RAPID REVIEW

Evidence for Strategies that Address Substance-Use Related Stigma

Published: April 2024

Key Findings

- The review found 36 peer-reviewed articles and 8 from grey literature meeting inclusion criteria. Published between 2019 and 2023, the studies primarily focused on the United States (24 studies), Canada (8 studies), and other OECD countries. Findings indicate the multifaceted nature of stigma intervention strategies across different levels: interpersonal/social (18 studies), institutional (16 studies), and population/structural (2 studies).

- Language interventions showed mixed outcomes, while training/skill-based programs demonstrated effectiveness, particularly those incorporating motivational interviewing and contact with individuals with lived experience of substance use. General education interventions targeting specific groups, such as librarians and faith-based communities, displayed positive effects on knowledge and attitudes. Increasing connection strategies, such as including patient panels, significantly reduced stigma.

- Policy and practice-based interventions, like addiction consultation services with trauma-informed approaches, highlighted the influence of past healthcare experiences in perpetuating stigmatization cycles. Public campaigns with visual messaging and narrative vignettes contributed to decreased stigma levels among healthcare professionals. Multi-component interventions, combining training, education, and connection strategies, consistently demonstrated significant reductions in stigma across various populations.

- The review highlighted the importance of adopting an intersectional lens, considering factors like gender, occupation, concurrent stigmatized illnesses, religion, and race.

- Despite progress, challenges and gaps persist, including the limited evidence for multi-level interventions, the need for institutional support for community engagement, and the importance of authentic engagement for effective and sustained stigma reduction.

Background

In a Canadian national survey, nearly half of individuals who use(d) substances report experiencing stigma or discrimination during the time they were using substances.[1] Link and Phelan build from Goffman's original conceptualization of stigma, and define stigma as the co-occurrence of multiple components, including labeling, stereotyping, separation, status loss, and discrimination.[2] They describe that for stigmatization to occur, power (in the form of social, economic, and political) must be exercised, in which then the components of stigma can unfold (ibid). The prevalence of various stigmatized processes and its impact on individuals influences the allocation of opportunities.[2]

Stigma operates across multiple interconnected levels (e.g., institutions, populations, interpersonal relationships) and contributes to discrimination and inequities in both social and health domains (e.g. access, experiences, outcomes).[3] This frequently leads to adverse effects including social, psychological, behavioural, and medical dimensions.[4,5] For instance, stigma can deter seeking help due to fear of judgment or legal issues, lead to hiding drug use or using drugs alone, impede housing and job opportunities, and result in lower quality healthcare due to negative perceptions, attitudes, and bias.[6]

Adding to the complexity is the intertwining of health-related stigma with other types of marginalization, which exacerbate its detrimental effects. This intersectional encounter, where health-related stigma combines with oppressive social aspects such as sexism, heterosexism, and classism, can result in concealment, exclusion, and obstacles to accessing services, education, work opportunities, and creating social connection.[3,6] Acknowledging the complex interplay of stigma across these levels is crucial for designing effective and sustainable interventions to reduce stigma associated with substance use.[6-9]

In Canada, the impacts of stigma contribute to and drive opioid-related deaths. At the national level, the impact of opioid-related deaths is apparent, with an average of more than 20 such deaths occurring daily in 2022.[10] Across Canada, regional disparities persist, with certain provinces and territories, notably British Columbia, Alberta and Ontario, experiencing most (87%) of all accidental apparent opioid toxicity deaths in 2022.[10]

One aspect of substance use-related stigma is the conflation of any use as problematic. Stigmatization oversimplifies a well-recognized range of substance use experiences by framing it solely within a criminalized, moral, and willpower framework, neglecting the role of public health in supporting people who use substances. Addressing stigma related to substances and substance use is imperative, particularly given evidence of its impacts. Given that stigma operates on multiple levels, so do its impacts. More specifically, stigma can affect the resources that policy makers and governments dedicate to supporting people who use drugs. It also plays out in the ways that services and supports are rolled out, shapes the type of care that patients receive, and has been shown to be a barrier in people's decisions to seek services and treatment.[11]

To deepen our understanding of this issue and the pathways to action in anti-stigma work, this rapid review investigated the characteristics and effectiveness of interventions aimed to reduce substance use-related stigma. It used the *Action Framework for Building an Inclusive Health System* to guide the identification and categorization of existing evidence for anti-stigma strategies and interventions.[12] Furthermore, the interventions were thematically organized by type, with a description of their level of impact and effectiveness in reducing stigma among study samples.

Methods

Search Strategy

The synthesis employed a rapid review approach to investigate the evidence on anti-stigma interventions addressing substance use-related stigma. The secondary outcome of interest of the review included any evidence for the effectiveness of anti-stigma interventions which have been implemented and evaluated. Initial searches in May, 2023 were conducted across three databases (MEDLINE, PsycInfo, CINAHL) with the assistance of a Public Health Ontario librarian. Additionally, grey literature searches were performed using custom Google search engines, targeting Ontario's public health units, Canadian Health Departments and Agencies, US State government websites, international public health resources, and Google Canada.

Selection Criteria

The inclusion criteria encompassed research, reports, reviews, and resources that contained details about an intervention addressing stigma towards people who use drugs (PWUD) (e.g., population engaged, stigma level addressed, and/or evaluation of impact). Specifically, our scope included interventions such as campaigns, strategies, and resources that address stigma towards PWUD. An evaluation of impact was not mandatory for our selection criteria, but was considered during the screening process to contextualize change efforts. The decision to include articles without an evaluation element was made to include a broad spectrum of strategies and resources that, while not robustly documented, are accessible and have been implemented across many settings. Our scope included campaigns, interventions, or strategies addressing stigma towards people who use drugs.

Anti-stigma interventions included strategies such as skills-based training (e.g., training modules for healthcare professionals), education (e.g. educational workshops for the general public), resource provision (e.g., language guides), and contact-based learning with people with lived/living experience (PWLLE) to reduce stigmatizing attitudes, perceptions, and behaviours (e.g., collaborative learning exchange workshops, guest panel speakers). The primary outcomes of interest were measures of stigma reduction, and other evaluation outcomes used to assess the impact of the intervention. The search focused on studies written in English, originating from Organisation for Economic Co-operation and Development (OECD) countries, and published from 2019 onwards (5 years) to capture the evidence most relevant to our current context in Canada.

Results

The initial database search yielded 1923 results. After a thorough review of titles and abstracts by three team members, 99 articles were selected for full-text review. Ultimately, 36 peer-reviewed articles met the inclusion criteria. Additionally, a grey literature search identified 70 records, resulting in eight inclusions after full-text review. Excluded articles and grey literature sources were primarily descriptive or commentary pieces, lacked a clear focus on anti-stigma interventions, were non-English resources, or originated from non-OECD countries. The final step involved data extraction from the 44 selected articles, carried out by a single reviewer.

Study Characteristics

The articles included in this review were published between 2019 and 2023, comprising studies from several settings. Studies included in the review were primarily conducted in the United States (24 studies), Canada (8 studies), and other OECD countries including Australia (2 studies), Ireland (1 study), and the United Kingdom (1 study); six studies had a global scope for their research. A variety of methods were used in the studies, with quantitative approaches being the most common (14 studies), followed by mixed methods (7 studies), systematic reviews (7 studies), randomized controlled trials (RCTs) (5 studies), and qualitative methods (5 studies).

Strategies spanned diverse settings, with a majority from healthcare, including healthcare workers, as well as medical, nursing, and pharmaceutical students (25 studies). Other audiences included the general population/public (six studies), youth/students (two studies), non-healthcare setting workers (two studies), media (one study), and the justice system (one study). Four studies included multiple populations/audiences for their intervention.

Furthermore, seven studies incorporated an intersectional component, considering factors such as gender, occupation, concurrent stigmatized illnesses (e.g., HIV), and religion in their anti-stigma intervention. Evaluation components were included in 35 studies, primarily using pre/post surveys to assess outcomes such as changed attitudes or perceptions towards people who use drugs, and motivation to change stigmatizing behaviours and practices in healthcare settings.

Intervention Characteristics

STIGMA LEVELS

In our review, we aimed to identify the levels at which stigma operated in the included studies. We classified the studies under the stigma level categories based on the goals of the interventions rather than intervention outcomes (e.g., participating in a structural-level anti-stigma intervention and demonstrating improved individual-level attitudes). The definitions for each stigma level can be found in Table 1.

Table 1. Stigma levels and definitions from the Action Framework for Building an Inclusive Health System

Stigma Level	Definition
Individual level	Refers to the person who experiences the stigma. It operates through enacted stigma (e.g., unfair treatment), which causes psychological stress; internalized stigma (e.g., low self-esteem and feelings of shame); and anticipated stigma, resulting in reluctance to seek support.[12]
Interpersonal/Social level	Occurs at the person-to-person level, involving family, friends, social and work networks, as well as healthcare and service providers.[12] Interpersonal stigma manifests through language, such as using derogatory terms or dehumanizing labels, intrusive attention and questions, and harassment and assault.

Stigma Level	Definition
Institutional level	Occurs at the level of health system organizations, medical and health training schools, community sector organizations, and social service organizations.[12] It involves aspects like staff education, stigmatizing practices, experiences of discrimination/exclusion (e.g., lack of empathy from staff), non-inclusive physical environments, and institutional policies causing harm (e.g., low investment of services).
Population/Structural level	Occurs at the level of mass media, policies, and laws.[12] Population stigma involves widely held stereotypes, negative portrayals in media (e.g., people who use drugs portrayed as violent), and discriminatory policies and laws, leading to inadequate legal protections or lack of enforcement of these protections.

Individual level stigma: In our review, there were no articles or resources that solely focused on the individual experience of stigma.

Interpersonal/Social level stigma: 18 studies assessed interventions addressing interpersonal/social stigma.

More specifically, four studies focused on social stigma by addressing the impact of language on stigmatizing attitudes among graduate students and the general population.[13-16] Additionally, 10 articles facilitated training sessions or educational forums to: improve attitudes towards people with an opioid use disorder (OUD) and opioid overdose reversal knowledge, increase knowledge about best practices, improve general perceptions of morality and empathy towards people who use drugs (PWUD) (i.e. blame, avoidance, dangerousness), and to improve patient/provider interactions.[17-26] The intended audience of these social stigma interventions included healthcare workers, medical students, nursing students, pharmaceutical students, and the general population (ibid). Social stigma interventions were also conducted in non-healthcare settings to evaluate stigmatizing perceptions and empathy among librarians and undergraduate students.[27,28] Furthermore, two community-based communication strategies to reduce stigma related to addiction were implemented with participants in mosques and incarcerated individuals.[29,30]

Institutional level stigma: Sixteen studies examined stigma at the institutional level. The majority of articles (14) introduced stigma-related curricula and training modules for healthcare workers and students in medicine, nursing, and pharmaceuticals to reduce stigmatizing attitudes and behavioural intentions to maintain social distance from PWUD.[31-44] Moreover, two studies explored institutional level stigma by assessing practices, experiences, and interactions in health care settings between hospital-based providers and patients.[45,46]

Population/Structural level stigma: Two studies delved into the population/structural level of stigma. The first focused on encouraging non-stigmatizing language for media/news outlets,[47] while the second study attempted to change empathy and stigma levels in the general public by introducing an empathy intervention and comparing it to a widely used training intervention and a control intervention.[48]

Multiple levels of stigma: Finally, six studies including reviews explored stigma across multiple levels, taking into account interventions targeting stigma at more than one of the identified levels.[36,45,49-52] By analyzing stigma at these various levels, the studies shed light on the complexities of stigma and provided insights into the diverse approaches taken.

Intervention Type and Impact

The studies included in the review employed various types of strategies to address substance use-related stigma. The definitions of each intervention type can be found in Table 2.

Table 2. Intervention types and definitions

Intervention Type	Definition
Language and terms	Aim to shape understanding and impact through resources that addressed appropriate language usage, public education on terms to use or avoid, and language guides for media/news outlets
Training/skills-based	Structured training tools with start and finish, including online modules, presentations, workshops, stories from PWLLE, videos, motivational interviewing, and self-guided learning programs, to educate participants about stigma reduction
General education	Building awareness about stigma and strategies to reduce it, often through presentations to students or staff
Increasing connection	Interventions that focus on increasing connections/contact between people who use drugs and staff, general public, etc.
Policy and practice-based	Introducing policies and standards focused on stigma reduction (e.g., changes to intake processes, integrating trauma informed approaches, working with PWUD)
Public campaigns and messaging	Interventions that focus on and represent messages, images, storytelling videos, commercials, and narratives of PWLLE and around substance use (i.e. framing of substance use, highlighting role of adverse childhood experiences, ACEs)
Multi-component	Records that review multiple types of interventions (e.g. interventions that combined training with contact-based education, and reflections throughout the training from participants)

Furthermore, of the 44 included studies, 38 articles included an evaluation component assessing the level of impact of their anti-stigma interventions.

LANGUAGE INTERVENTIONS

Four studies focused on language and terms.[13-15,47] Language interventions generally reduced stigmatizing attitudes and language use, but the impact varied across studies.

In one study, participants exposed to two versions of a survey featuring pre-modified (e.g., "addict") and post modified nouns (e.g., "people with addiction"), exhibited distinct responses.[13] Those with pre-modified versions demonstrated higher scores in stigmatizing authoritarianism (e.g., sentiments about the need to hospitalize, discipline, or control people with an addition) and social restrictiveness

(e.g., sentiments of dangerousness and the desire to maintain a social distance from people with an addiction), while scoring lower in benevolence and community mental health ideology.[13] Another study analyzed the impact of adopting a language-guideline stylebook in news outlets, finding that while the proportions of articles with proscribed terms decreased (e.g., the use of addict vs. people with addiction), the difference was not statistically significant.[47] Furthermore, research examined the effects of various terms on stigma reduction.[14] Notably, while exposure to the term 'chronically relapsing brain disease' correlated with the lowest blame attributions, it also led to higher perceptions of dangerousness, lower belief in recovery, and increased support for coercive policies, highlighting the complexity of stigma surrounding OUD and the need for careful terminology selection.[14] Moreover, a study investigating attitudes towards PWUD demonstrated that presenting ACEs was associated with decreased public stigmatization.[15] This study involved vignettes with description of the subject's condition, such as 'addict' vs. substance use disorder; and life history including 'tough life' vs. having experienced a list of ACEs including 'suffered physical abuse', 'neglect', 'mother victim of domestic violence', and 'father imprisoned').

Gender was considered in two studies that examined language use and attitudes.[14,15] In both studies, the authors distributed visual illustrations paired with language to investigate any differences in attitudes towards the illustrations based on gender (note: the analyses used the male/female sex binary in the visual illustrations). The first study[14] revealed notably harsher attitudes towards a woman displaying opioid-related impairment in contrast to a man, while the other study[15] found no significant attitude differences based on gender.

TRAINING/SKILLED-BASED PROGRAMS

Eighteen studies used structured skill-based training programs.[17-20,24-26,32,34,37,39,41,43,44,46,49,50,52] Training programs varied by length, approach (education, contact, or both), and delivery method (online or in-person). Most training programs were created for healthcare worker audiences including medical practitioners, and pharmaceutical, nursing, and medical students.[17-20,25,26,32,34,37,39,41,43,44,46,49,52] Training interventions have shown varying degrees of impact in reducing stigma towards individuals who use drugs or have substance use disorders. One review that assessed quality of interventions demonstrated that higher quality studies incorporated components such as motivational interviewing or communication training, along with mentorship or contact with individuals in recovery, which yielded notable results.[49] These interventions not only improved attitudes and communication skills among healthcare professionals and students, but also maintained gains in attitudes, perceptions, and behaviours at 12-month follow up.[49] Additionally, training, in both in-person and virtual settings, showed effectiveness for significant reductions in stigma and social distancing scores, and enhanced opioid overdose reversal knowledge/preparedness.[17,18,32] Among union workers, training interventions showed noteworthy impact by enhancing participants' knowledge, reducing stigma-related concerns about seeking help (e.g., recovery supports) for themselves and others struggling with addiction, increasing confidence, and improving the ability to assist coworkers with opioid use, ultimately fostering a stronger support system and crisis response within their union groups.[50]

The trauma and resiliency informed practice (TRIP) training program, aimed at reducing stigmatizing attitudes and behavioral intentions towards individuals with OUD, involves a one-day workshop and post-workshop coaching focused on mental health and resiliency through trauma-informed practice principles.[46] Delivered to health service providers, the program successfully resulted in a reduction of stigma from pre- to post-workshop evaluations.[46]

In addition, training programs including educational videos have demonstrated positive changes in nursing students' knowledge, attitudes, and stigma perceptions, especially in domains related to

familiarity, dangerousness, social distance, and motivation towards people with substance use disorders (SUD).[20,54] Notably, sustained changes in nursing students' attitudes and perceptions after receiving educational interventions were positively influenced by interacting with a person who uses drugs.[37]

Despite some differences in opinion toward best practices of harm reduction techniques, presentations and educational videos have contributed to positive shifts in knowledge, attitudes, and perceptions, indicating potential effectiveness in altering stigmatizing perspectives among healthcare professionals.[19] In some instances, no significant reduction was observed in self-reported stigma after stigma reduction training, particularly among healthcare providers. One study found that a stigma reduction intervention did not significantly impact primary care clinicians' stigma, intentions, but observed that higher stigma levels were associated with decreased willingness to work with such patients and a belief in the ineffectiveness of treatments, suggesting stigma may serve as a barrier to OUD care in primary care settings.[41] Similarly, among a sample of practitioners in behavioural health and primary care (e.g., social worker), there were no changes between baseline and 12-month scores on perceptions of SUDs and patients who use substances after participating in training on an evidence-based model of screening, brief intervention, and referral to treatment (SBIRT).[34] In contrast, a separate study evaluated the effectiveness of a training program involving 11 service providers in a pilot group.[26] The results showed a significant decrease in participants' mean scores for blame, avoidance, and segregation after completing the training, suggesting a notable shift in their stigma levels.[26]

In an evaluation report covering four programs, the Opening Minds Provider Attitudes Toward Opioid Use Scale (OM-PATOS) was employed to evaluate the attitudes and behavioral intentions of healthcare practitioners.[44] The first program, Understanding Stigma, is a web-based anti-stigma intervention for healthcare practitioners that incorporates social contact elements, demonstrating promise in reducing opioid-related stigma and suggesting potential enhancement through an opioid-specific module.[44] The second program, Stigma Ends with Me, is an in-person workshop by the Community Addictions Peer Support Association (CAPSA), and demonstrated reduced substance use-related stigma for various occupations.[44] The third program, an opioid use-specific social contact intervention for nursing students, yielded a moderate effect size in shaping attitudes and behaviors within a brief 1.5-hour session.[44] Lastly, the TRIP training at British Columbia's Fraser Health Authority, designed for direct service providers, showed improvements in stigma reduction with a medium effect size, emphasizing the benefits of trauma and resiliency informed practice.[44]

GENERAL EDUCATION

Five studies aimed to disseminate general education to members of the general public (e.g., rather than specific health professional audiences).[27-30,48] General education interventions included awareness videos with narratives, faith-adapted educational seminars, and peer-delivered videos.[28-30]

General education interventions aimed for specific audiences have demonstrated improvements in knowledge and attitudes towards people who use drugs. One study demonstrated that educational sessions improved librarians' understanding of how widespread substance use disorders are.[27] Moreover, awareness videos significantly reduced stigmatizing attitudes and perceived public stigma, while increasing empathy toward individuals with OUD.[28] The study categorized the videos based on factors like the narrator's race, ethnicity, gender, and story perspective; and despite variations, all awareness videos successfully reduced stigma and enhanced empathy for those with opioid use disorder.[28] Seminars held in a mosque led to increased addiction knowledge and decreased social stigma perceptions among local Muslims attending the mosque, as the open space facilitated communication about addictions and substance use.[29] Empathy-focused general education yielded

lower stigma scores among incarcerated individuals towards other incarcerated individuals, while a video intervention improved attitudes towards medication for opioid use disorder (MOUD).[30]

Race and time spent incarcerated were demonstrated to influence negative perceptions of medication for opioid use disorder (MOUD).[30] Attitude changes towards MOUD were influenced by race, showing greater increases in attitude scores post-intervention among non-Hispanic Black participants compared to non-Hispanic White participants.[30] Moreover, pre-video MOUD attitudes were also associated with baseline time incarcerated, with those incarcerated for less than a year having higher initial MOUD attitude scores, potentially indicating heightened MOUD stigma in the correctional setting (ibid). These findings underscore the critical role that race and incarceration experiences play in shaping attitudes towards MOUD, with a particular emphasis on the need for targeted interventions to reduce stigma within these spaces.

INCREASING CONNECTION

Additionally, three studies concentrated their anti-stigma work on increasing connections.[23,35,40] Strategies included PWLLE as speakers in seminars, adding a Q&A discussion with the audience, and attending alcohol anonymous (AA) meetings.

Interventions focusing on increasing connection have shown significant impacts on reducing stigma. Through pre/post intervention surveys, one study revealed notable improvements in stigma scores after a social contact intervention, while no differences were observed for the curricular content on mental illness and addiction; emphasizing shifts in understanding when PWLLE were sharing knowledge and experiences first-hand.[35] Another study identified attitudes of students after they visited an AA meeting, highlighting their deeper appreciation for the complex nature of addiction, resulting in a reduction of stigmatizing attitudes towards those with substance use disorders, and explicit intentions to apply gained insights in their medical practice.[40] Moreover, students from medicine disciplines (e.g., medical, nursing, pharmacy) attended patient panels, which included individuals with a history of OUD sharing their personal stories and facilitating a question and answer period.[23] The patient panel led to reduced stigma towards individuals with OUD for a majority of students, highlighting the potential for such experiences to reshape attitudes.[23] Many of these students noted that the panel reinforced their 'humanistic' views, increasing compassion, and decreasing bias and stigma, leading to a decrease in stigma and stereotypes for patients on the panel and other individuals experiencing addiction, while also highlighting the value of hearing real patient stories and narratives and learning about treatment and recovery options.[23]

POLICY AND PRACTICE-BASED

One study implemented an addiction consultation service (ACS) including trauma-informed approaches while working with PWUD to reduce stigma among hospital-based providers.[45]

The findings from this study demonstrate policy and practice-based factors that either enhance or reduce stigma towards individuals who use drugs.[45] Hospital-based provider focus groups and patient interviews revealed four key themes: the influence of past experiences in healthcare on perpetuating stigmatization cycles between providers and patients; the role of medical chart documentation in unintentionally or intentionally reinforcing enacted stigma among providers; the positive impact of an ACS in reducing enacted stigma among providers by facilitating evidence-based SUD treatment and reshaping the narrative around SUD; and emphasizing the pivotal role played by ACS team members in helping hospitalized SUD patients overcome internalized stigma by promoting self-worth, self-efficacy, and mutual respect.[45]

PUBLIC CAMPAIGNS AND MESSAGING

One study implemented an addiction consultation service (ACS) including trauma-informed approaches while working with PWUD to reduce stigma among hospital-based providers.[42] Exposure to OUD-related messages delivered by visual campaigns and narrative vignettes (e.g. display of terms to encourage the use of non-stigmatizing language), when combined, led to decreased stigma levels and shifts in perceptions among health care professionals, underlining the role of visual messaging in altering attitudes.[42]

MULTI-COMPONENT INTERVENTIONS

Eight studies conducted reviews examining and reviewing multiple interventions across different levels to gain comprehensive insights into their impact on stigma reduction.[21,22,31,36,38,51,52,54] Among these reviews, five assessed interventions that combined several components to reduce stigma, including training with contact-based education, and reflections throughout the training from participants.[21,31,33,38,52]

Diverse multi-component approaches have demonstrated impactful reductions in stigma towards PWUD. The integration of training and contact-based education in a nursing curriculum resulted in heightened awareness of stigma's impact on individuals and nursing practice, with students and nurses committing to ethical, collaborative, and person-centred approaches to care following the multi-component intervention.[31] Similarly, educational forums paired with a panel discussion of PWLLE led to significant shifts in attitudes towards opioid use and reduced stigmatizing beliefs, fostering understanding and empathy among a sample of students.[21] In addition, the highest quality studies in two systematic reviews included interventions that combined communication training and contact with individuals in recovery from SUDs, demonstrating sustained improvements in attitudes and communication skills and indicating the potential for long-lasting impact.[38,53] Similarly, another study demonstrated that multi-component interventions encompassing contact-based approaches, organizational planning, and innovative education yielded measurable reductions in stigmatizing attitudes towards substance use, highlighting the effectiveness of these multi-faceted approaches among healthcare workers.[52] An additional multi-component intervention included an educational intervention that was facilitated by peer support workers with lived/living experience.[22] Following the intervention, participants showed significant improvements in personal perceptions and on their beliefs about others' views toward people who use opioids.[22]

In a systematic review, a variety of studies adopted strategies including information-based education, skills building, individual-level counselling and group support which contributed to stigma reduction towards PWUD.[51] In this review, the most common stigma reduction strategies involved information-based and skills building approaches, which included education to enhance drug use knowledge, or the effect of stigma manifestations on health and well-being.[51] One study within the review used an online contact intervention featuring a short three-to-five minute video where individuals who use drugs shared their real-life experiences of encountering discriminatory attitudes or anticipated stigma in community and healthcare settings, resulting in a notable reduction in negative attitudes and discrimination among the Australian general public towards these populations.[51] In contrast, interventions targeting different stigma types (self, structural, and social) revealed mixed effects on reducing stigma in one study, suggesting the complexity of these interventions' impacts.[36]

Discussion

This review examined interventions to address stigma at different levels, and evaluated the effectiveness of these studies. Interestingly, there were no articles that mainly focused on individual-level stigma, signaling a clear gap in research and interventions. Interpersonal and social-level stigma interventions primarily addressed language impact and training sessions aimed at diverse audiences, including healthcare workers, students, and the general population. Similarly, institutional-level interventions predominantly introduced curricula and training for healthcare professionals to address stigmatizing practices. Population/structural-level efforts involved initiatives like advocating for non-stigmatizing language in media and improving empathy and reducing stigma levels in the general public. Additionally, several studies explored interventions targeting stigma across multiple levels of interaction, highlighting the multifaceted nature of stigma and the need for diverse strategies of stigma reduction.

The findings highlight the potential of diverse interventions to address the complexity of substance use stigma and target reductions at multiple levels of stigma related to substance use. While there was evidence for reduced stigmatizing attitudes, behaviours, and practices among study participants across studies, the complexity of addressing stigma emerged, with mixed or insignificant results of stigma reduction in many cases. These insights offer valuable guidance (e.g., reproducible research studies in specific contexts, strategies which have higher likelihood for effectiveness compared to others, potential considerations or targeted strategies to address stigma within a particular population/group of individuals) for creating more supportive environments for individuals who use drugs and addressing the multifaceted challenges of stigma and discrimination.

Language interventions have demonstrated potential in mitigating stigma towards individuals who use drugs, with effects varying between studies.[13-16,47] While some interventions yielded reduced stigmatizing attitudes and language use, the outcomes were mixed, underscoring the complexity of addressing stigma in this context. Given the multifaceted nature of stigma, no single term adequately encompasses its various dimensions, and different terms come with trade-offs. Lie's critique of the dominant Chronic, Relapsing Brain Disease (CRBD) model for OUD/SUD underscores its potential to perpetuate stigma and inequalities, suggesting a paradoxical impact of decreasing blame while potentially garnering support for coercive policies (e.g., forced threatened, deepened criminalization).[55]

Not all training interventions resulted in significant changes, and some findings highlighted the complexity of addressing stigma.[17-20,24-26,32,34,37,39,41,43,44,46,48,49,54] While most interventions produced statistically significant improvements, smaller sample sizes might have influenced the outcomes. Overall, these studies demonstrate the impacts of training interventions on reducing stigma associated with substance use, though the extent of this impact varies depending on the specific approach (e.g. using combined interventions, in-person or virtual, the incorporation of follow-up phases) and context (e.g. institutional/occupational support, personal experience with someone with lived/living experience of substance use).

General education interventions for specific groups have demonstrated significant positive effects on knowledge and attitudes, such as enhancing understanding of substance use commonality.[27-30,47] Additionally narrative-based videos have notably reduced stigmatization towards opioid use disorder and improved attitudes towards medication for OUD, underscoring the importance of tailoring interventions to address diverse perspectives and unique circumstances within different populations.[28,30] The evidence underscores the significance of interventions aimed at fostering connection in reducing stigma towards individuals who use drugs or have SUD.[23,35,40] The impact is evident through pre/post intervention surveys showing improved stigma scores after social contact

interventions. There is a need to also consider community-led interventions, particularly those led by people who use drugs (such as photovoice and cell film projects) as they play a vital role in demystifying PWUD and destigmatizing harm reduction initiatives.

The insights gathered from the practice and policy-based intervention emphasize the importance of implementing addiction consultation services with trauma-informed approaches in hospitals to create a supportive environment for individuals with substance use disorders, recommending the integration of education to reduce stigma into the clinical practice of all providers.[45] Additionally, access to in-hospital addiction experts, using evidence-based medications, and adopting person-first language in medical charts are suggested strategies to further reduce stigmatizing interactions in hospital settings.[45]

Finally, multi-component interventions (reviews or interventions that contain multiple strategies to address multiple levels of stigma) have significantly reduced stigma related to substance use disorders by integrating training and education strategies, as well as increasing connection with PWLLE to encourage spaces of knowledge-sharing. These approaches have led to increased awareness, shifted attitudes, improved empathy, and changed beliefs and practices among various populations, demonstrating the potential for sustainable and impactful reductions in stigma.[21,22,31,36,38,51,52,54]

In addition to adopting the appropriate intervention, incorporating an intersectional lens into anti-stigma strategies is crucial as it recognizes the diverse and interconnected layers of identity and experience that individuals possess. By considering factors such as gender, occupation, concurrent stigmatized illnesses like HIV, and religion, interventions can better address the unique ways in which stigma intersects and compounds, leading to more effective and tailored strategies. For instance, gender analyses revealed divergent attitudes towards individuals with opioid-related problems, with gender differences affecting perceptions of stigma.[14,15] Similarly, targeted anti-stigma efforts for individuals in occupations with high physical demands and injury risks have demonstrated positive knowledge changes and reduced stigma concerns among participants, effectively enhancing the ability to support co-workers struggling with opioid use.[48] Findings on stigma experiences of Muslim populations in Canada underscored the potential for open dialogue and safe spaces to address addiction stigma within faith-based communities, as witnessed in the transformation of a mosque into a platform for addiction discussions.[29] The discussed barriers included a more complex fear of stigma due to fear and shame of judgment and ostracizing from their communities, and fear of discrimination from non-Muslims in addition to the stigma of addiction in itself.[29] Lastly, examining race-related differences and time incarcerated uncovered variations in attitude changes towards MOUD.[30] These studies acknowledge that individuals do not experience stigma in isolation, and by acknowledging these intersecting aspects, interventions can more comprehensively address the multifaceted challenges of stigma and discrimination.

Current knowledge on the implementation and evaluation of anti-stigma interventions for substance use stigma faces several gaps and challenges. For instance, this review identified a scarcity of multi-level stigma interventions specifically addressing substance use. To address these challenges, there is a need for institutional support for active community engagement (e.g., inclusion in decision-making) and changes at provincial and national levels to promote accountability through the inclusion of measurement of community engagement efforts in analytic plans.[56] In addition, there is also a need for concerted efforts for those in positions of power and privilege to support the initiatives and movements of PWUD. Finally, community engagement, done well, is critical for effective stigma reduction activities, including the involvement of PWUD in the designing, delivering, and evaluating of services and supports.[56,57] The term "meaningful" engagement is often overused and has consequently lost its genuine significance. Authentic community engagement requires the investment of time, effort, and the gradual building of relationships to foster trust, leading to effective stigma reduction over time.

Implications

Consultations by Public Health Ontario (including community and collaborative initiatives across Ontario), have identified stigma as a priority and cross cutting component for strengthening local capacity to respond to the worsening drug toxicity crisis. Therefore, anti-stigma interventions can be integral to supporting the wellbeing and health of people who use drugs. As discussed, a wide range of interventions have potential for positive changes in anti-stigma efforts. Anti-stigma work can be implemented at multiple levels of interaction, (individual, interpersonal, institutional, population) and may aim to reduce stigmatizing attitudes, perceptions, behaviours, and practices. However, implementation considerations and adaptation needs are important in terms of the context for intervention, type and level of intervention, mode of delivery, and partnership in delivery.

Limitations

The emphasis on peer-reviewed and grey literature sources could have hindered the inclusion of valuable community-based efforts that remain unrecorded. The use of systematic reviews may have also meant that there was a lack of detail of the interventions included and evaluated. In addition, our concentration on three databases for screening might have limited the extent of relevant articles identified. Furthermore, in this review, we did not undergo quality appraisal of the included articles due to time constraints, potentially including studies with less rigour in their methodology.

Our search terms were specific to opioid or substance use, and therefore did not include articles that evaluated or addressed stigma for people who reported only alcohol, tobacco, or cannabis use. Furthermore, there was limited focus on intersectionality despite the importance of adopting an equity lens in substance use work, particularly around criminalization and discrimination.

Conclusion

The rapid review encompassed studies from 2019 to 2023, examining interventions to reduce stigma related to substance use across various settings and populations. We highlighted the ways in which interventions addressed stigma at a range of levels starting with individual and moving into population/structural levels, with the hope of prompting reflections from groups and organizations on areas of anti-stigma action to explore and/or prioritize. These findings describe a range of interventions that collectively underscore the multifaceted nature of stigma and the need for multi-level aims to observe stigma reduction. They also highlight the importance of understanding the nuances underlying stigma in our efforts to address it.

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Citation

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Community Opioid/Overdose Capacity Building

Community Opioid/Overdose Capacity Building (COM-CAP), started in 2019, is a four-year project funded by Health Canada's Substance Use and Addiction Program. The goal of COM-CAP is to support community-led responses to opioid/overdose-related harms in communities across Ontario. The supports focus on strengthening the knowledge, skills, and capacity of the key stakeholders involved.

- The Ontario College of Art & Design University (OCAD U) - Health Design Studio

- University of Toronto- Strategy Design and Evaluation Initiative

- Black Coalition for AIDS Prevention

- Chatham-Kent Public Health

- NorWest Community Health Centres

- Drug Strategy Network of Ontario

- The Ontario Network of People Who Use Drugs

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