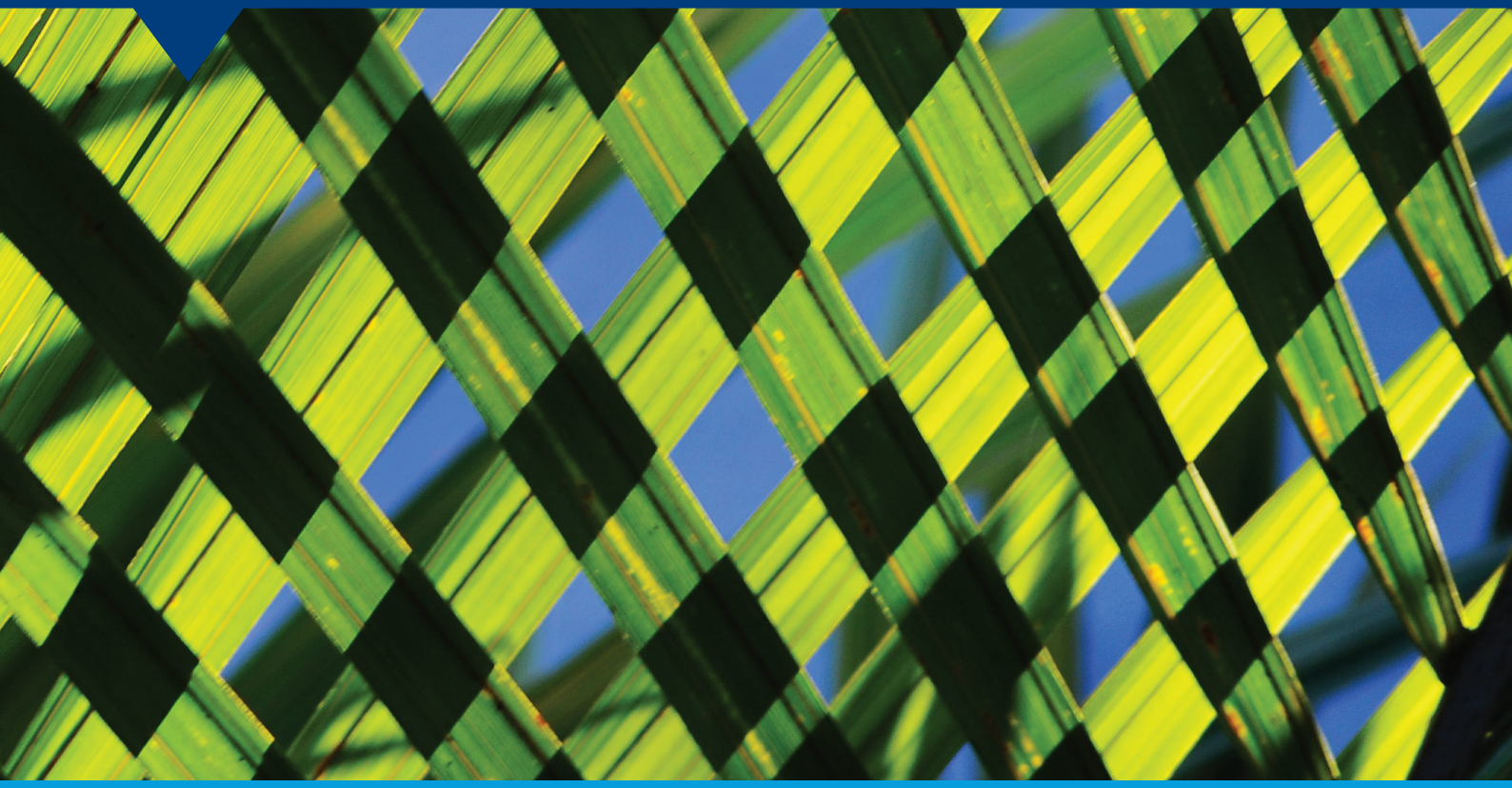
REDUCING STIGMA TOWARDS AOD SERVICE USERS

FINAL PROJECT REPORT / **JUNE 2014**



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aodcollaborative.org.nz
WORKING TOGETHER TO MAXIMISE POSITIVE OUTCOMES

AOD Provider Collaborative

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Report compiled by Paula Parsonage, Health & Safety Developments Ltd. June 2014.

Executive Summary

The Counties Manukau AOD Provider Collaborative undertook focus groups and commissioned a review of selected literature to confirm local experiences and current evidence-based approaches to structural stigma and de-stigmatisation for AOD service users, families and significant others. The findings are summarised in this report.

Stigma can be defined as *"the situation of the individual who is disqualified from full social acceptance"* (Goffman: 1963: 9, cited in Carroll et al, 2013). AOD service users are a stigmatised group that has been largely overlooked in destigmatisation initiatives, thus there is little evidence in relation to what works to reduce stigma against this group.

Stigma occurs at personal, social and structural levels (i.e. in policy, law and social institutions) and includes self-stigma (stigmatising beliefs internalised by those who are stigmatised). Stigma contributes towards social exclusion, hinders social reintegration for those in recovery, creates psychological distress and is a significant barrier to treatment-seeking for those experiencing AOD problems and their families. There is evidence that those experiencing AOD related problems are more stigmatised than those with mental health problems, being seen as more responsible for the onset and cessation of their illness, more blameworthy and more dangerous than those with other mental health problems. Those in treatment for AOD problems experience the greatest level of stigma and some subgroups are more heavily stigmatised (e.g. those receiving opioid substitution therapy). There are prevailing social views that treatment for addiction is not effective and there is little public understanding of recovery.

Health professionals, employers and media are thought to be important targets of anti-stigma strategies. The health professionals and employers as they are in a position to reduce barriers to treatment and employment and media because they have a pivotal role in reinforcing cultural views including stereotypical views. These groups need to be better informed, educated and supported in order for this to change. Local experience in Counties Manukau suggests that AOD service staff, especially front line staff could benefit from destigmatisation training.

Strategies for reducing stigma include those based on protest, education and contact. There is evidence to support education and contact-based approaches as follows:

- Self-stigma can be addressed through acceptance and commitment therapy (ACT).
- Social stigma can be addressed by promoting positive stories and portrayals of AOD service users
- Structural stigma can be addressed through contact-based training and education.

There is agreement in the literature that those with experience of AOD related problems and their families should be engaged in developing and implementing strategies.

The focus group findings and literature confirm that stigma is an issue worth addressing, particularly for those receiving AOD treatment. That stigma is a barrier to treatment seeking, the fact that AOD service users experience the worst levels of stigma and the prominence of self-stigma all combine to emphasise that those providing AOD services are right to concern themselves with stigma and attempt to address it.

Based on the information in this report it is recommended:

That addressing stigma remains a priority focus for the Counties Manukau AOD Provider Collaborative and that the Collaborative continues to strive to influence policy and decision makers at a regional and national level to support comprehensive destigmatisation efforts and to support each other to address stigma at the local level.

That the Counties Manukau AOD Provider Collaborative develops an action plan to continue efforts to address stigma. The plan would need to be developed and implemented in partnership with service users and families and made in consideration of available resources. It could include any or all of the following:

- A project focused on coordinating, encouraging and supporting AOD treatment providers to develop ways to explicitly address stigma, including self-stigma, within routine service delivery. The project could be self-led by services. Those services already undertaking steps to address stigma could support other services to do so. Consideration could be given to trialling the use of ACT to address self-stigma. Provision of destigmatisation training and support to first contact staff could be prioritised.

- Development of an education and support programme aimed at one of the identified target groups (in consideration of local priorities) e.g. health professionals (including those in AOD services), employers, or media. The programme would aim to reduce stigmatising beliefs and promote the role of the target group in supporting social inclusion.

- A media project focused on generating and promoting positive stories of recovery and treatment effectiveness in local media and organisational publications. A realistic target number of published positive stories could be set. A project such as this is best led by service users and families and ideally would be led by the Counties Manukau Consumer Network.

Introduction

> ..... *even former drug users, some of whom had been in recovery for many years, are often subject to widespread prejudice and discrimination. Despite their efforts to move on from drugs, they experience stigma in many aspects of their lives.*
>
> UK Drug Policy Commission 2010:7

The Counties Manukau AOD Provider Collaborative has undertaken a project to understand ways to reduce stigma towards AOD service users and decrease the barriers they face when accessing treatment options in the community.

As part of this broad objective a working group within the Counties Manukau AOD Provider Collaborative coordinated focus groups with key stakeholders in Counties Manukau to identify views and experiences related to AOD services and stigma.

The Counties Manukau AOD Provider Collaborative also commissioned a review of selected literature to confirm current evidence-based approaches to structural stigma and de-stigmatisation for AOD service users, families and significant others.

The key themes from the focus groups[1] and the literature findings are summarised in this report.

Focus group results

Participants

Three focus groups were conducted from September to November 2013. The groups comprised clinicians, peers and Pacific consumers and families. In total 23 people participated, 13 were female, seven were male and gender was not defined for three participants.

Stigma and AOD service location

Focus group participants identified service location as a factor that can be stigmatising but also normalising. It was noted that services are often located in low socioeconomic areas and this was viewed as stigmatising. Additionally services are often highly visible and if provided in a stand-alone building *"people know you are there to use a service."* It was suggested that co-locating AOD services with other health services can allow more privacy and reduce feelings of stigma.

[1] Focus group notes were collated and analysed by Sam White, Odyssey House and Fiona Greenman, DRIVE, AOD Consumer Network.

Participants commented that location is important and accessibility is a key consideration.

A further point was that an informal, welcoming and socially inclusive location is preferred for example: *"…like McDonald's, it feels like a normal place."*

AOD service names

Focus group participants expressed a range of views on AOD service names and their relationship to stigma. Some participants were unconcerned about service names for example:

> *"A name means nothing it depends on where I am in my journey."*
>
> *"The name means nothing if it doesn't have a good reputation."*

In contrast others stated that names can decrease and increase self-stigma i.e. how a person sees themselves may be negatively or positively reinforced by the name of a service and names can improve accessibility or be a barrier. For example:

> *"Names with negative words in them like detox or dependence indicate that something is wrong with the person, they are stuck, diagnosed, helpless, labelled, boxed, dangerous, unpredictable, and incompetent."*

Some stated the use of Maori names which can be a barrier to some people and can also be stigmatising toward Maori, i.e. leading to an impression that only Maori have AOD issues.

A father example was that the name Alcoholic Anonymous[2] presents as a barrier for some people.

It was noted generally that Non-Government Organisations (NGO) tend to use more positive language in naming services.

One further comment was that service names should be clear for example, needle exchange. Having a clear name is helpful.

Service language

Focus group participants agreed that language conveys much stigma and that language used within services can reinforce stigma and be *"recovery limiting."* Terms like risk and safety are constantly used within AOD services and participants noted this language as labelling which then determines practice. The following examples illustrate this theme:

[2] Note: Alcoholics Anonymous (AA) is not an AOD service however some perceive AA in the same way as they perceive AOD services.

"People use loaded words that you don't identify yourself with."

"Clean time…implies before clean I was dirty, or if I slip even briefly I'm dirty, I've done something wrong when to me it's part of the journey."

Related to the use of language, there was a theme that clinicians portray themselves as experts and that this can also be stigmatising. As an example, one participant reflecting on this tendency offered the following comment:

"People don't care about what we know until they know we care."

Attitudes and beliefs of staff

Participants noted that attitudes and beliefs of staff can contribute to stigma and that overall the AOD sector is highly judgemental of service users. This strongly aligns with research summarised below which identifies that AOD service users are among the most stigmatised of AOD users. Participants noted that blame is commonly experienced and that service users are seen as issues not people. The following comments provide examples:

"Body language tells me they've already judged me before the session has even started."

"I feel like a problem to be solved"

There was a suggestion that first contact staff such as receptionists and administration officers should be offered de-stigmatisation training as a priority group.

Focus group summary

Focus group findings are useful in highlighting some of the priority issues relating to stigma identified by local service users, family members, peers and clinicians. Key themes identify that service location and names can be unintentionally stigmatising and that AOD professional language and staff attitudes and beliefs are experienced as stigmatising by service users. In particular front line staff within AOD services are identified as a priority group for destigmatisation training.

Literature findings

Literature selection and limitations

Literature was identified by searching on key terms including:

- Addiction and stigma
- Drug use and stigma
- Alcohol and stigma
- Destigmatisation and addiction
- Destigmatisation and alcohol
- Destigmatisation and drug use

Relevant literature published within the last 10 years was selected. The review was limited to material that could be accessed within the time available. A total of 28 relevant documents were identified and analysed for key themes. The documents include a mix of research, literature reviews, evaluation reports, policy and guidance. None of the material originated in New Zealand with the majority being from the UK and the USA.

Very little literature was identified that provided evidence to support approaches to addressing structural stigma and de-stigmatisation for people facing AOD related problems. In reality there has been little work done to address stigma for this group so little opportunity to accumulate evidence. Clearly this limits the findings of this review.

Understanding stigma

Stigma can be defined as *"the situation of the individual who is disqualified from full social acceptance"* (Goffman: 1963: 9, cited in Carroll et al, 2013).

In order to shape interventions for reducing stigma the foundations of stigma in general must be understood. (Janulis, 2010; Room, 2005). Broad levels or strata of stigma, are identified offering various ways of looking at the issue and frameworks for shaping responses to reduce stigma. For example the following framework of self-stigma, social stigma and structural stigma is frequently referred to:

***Self-stigma*:**

Self-stigma is stigma derived from within the person who is stigmatised. The person accepts negative cultural stereotypes, they feel blameworthy, ashamed and undeserving, and they attempt to hide their stigmatising condition (e.g. addiction to AOD) from others. This may include avoiding situations so that they do not have to face stigmatising responses. This is a key reason why people facing problems with AOD use and their families fail to seek treatment (Livingston et al., 2012; Landry, 2012; Pietrus,

2013).

***Social stigma*:**
Social stigma (also referred to as cultural or public stigma) is stigma that is endorsed by the public against a specific stigmatised group, manifesting in discrimination against them. Social stigma is usually based in deeply held beliefs e.g. people experiencing addiction are violent and dangerous, rarely recover from their addiction and treatment does not work (Livingston et al., 2012; Landry, 2012; Pietrus, 2013).

Structural stigma:
Structural stigma is embedded in social policy, law and social institutions, such as health systems, education, justice etc. For example failure to provide health care for people experiencing problems with AOD, and failure to adequately fund AOD treatment (Livingston et al., 2012; Landry, 2012; Pietrus, 2013).

Similar to the framework above, Buchannan (2008) drawing on the work of Thomson (2006), names dimensions of stigma as: Personal i.e. thoughts, feelings and actions of individuals; cultural i.e. shared social values and shared ways of seeing and doing and Structural i.e. built in to social institutions, social policy and legislation.

Landry (2012) provides a different framework in relation to stigmatising of AOD service users defining the following strata of stigma:

- Stigma from within: which equates to self-stigma as outlined above.
- Stigma from the recovering community: referring to different beliefs about the 'right' ways to recover.
- Stigma from treatment providers: for example, perpetuating use of stigmatising language.
- Stigma from the outside: equating to social and structural stigma as outlined above.

Lastly, Kulesza et al. (2013) identify public stigma, perceived stigma (i.e. belief that most people hold stigmatising views) and enacted stigma (i.e. stigma which results in direct discrimination and rejection of a group such as AOD service users).

Stigma can involve both positive and negative social forces for example stigma may deter undesirable behaviour such as discouraging use of alcohol and other drugs which may be seen as a positive force. At the same time stigma can create a barrier towards seeking help for problems related to AOD use which may be seen as a negative force (Schomerus et al 2010; White 2009).

Stigma can have a 'social purpose' i.e. by promoting exclusion and conformity; in-groups and out-groups (Ahern et al 2007; Schomerus et al 2010).

While there have been studies of stigma for decades, stigma and discrimination against

people experiencing problems with AOD has been undertaken only within the last decade (Kulesza et al., 2013).

AOD service users are particularly stigmatised

> *[Public perception is that] people with drug dependence are to blame for their problems, and could give up if they really wanted to.*
>
> UK Drug Policy Commission 2012: 124

AOD disorders are perceived by the public as among the most dangerous of psychological disorders (Janulis, 2010). People suffering from these disorders are viewed as having a choice and being more responsible for the onset and cessation of their illness, being more blameworthy and being more dangerous than those with other mental health problems (Corrigan et al 2009; Lloyd, 2010; Singleton 2011; UK Drug Commission, 2012).

For example, Schomerus et al (2010) reviewed 17 representative population studies comparing substance use disorders with other mental disorders and found alcoholism to be particularly severely stigmatised. Those with alcohol related disorders are much more likely to be held responsible for their health problem, not regarded as ill, more socially rejected and at risk of structural discrimination. This was underscored by Singleton (2011) who found those with drug dependence face significantly more negative public attitudes than those with other mental health problems.

There are also different perceptions of subgroups of AOD service users, for example, those with multiple issues are more discriminated against as are those from ethnic minority groups, and those who receive opioid substitution therapy (White, 2009). White (2009) notes that opioid substitution therapy has never attained fully legitimate status as a treatment type despite the evidence base to support its effectiveness.

Janulis (2010) states that there are different levels of stigma associated with different drugs noting for example that alcoholism is more likely than other drug related disorders to be viewed as a genetic problem. Even so, it is still viewed as a moral failure for which the person suffering from the disorder is seen as being responsible.

Livingston et al (2012) note that stigma towards AOD service users manifest differently to that of other mental health disorders and that approaches to developing social acceptance are therefore complex. They note links between AOD use and other stigmatised conditions (e.g. HIV/AIDS) and undesired behaviour (e.g. drink driving and other criminal activity). These stereotypes can guide public policy and social action. They further note the importance of showing that these attributes are not generally applicable to all AOD service users.

Stigma is a barrier to recovery

> *Drug users are expected by society to change their behaviours and demonstrate better personal responsibility. But, in return, society has to look at itself, to begin to challenge the negative attitudes and barriers that can keep those with addictions and drug dependency problems locked into dysfunctional lifestyles. The public needs to understand better the nature of addiction and the routes out of it.*
>
> UK Drug Policy Commission 2012:14

Many researchers view stigma as key barrier to recovery which must be addressed. They argue that society as a whole needs to be engaged to support reintegrating people with drug problems into society (Buchanan, 2004; Keane 2007, Singleton, 2011; Minister's Advisory Group on the 10-Year Mental Health and Addictions Strategy 2010, UK Drug Policy Commission 2012).

For example Buchannan (2004) notes that stigma is related to isolation from the non-drug using population, social exclusion, low self-esteem, lack of hope and opportunity and poor experiences in relation to education and employment. He challenges the assumption that addiction can be overcome by individuals making internal adjustments and argues that this ignores the socio-political context in which drug use occurs.

Stigma delays help-seeking and reintegration

> *Stigma experienced by drug dependent users and their families often delays people seeking help. They fear that once they do, they will be stuck with the label 'hopeless addict' for life.*
>
> UK Drug Policy Commission 2010:2

Stigma is viewed as a barrier to implementing policy and programmes aimed to assist AOD service users, partly because reintegration is severely hindered. AOD service users face significant barriers in achieving social reintegration for example they can have difficulty obtaining employment and housing (Buchannan, 2006; Keane, 2007; Singleton, 2011, Drug Policy Commission 2010, UK Drug Policy Commission 2012).

Stigmatised AOD users and their families are less likely to seek help which creates a critical barrier to recovery and also undermines policy efforts (Buchannan, 2006; Myers et al, 2009; Minister's Advisory Group on the 10-Year Mental Health and Addictions Strategy 2010; Singleton, 2010; Singleton, 2011; UK Drug Policy Commission 2012).

However the findings of Kulesza et al. (2013) are somewhat at odds with other research. Kulesza et al. (2013) reviewed 26 articles describing 28 studies evaluating the impact of stigma. They state that the only consistent finding is that there is a relationship between stigma and psychological well-being: *"Specifically, results suggest that stigma has a detrimental effect on psychological well-being among individuals who use drugs (p1)."*

Health professionals and stigma

The beliefs held by health professionals in relation to those experiencing problems related to AOD use is seen as an important area for investigation because of the generally poor levels of health in AOD service user populations. Health professionals are seen as playing in important role in both providing treatment and acting as gateways or gatekeepers to health treatment (Ahearn et al, 2007; Janulis, 2010; Lloyd, 2010).

Van Boekel et al (2013) reviewed 28 studies of health professionals' attitudes and behaviours, finding that in general health professionals have a negative attitude towards AOD service users. They are less engaged and have diminished empathy resulting in their patients feeling disempowered and experiencing poorer treatment outcomes. Van Boekel et al (2013) also found that professionals lack education, training and support to enable them to work effectively with this group of health treatment consumers.

The level of personal experience that a health professional has had with addiction makes a difference, for example doctors with the most positive attitudes were those who had family members with a psychiatric illness Minister's Advisory Group on the 10-Year Mental Health and Addictions Strategy 2010 (Ontario).

AOD service users report the highest levels of stigma

> *Entering treatment for alcohol or drug problems is potentially humiliating evidence of failure in self-management.*
>
> Room 2005:152

People who are in treatment for AOD problems often report the highest level of stigma and rejection (Janulis, 2010; Lloyd, 2010; Luoma, 2007; Room, 2005). This does not seem to be primarily because those entering treatment are facing the most serious problems. For example,

> *"In general, our data are suggestive of the idea that stigma-related rejection may occur with increasing frequency with greater numbers of treatment episodes. One alternative hypothesis is that those with the most serious problems are those most likely to return to treatment and also those most likely to suffer from stigma. However, our data argue against this hypothesis in that stigma-related rejection continued to predict number of treatment episodes even after controlling for current severity."*
>
> Luoma et al. 2007:1342

Treatment programmes often use stigmatising language and programming with the effect that people fail to seek treatment and treatment fails to be adequate. This is

reflected in individuals' experience of treatment but also at a structural level such as inadequate funding and sending those with AOD disorders to jail etc. (Juman, 2012)[3].

Employers as a target group

Employment offers a key means of participation in society (Keane, 2007; UK Drug Policy Commission 2012). Employers then are a target group for reducing stigma and the impact of stigma on the lives of AOD service users.

Singleton & Lynam (2009) argue that employers' concerns about risks of employing recovering AOD users need to be addressed and negative stereotypes and stigma challenged to support AOD service users into work. They note that there are unintended consequences of policy initiatives such as sanctions for people who do not try to gain employment as these reinforce negative beliefs about AOD service users in relation to poor work ethic and unfitness to work. Further, they argue for localised engagement strategies targeting employers to build knowledge and understanding of recovery and provide practical guidance for recruitment and employment, emphasising the benefits to employers of engaging with this group.

The role of media

Media are an important target for intervention. Some research has investigated press reporting of drug use which is largely dominated by themes of crime and celebrity. The language used in media portrayals of drug use and those who use drugs has a powerful role in framing public understanding. Recovery and reintegration are rarely spoken about (Lloyd, 2010; Seymour, 2012; Pietrus, 2013).

The UK Drug Policy Commission in collaboration with the Society of Editors published a guide for journalists. The focus of the guide is to provide facts to support accurate reporting rather than telling journalists what to think or criticising them. Guidance is provided on language and on what the media can do to reduce their role in stigmatising people experiencing drug addiction (Seymour, 2012).

Interventions to reduce stigma

As noted there is limited evidence as to "what works" in reducing stigma against AOD service users.

Three broad strategies have been used to address stigma related to behavioural health disorders:

Protest:

Protest involves confronting inaccurate and exaggerated beliefs, eliminating negative

[3] See National Committee for Addiction Treatment (NCAT) 2011, for a discussion of underfunding in New Zealand.

portrayals, reducing the amount of times such negative portrayals are put before the public. Media are often a target of protest strategies. The effectiveness of this strategy is not clear (Janulis, 2010). There can be a "rebound effect" from telling people what to think which can make things worse (Corrigan et al, 2009). Janulis (2010) suggests that protest is unlikely to change attitudes or create positive views of people who experience AOD problems however he notes that reducing the frequency of negative portrayals of mental illness could reduce the availability of such stereotypes.

***Education**:*
Education is the most commonly used anti-stigma intervention. Generally education is used to change inaccurate beliefs, eliminate negative attitudes, and create positive attitudes towards stigmatised groups. Research on the effectiveness of education as a strategy indicates mixed results. Janulis (2010) reports that interventions targeting attributions have been effective in changing some beliefs e.g. education can improve understanding of the effectiveness of treatment and the potential for recovery.

Contact:
Contact interventions generate increased interpersonal contact between stigmatized and non-stigmatized groups. These interventions improve acceptance of stigmatised groups decreasing negative attitudes rather than increasing positive attitudes (Janulis, 2010). Singleton (2011) suggests that the contact strategy is promising in relation to increasing familiarity and decreasing fear and dangerousness.

Livingston et al. (2012) report on a systematic review of research that has empirically evaluated interventions aimed at reducing stigma related to substance use disorders. In summary, thirteen studies were reviewed as follows:

- Three focused on people with substance use disorders (self-stigma)
- Three targeted the general public (social stigma)
- Seven focused on medical students and other professional groups (structural stigma)

They conclude that some interventions demonstrate promise for achieving meaningful improvements in stigma related to substance use disorders:

- Self-stigma: therapeutic interventions such as group-based acceptance and commitment therapy (ACT). ACT has been shown to be effective in reducing shame and internalised stigma.
- Social stigma: brief motivational interviewing (conducted with members of the public) and communicating positive stories of people with substance use disorders
- Structural stigma: contact-based training and education programs targeting professionals and trainee professionals (e.g. medical students, health professionals, police).

Masuda et al. (2012) report that both social and self-stigma may be modifiable through clinical intervention such as Acceptance and Commitment Therapy. The approach

typically employs a focus on developing awareness of prejudicial thoughts and feelings, accepting these as a result of using language and learning cultural norms in a prejudiced society, noticing automatic processes of judgement and orienting to actions that are positive and consistent with participant's own values of how to treat people. Masuda et al (2012) report on three trials where ACT was used to reduce social stigma and three targeting self-stigma, two of which focused on people experiencing AOD related problems. The first of the latter trials showed reductions in internalised shame, improved self-esteem and greater psychological flexibility on the part of participants. The second, larger trial showed the same results and also better general mental health, increased quality of life, increased social support, more treatment attendance and fewer days of substance use. While these findings require further validation the researchers note that ACT shows promise in reducing stigma.

There are a number of examples and recommendations in the literature in regard to strategies for reducing stigma.

The Australian National Centre for Education and Training on Addiction (2006) developed a programme to change the views of health professionals towards drug users. The learning activities within the programme facilitate participants to undertake "deep processing" which the authors state has been shown to be effective in changing beliefs.

The UK Drug Policy Commission (2012) promotes public education about addiction and recovery and innovative projects to promote increased contact with recovering drug users. Two examples of such project are *The Brink* recovery bar in Liverpool established by Action on Addiction, and the *Tea Room Social Enterprise* set up by Burton Addiction Centre.

In Canada the Minister's Advisory Group on the 10-Year Mental Health and Addictions Strategy (2010) recommend a public education campaign to dispel myths and promote rights of people with addiction and development of a range of anti-stigma programmes targeted at key groups including children and young people, health providers, first responders and general health, education, justice and social service workers, employers and landlords.

They note that a key strategy is engaging people with lived experience of addiction and their family members as spokespeople. This view is supported by The Center for Substance Abuse Treatment (2000).

Buchanan (2008) argues that stigma must be addressed at the personal, cultural and structural levels. He advocates challenging language, notions and images that are used to make sense of drug use.

Summary of literature findings

Stigma occurs at personal, social and structural levels and includes self-stigma. There is a level of consensus that stigma contributes towards social exclusion, prevents social reintegration, creates psychological distress and is a significant barrier to treatment-seeking for those experiencing AOD problems and their families. Those in treatment for AOD problems experience the greatest level of stigma.

It is important to note that none of the research or guidance reported on in this summary has been generated in New Zealand. It is only possible to hypothesise that many of the findings and suggested strategies apply in this country and therefore stigma is a priority issue for AOD service users. That stigma is a barrier to treatment seeking, the fact that AOD service users experience the worst levels of stigma and the prominence of self-stigma all combine to emphasise that those providing AOD services are right to concern themselves with stigma and attempt to address it.

A number of frameworks can be applied to assist in understanding stigma. The framework of self-stigma, social stigma and structural stigma appears helpful in the AOD context.

AOD service users are a stigmatised group and have been largely overlooked in destigmatisation initiatives, thus there is little evidence in relation to what works to reduce stigma against this group.

Employers, health professionals and media are thought to be important targets of anti-stigma strategies.
There is some evidence to support the following:

- Self-stigma can be addressed through acceptance and commitment therapy.
- Social stigma can be addressed by promoting positive stories and portrayals of AOD service users
- Structural stigma can be addressed through contact based training and education.

There is agreement in the literature that those with experience of AOD related problems and their families should be engaged in developing and implementing strategies.

The literature confirms that stigma is an issue worth addressing, particularly for those receiving AOD treatment. However the evidence base for effective interventions is at a very early stage of development.

Recommendations

Based on the information above it is recommended:

That addressing stigma remains a priority focus for the Counties Manukau AOD Provider Collaborative and that the collaborative continues to strive to influence policy and decision makers at a regional and national level to support comprehensive destigmatisation efforts and to support each other to address stigma at the local level.

That the Counties Manukau AOD Provider Collaborative develops an action plan to continue efforts to address stigma. The plan would need to be developed and implemented in partnership with service users and families and made in consideration of available resources. It could include any or all of the following:

- A project focused on coordinating, encouraging and supporting AOD treatment providers to develop ways to explicitly address stigma, including self-stigma, within routine service delivery. The project could be self-led by services. Those services already undertaking steps to address stigma could support other services to do so. Consideration could be given to trialling the use of ACT to address self-stigma. Providing destigmatisation training and support to first contact staff could be prioritised.

- Development of an education and support programme aimed at one of the identified target groups (in consideration of local priorities) e.g. health professionals (including those in AOD services), employers, or media. The programme would aim to reduce stigmatising beliefs and promote the role of the target group in supporting social inclusion.

- A media project focused on generating and promoting positive stories of recovery and treatment effectiveness in local media and organisational publications. A realistic target number of published positive stories could be set by the group. A project such as this is best led by service users and families and ideally would be led by the Counties Manukau Consumer Network.

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