the barriers to treatment faced by a woman of low socioeconomic status led to increased support for expanded coverage for drug use disorder 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.

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-

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[28] Corrigan, P., Schomerus, G., Shuman, V., Kraus, D., Perlick, D., Harnish, A., Kulesza, M., Kane-Willis, K., Qin, S., and D. Smelson (2017), Developing a research agenda for understanding the stigma of addictions Part I: Lessons from the mental health stigma literature. American Journal on Addictions. 26(1):59-66 (https://doi.org/10.1111/ajad.12458).

[29] Phelan, J. C., Lucas, J. W., Ridgeway, C. L., and C. J. Taylor (2014), Stigma, status, and population health. Social Science & Medicine. 103:15-23 (http://dx.doi.org/10.1016/j.socscimed.2013.10.004).

[30] Kennedy-Hendricks, A., McGinty, E. E., and C. L. Barry (2016), Effects of competing narratives on public perceptions of opioid pain reliever addiction during pregnancy. Journal of Health Politics, Policy and Law. 41(5):873-916 (http://dx.doi.org/10.1215/03616878-3632230).

[31] *Ibid.*

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 illness,[33] and that stigma towards people 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 people who use drugs may differ from that experienced by people who 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 and discriminatory attitudes, labels and stereotypes 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 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. Much of the current research around self-stigma is related to mental health.

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[32] Goffman, E. (1963), Stigma: Notes on the Management of Spoiled Identity. New York: Simon & Schuster.
[33] Barry, C. L., McGinty, E. E., Pescosolido, B., and H. H. Goldman (2014), Stigma, discrimination, treatment effectiveness and policy support: comparing public views about drug addiction with mental illness. Psychiatric Services. 65(10):1269-72 (http://dx.doi.org/10.1176/appi.ps.201400140).
[34] Ahern, J., Stuber, J., and S. Galea (2007), Stigma, discrimination and the health of illicit drug users. Drug and Alcohol Dependence. 88(2-3):188-96 (http://dx.doi.org/10.1016/j.drugalcdep.2006.10.014).

Corrigan et al. have worked on a four-stage model of self-stigma for mental health[35] 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 people with substance use disorders describes a direct effect of public stigmatization, which contributes to a sense of shame and results in a pattern of consumption of substances that is 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 reviewing social and structural factors that contribute to a sense of social exclusion and to an internalization of social prejudices.[37]

Structural stigma encompasses policies, laws, regulations and practices that influence the design of or implementation of health, care and social services. Structural stigma can be pervasive and difficult to recognize and contributes to adverse health outcomes for members of the stigmatized group.[38] 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 is encapsulated in policies and practices that marginalize affected populations, thereby impeding their access to health, care or social services. Another example of structural stigma is seen when affected populations are unable 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.[39]

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[35] Corrigan, P. W., Rafacz, J., and N. Rüsch (2011), Examining a progressive model of self-stigma and its impact on people with serious mental illness. Psychiatry Research.189(3):339-43 (https://doi.org/10.1016/j.psychres.2011.05.024).

[36] Matthews, S., Dwyer, R., and A. Snoek (2017), Stigma and self-stigma in addiction. Journal of Bioethical Inquiry. 14(2):275-86 (http://dx.doi.org/10.1007/s11673-017-9784-y).

[37] Mora-Rios, J., Ortega-Ortega, M., and G. Natera (2016), Subjective experience and resources for coping with stigma in people with a diagnosis of schizophrenia: An intersectional approach. Qualitative Health Research. 26(5):697-711 (https://doi.org/10.1177/1049732315570118).

[38] Hatzenbuehler, M. L. (2016), Structural stigma: Research evidence and implications for psychological science. American Psychologist. 71(8):742-51 (https://doi.org/10.1037/amp0000068).

[39] Link, B.G., Yang, L.H., Phelan, J.C., and P.Y. Collins (2004), Measuring mental illness stigma. Schizophrenia Bulletin. 30(3):511-41 (https://doi.org/10.1093/oxfordjournals.schbul.a007098).

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. CSRH works 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, Australia's Department of Health has provided funding to CSRH to develop and implement the Stigma Indicators Monitoring Project. The project aims to develop an indicator of stigma among priority groups identified by the five national strategies addressing bloodborne viruses and sexually transmitted infections, including people who inject drugs, men who have sex with men, people living with HIV, people living with viral hepatitis (B and C) and people who engage in sex work.

Within each of the five strategies there is an objective to "eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health". The Monitoring Project aims to identify indicators and ways to measure stigma and monitor progress towards these objectives. For example, in 2018, questions included in an online survey of health workers asked whether they would behave negatively towards other people because of certain attributes, or whether they had witnessed other health workers behaving negatively towards others within the past 12 months because of those same attributes.

The work of the Monitoring Project is ongoing and includes reports to inform 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". The project has also published a number of journal articles highlighting the impact of stigma, including upon people who inject drugs. 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.

Reducing stigma will improve access to health, care and social services for affected populations. In 2016, the *American Journal on Addictions* published an article proposing three distinct approaches for addressing stigma among different stakeholder groups with a role in perpetuating or reducing stigma.[40] These are: 1) a service approach that seeks to decrease stigma so that 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, and 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 within a carefully planned, integrated and comprehensive approach, as a mitigation strategy for potential unintended negative consequences.

Education interventions that raise awareness of the general public, policymakers, health and social service providers, and 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 services.[41] While increasing knowledge may change perceptions or attitudes among health professionals, there is only limited evidence that this is linked to sustained changes in the practice of health care. 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.

Contact interventions, a facilitated and meaningful exchange with people with lived experience, are a common stigma reduction approach. These can be particularly effective when they involve people in recovery from drug use disorders. A meta-analysis found that the

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[40] Corrigan, P., Schomerus, G., Shuman, V., Kraus, D., Perlick, D., Harnish, A., Kulesza, M., Kane-Willis, K., Qin, S., and D. Smelson (2017), Developing a research agenda for understanding the stigma of addictions Part I: Lessons from the mental health stigma literature. American Journal on Addictions. 26(1):59-66 (https://doi.org/10.1111/ajad.12458).

[41] WHO (2014), Guidelines for the identification and management of substance use and substance use disorders in pregnancy, p.7 (https://apps.who.int/iris/bitstream/handle/10665/107130/9789241548731_eng.pdf).

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.[42] Among these three, increased knowledge appeared to have the smallest effect.

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.[43] One example is pilot programmes in the United States under initiatives such as the Recovery Community Support Program (later the Recovery Community Services Program) which support people in recovery to drive a rights and worth agenda, such as framing National Recovery Month as an opportunity to show that recovery is possible and celebrate it as a time of hope for those affected by a substance use disorder and their loved ones.[44]

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

The Mental Health Commission of Canada (MHCC) was founded in 2007. 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 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, caring orientation and helping behaviours. In the most effective interventions, personal stories and experiences are tailored to reflect and reinforce the programme's main educational objectives. They typically 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.[45,46]

[42] Pettigrew, T. F., and L. R. Tropp (2008), How does intergroup contact reduce prejudice? Meta-analytic tests of three mediators. European Journal of Social Psychology. 38:922-34. (https://psycnet.apa.org/doi/10.1002/ejsp.504).

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

[44] Kaplan, L., Nugent, C., Baker, M., Westley Clark, H., and B. M. Veysey (2010), Introduction: The Recovery Community Services Program. Alcoholism Treatment Quarterly. 28(3): 244-55 (https://doi.org/10.1080/07347324.2010.488522).

[45] Knaak, S., Christie, R., Mercer, S., and H. Stuart (2018), Stigma and the opioid crisis: Final report. Ottawa: Mental Health Commission of Canada (https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2019-07/Opioid_Report_july_2019_eng.pdf).

[46] Knaak, S., Kharpal, K., Benes, K., and M. Bartram (2021), Reducing opioid and substance use stigma in healthcare and other direct service delivery settings. Evaluation results from four programs. Ottawa: Mental

Well-informed, educated and trained health-care providers can contribute to effective strategies that address the needs of affected populations and reduce stigma. 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. The *International Standards on Drug Use Prevention*[47] and the *International Standards for the Treatment of Drug Use Disorders*[48] provide guidance for practitioners on effective health strategies and practices related to drug prevention, treatment and care.

UNODC also addresses the needs of people who use drugs and people in prison settings – two key populations that are vulnerable to HIV, viral hepatitis, tuberculosis and other communicable diseases. UNODC, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO have developed evidence- and rights-based responses for people who use drugs,[49,50,51] including a widely endorsed comprehensive package of interventions for the prevention, treatment and care of HIV among people who inject drugs. The comprehensive package includes:

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

Health Commission of Canada (https://mentalhealthcommission.ca/wp-content/uploads/2021/09/Reducing_Opioid_and_Substance_Use_Related_Stigma_Evaluation_Results_eng.pdf).

[47] UNODC, WHO (2018), International standards on drug use prevention, second updated edition (https://www.unodc.org/unodc/en/prevention/prevention-standards.html).

[48] UNODC, WHO (2020), International standards for the treatment of drug use disorders (https://www.unodc.org/documents/International_Standards_2016_for_CND.pdf).

[49] WHO (2012), 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 (https://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/Target_setting_guide2012_eng.pdf).

[50] 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).

[51] 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 people, including those who are most vulnerable and experience stigma and discrimination. It is important to recognize that civil society partners and advocates should 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 people who use drugs.

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

In 2018, CityWide, an organization in the Republic of Ireland, launched the "Stop the Stigma" campaign to raise awareness and challenge drug-related stigma and the impact it has on people who use drugs. In phase one, Citywide commissioned research to develop a template for an anti-stigma training programme for staff in 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 the impact of the programme.

A follow-up survey of participants in the pilot training programme showed that it met their expectations. These included understanding stigma and how to address it, and learning about their own stigma, how it affects their practice and the impact it has on services and service users. The survey findings measured stigma across nine domains, and results showed improvements in eight of these. 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-outs.[52]

A cross-cutting theme between education interventions and contact interventions is the importance of language in promoting stigmatizing attitudes. Eliminating such language is a practical strategy that can be used in conversations at all levels: between individuals, within services and in discussion of national and international policy. A change in language contributes to changes in attitudes and ultimately in actions. In many areas of the health-care profession, it is not uncommon to see a change in language over the years as the body of evidence in science and practice changes.

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[52] Comiskey, C., Banka, S., McDonagh, D and Galligan, K. (2021), An evaluation of the co-design of a CityWide pilot anti-stigma training programme (https://www.citywide.ie/assets/files/pdf/citywide_anti-stigma_training_report_final.pdf).

Researchers and professionals in the fields of drug use prevention, drug use disorder treatment, as well as 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 that used to describe people with mental health conditions and people with chronic conditions or disabilities (e.g., "person who uses drugs" rather than "drug user"; and "person with a substance use disorder" or "person in recovery" as opposed to "addict", "alcoholic" or "reformed addict").

While adopting neutral, science-based, person-first language is critically important, it should be recognized that 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 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 practice

The following is a list of examples of good practice in promoting non-stigmatizing attitudes and ensuring the availability of, access to and delivery of health, care and social services for affected populations. These examples are 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 people 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 disorder treatment centre staff and other health practitioners.
- Incorporating mandatory professional and licensing courses on drug use and stigma for all health and social care practitioners.
- Supporting increased community awareness through public discourse and transparency about drug use via other discussion venues.
- Ensuring that policymakers regularly receive 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 that promotes stigmatizing attitudes, and changing documents and direct communication with other professionals.
- Focusing on skills-based training, where participants practise and teach strategies to promote non-stigmatizing attitudes, in addition to awareness-raising content-based lectures, including personal reflections to consider 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 on drug use.
- Underlining the responsibility of police officers and prison staff not to punish or harass people and to respect the dignity and rights of people whose 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 system.
- 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.

- 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 affected populations – as appropriate in the context of the therapeutic process, and with adequate training and support – as staff members in treatment services 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 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, when and 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 that affected populations are meaningfully engaged within an equal power structure in intervention and policy development and the implementation of programmes.
- Embracing respect for all people, 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 people.
- Ensuring that, at every point on the continuum of care for affected populations, health and social-service practices are based on science and evidence of effective care.
- Supporting informed and voluntary participation at any level of care for people 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 whereby all people receive the best health care 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).
- Practising quality health care that is no less than what would be provided to other people in need of care, 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 health care 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 those for other health conditions – i.e., that they are clean, spacious, respectful of privacy, welcoming and of adequate construction.
- Ensuring that treatment and care services respond to the special treatment and care needs of population groups.

Policy development and research

- Advocating for the promotion of non-stigmatizing attitudes about access to services of affected populations, in the design and production of any strategic instrument on drugs.

- Investing time and resources into mapping available services and collecting accurate data related to experiences in a health-care 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 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 research into stigmatizing attitudes; the consequences of stigma 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, and that 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 system, in accordance with domestic legislation and applicable international law.

- Developing a policy within health-care systems which includes provisions that do not exclude or discriminate against affected populations or their families.

- Assessing current policies around the employment of people with a history of drug use, to enact policies and regulations that ensure that affected populations can be gainfully employed and can access health care related to their drug use or drug user disorder without the fear of losing employment.

- Conducting a cost analysis of the health-care costs associated with people 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 health-care 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 examples of good practice, including from the field of mental health, indicate that it is possible to promote non-stigmatizing attitudes in order 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 include 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 ensuring that no one is left behind.

Annex
List of participants in the informal technical consultation

(Participants are listed in alphabetical order of surname/family name)

Dr Zeinab Abbas, Coordinator, Narcotics Department, Ministry of Public Health Lebanon, Lebanon

Dr Višnja Banjac, Head of Department for Addiction Disorders, Clinic of Psychiatry, University Clinical Center of the Republic of Srpska, Bosnia and Herzegovina

Dr Thilo Beck, Chief Physician Psychiatry, Arud Zentrum für Suchtmedizin, Switzerland

Ms Giovanna Campello, Officer-in-Charge, UNODC Prevention, Treatment and Rehabilitation Section

Mr Paskorn Chaivanichsiri, former Deputy Director General, Department of Medical Services, Ministry of Public Health, Thailand

Ms Judy Chang, Executive Director, Secretariat of the International Network of People who use Drugs, Australia

Mr Bobby Chauhan, Manager, International Relations Unit, Office of Drug Policy and Science, Controlled Substances Directorate, Health Canada, Government of Canada

Mr Sewraz Corceal, Senior Specialized Nurse, Harm Reduction Unit, Ministry of Health and Wellness, Mauritius

Dr Patrick Corrigan, Distinguished Professor and Associate Chairperson for Research, Department of Psychology, Illinois Institute of Technology, United States

Dr Ed Day, Clinical Reader in Addiction Psychiatry, Institute for Mental Health, University of Birmingham, United Kingdom

Mr Domingos Duran, Head of Division, Therapeutic Intervention Division, DG Intervention on Addictive Behaviours and Dependencies, Ministry of Health, Portugal

Dr Mohamed Fayek, Chief Executive, Erada Center for Treatment and Rehab, United Arab Emirates

Ms Nadia Gasbarrini, Programme Manager, Villa Maraini Foundation and Red Cross/Red Crescent Partnership on Substance Abuse, Italy

Mr Peter Gaumond, Senior Policy Analyst, Office of National Drug Control Policy, Executive Office of the President, United States

Mr Lee Imray, Drugs and Alcohol Unit, Crime Policing and Fire Group, Home Office, United Kingdom

Mr Morris Kamenderi, National Authority for the Campaign Against Alcohol and Drug Abuse, Kenya

Mr Thomas Kattau, Deputy Executive Secretary, Pompidou Group, Council of Europe

Dr John F. Kelly, Director, Recovery Research Institute, Harvard Medical School, and Associate Director, Center for Addiction Medicine, Massachusetts General Hospital, United States

Dr Stephanie Knaak, Senior Research Consultant, Mental Health Commission of Canada, Canada

Dr Dzmitry Krupchanka, Department of Mental Health and Substance Abuse, World Health Organisation

Dr Magdalena Kulesza, United States

Dr Jamie Livingston, Associate Professor, Department of Criminology, Saint Mary's University, Canada

Ms Annie Madden, Community Engagement & Liaison Officer, Centre for Social Research in Health, Australia

Ms Daniela Masci, Social Worker, Villa Maraini Foundation, Italy

Ms Elizabeth Mattfeld, Programme Officer, UNODC Prevention, Treatment and Rehabilitation Section

Ms Kirsten Mattison, Director, Office of Drug Policy and Science, Controlled Substances Directorate, Health Canada, Government of Canada

Dr Beth McGinty, Associate Professor, Associate Chair for Research and Practice, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, United States

Dr Ryan McNeil, Director of Harm Reduction Research, Yale Program in Addiction Medicine, Canada

Dr Maria Melchior, Department of Social Epidemiology, INSERM France, France

Dr Jazmín Mora-Rios, Researcher in Medical Sciences, Direction of Epidemiological and Psychosocial Research, National Institute of Psychiatry Ramón de la Fuente Muñiz, MexicoProf. Dr Telmo Mota Ronzani, Center for Research, Intervention and Evaluation for Alcohol & Drugs – CREPEIA, Department of Psychology, Federal University of Juiz de Fora, Brazil

Ms Gabriela Olivera, Technical Advisor, National Drug Secretariat, National Drug Board, Presidency of the Republic, Uruguay

Dr Iuliia Paskevska, Head of Department, Associate Professor, Center for Mental Health and

Monitoring of Drugs and Alcohol, Ministry of Health, Ukraine

Dr Soumaya Rachidi, Focal Point, National Programme on Prevention and Treatment of Addictive Disorders, Mental Health Office, Ministry of Health, Kingdom of Morocco

Dr Ramin Radfar, Director General, Thought, Culture and Health Drug Abuse Prevention Institute, Affiliated Researcher, UCLA Integrated Substance Abuse Programs, Iran

Dr Mohd Rafidi Jusoh, Treatment, Medications & Rehabilitation Division, National Anti-Drugs Agency, Ministry of Home Affairs, Malaysia

Dr Laramie R. Smith, Assistant Professor, Division of Infectious Diseases and Global Public Health, School of Medicine, UC San Diego; Co-Director, SDSU-UCSD Joint Doctoral Program in Interdisciplinary Research on Substance Use (IRSU); Faculty Lead, UCSD Center for AIDS Research Transgender/Nonbinary Community Advisory Board (TCAB), United States

Dr Sven Speerforck, Senior Physician, Department of Psychiatry and Psychotherapy, University Medicine Leipzig, Germany

Prof. Hae Sun Suh, Associate Professor, College of Pharmacy, Pusan National University, Republic of Korea

Ms Gulmira Suleimanova, Project Manager for Afghanistan and Central Asia, Drug Advisory Program, Colombo Plan Secretariat

Dr Andrew B. Thompson, Bureau of International Narcotics and Law Enforcement Affairs, US Department of State, United States

Ms Judith Twala, Manager in Counselling and Rehabilitation, National Authority for the Campaign Against Alcohol and Drug Abuse, Kenya

Mr Godlove Adams Vanden-Bossche, Head, Counselling, Referral and Social Re-Integration Unit, Narcotics Control Board, Ghana

Dr José Luis Vázquez Martínez, Treatment Specialist, Drug Demand Reduction Section, Inter-American Drug Abuse Control Commission, Organization of American States

Mr Paul Williams, First Secretary, Permanent Mission of Canada to the International Organizations in Vienna

Dr Tun Zaw, Deputy Director General, Department of Rehabilitation, Ministry of Social Welfare, Relief and Resettlement, Myanmar

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