Ending Stigma for Whom? A Critical Community-Based Participatory Research Project to Examine Canadian Substance Use-Focused Anti-Stigma Campaigns

by

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Abstract

In the escalating crisis of drug toxicity deaths in Canada, reducing stigma towards people who use drugs (PWUD) has emerged as a priority, and mass media substance use-focused anti-stigma campaigns have become a popular intervention; however, the harms experienced by PWUD are distributed inequitably and shaped by structural stigma (e.g., racism, classism). So, who are these anti-stigma campaigns really for? Drawing on critical theorizations of stigma, this dissertation utilizes a community-based participatory research approach to examine how PWUD are represented in Canadian substance use-focused anti-stigma campaigns, as well as the potential implications for marginalized PWUD. Study one examined the prevalence, timing, and location of substance use-focused anti-stigma campaigns across Canada and tracked patterns in how PWUD were represented. A comprehensive review identified 134 Canadian substance use-focused anti-stigma campaigns from 2009-2020. Systematic visual and textual analysis of these campaigns found that they tended to centre White-appearing, middle-upper class PWUD and frequently included concepts of stigma and anti-stigma strategies (e.g., "addiction does not discriminate") that individualized the problem of stigma and obscured the structural inequities (and intersecting systems of oppression) that shape substance use-related harms. Study two critically examined the potential implications for marginalized PWUD of anti-stigma campaigns that centre White, middle-class PWUD. Eight focus groups were conducted with marginalized PWUD (e.g., Indigenous, poor) who analyzed two examples of mainstream anti-stigma campaigns (Stop Overdose BC, End Stigma). Reflexive thematic analysis revealed how some participants hoped the campaign message that "anybody" could be a PWUD might benefit them by addressing the stereotypes associating substance use with their other marginalized social identities (e.g., Indigenous, poor). However, participants also critiqued the campaigns for purposely excluding representations of PWUD like them and ignoring the forms of stigma that PWUD like them faced. Participants worried that campaigns like these could exacerbate the stigma and exclusion they face by negatively contrasting marginalized PWUD like them with the privileged PWUD represented in the campaigns. This dissertation recommends that anti-stigma interventions more deeply reckon with how substance use stigma intersects with other systems of oppression and work towards addressing structural inequities at the heart of the drug toxicity crisis.

Keywords: substance use stigma; anti-stigma campaigns; substance use health inequities; health communication; drug toxicity crisis; overdose

Dedication

For their friendship, mentorship, practical assistance with this dissertation project and all the laughter and wisdom they shared with me so generously, I dedicate this to three of my community collaborators who tragically lost their lives: Sandra Czechaczek (1964-2019), Boomer Bundy (1963-2023), and Earl Greyeyes (1951-2023). I also dedicate this work to all those who have died from toxic drugs, from toxic drug policy, and from toxic stigma, and to all who continue to resist stigma where they see it.

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List of Acronyms

2SLGBTQIA	2-Spirited, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual
ARYS	At-Risk Youth Study
BCAPOM	British Columbia Association of People on Opiate Maintenance
BCCSU	British Columbia Centre on Substance Use
CAB	Community Advisory Board
CBPR	Community Based Participatory Research
CCSA	Canadian Centre on Substance use and Addiction
DTES	Downtown Eastside
FNHA	First Nations Health Authority
MMHA	Ministry of Mental Health and Addictions
ODPRN	Ontario Drug Policy Research Network
PHAC	Public Health Agency of Canada
PRA	Peer Research Assistant
PWUD	People Who Use(d) Drugs
PWLLE	People With Lived and Living Experience
SIA	Social Identity Approach
VANDU	Vancouver Area Network of Drug Users
WAHRS	Western Aboriginal Harm Reduction Society

Chapter 1.

Introduction

Since at least 2016, Canada has been experiencing an escalating crisis of deaths due to the unregulated, unpredictable, and ultimately toxic supply of illicit opioids and stimulants. The unknown and powerful potency of synthetic opioids such as fentanyl and its analogues in the illicit drug supply has claimed many thousands of lives to date in this "drug toxicity crisis[1]" of unprecedented severity and scale in Canada. According to national data, 38, 514 people died of apparent opioid-related toxicity in Canada from January 2016 to March 2023 (Public Health Agency of Canada, PHAC, 2023). In 2016, when national surveillance data collection on apparent opioid toxicity deaths began, 2831 individuals died in this way, a national rate of 7.8 deaths per 100, 000. In 2022, 7483 individuals died of apparent opioid toxicity in Canada, a national rate of 19.5 deaths per 100, 000 (PHAC, 2023).

As deaths due to toxic drugs have escalated, stigma towards people who use drugs (PWUD) has increasingly been acknowledged for its fundamental role in this public health crisis (Corrigan & Nieweglowski, 2018; Fischer, 2020; National Academies of Sciences, Engineering and Medicine, NAS, 2016; PHAC, 2019; Tsai, et al, 2019). In short, stigma, often defined broadly as a mixture of prejudice, stereotypes and discrimination towards PWUD, has been positioned as heightening the risk of health harms for PWUD by making it more likely an individual will hide their substance use from

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[1] While the escalating crisis of deaths due to drugs was initially referred to as an "opioid crisis", increasing deaths amongst people who mainly use stimulants suggests it is instead a crisis of toxic drug supply driven by adulteration with powerful synthetic opioids, primarily fentanyl and analogues such as carfentanil (Ciccarone, 2017; Government of Canada, 2023a), and more recently illicit benzodiazepines (e.g. etizolam, xylazine, Friedman, et al., 2022; Laing, et al., 2021). The term "overdose crisis" has also been well-used in public discourse but has been criticized by PWUD as inaccurate for implying that people have intentionally "taken too much" of a substance when in reality the majority of "overdose" experiences are accidental and result from ingesting substances whose unknown potency is a result of the unregulated nature of the illegal drug market. The terms "drug toxicity deaths" and "drug toxicity crisis" will be used throughout this dissertation as they more appropriately describe the reality of the crisis as rooted in the unregulated drug supply (i.e., a prohibition policy choice) rather than a specific substance (opioids) or user behavior (overdose).

others, less likely someone will seek help or treatment if their substance use becomes problematic (e.g. a substance use disorder), and less likely that life-saving services for PWUD or policy changes that may increase safety for PWUD will be supported by governments and the public (Government of Canada, 2023b; Tsai, et al., 2019). In response, many governments, organizations, and other stakeholders have initiated mass media anti-stigma campaigns aimed at improving public attitudes towards PWUD.

But how does this recent turn towards stigma reduction as a priority, and anti-stigma campaigns as a solution, fit within the wider history of drug policy (and substance use stigma) in Canada? Like many countries, Canadian drug policy has its origins in the colonial, racist and classist exclusion of marginalized communities vis-à-vis the criminalization and stigmatization of their substance use (Boyd, 2017; Carstairs, 1999; Malleck, 2015). Stigma towards PWUD is not random or natural; it is a policy choice driven by the criminalization of illicit substances and those who use them (Scher, et al., 2023). The persistent inequities in substance use health across Canada (e.g., over-representation of Indigenous peoples and people with lower incomes in drug toxicity deaths, Carriere, et al., 2021; van Draanen, et al., 2023; First Nations Health Authority, FNHA, 2021) are a testament to the ongoing impacts of drug policies, especially criminalization and enforcement, that disproportionately and negatively impact PWUD who are marginalized by their racial and class identities. If these inequities are themselves rooted in policy choices and driven by systems of stigma and exclusion, how might anti-stigma interventions play a part in addressing them? The recent upsurge of substance use anti-stigma campaigns in response to the growing epidemic of drug toxicity deaths requires a critical analysis of how, and for whom, these interventions are intended to reduce stigma.

Before laying out the objectives of this dissertation I will first review the social status of PWUD as a disadvantaged and stigmatized group, social psychological and sociological perspectives on stigma and public health research on the role of stigma as a risk factor for drug toxicity death. This is followed by a review of the intergroup context of substance use stigma, along with its intersections with other systems of oppression, and the introduction of a critical perspective on substance use stigma that views stigma as a tool used by those with power to maintain unequal intergroup relations. Turning back to the context of Canadian substance use-focused anti-stigma campaigns, I briefly review how stigma became a priority within the worsening drug toxicity crisis in Canada, and how anti-stigma campaigns were mobilized in response. This is followed by a critical discussion of how these forms of mass communication may contribute to public discourse about substance use, the problem of stigma, and constructions of PWUD who are seen as more or less deserving of compassion and support.

1.1. People Who Use Drugs as a Low Status Group

In Canada, the United States, the United Kingdom and indeed most countries around the world, PWUD are constructed as a low status group that is extremely vilified within society (Global Commission on Drug Policy, 2017; Lloyd, 2010, 2013; Manthey, et al., 2023; Yang, et al., 2017). Indeed, PWUD are routinely identified as one of the most despised groups in society, owing to a combination of normalized mistrust, disgust, dehumanization, perceptions of dangerousness, narratives of individual moral culpability, and association with infectious diseases (HIV/AIDS, Hepatitis C, etc.) commonly attached to this social category (e.g. Blendon & Young, 1998; Harris & Fiske, 2006; Kulesza, et al., 2014; Nieweglowski, et al., 2018; Smith, 2010). A 2014 online survey of attitudes towards people with “drug addiction” in the United States found that large majorities of respondents endorsed measures of social distancing from PWUD (e.g., 90% opposed a person with a drug addiction marrying into their family) and supported blatant discrimination against PWUD including denying employment and housing based on a person’s perceived dependence on substances (Barry, et al., 2014). A 2018 online survey with a nationally representative U.S. sample found that large majorities of respondents agreed that people who use opioids are “worthless” and “weak” and reported that they did not want a person who uses opioids to marry into their family or start a job working alongside them (McGinty, et al., 2018). In Canada, 25% of respondents in an Angus Reid national poll reported having no sympathy for people who are dependent on substances and 35% felt PWUD would merely “take advantage” of increased government assistance if it were offered (The Salvation Army, 2012). As recently as 2021 a nationally representative survey commissioned by Health Canada found that one quarter of Canadians surveyed agreed “I don’t have much sympathy for people who misuse opioids” and slightly less than one third agreed that “A lack of self-control is usually what causes a dependence upon or an addiction to opioids” (Earnscliffe Strategy Group, 2022).

These persistent and powerful negative attitudes towards PWUD can be explained in part by the uniqueness of anti-drug user sentiment (Corrigan, et al., 2017a). Stigma towards PWUD is unlike other present-day group-based social stigmas (e.g., towards people with mental illnesses, gender and sexual minorities, non-White racial groups etc.) in that it remains, for the most part, legally sanctioned by governments via drug criminalization and socially accepted more generally within society at large (Barry, et al., 2014; Corrigan & Nieweglowski, 2018). For example, explicit discrimination towards PWUD is not against the law and the criminalization of illicit substances can be seen to legitimize the maltreatment of PWUD by police, health care workers and the general public (Corrigan, et al., 2017a; Corrigan & Nieweglowski, 2018; Scher, et al., 2023). The fact that prejudiced attitudes towards PWUD are widely accepted within most societies is arguably the result of the long, brutal, and ongoing “war” on drugs and the people who use them (Boyd, et al., 2016; Buchanan & Young, 2000).

1.2. Substance Use Stigma and the Drug Toxicity Crisis: Interpersonal, Intrapersonal and Intergroup Impacts

Stigma has most famously been defined as a “discrediting mark” or “spoiled identity” (Goffman, 1963) that marks others as negative and different, either as individuals or group members. In the more collective terms of Social Identity Theory (Tajfel & Turner, 1979), stigma can be related to the theoretical concept of “negative distinctiveness” associated with a social category: certain groups are marked by other, more powerful groups, as both different (distinctive) and worse (negative) in the social comparison of an intergroup context where ingroup members are motivated to improve their group’s status by derogating the status of other groups (Reicher, 2007; Reicher, et al., 2010). Sociological theorizations of stigma broadly align with social psychological theorizations of prejudice (Phelan, et al., 2008), though in both realms critical reconceptualizations of stigma/prejudice have urged a turn towards understanding the origins, motivations, and functionality of stigma for people with power (Link & Phelan, 2014; Parker & Aggleton, 2003; Pescosolido & Martin, 2015; Reicher, 2007; Tyler & Slater, 2018; Tyler, 2018, 2020). In public health contexts, stigma is typically examined in terms of its health impacts between (interpersonal) or within (intrapersonal) individuals and understood as a combination of the negative attitudes, stereotypes and discrimination experienced by people (e.g., PWUD) whose group memberships are of low status in a given social context (Earnshaw, 2020; Link & Phelan, 2001). In the next sections I briefly review research on the impacts of substance use stigma experienced at the interpersonal (public stigma) and intrapersonal level (self-stigma), before turning attention towards some consideration of "structural stigma" and its impacts at the intergroup level.

1.2.1. Interpersonal and Intrapersonal Impacts of Substance Use Stigma

A large body of research in social psychology has demonstrated the negative direct effects of experiencing group-based stigma and prejudice for well-being, with these effects found to be especially negative for disadvantaged minority groups and strongest for groups such as those experiencing mental illness or other chronic health conditions, such as HIV, obesity, or physical disability (Schmitt, et al., 2014). A systematic review of 28 studies examining the relations between various levels of stigmas associated with substance use and health outcomes found a consistent, direct, negative relationship between the perception of stigma towards PWUD and psychological well-being (Kulesza, et al., 2013). Two large-scale cross-sectional studies from Australia's National Illicit Drug Reporting System demonstrate that people who inject drugs (PWID) regularly experience discrimination for their drug use across a wide range of settings (e.g. pharmacies, health care, social services) and that more frequent discrimination was correlated with risky injecting practices, an increased risk of overdose, decreased psychological well-being and decreased mental and physical health (Couto e Cruz, et al., 2018a; Couto e Cruz, et al., 2018b; Couto e Cruz, et al., 2019). While research in this area is growing, there remains a dearth of research on stigma towards PWUD, explained in part by the historical, and ongoing, widespread social acceptance of this stigma by the general public and stigma researchers alike (Corrigan, et al., 2017a; McGinty & Barry, 2020).

In addition to its harmful direct effects on well-being, stigma towards PWUD exacerbates the health and social harms associated with the use of illicit substances (International Network of People Who Use Drugs, INPUD, 2014a; Tindal, et al., 2010). Stigma has arguably contributed to the drug toxicity crisis by stalling progress on the implementation of potentially lifesaving harm reduction interventions (Bennett & Larkin, 2018; Dear, 1992; McGinty, et al., 2018; Smith, 2010; Strike, et al., 2004), limiting access to opioid agonist therapies such as methadone or buprenorphine (Leshner &

Dzau, 2019; Wakeman & Rich, 2018), exposing PWUD to direct discrimination and violence in the form of exclusion from housing, healthcare, employment and public space (Bennett & Larkin, 2018; Collins, Boyd, et al., 2018; Fleming, et al., 2019; Fraser, et al., 2017; Goodman, et al., 2017), discouraging disclosure of substance use to others and thereby increasing the likelihood of using drugs alone and dying from drug toxicity (Corrigan & Nieweglowski, 2018; Couto e Cruz, et al., 2018b; Fraser et al., 2017; NAS, 2016), and, when stigma is “internalized” (i.e. when a PWUD comes to believe stigmatizing narratives about themselves because of their substance use), reducing the likelihood that PWUD will access available medical care or harm reduction services (Rivera, et al., 2014; Wu, et al., 2011) or successfully enter and complete addiction treatment (Ashford, et al., 2019; Corrigan, et al., 2016; Keyes, et al., 2010; Radcliffe & Stevens, 2008). Furthermore, stigma towards PWUD persists as a barrier to the implementation of evidence-based harm reduction policy to promote public health, reduce harm and prevent drug toxicity deaths (Fischer, 2020; INPUD, 2014a, 2014b; McGinty, et al., 2018; NAS, 2016; Tsai et al., 2019). For example, people with highly stigmatizing attitudes towards people with a prescription opioid use disorder (OUD) have been found to be more likely to support punitive policies (e.g., “Arrest and prosecute people who obtain multiple prescriptions from different doctors”, Kennedy-Hendricks, et al., 2017).

1.2.2. Intergroup Impacts of Substance Use Stigma

In addition to the most commonly emphasized “public stigma” (i.e. the stigmatizing attitudes, beliefs, and actions of the general public towards PWUD) and the potential for internalization of this public stigma (e.g. PWUD concealing or feeling ashamed of their drug use), scholars have identified “structural stigma” (i.e. stigma embedded in laws, policies or social norms at a structural or systemic level) as a fundamental driver of health inequities related to stigmatized behaviors such as the use of illicit drugs (Hatzenbuehler, et al., 2013; Hatzenbuehler, 2018; Tsai, et al., 2019). Examples of structural stigma may include harsh, “tough on crime” drug policies that disproportionately criminalize, incarcerate, and otherwise target racialized, Indigenous, and low-income communities (Fraser, et al., 2017; Scher, et al., 2023; Seear, et al., 2017), exclusionary policies that target PWUD for surveillance and refusal of essential health and social services (Hawk, et al., 2022; Livingston, 2020; Murney, et al., 2020;

Meyerson, et al., 2020) or the wider systems of oppression built into society such as racism, colonialism, sexism, classism and cis-heteronormativity (Hatzenbuehler, 2018). As Hatzenbuehler and colleagues (2013) have argued, the unequal distribution of the effects of structural stigma is a “fundamental cause” of population level health inequities.

The impact of structural stigma on producing substance use health inequities is readily apparent in the heightened risk of drug toxicity death for members of marginalized subgroups who use drugs. For example, in British Columbia (BC) from 2015 to 2016, Indigenous people (who suffer the structural stigma of a legacy of colonial policies such as residential schools, attempted genocide and the dispossession of land that deeply fractured and disadvantaged Indigenous communities) were approximately five times more likely than non-Indigenous people to experience drug toxicity, and approximately three times more likely to die from accidental drug toxicity (First Nations Health Authority, FNHA, 2017). Similarly, data from Statistics Canada shows that economically marginalized people (i.e., those utilizing social assistance or with little or no employment in the past five years who face structural stigma related to classism and policies designed to perpetuate rather than alleviate poverty, Swanson, 2001) were over-represented in a cohort (2007-2016) of 3128 overdose deaths in BC (Schellenberg, et al., 2019). Men are persistently over-represented in overdose deaths (PHAC, 2023), yet cis-women and people who identify as transgender also experience significant harms and vulnerabilities with the context of the drug toxicity crisis due to gendered power imbalances, sexual violence and transphobia intersecting with stigma towards PWUD (Boyd, et al., 2018; Boyd, 2019; McNeil, et al., 2014). While stigma (most often defined broadly at the interpersonal and intrapersonal level) around substance use has gained prominence as an explanatory narrative for rising numbers of drug toxicity deaths, it is clear that substance use health harms in the drug toxicity crisis have not impacted all groups equally. This suggests that the unequal intergroup experiences of substance use stigma, and the resulting health inequities, are driven by the complex intersections of substance use stigma with racism, classism, and other systems of oppression.

1.3. Intersectionality and Stigma Towards Marginalized Subgroups of PWUD

Importantly, PWUD are not a homogenous group and experiences with stigma and discrimination are not experienced in the same way or to the same extent by everyone who uses illicit substances. For example, the superordinate category of people who are criminalized and stigmatized for their use of substances is comprised of many intersecting and overlapping social categories determined by age (e.g. younger vs. older PWUD), gender (e.g. male vs. female), frequency and amount of drug use (e.g. people with a substance use disorder vs. people who use recreationally), genesis of use (e.g. to cope with adversity vs. for fun and pleasure) drug of choice (e.g. users of powder cocaine vs. crack cocaine; stimulant users vs. opiate users), method of consumption (e.g. smoking, snorting, swallowing or injecting), method of attainment (e.g. engaging in sex work vs. engaging in petty crime to generate income to purchase drugs), and recovery approach (e.g. complete abstinence vs. use of medications for opioid use disorder vs. abstinence not a goal) (Sibley, et al., 2023). While recent qualitative research by Sibley and colleagues (2023) has begun to examine the intragroup dynamics amongst these demographic and behaviorally defined subcategories of PWUD (including stigmatization between subgroups of PWUD, see also Sibley, et al., 2020; Simmonds & Coomber, 2009) one limitation is its focus on White PWUD living in rural areas and mostly using opiates. Less research has examined the intergroup dynamics between subgroups of PWUD differentiated by racialization and class (e.g., White middle-class PWUD vs. poor Indigenous PWUD).

When an individual's drug use intersects with other marginalized identities (e.g., racialized groups, gender non-conforming or queer folks, people who are low-income, people who are homeless, people with other health comorbidities), the effects of stigma are qualitatively different from either stigmatized identity on its own, and often much worse (Bowleg, 2012; Crenshaw, 1993). In an experimental study, Kulesza and colleagues (2016) found that participants demonstrated a significant increase in "addiction stigma" towards a Latinx person compared to a White person represented as a person who injects drugs. These findings are supported by qualitative research on the link between intersectionally stigmatized group memberships (including PWUD) and health inequities. For example, a community-based study with the *Western Aboriginal Harm Reduction Society (WAHRS)* in Vancouver's Downtown Eastside (DTES) neighborhood documented how Indigenous people who use illicit drugs and alcohol are routinely stereotyped as drug-seeking, denied adequate health care, and discriminated against based on their substance use, racialized identities and residence in the stigmatized neighborhood of the DTES (Goodman, et al., 2017). In another qualitative study, women receiving opioid agonist therapy in the UK with intersecting stigmatized identities that included being a woman, being identified as a drug user, being positive for sexually transmitted infections (STIs), experiencing homelessness and engaging in sex work, were found to experience social isolation as a result and to have internalized their low status to a certain extent, refraining from engaging in health care as a result of not feeling like they deserved to be healthy (Medina-Parucha, et al., 2019).

Historical analyses of the origins of drug criminalization in Canada and the United States describe how prohibitive drug laws were originally developed in part to justify the exclusion of racialized peoples from White society by associating them with newly-created narratives of the moral corruption and chaotic danger that accompanied drug use (Boyd & Carter, 2010; Boyd, et al., 2016; Carstairs, 1999; Hansen, et al., 2023; Herzberg, 2020). For example, the earliest drug criminalization law in Canada was enacted in the wake of a 1907 race riot in Vancouver. Members of the Asiatic Exclusion League destroyed Vancouver's Japantown and parts of Chinatown as an expression of wider anti-Asian sentiments at the time[2]. When federal Deputy Minister of Labor Mackenzie King visited Vancouver in the wake of the riot's destruction, he was alarmed to glimpse the size of the Chinese opium importation and manufacturing business, how it enriched certain Chinese businessmen, and how it may be causing negative impacts for both the Chinese community and White community in BC. With some prodding from local Chinese anti-opium campaigners, and taking inspiration from sensational local news stories highlighting the dangers of opium for White women in particular, King drafted a report to parliament arguing that the opium business (and its Chinese associations) presented a moral threat to Canadian society, and should be curtailed. Shortly after, parliament adopted Canada's first federal anti-drug law (the 1908 Opium Act) to specifically criminalize the importation, manufacture, and sale of opium. While this initial law did not criminalize the use or possession of opium by individual users, it did in practice exclusively target Chinese businesses who at the time where the only

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[2] White labour's racial resentment had been building towards Chinese labourers for some time, and Japanese labourers more recently. White labour unions and organizers were incensed by the very low wages that Japanese and Chinese labourers would agree to work for (since unlike White laborers in BC, they typically did not have families to support and could live quite frugally) which White labourers could not accept. In line with racial prejudices at the time, it was the labourers willing to work for low wages who were targeted, rather than the (White) owners of industry who sought to exploit cheap labour (Boyd, 1984; Carstairs, 1999; Solomon & Green, 1982).

group profiting from the importation, manufacture, and sale of opium (Solomon & Green, 1982). The law did nothing to curtail the larger, primarily White-operated patent medicine manufacturing and sale businesses that many have argued were at the time contributing to far greater levels of opiate addiction (i.e., to liquid morphine) amongst primarily White, middle-upper class women (Boyd, 1984; Boyd, et al., 2016; Carstairs, 1999; Solomon & Green, 1982). As one senator commented during the 1908 debate on the Opium Act, the law would not have passed so easily if it had instead targeted an industry primarily "carried out by White people" rather than Chinese people (as cited in Solomon & Green, 1982, footnote, p. 315).

Campaigns advocating for even more heavily prohibitive drug laws followed throughout the 1920s in Canada and these were even more strongly influenced anti-Chinese racism. Public campaigns accompanying the push for further drug prohibitions worked to heighten representations of outgroup threats in order to exclude people of Asian descent from the burgeoning Euro-Canadian society through criminalization of their substance use and fines and incarceration for those found in possession of the newly outlawed substances (Carstairs, 1999; Murphy, 1922). Thus, the stigma associated with a particular form of substance use was developed within a specific context of intergroup relations, enshrined in criminal law, and deployed to increase a dominant group's power to exclude and harass a racialized outgroup (Boyd, 1984; Carstairs, 1999; Reicher, 2007; Solomon & Green, 1982).

In many similar examples, stigma towards PWUD has been central to the criminalization, exclusion, and incarceration of racialized groups throughout the history of Canada and the United States. For example, the initial prohibition of alcohol for Indigenous peoples in Canada supported colonial efforts to control and contain this population, making inclusion in the Canadian state (i.e., citizenship) contingent on sobriety from alcohol (Campbell, 2008). Likewise, early reform movements to criminalize the use of cannabis were entangled with racist associations with how cannabis supposedly produced unruly and "murderous" behavior in Mexican immigrants to the U.S. and Canada (Campos, 2012; 2018; Giffen, et al., 1991). The enforcement of cannabis criminalization has also been racialized and fuelled mass incarceration of racialized peoples in both Canada and the U.S. (Alexander, M. 2010; Owusu-Bempah & Luscombe, 2021; Khenti, 2014; White & Holman, 2012), and the racial injustices of unequal cannabis prohibition enforcement persist in Canada post-legalization (Wiese, et al., 2023). Another well-known example is the U.S. sentencing disparities associated with different forms of cocaine such that someone (typically a White person) caught with 100 grams of powder cocaine would technically receive the same penalty as someone (typically a Black person) with just one gram of crack cocaine, resulting in Black people being 18 times more likely to receive a lengthy prison sentence for cocaine possession than White people (Boyd, et al., 2016; Reinarman & Levine, 1989, 1997).

If there was any doubt that the criminalization and stigmatization of PWUD has been deployed strategically by powerful members of dominant groups to achieve the exclusion and denigration of threatening outgroups, a 2016 exposé by Harper's journalist Dan Baum demonstrated this in explicit detail. Baum recounted an interview he conducted in 1994 with John Ehrlichmann, President Richard Nixon's domestic policy chief during the initial declaration of Nixon's notorious "War on Drugs". Ehrlichmann claimed that the harsh enforcement practices of the "War on Drugs" were a strategy designed primarily with the goal of finding ways of disrupting the political threat of Black and "anti-war left" social movements by associating them with the dangerous and unpredictable effects of substance use and justifying their constant harassment by police and vilification in the media (Lopez, 2016).

1.4. Stigma as a Tool: A Critical Perspective on Substance Use Stigma

An emphasis on the intergroup context of substance use stigma is complemented by a critical perspective on the origins and functions of stigma. This perspective suggests that individuals and groups with power (elites) wield stigma as a weapon to separate and categorize marginalized groups in order to expand and consolidate their social power (Fraser, et al., 2017; Friedman, S., et al., 2021; Link & Phelan, 2014; Parker & Aggleton, 2003; Phelan, et al., 2008; Reicher, 2007; Scambler, 2018; Tyler, 2020). As critical drug scholar Suzanne Fraser and colleagues (2017) suggest, a robust interrogation of the social science concept of "stigma" (especially substance use stigma) shows that stigma is not merely the result of an information deficit or individualized prejudiced personalities but must be considered in its historical context as a tool that has been deployed by those with power for strategic purposes to achieve the denigration of particular groups of people (see also Link & Phelan, 2014; Phelan, et al., 2008; Reicher, 2007; Tyler, 2020).

While historical examples of the promotion of stigma towards PWUD for 'functional' purposes are numerous, the phenomenon of people with power deploying substance use stigma to increase or maintain their hold on power persists. UK sociologist Imogen Tyler coined the term "stigmacraft" to describe the persistent employment of stigma by politicians, business interests and others to whip up voter support, ram through exclusionary and corporate-friendly policies and generally shore up the power of elites. For example, fear-based political campaigns often emphasize public safety and exaggerate the potential risks posed by people who are experiencing homelessness, poverty or problems with substance use in order to draw voter support (Friedman, 1998; Friedman, S., et al., 2021; Swanson, 2001). Stigmatizing news media reporting often sensationalizes local experiences of substance use to drive higher ratings and readerships (Fraser, et al., 2017; McCradden, et al., 2019; McGinty, et al., 2019) and may often encourage, or complement, local citizens groups organizing to demonize PWUD and resist harm reduction or addiction treatment services in their neighborhoods (Davidson & Howe, 2014; Tempalski, et al., 2007). The power of police narratives to define the harms of drugs and the people who use them is often wielded through media reports and police positioning as authoritative "claims makers" (i.e., unquestioned authorities on social issues, Boyd & Kerr, 2016) who ensure the health of police budgets by frequently touting the public safety risks posed by drugs. The necessity of police, and a prohibitionist approach to drugs, is likewise supported by stigmatizing prohibitionist drug education and prevention programs targeting students, such as the "Drug Abuse Resistance Education" or D.A.R.E. program in schools which has repeatedly been found to lack efficacy in reducing illicit drug use (Pan & Bai, 2009; West & O'Neal, 2004). A final source of substance use stigma production and promotion, in this case intended to protect public health (Bayer, 2008; Bell, et al., 2010; Guttman & Salmon, 2004), is the use of public health anti-drug public service announcements (PSAs) that exaggerate or misrepresent the potential harms of illicit substances (Douglass, et al., 2017; Ti, et al., 2017), even though such PSAs have been found to be ineffective at reducing drug use (Marsh, et al., 2017; Werb, et al., 2011).

The history of drug policy developments and ongoing political stigmacraft in both Canada and the US suggest the importance of a more structural, historical, and functional perspective on the impacts, and origins of substance use stigma. In particular, it is essential to consider the intergroup context of substance use stigma. Whereas much public health discourse on stigma as a risk factor in the drug toxicity crisis emphasizes the interpersonal and intrapersonal experience of stigma for PWUD, this dissertation adopts a critical perspective on stigma and centres the intergroup context of substance use stigma in analysing the recent upsurge in substance use-focused anti-stigma campaigns across Canada. This perspective tells us that stigma towards PWUD is not natural or to be taken for granted. Stigma has a history (Tyler & Slater, 2018). Stigma towards PWUD has historically been deployed to justify and deepen the exclusion of racialized communities, Indigenous peoples, people of lower-class status and other marginalized groups (Drug Policy Alliance, 2019; Lopez, 2016). Given how the perpetuation of stigma towards PWUD (and especially those associated with other marginalized subgroups) has been useful for those with power, a sudden turn to "stigma reduction" should raise some critical questions (Tyler & Slater, 2018).

1.5. Canada's Drug Toxicity Crisis and the Emergence of Anti-Stigma Interventions

Stigma towards PWUD has only recently become a widespread fixation as a problem and point of intervention in the drug toxicity crisis. A critical content analysis of Canadian print news media on the "opioid epidemic" in Canada found that in the 425 relevant newspaper articles identified and reviewed from 2000 to July 2016 "stigma" was not mentioned a single time, but in the 401 relevant articles identified from August 2016 to December 2017 "stigma" was mentioned 16 times (Webster, et al., 2020). Some of the earliest signs of movement towards prioritizing stigma reduction as a response to the worsening drug toxicity crisis in Canada took place in British Columbia (BC), the Canadian province that has routinely experienced the highest per capita rates of drug toxicity death (PHAC, 2023). Starting in 2016, shortly after BC declared a public health emergency, the BC Centre for Disease Control (BCCDC) convened three "overdose action exchange" meetings in 2016, 2017 and 2018 that brought together numerous stakeholder groups from across BC and Canada to discuss responses to the crisis. Stigma reduction emerged as a key action item in each of these meetings (BCCDC, 2016, 2017, 2018). Similarly, a summary of responses from the more than 200 individuals representing 118 stakeholder organizations from across Canada at an "Opioid Symposium" convened by the Government of Canada in Toronto, Ontario in September 2018 described stigma towards PWUD as an important area to address in responses to the drug toxicity crisis (Government of Canada, 2019a). The Government of Canada has even tied stigma-reduction to Canadian identity on its web page on "Stigma around substance use" in the context of the drug toxicity crisis. The site states that it is "important that as Canadians, we reduce stigma around drug use, so people can get help when they want and need it" (Government of Canada, 2023b). In 2018, Canada took its anti-stigma efforts international by advocating, along with Uruguay, for the adoption of an anti-stigma resolution at the 61st session of the Commission on Narcotic Drugs at the United Nations which called on all member nations to support the removal of "stigma as a barrier to the availability and delivery of health, care and social services to PWUD" (United Nations, 2018).

The positioning of stigma reduction as an important goal in the midst of the worsening drug toxicity crisis coincided with governments, health authorities, drug user organizations (DUOs) and NGOs across Canada developing and implementing a variety of interventions (e.g., social marketing campaigns, websites, anti-stigma workshop trainings) intended to reduce stigma towards PWUD in society at large. These interventions were most often intended to help shift public attitudes (i.e., public stigma) towards PWUD to hopefully reduce incidents of discrimination towards PWUD and in turn reduce feelings of shame and judgement experienced by individual PWUD.

Anti-stigma interventions can take many forms. One common approach is to treat stigma as a deficit of information that can be remedied by proper education about a stigmatized group or condition, often through information campaigns or anti-stigma workshops for the general public or competency training for service providers (Hansen, et al., 2018; Lancaster, et al., 2017; Metzl & Hansen, 2014). Another approach involves intergroup contact where PWUD are brought together to interact with non-drug users under conditions that facilitate building relationships, sharing personal stories of substance use, and dispelling negative stereotypes about PWUD (Allport, 1954; Corrigan & Nieweglowski, 2018; Kharpal, et al., 2021; Paluck, et al., 2018; Pettigrew & Tropp, 2006). Another common strategy that was widely adopted in early efforts to combat substance use stigma was to address the harms of stigmatizing language (e.g., "junkie", "drug abuse") by adopting person-centred and non-moralizing terminology when referring to PWUD and substance use more generally (Ashford, et al., 2018; Collins, et al., 2018; Fraser et al., 2017; Goodyear, et al., 2018). Another approach, associated with developments in the neuroscience of mental health and addiction, advocated shifting attributions for substance use problems by reconceptualizing the nature of addiction. For example, replacing a “moral failing” model of addiction with a “brain disease” or “psychosocial” model of addiction (Fraser, et al., 2017; McGinty, et al., 2015; Meurk, et al., 2014; Wiens & Walker, 2014). Arguably protest and advocacy to eliminate discrimination towards PWUD or adjust stigmatizing legislation or policies, often engaged in by PWUD themselves, can also be thought of as an anti-stigma intervention (NAS, 2016), though here it is often structural stigma, rather than more individual-level forms of stigma, that is the target.

Then there are anti-stigma campaigns. Mass media social marketing anti-stigma campaigns are an especially popular intervention that has been widely used across Canada in an attempt to address substance use stigma. “Social marketing” refers to approaches to mass media communication that draw on the tools of commercial marketing, not to drive consumption of commercial products but to change audience behaviors or attitudes related to a social issue (Lavack, 2007). Mass media social marketing anti-stigma campaigns often take the form of large-scale print media (e.g. on transit shelters or billboards), posters in public spaces or private business, radio and TV spots (e.g. PSAs) and online dissemination (e.g. websites, social media posts) of messaging or images meant to destigmatize a social group or behavioral condition such as substance use (Clement, et al., 2013; Kerr, et al., 2015). For example, in January 2018 the Province of BC, in partnership with the Vancouver Canucks sports team, launched its “Stop Overdose” social marketing anti-stigma campaign. The campaign featured radio ads, TV spots, social media posts, and most recognizably, large colourful posters at bus stop and Skytrain shelters across the province. One of its explicit goals was to “reduce stigma towards PWUD” as a means of addressing the drug toxicity crisis (Ghossoub, 2018; Regan Hansen, Ministry of Mental Health and Addictions, personal communication, June 14, 2018). Many jurisdictions and organizations across Canada have followed suit with their own widely shared mass media social marketing style anti-stigma campaigns.

1.6. A Critical Perspective on Substance Use-Focused Anti-Stigma Campaigns: Unprecedented and Underexplored

Prior to the most recent wave of opioid-related drug toxicity deaths, most substance use-related mass media campaigns featured stigmatizing representations of substance use and PWUD (Bayer, 2008; Courtwright, 2013). Their ostensible goal was to communicate the risks of substance use in order to prevent people (especially youth) from initiating substance use (Boyd, 2017). These “anti-drug” campaigns (e.g., “This is your brain on drugs” released in 1987 by The Partnership for a Drug Free America, see Moreau, 2016) have been identified as an important source of stigma towards PWUD (Douglass, et al., 2017; Sola-Morales & Quiroz, 2019; Ti, et al., 2017). The history of stigmatizing anti-drug prevention campaigns in health communication about substance use makes the recent upsurge in anti-stigma campaigns all the more surprising, and unprecedented.

In 2007, well before the onset of the drug toxicity crisis in Canada, social marketing scholar Anne Lavack published a review paper outlining how one might use the tools of social marketing to “destigmatize addictions”. The review is striking for its lack of concrete examples of social marketing anti-stigma campaigns. While Lavack does profile four case studies she seems to associate with social marketing (e.g., an anti-stigma toolkit, a conference, a research study and an annual awareness month), none of them resemble the more recent examples of anti-stigma campaigns (e.g. posters, PSAs, social media advertising) that have proliferated within the worsening drug toxicity crisis. Indeed, research on stigma towards PWUD has only begun to expand in recent years and investigations of interventions to reduce stigma towards PWUD remain sparse (Barry & McGinty, 2020; Corrigan, et al., 2017b, 2017c; Corrigan & Nieweglowski, 2018; Kulesza, et al., 2014; NAS, 2016; Nieweglowski, et al., 2018). While some research has examined the efficacy of social psychological interventions (e.g., exposure to vignettes of PWUD with different characteristics or using different labels in online survey experiments) to reduce stigma towards PWUD (Corrigan & Fong, 2014; Corrigan, et al., 2015; Crapanzano, et al., 2014; Livingston, et al., 2012), no research has critically or systematically examined the content of substance use-focused anti-stigma campaigns. Indeed, critical analyses of health communication campaigns in general remain rare (though see Khan, 2014; Tyler & Slater, 2018) and have recently been identified as a key priority in the health communication literature (Walsh & Foster, 2021). As Tyler and Slater point out, both stigma and anti-stigma initiatives “are the site of intensive social struggles” (2018, p. 725, see also, Costa, et al., 2012).

While this dissertation does not take up the question of whether or not mass media social marketing anti-stigma campaigns are effective at reducing stigma towards PWUD (they may not be, see Clement, et al., 2013), it treats anti-stigma campaigns as important sites of inquiry because they show us how the organizations and individuals who make anti-stigma campaigns conceptualize the problem of stigma: what stigma is, who is represented as being impacted by stigma, and how stigma can be addressed. Anti-stigma campaigns often represent PWUD in particular ways, and these social representations can be the object of analysis (Moscovici, 1988; Elcheroth, et al., 2011). How do anti-stigma campaigns construct the social category of PWUD? These questions represent an important gap in research on understanding and addressing substance use stigma. Given the complexity of substance use stigma, including the deeply unequal context of structural inequities in substance use health, the intersections of substance use stigma with other systems of oppression (e.g. racism, classism, colonialism, etc.) and the ongoing production of stigma towards PWUD through various structural mechanisms (including the criminalization of drugs and the people who use them, Livingston, et al. 2022; Scher, et al., 2023; Seear, et al., 2017), this dissertation sets out to describe the recent turn towards anti-stigma campaigns in Canada and reckon with its implications for intergroup relations between subgroups of differently positioned PWUD.

Taking as a starting point that anti-stigma interventions should be inclusive of the entire social category of PWUD, not merely its privileged subgroups, this dissertation explores how mass media social marketing anti-stigma campaigns in Canada represent both PWUD and the "problem" of stigma towards PWUD, as well as the psychological, social and political implications of these representations for PWUD who are marginalized by the positioning of their other social identities (i.e. race, class, gender, etc.) within social hierarchies. To investigate the relatively uncharted landscape (Corrigan & Nieweglowski, 2018; McGinty & Barry, 2020) of substance use-focused anti-stigma campaigns, this dissertation integrates critical theorizations and research on stigma towards PWUD (Fraser, et al., 2017; Link & Phelan, 2001, 2014; Phelan, et al., 2008; Tyler, 2020). To ground the critical analysis in the expertise of lived and living experience with both criminalized substance use and stigma, this dissertation also employs a community-based participatory research (CBPR) approach to collaborate closely with those most affected by anti-stigma interventions: PWUD themselves.

1.7. Dissertation Objectives

In what follows, I describe two studies conducted in collaboration with PWUD: 1) a systematic review and analysis of 134 substance use-focused anti-stigma campaigns identified in Canada from 2009-2020 and 2) a series of focus groups where structurally vulnerable PWUD react to and analyze two mainstream anti-stigma campaigns. These studies address the two main objectives of this dissertation:

1. To examine how PWUD and the problem of stigma are represented in anti-stigma campaigns created by governments, health organizations and other groups in Canada, with specific attention to representations of structurally vulnerable subgroups of PWUD (e.g., low-income/homeless, Indigenous and/or other racialized groups, women, trans/gender diverse).
2. To explore structurally vulnerable PWUD's responses to two mainstream anti-stigma campaigns (BC's 2018 "Stop Overdose" campaign and Health Canada's 2019 "End Stigma" campaign), with specific attention to investigating participant reactions to their exclusion from these campaigns and their analysis of the implications of anti-stigma campaign messages and representations of PWUD.

1.8. Approach to the Research

1.8.1. Positionality

As a researcher, it is important to situate myself as an outsider to the lived experiences and communities at the core of this dissertation project. My social identities do not include any of the marginalized groups (e.g., racialized, lower-income) that are disproportionately targeted by drug prohibition and experience the worst substance use health inequities. I was raised and socialized as a White, cisgender, male, able-bodied, settler within a rural-suburban community in Langley, BC. Culturally, the context of my socialization (family, school, community) was predominantly politically conservative and evangelical Christian. In practice, this meant the topic of criminalized substance use, or "addiction" and "drugs", mostly entered family conversation, school teaching, or youthful banter between friends as an epithet (e.g., "You crackhead", "What a stoner") or a moral lesson. For example, when occasionally driving home to Langley with my family from Vancouver we would sometimes take a route through the Downtown Eastside neighborhood. I clearly recall the loud sound of our vehicle doors being locked and then feeling fear as the locking doors implied the people walking or congregating along the dirty sidewalks of Hastings Street (who appeared to my young self to be rough-looking, impoverished, and likely dependent on illicit substances) were a threat to our White, middle-class, suburban family. As we drove through the neighborhood (where I would many years later develop close collaborative relationships and befriend many residents, including PWUD), my parents explained how the entrenched poverty we were observing, safari-like, along Hastings Street out the tinted doors of the family van was no doubt the *result* of addiction. This stands out to me as a powerful early lesson in how my communities constructed social failure vis-à-vis the spectre of losing one's autonomy to the grim powers of addictive substances. Indeed, the intersection of "Main and Hastings" at the heart of the DTES neighborhood served as not so much a direct threat to my neighborhood or community (the DTES is approximately an hour or more drive from my parents' residence in Langley where I grew up) but rather a warning sign. It was constructed symbolically in my suburban, conservative, Christian communities as the "bad place" where you might eventually end up if you strayed from the narrow path and got involved with drinking, drugs, or the wrong kind of friends.

It is also essential to acknowledge that I do not have any personal lived or living experience with criminalized substance use. This lack of lived experience also includes those close to me including my immediate, and even extended family, who have all been fortunate to remain virtually untouched by serious addiction to alcohol or drugs or experienced health harms due to drug toxicity (e.g., overdose). While in high school, neither I, nor my close friends, drank alcohol, used illicit drugs or "partied". In Grade 11, I recall an episode where a small group of my close friends purposely avoided inviting me or telling me when they experimented with under-age drinking one night because of my reputation as someone who would disapprove. During the first year of my undergraduate degree at McGill (living on my own for the first time, across the country from my family) I recall having made a pact with a high school friend to go through that year completely abstinent from alcohol, a feat easily accomplished. These commitments to *not* seeking even mild intoxication through legal substance use during the formative early years of my young adulthood were likely rooted in my own interpretation and fundamentalist adherence to what I saw as Christian norms of moral practice. These norms were shared by some, but not all in my faith community, and certainly not shared by my immediate family who regularly enjoyed moderate consumption of alcoholic beverages. They were also rooted in my deeply socialized stigma towards people who drank alcohol or used other drugs.

Over time, I learned more about how the social determinants of health (e.g., poverty, lack of housing or food access, mental health, adverse childhood experiences, etc.) played a role as risk factors for negative substance use health. Through my undergraduate degree and into the early years of my MA, I increasingly met, and learned from, people who used illicit drugs as I engaged with more diverse faith communities, higher education, and social activism. In 2013, when I moved back to Vancouver from Montreal, I began to learn more about the decades of local grassroots activism and organizing around harm reduction and drug policy reform emanating from the DTES and especially the *Vancouver Area Network of Drug Users (VANDU)*. This put me on a trajectory towards developing a functionalist perspective on substance use (i.e. the recognition that psychoactive substances are often useful and even beneficial for those who use them, Ivsins & Yake, 2020), a political orientation towards drug policy that is critical of the harms (and racist, classist roots) of drug prohibition, an approach that seeks to centre the autonomy of PWUD, and positive and close relationships with individuals who actively use illicit substances.

My positionality is thus best characterized as someone who grew up as, and remains, an outsider to both the experiences and identities at the heart of this dissertation project. I have continued to benefit from my many intersectionally privileged social identities. I was deeply socialized in substance use stigma as a young person and this drove my commitment to not gaining lived experience using criminalized (or legal, for many years!) psychoactive substances. Given these personal limitations or “blind spots” in my position, as well as my commitment to not exacerbating the many harms experienced by people who use criminalized drugs through further exploitation or misrepresentation in research (Boilevin, et al., 2018), it felt necessary to approach this project in a way that fully involved PWUD from structurally vulnerable subgroups (i.e., marginalized social categories) as close partners and collaborators.

1.8.2. Community-Based Participatory Research (CBPR)

The two studies included in this dissertation were informed by a community-based participatory research (CBPR) approach that involved collaborating with structurally vulnerable PWUD throughout the project. CBPR, and related “action research” approaches to community-involved inquiry emerged out of the early work of social psychologist Kurt Lewin (1946) who not only sought to study how intergroup relations could be improved but did so in the context of actually working towards their improvement in community settings. Later developments in critical pedagogy and participatory approaches to both democracy and knowledge production emerged in Latin America with the work of Paulo Freire (1970, 1982), Orlando Fals-Borda (1987) and Ignacio Martin-Baró (1994). This led to the development of CBPR approaches and their integration with more revolutionary forms of research praxis that was not merely *for* everyday people but *by* and *with* them as well (Torre, et al., 2012). As Torre and colleagues (2012) explain, all of these early practitioners developed ways of contesting what liberation psychologist Ignacio Martin-Baró (1994) referred to as the "collective lie" of overly psychological or ideological understandings of social and political problems (e.g., an overly psychological and individualized view of stigma towards PWUD that ignores its structural and intergroup context).

A key commitment of CBPR is the importance of equity in research; it rejects the ways in which academic expertise and ways of knowing have historically been privileged above community or grassroots knowledge, often to the detriment of research and the disrespect of communities under scrutiny (Minkler, 2000, 2005; Travers, 1997). In contrast, CBPR elevates a variety of expertise (e.g., local knowledge) and brings people with diverse expertise together in collaboration to determine the approach to answering the study question, data analysis strategy and meaningful co-presentation of the study's findings back to the community (Boilevin, et al., 2018; Torre, et al., 2012). CBPR is especially useful as an approach to work taking place in heavily researched communities as close collaboration with community members may enable the research to avoid replicating disrespectful, stigmatizing, or otherwise harmful practices commonly associated with research in a community such as Vancouver's Downtown Eastside (DTES) neighborhood (Boilevin, et al., 2018; Damon, et al., 2017).

Through adopting this approach, I sought to include the voices, expertise, and perspectives of PWUD who experience stigmatization and criminalization for their substance use (and other, intersectionally stigmatized identities) in the research design, data collection, data analysis and research products. As a university-based researcher with no lived experience of criminalized substance use or related stigma, my vantage point on this issue is inherently limited. My numerous privileged social categories (e.g., cis-male, White, settler, able-bodied, etc.) offer me an inadequate lens through which to observe and understand important features of the context of illicit drug use, stigma and community norms. Therefore, it was important for my research to be guided by people with lived or living (i.e., current or former) experience of being stigmatized and criminalized for their use of illicit substances (Minkler, 2004). This approach explicitly challenged the ways in which PWUD are consistently excluded from society, part of the focus of the study overall. Furthermore, CBPR has been found to assist with participant recruitment amongst marginalized populations (e.g., PWUD) as peer collaborators can draw on their existing social networks within the community to invite potential participants to the study (Damon, et al., 2017; Hayashi, et al., 2012).

1.8.3. Formation of a Community Advisory Board (CAB)

The primary means by which this project integrated lived expertise was through the formation of a “community advisory board” or CAB. CAB members were recruited from the *Vancouver Area Network of Drug Users (VANDU)*, the *Western Aboriginal Harm Reduction Society (WAHRS)* and the *British Columbia Association of People on Methadone (BCAPOM)*, three of the largest drug user organizations in Vancouver’s DTES neighborhood. I made initial contact with CAB members by presenting an initial summary of the study proposal to each respective organization’s board of directors or general membership. Following the internal protocols of each of these organizations for fairly allocating paid research opportunities to their members (i.e., typically some form of random draw of names out of a subset of interested individuals), two individuals from each organization were selected to join the CAB. Two individuals who initially agreed to join the CAB were subsequently unable to participate and one individual was added later, resulting in a group of five CAB members including two women (Laura and Samona), three men (Earl, Boomer and Al), two members who identified as Indigenous (Earl and Boomer), one member who was in his 60s (Earl) and all five members who identified as active users of multiple criminalized substances.

Fortuitously, three of the five selected CAB members were individuals with whom I had developed prior relationships in the context of my other work in the DTES facilitating a series of workshops on research ethics in the neighborhood (“Research 101”, see Boilevin, et al., 2018; Neufeld, et al., 2019). This familiarity contributed to a strong norm that CAB members could freely express their opinions and perspectives without feeling obliged to give me the response they thought I was looking for or feeling the need to hold back when it came to critiquing my draft ideas or proposals. This strengthened the role of the CAB in the project. To further account for the inevitable power imbalance of a socially privileged PhD student collaborating with PWUD from less powerful social positions, I also ensured that CAB meeting agendas were carefully structured to create adequate space for members to contribute their unique insights and expertise to the project without undue influence from me and without having discussion dominated by just one or two voices.

CAB members met in-person with me approximately bimonthly from May 2019 to December 2020 to plan, guide, and help analyze preliminary data. For example, we collaboratively reviewed a draft version of the focus group guide for Study 2 (see Appendix F), and CAB members shared various insights and suggestions on the questions and structure which were then incorporated into an updated version of the guide. All CAB members were compensated with $30 for each meeting which typically ran from one to one and a half hours. After June 2020, CAB meetings were held online to respect distancing protocols with the onset of the Covid-19 pandemic.

Throughout Study 2 I employed more facets of a CBPR approach by working with two “peer research assistants” (PRAs) employed by the BC Centre on Substance Use (BCCSU). As members of the BCCSU’s Qualitative and Community-Based Research Team these PRAs helped me to facilitate participant recruitment in the DTES neighborhood as well as plan and execute focus group data collection. I trained two PRAs (Sandra and Al) in the administration of the focus group guide and met regularly with both PRAs to discuss emergent issues as data collection progressed. I also drew on the insights and perspectives of the PRAs and other CAB members in developing an initial data analysis plan for both studies.

To guide my own reflexivity throughout the project I wrote notes describing discussions held with members after each CAB meeting, focusing especially on points of possible tension, disagreement, or suggestions from CAB members. Keeping a record of these discussions also aided my reflection on evolving power dynamics within the context of the community-based research team. This enabled me to better attend to how I may have been perpetuating problematic assumptions or research practices (Boilevin, et al., 2018; Muhammad, et al., 2012).

1.8.4. Epistemology and Ontology

My approach to this project is grounded in pragmatic critical realism and social constructionism. Critical realism both acknowledges the possibility of acquiring “real” empirical knowledge about the world and at the same time recognizes that all knowledge and experience of the world is socially constructed and influenced by both personal and contextual factors (Bazeley, 2013; Botha, 2021; Willig, 1999). Critical realism is well-suited to CBPR because its approach to knowledge construction corresponds to the “everyday”, common sense understanding of reality that is familiar to study participants and community collaborators (Bazeley, 2013). Thus, critical realist research methodology and conclusions should be readily understandable to a wide, non-academic audience (e.g., public health officials and anti-stigma practitioners), and directly applicable to the real-world contexts of PWUD. A social constructionist epistemological approach recognizes that knowledge produced through this dissertation research is an interactive co-production of the participants or data (i.e., anti-stigma campaigns) as well as the researcher and analyst. The knowledge generated through this dissertation must be understood as contextualized and shaped by my positionality as a socially privileged PhD candidate, my limited but evolving background knowledge of substance use patterns and the lived experience of stigma, the wider social context of the DTES neighborhood in Vancouver and the structural context of Canadian drug policy.

A pragmatic approach means that research questions are prioritized over allegiance to specific research methods. That is, a variety of research methods can be employed within the same study to answer the research questions, recognizing that “different methods are appropriate for different situations” (Patton, 2002, p. 69) and “eschew[ing] methodological orthodoxy in favor of methodological appropriateness” (Patton, 2002, p. 69). The appropriateness of the analytical steps taken to reach certain conclusions about the data, rather than strict adherence to the form of a traditional methodology, is the key to evaluating the quality and soundness of the research findings (Bazeley, 2013; Tafreshi, et al., 2016).

1.9. Conclusion

PWUD are a highly stigmatized group in need of greater inclusion and compassion within all segments of society (Knaak, et al., 2019; Tsai, et al., 2019). In this context, anti-stigma campaigns are a welcome change from fear-based anti-drug campaigns and war on drugs rhetoric. In theory, these campaigns are intended to challenge the marginalization of PWUD and ultimately contribute to less harm, fewer drug toxicity deaths and better outcomes in general for this stigmatized group. But how and for whom are these campaigns meant to operate? History teaches us that stigma towards PWUD has often served strategically to shore up the privilege of powerful ingroups and keep the powerless down. Thus, we should view the recent spate of anti-stigma campaigns developed by governments, health organizations and other stakeholders critically, asking how these interventions might function to reduce stigma, for whom they are most likely to do this, and how else, beyond stigma reduction, anti-stigma campaigns might contribute to ongoing societal discourse about the role and status of PWUD.

Chapter 2.

Overdose Can Affect Anyone? A Critical Review of 134 Canadian Substance Use Focused Anti-Stigma Campaigns, 2009-2020

In response to rapidly increasing numbers of opioid-related overdoses and overdose deaths since approximately 2016, reducing stigma towards people who use drugs (PWUD) has emerged as an unprecedented and important public health goal in Canada and the United States (Buchman, et al., 2017; Corrigan & Nieweglowski, 2018; Fischer, 2020; McCradden, et al., 2019; McGinty & Barry, 2020; Tsai, et al., 2019). However, to critical drug studies researchers, historians of drug policy, and people with lived and living experience (PWLLE) of criminalized substance use, this recent attention to stigma raises some critical questions. It has been well established that stigma towards PWUD has created significant problems for the health, well-being, dignity, and human rights of PWUD long before the most recent wave of drug-related deaths (Friedman, et al., 2021; Lloyd, 2013; Room, 2005). A critical perspective on the history and function of substance use-related stigma questions why stigma is being addressed now, how it is being addressed, and for whom (Parker & Aggleton, 2005; Tyler, 2020).

Among many tactics employed to “reduce stigma”, mass media public awareness campaigns have received significant investment as an anti-stigma intervention by a wide variety of actors in Canada including all levels of government (federal, provincial, municipal), non-profit organizations, public health authorities, grassroots groups of PWUD and more. However, research demonstrating the effectiveness of mass media anti-stigma campaigns to change attitudes in general (Clement, et al., 2013) and towards PWUD specifically (McGinty & Barry, 2020; Corrigan, 2012; Corrigan, et al., 2017b, 2017c), remains underdeveloped and unclear. The few examples of evaluated campaigns suggest potential positive (e.g., “Lives of Substance”, Treloar, et al., 2019; “Know the Truth”, Rath, et al., 2020) and negative (“Stop Overdose BC”, Insights West, 2019) associations between campaign exposure and audience members’ stigmatizing attitudes towards PWUD.

While more research could evaluate the effectiveness of anti-stigma campaigns in reducing stigma towards PWUD, this paper explores anti-stigma campaigns in a different way. As Carol Bacchi (2009, 2018) points out in her influential “What’s the problem represented to be?” approach to studying government policies and actions, interventions in the public realm provide a window of insight into how problems are understood by those creating the interventions. Anti-stigma campaigns thus reveal their creators’ understandings of a problem (“stigma”) and its potential solution. What can an analysis of the recent attention put on substance use stigma reduction tell us about the intuitions of governments, public health authorities, grassroot groups and others who make anti-stigma campaigns when it comes to conceptualizing stigma: what it is, who it affects, and how? While health communication campaigns in other areas have occasionally been critically analyzed (e.g., Khan, 2014; Tyler & Slater, 2018), these analyses are usually limited to case studies of individual campaigns. The present study fills a gap in research on stigma towards PWUD by providing the first known systematic description and analysis of how widely and publicly shared anti-stigma campaigns targeting substance use-related stigma across an entire country represent the stories and identities of PWUD impacted by stigma and how they choose to define, problematize, and challenge “stigma” itself.

2.1. Social Identity, Intersectionality, and Substance Use-Related Stigma

The Social Identity Approach (SIA; Reicher, 2007; Reicher, et al. 2010) is a social psychological perspective that emphasizes the wider social context of intergroup relations as embedded in social and political processes that unfold through history at the behest of powerful groups and leaders to define the boundaries and meaning of social categories. While the SIA has not often been applied to understanding substance use-related stigma (for exceptions, see; Sibley, et al., 2023; Simmonds & Coomber, 2009; Wood & Elliot, 2020), it offers a useful framework for understanding how stigma operates and has operated through history as an intersectional force of group boundary drawing, exclusion, and social control by elites (Reicher, 2007; Tyler, 2020). Indeed, a fundamental piece of context in analyzing anti-stigma campaigns is the unequal history of how substance use-related stigma has been attached to various marginalized social groups. Importantly, the SIA holds potential for understanding prejudice or stigma as far more than mere negative attitudes (e.g., Allport, 1954, see Reicher, 2007) or "discrediting marks" divorced from history or context (e.g. Goffman, 1963, see Tyler, 2018; Tyler & Slater, 2018). Rather, stigma is a process by which social categories are drawn and redrawn, with certain social groups branded as threats and targeted for exclusion, dehumanization, and subjugation as a means of consolidating power (Link & Phelan, 2014; Reicher, 2007; Tyler, 2020). A political and historical account of substance use-related stigma reveals how powerful politicians and organizations have used stigma as a weapon to mark out racialized, impoverished, and otherwise marginalized communities for removal, scapegoating and control based on their alleged use of illicit substances (Fraser, et al., 2017; Friedman, et al., 2021; Szasz, 2003).

Throughout history and into the present, negative associations have been established between a wide variety of psychoactive substances and social groups marginalized by their racialization, class status, gender, sexual minority status, or disability status. These intersections of substance use-related stigma and other forms of group-based oppression have been well-documented, and often held up as evidence of how substance use stigma has been wielded by powerful groups as a means of further stigmatizing the marginalized groups they wish to oppress, criminalize and control (Boyd, 2017a; Daniels, et al., 2021; Dittrich & Schomerus, 2022; Fordham, 2020; Hart, 2021; Herzberg, 2020; Musto, 1999). Most commonly, substance use stigma has played an important role in racist and classist systems of oppression. For example, as Indigenous communities in what came to be known as Canada faced massive economic shifts, land theft, removal of Indigenous children to residential schools and other disruptive colonial policies, alcohol (first introduced by European fur traders) was increasingly used by Indigenous peoples to cope with cultural dislocation and collective trauma (Alexander, B., 2010; Maracle, 1994). Problems with alcohol in Indigenous communities were characterized with scapegoating biogenetic explanations and demeaning stereotypes of "drunken Indians", aiding in the dehumanization of Indigenous peoples necessary to justify colonial policies of Indigenous extermination and assimilation (Boyd, 2017a). Indigenous alcohol use was also weaponized by colonial prohibition policies that required the revocation of legal Indian status if an Indigenous person wanted to consume alcohol legally (Boyd, 2017a; Cambpell, 2008; Valverde, 2004).

Opium was famously the subject of Canada's first drug laws (other than *the Indian Act*, Campbell, 2008) created as part of a wider program of criminalizing and demonizing people of Chinese heritage to hasten their exclusion and consolidate White dominance in society (Boyd, 2017a; Carstairs, 1999, 2006; Malleck, 2014). In cannabis-related drug scares, the "killer weed" was widely represented as inciting murderous violence amongst its users, sometimes portrayed as Mexican immigrants or African American musicians (Baum, 2018; Campos, 2018). More recently, cannabis criminalization has been demonstrated to be a major driver of the disproportionate policing, surveillance, and incarceration of Black Canadians (Khenti, 2014; Owusu-Bempah & Lanscombe, 2020). Heroin and crack cocaine were strongly associated with lower-income Black and Latinx youth in urban centres and constructed as 'demon drugs' scapegoated as the cause of 'urban decay' and responsible for transforming racialized others into super-powered criminals that threatened the safety of White suburbs (Hartman & Golub, 1999; Reinarman & Levine, 1989, 1997). These associations in turn fuelled racist sentencing disparities which targeted Black people who used crack cocaine and fuelled mass incarceration in the United States (Alexander, M., 2010; Lowney, 1994). Crystal meth has been associated most strongly and negatively with lower-income Whites through a process of "pseudo-racialization" that demeans and excludes users as "White trash" (Murakawa, 2011; Peterson, et al., 2019). Similarly, prescription opioids such as OxyContin were initially referred to as "hillbilly heroin" as early waves of the "opioid crisis" were represented as primarily affecting poor Whites in deindustrialized and rural areas of the United States such as Appalachia (Tunnell, 2005). More recently, experimental studies have demonstrated that people who use opioids represented as poor or working class are stigmatized more severely than those represented as middle class (Kennedy-Hendricks, et al., 2016; Wood & Elliot, 2020).

Negative associations between certain social groups and substances are often the creation of opportunistic politicians, media conglomerates, law enforcement and business interests (Friedman, et al., 2021) who seek to construct outsider groups as threatening their group interests and dominance. The perception of outsider threats to the ingroup in turn helps build support for punitive and criminalizing policies to control these groups, thus consolidating the power of elites (Carstairs, 1999; Link & Phelan, 2014; Parker & Aggleton, 2005; Reicher, 2007; Tyler, 2020). At various times and for various reasons, marginalized groups' alleged substance use habits have proven to be a useful focus for eliciting fear and disgust in the general public. Thus, substance use-related stigma has been promoted and operationalized as a tool by which other forms of oppression or inequality are justified (Earnshaw, 2020).

2.2. Group-Based Inequities in Substance Use-Related Harms

The effects of these unequal histories of drug policy, stigmatization and criminalization are apparent in the unequal distribution of substance use-related harms, including overdose morbidity and mortality (Bourgois, et al., 2017; Hatzenbuehler, 2016). In Canada and the United States, health inequities and stigma-based exclusion related to race, class, sexual and gender minority status (e.g., 2SLGBTQIA), age and physical disability make members of groups who also use drugs "structurally vulnerable[3]" and therefore at heightened risk of opioid-related morbidity and mortality.

For example, Canadian epidemiological data routinely demonstrate that non-White racialized groups are over-represented among those who experience both fatal and non-fatal overdoses (Carriere, et al., 2018; Belzak & Halverson, 2018; Ontario Drug Policy Research Network, Office of the Chief Coroner for Ontario, Public Health Ontario, and Centre on Drug Policy Evaluation, 2020). Indigenous people in Canada are over-represented both nationally and provincially in overdose morbidity and mortality (Carriere, et al., 2018; First Nations Health Authority, FNHA, 2021; Alberta Government and Alberta First Nations Information Governance Centre, 2017, 2021; Saskatchewan Coroner's Service, 2022; The Institute of Clinical Evaluative Sciences & Chiefs of Ontario, 2017).

In terms of social class, people who are unemployed, experiencing homelessness or housing instability or working in low pay or working-class jobs (e.g.,

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[3] "Structural vulnerability" is a social science concept that foregrounds how forces of "structural violence" (e.g. Farmer, et al., 2006) such as economic inequality, systems of intergroup oppression or war increase the health risks faced by certain individuals and groups. According to Bourgois and colleagues (2017), "Patients are structurally vulnerable when their location in their society's multiple overlapping and mutually reinforcing power hierarchies (e.g., socioeconomic, racial, cultural) and institutional and policy-level statuses (e.g., immigration status, labor force participation) constrain their ability to access healthcare and pursue healthy lifestyles" (p.17; see also Bourgois & Hart, 2011).

construction, transport, trades) are also routinely over-represented in overdose mortality and morbidity (Carriere, et al., 2018; BC Coroner's Service, 2022; van Draanen, et al., 2020; The Ontario Drug Policy Research Network (ODPRN), et al., 2020; ODPRN, et al. 2021, 2022). Age-based epidemiological analyses show an over-representation of overdose mortality amongst individuals in the age range of 20-59 (PHAC, 2023), though more public and media attention tends to focus on "youth" impacted by substance use harms (Johnston, 2020). Data from Canada and the United States show that physical disability, and especially disabilities that result in chronic pain, are associated with both elevated risk of problematic substance use and overdose morbidity and mortality (BC Coroner's Service, 2018; Glazier & Kling, 2013; Martin, et al., 2020). Some evidence suggests this association is mediated by factors related to the wider social exclusion of people with disabilities (Ford, et al., 2018). Other marginalized groups at an elevated risk of overdose mortality include people with a co-occurring mental health diagnosis (Keen, et al., 2022) and people recently released from incarceration (Merrall, et al., 2010; Gan, et al., 2020; McCaughrin-Contreras, et al., 2021). The intersections of multiple forms of identity-based exclusion (e.g., poor, disabled, and Indigenous) and substance use-related stigma have also been documented as producing exacerbated harms for PWUD (Collins, Boyd, et al., 2019; Goodman, et al., 2017; Hansen, 2017; Persmark, et al., 2020).

Gender presents an exception to this pattern of marginalized groups experiencing heightened overdose mortality and morbidity. While men remain a socially privileged group, they are also consistently over-represented in overdose mortality nation-wide (PHAC, 2023) suggesting the possible role of harmful norms of masculinity that discourage support-seeking and increase overdose risk (Bardwell, et al., 2019; Berman, 2017; CBC Radio, 2017; Llana, 2019; Todd, 2017). Nonetheless, the intersections of sexism and substance use-related stigma for women who use drugs are well-documented (Boyd, 2017b; Campbell & Herzberg, 2017) and include the intense stigma reserved for mothers who use drugs (i.e. "the good mother ideal", Nichols, et al., 2020) and how overdose risk is exacerbated by the negotiation of structural and interpersonal gender-based violence, including violence towards women who use drugs and engage in sex work (Boyd, et al. 2018: Collins, Bardwell, et al., 2019; Lavalley, et al., 2020; Maher, 2016; McNeil, et al., 2014; Thumath, et al., 2021). For sexual and gender minority groups, a combination of stigma-based exclusion (i.e., structural stigma), health inequities and elevated mental health risks in these populations exacerbate risks of substance use as well as overdose morbidity and mortality (Day, et al., 2017; Goodyear, et al., 2020; Hatzenbuehler, et al., 2015; Lyons, et al., 2015; Restar, et al., 2020; Scheim, et al., 2017; Terrell, et al., 2021).

2.3. The Present Study

As critical accounts of stigma argue (Fraser, et al., 2017; Reicher, 2007; Tyler, 2020), stigmatization can be understood as a process of drawing boundaries that mark out what subgroups are excluded and included in a wider superordinate group (e.g., “citizens”, “humans”). Given the complex entanglements of substance use stigma with multiple layers of group-based inequality and intersecting systems of oppression, do interventions to reduce stigma towards PWUD redraw group boundaries to promote re-inclusion and ultimately reduce overdose risk for some groups more than others? Are representations of those most severely impacted by historical, intersectional stigma and ongoing health inequities prioritized, or do anti-stigma campaigns primarily represent the interests (and identities) of already-privileged groups?

This study examines materials developed and disseminated widely as a part of 134 substance use-related anti-stigma campaigns produced in Canada from 2009 to 2020. The selection of Canada as a geographic area for this review made data analysis more manageable (several hundred more anti-stigma campaigns were initially identified in the United States) and more interpretable (the United States and Canada have different political and policy landscapes as well as distinct ethnic make-ups, both of which provide a backdrop to the study’s findings). The period 2009-2020 reflects the earliest substance use anti-stigma campaign that could be identified at the time of the review (“Just Talk PEI”, Health PEI, 2009) and enabled observation of the dearth of anti-stigma campaigns prior to the fentanyl-driven wave of Canadian overdoses beginning in approximately 2016. December 2020 was identified as the end of the review period due to a need to end data collection and the changing nature of both public health communication in Canada (e.g., an influx of Covid-19 related public health campaigns) and the nature of the drug toxicity crisis (impacted by Covid-19 related disruptions). Systematic review of all Canadian substance use-focused anti-stigma materials from this 11-year period reveals how campaigns represent the social category of people with current and former experience of illicit substance use, how campaigns conceptualize "stigma", how they frame stigma as a problem that needs to be addressed, and how, and for whom, strategies employed within campaign messaging work to challenge substance use-related stigma.

2.4. Method

2.4.1. Community-Based Participatory Research

This study adopted approaches from community-based participatory research (CBPR) (Boilevin, et al., 2018; Torre, et al., 2012). To centre the perspectives of structurally vulnerable PWUD in analysing substance use focused anti-stigma campaigns this project was developed in collaboration with a small group of PWLLE of illicit substance use, criminalization, and stigmatization[4]. These individuals formed a "community advisory board" (CAB) for the study and were instrumental in guiding study development, campaign search strategy, coding framework and interpreting study findings through the unique expertise provided by their current and former experience of substance use stigma as well as other marginalized identities (e.g., low-income/working class, Indigenous). Their perspective was instrumental for placing analyses of anti-stigma campaigns and substance use stigma/criminalization in a wider historical and political context.

2.4.2. Identifying Canadian Anti-Stigma Campaigns

A variety of search strategies were used to identify Canadian substance use-related anti-stigma campaigns including word-of-mouth, systematic Google searches (e.g., Alberta, Toronto, etc. AND "anti-stigma campaign" or "stigma campaign"), reviewing local drug strategy documents and media coverage, reviewing the social media accounts of harm reduction, addiction treatment and public health organizations and by emailing key

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[4] A total of six CAB members were recruited following internal organizational protocols (e.g. random name-drawing from the subset of group members who were interested in the study after a brief introduction from the first author) from the *Vancouver Area Network of Drug Users (VANDU)*, *BC Association of People on Opiate Maintenance (BCAPOM)* and *Western Aboriginal Harm Reduction Society (WAHRS).* The first meeting was held May 7, 2019 and eleven meetings in total took place until Dec. 2020. Meetings from July 2020 onwards were held virtually by Zoom to respect Covid-19 safety protocols. CAB members were paid $30 per each meeting (1-1.15 hours)

contacts within local drug strategy coalitions, public health agencies or government organizations for information on any anti-stigma campaigns they had produced or were familiar with. To be included in the dataset each campaign needed to 1) have reducing stigma towards PWUD as at least one of its goals 2) have been shared widely and 3) have materials available for review and coding. The search began in June 2019 and ended in June 2021. In total, 134 anti-stigma campaigns were identified in Canada during the 11-year period from January 2009 to December 2020. See Appendix A for more details on search strategy and inclusion criteria.

2.4.3. Analytical Approach

Analysis was informed by critical approaches to understanding stigma and stigma reduction (e.g. Reicher, 2007; Tyler, 2020) as well as perspectives from policy studies (e.g. Bacchi's 2009, 2018 "what's the problem represented to be?" approach to understanding policy responses like anti-stigma campaigns as not necessarily addressing but "giving shape to problems"), critical visual discourse analysis (Gleeson, 2012; Khan, 2014; Norton, 2018; Rose, 2016; Steer, 2019) and representations analysis (Hall, et al. 2013). Analysis drew from these perspectives with an overall goal of critically reading each individual anti-stigma campaign to understand when, where and by whom each campaign had been produced, how campaign creators chose to represent the identities of PWLLE in campaign materials, how each anti-stigma campaign defined stigma and represented the "problem" of stigma, and what anti-stigma strategies campaigns employed. Analysis also used frequency count strategies commonly used to assess representation and diversity in visual materials (see Ishizuka & Stephens, 2019; Norton, 2018, pp. 109-131; Revier, 2020). CAB members also helped shape the analytical approach. For example, the CAB provided ideas for initial analytical focus (e.g., examining over-representation of White, middle class PWUD in campaigns), reviewed select individual campaign materials together and collaboratively worked to interpret campaign messages, and helped unpack the meaning of common anti-stigma narratives like "addiction does not discriminate" from their perspectives as PWUD experiencing structural vulnerabilities.

2.4.4. Coding Framework

An initial coding framework was developed in collaboration with the CAB (e.g., CAB members suggested that I code for each campaign's emphasis on addiction recovery or treatment as a goal of stigma reduction) and then revised and adapted iteratively as coding proceeded and additional features of the data became clear. Two independent coders (a trained undergraduate research assistant and the first author) coded each campaign to capture where it had been produced, when it had been released, its target audience, what types of organizations had developed it, and content delivery formats. Most campaigns represented individuals in their materials and each of these individuals was coded for how they were represented in their relationship to substances (e.g., lived experience, service providers, family members), apparent race, class, gender, sexual orientation, age and physical disability status. Finally, each campaign was analyzed and coded in terms of how it defined "stigma", whether other forms of oppression were mentioned (i.e., intersectionality with substance use stigma), what the problem of stigma was represented to be and what anti-stigma strategies were employed. See Appendix B for a more detailed explanation of the coding framework and approach to representation coding.

I calculated correlation coefficients of independent subjective representation coding (i.e., coders categorizing campaign subjects by apparent race, class, gender, etc.) using SPSS (IBM Corp, 2021). This statistic represents the extent to which the two independent coder's frequency counts of all representation categories for each campaign were correlated, with "1" indicating perfect overlap. Correlations were greater than .75 in 23 out of 30 representation categories. Categories in which very few people were coded (e.g., Agreement that a person's social class was unclear, n=10, *r*=.38) or the boundaries of social categories were less clear (e.g. Agreement that a person was ambiguously non-white, n=67, *r*=.62) tended to have lower correlations. All but one (Agreement that a person was Latinx, *r*=-.037, n= p=.7) of the correlations were significant (p<.001). As an additional comparison I calculated absolute mean differences between the two independent coders' frequency counts, revealing only three variables (Agreement a person was "Middle class", "Younger adult", and "Middle-aged") with values greater than one. All discrepancies between independent coders were identified, discussed, and ultimately resolved collaboratively through regular meetings. More information on coding comparisons and a table with all correlation effect sizes is presented in Appendix C.

2.5. Results

The results of this review are divided into two main sections. First, the 134 anti-stigma campaigns are briefly characterized in terms of their release dates, launch locations, and other details about their origins, formats, and contents. Second, the main findings of the review are summarized in four key themes that deal with representations of PWLLE, intersectionality, stigma definitions and problematizations and a focus on “recovery” in anti-stigma messages.

2.5.1. Timing, Location and Background of Anti-Stigma Campaigns in Canada 2009-2020

Table 2.1 The emergence of substance use-related anti-stigma campaigns in Canada 2009-2020 by province/territory and year

Region	Year												TOTAL
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	
Canada-Wide	-	-	-	-	1	-	-	1	1	6	8	6	23
BC	-	-	-	-	-	1	-	1	4	7	7	6	26
Alberta	-	-	-	-	-	-	1	1	1	4	6	1	14
Saskatchewan	-	-	-	-	-	-	-	-	-	-	5	2	7
Manitoba	-	-	-	-	-	-	-	1	1	1	1	1	5
Ontario	-	-	1	1	3	1	2	1	2	10	12	11	44
Quebec	-	-	-	-	-	-	-	-	-	-	1	-	1
New Brunswick	-	-	-	-	-	-	-	-	-	-	3	-	3
Nova Scotia	-	-	-	-	-	-	-	-	1	1	-	-	2
PEI	1	-	-	-	1	-	-	-	1	-	-	-	3
Newfoundland & Labrador	-	-	-	-	-	1	-	-	-	-	1	-	2
Yukon	-	-	-	-	-	-	-	-	-	-	1	-	1
Northwest Territories	-	-	-	-	-	-	-	-	1	-	2	-	3
Nunavut	-	-	-	-	-	-	-	-	-	-	-	-	0
TOTAL	1	0	1	1	5	3	3	5	12	29	47	27	**134**

Note: A dash indicates no campaigns were identified in that province/territory that year

As shown in Table 2.1, the vast majority (85.8%) of anti-stigma campaigns in Canada were launched in the years 2017-2020. This timing roughly correlates with the dramatic upsurge of synthetic opioids, including fentanyl and its analogues, into some illicit drug markets in Canada (e.g. BC, Alberta) in approximately 2015, followed by dramatic increases in fentanyl toxicity each year since then (PHAC, 2023), sharp yearly increases in opioid-related (especially fentanyl) overdose deaths across Canada (Belzak & Halverson, 2018; Canadian Centre on Substance Use and Addiction, 2015) and the April 2016 declaration of the overdose crisis as a public health emergency in British Columbia (Government of BC, 2016). As the overdose crisis worsened and overdose deaths became harder to ignore, many organizations came to identify "stigma" as a contributor to overdose mortality, often as a predictor of using drugs alone. This link between stigma and overdose risk was reflected in the many campaigns that include a reference to overdose risk in their title or key campaign messages (e.g., "Stop Overdose", "Overdose Can Affect Anyone", "Overdose is Closer Than You Think"). Thus, anti-stigma campaigns began to emerge en masse in response to the worsening drug toxicity crisis.

The review identified at least one anti-stigma campaign in every province and territory across Canada except for the territory of Nunavut where the number of opioid-related overdoses has remained very low (PHAC, 2023). Most anti-stigma campaigns have been launched at the national level in Canada (23 campaigns shared nationally, 20 from 2018-2020), and provincially in BC (26 campaigns, 24 from 2017-2020), Alberta (14 campaigns, 11 from 2018-2020) and Ontario (44 campaigns, 33 from 2018-2020). These three provinces have also reported the highest total numbers and some of the highest age-adjusted rates[5] of overdose deaths in Canada every year since 2016 (PHAC, 2023). This suggests that anti-stigma campaigns have emerged in response to heightened rates of overdose deaths related to synthetic opioids like fentanyl by both time and location.

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[5] From 2016-2020), BC (16.4 to 31.4) and Alberta (14.3 to 20.7) have consistently had the highest age-adjusted rates of overdose deaths (per 100 000 population) in Canada, other than in 2016 when the Yukon Territories' rate was the highest in Canada at 18.2 (PHAC, 2023), though the very small population in the Yukon makes its overdose mortality rate prone to significant fluctuation.

Table 2.2 Summary of frequencies of anti-stigma campaign characteristics

	Total	Percentage
Intended Campaign Reach		
Province/Territory	40	30%
Specific City	33	24%
National	21	16%
County/Regional District	26	19%
University	5	4%
Indigenous Community	4	3%
Specific Service Providers	4	3%
Punjabi/Chinese-Speaking Community	1	1%
Intended Campaign Audience		
General Public	116	87%
Service Providers	14	10%
PWLLE	6	5%
Family and Friends of PWLLE	4	3%
Campaign Content Style		
Curated Stories	67	50%
Images and Messages	41	31%
Dramatized Stories	22	16%
Education Only (No individuals)	16	13%
Campaign Sharing Style		
Social Marketing (e.g., PSAs)	73	54%
Primarily online (e.g., social media)	50	37%
Interactive components	15	10%
Longer documentaries	7	5%
Organization Type		
Public Bodies of Some Kind	44	33%
Province/Territory Gov.	*18*	*13%*
BC Regional Health Authorities	*9*	*7%*
Ontario Regional Health Org.	*8*	*6%*
Health Canada (Federal Gov.)	*4*	*3%*
Indigenous Organizations	*4*	*3%*
Police	*1*	*1%*
Regional Drug Strategy Coalitions	24	18%
Grassroots Groups	24	18%
PWLLE Groups	*13*	*10%*

	Total	**Percentage**
Family Member Groups	*4*	*3%*
University Students	*5*	*4%*
Independent Individuals	*2*	*2%*
Harm Reduction Org.	14	10%
Large Non-Profit Organizations	11	8%
Small Non-Profits	9	7%
Professional Association	3	2%
Private Health Corporation	2	2%
University Researchers/Staff	3	2%
Stigma Focus		
Entirely Stigma-Focused	60	45%
Partially Stigma-Focused	66	49%
Less Explicit Stigma Focus	8	6%
Substance Focus		
“Drugs” or “Addiction”	84	63%
Opioids	44	33%
Naloxone	4	3%
Crystal Meth	1	1%
Cannabis	1	1%

Note: Some sections in Table 1 include percentages and totals that add up to more than 100% because some coding categories were not mutually exclusive, e.g., some campaigns had content directed towards both a general public audience and PWLLE themselves.

Additional details describing campaigns are presented in Table 2.2. The most common “reach” of a campaign was across a province or territory, regional district, or specific city with a smaller number of campaigns shared nationally or in a specific organization or community. Overwhelmingly, campaigns targeted a general public audience (e.g., they were shared on social media or in public spaces such as bus stops) with a smaller number of campaigns targeting individuals in a specific field who may work with PWLLE, PWLLE themselves or the friends and family of PWLLE.

Half of the campaigns conveyed their messages through “curated stories”, that is, campaign subjects selected by campaign creators to communicate personal narratives about substance use through audio, video, imagery and/or text. Nearly one third of the campaigns communicated their content more statically through a combination of “images and messages” that emphasized representations of identities and roles but not the stories or narratives of PWLLE. Most of these “images and messages” campaigns

(32/41 or 78%) utilized stock imagery to represent PWLLE. A smaller number of campaigns conveyed their message through “dramatized stories” in which actors (sometimes PWLLE) or animations represented some facet of the lived experience of PWLLE (often the experience of stigma itself). A minority of campaigns did not represent any individuals and focused solely on “education” (e.g., myth-busting about addiction). Campaign content was most commonly shared through traditional social marketing (e.g. PSAs, physical posters or billboards), but also through web-based forums (e.g. social media only), through interactive experiences either in person or virtual (e.g. Alberta’s Strathcona County Family and Community Services, “Opioids Don’t Discriminate”, November 2018), and through longer documentaries (those included ranged from 12 to 72 minutes) accompanied by widespread promotion with a clear goal of stigma reduction.

A broad range of organizations and actors have developed substance use-focused anti-stigma campaigns in Canada. Most often, these were publicly funded bodies with a focus on public health promotion or harm reduction. One third of the campaigns were developed by various levels of governments (including four Indigenous organizations), public health organizations or police. Slightly under one fifth of the campaigns were developed by local “drug strategy coalitions” or “opioid task forces”. These coalitions often received public funding and were usually comprised of staff from substance use-related service provider organizations, local public health authorities, police and PWLLE. Slightly less than one fifth of the campaigns were developed by “grassroots groups” including concerned citizens, family members of people affected by substance use or PWLLE themselves. The remainder of the campaigns were developed by organizations that provide harm reduction supplies and services to marginalized communities (including six organizations that focused on supporting people with HIV/AIDS), large (often national in scope) non-profits (including the Canadian Centre on Substance Use and Addiction, CCSA, a non-governmental organization under the direction of the federal minister of health that created seven campaigns and influenced or directed several more, creating an outsized influence on anti-stigma campaigns in Canada), smaller non-profits (including several treatment-focused organizations) that were often provincial or city-based, professional associations (e.g. Saskatchewan Union of Nurses), private health corporations (e.g. Emergent Biosolutions, the pharmaceutical company that makes and distributes naloxone in Canada) and university researchers or staff.

While many campaigns exclusively focused on stigma reduction as a goal, slightly more than half of the campaigns included stigma reduction as just one amongst several goals (e.g., education on signs of an overdose). A smaller number did not explicitly name "stigma" as a target within campaign content but were confirmed to have had stigma reduction as a goal through personal communication with campaign developers or the use of common anti-stigma slogans or strategies.

Most anti-stigma campaigns appeared to be implicitly, if not explicitly, focused on reducing stigma towards people are at risk of opioid overdose specifically. One third of all campaigns were identified as explicitly targeting stigma towards people who use "opioids" (e.g., Ontario Region of Peel's "Opioids Don't Discriminate", December 2019). This included three campaigns focused on addressing stigma around the opioid agonist therapy Methadone. An additional four campaigns attempted to destigmatize using the opioid antagonist Naloxone specifically. The remaining two-thirds of campaigns used language that focused on stigma towards substance use, addiction or "PWUD" in a general way. Nevertheless, these campaigns often contained messages around the apparent connection between stigma and overdose death, implying a focus on people at risk of opioid-related overdose. A smaller number of these general "substance use" anti-stigma campaigns focused on more commonly used legalized substances such as alcohol, tobacco or prescription pills (often implied to be opioids). However, this focus appeared more often in areas of the country where problems with alcohol (e.g., high risks for chronic and acute alcohol-related health harms) were more significant than problems with opioids (e.g. the Northwest Territories, the Atlantic provinces, see Government of New Brunswick, 2016) and in the years before the "opioid crisis" narrative gained national prominence. Just one anti-stigma poster (Saskatchewan Department of Health, October 2019) was identified that specifically targeted stimulant-related stigma, though people who use(d) stimulants occasionally appeared in anti-stigma campaigns targeting substance use or addiction-related stigma more generally. One campaign was identified that targeted cannabis-related stigma (#BTSCannabis, March 2020).

Overall, it appears that anti-stigma campaigns are a recent phenomenon in Canada that have been pursued in the wake of rising rates of drug toxicity death in terms of timing and location. A focus on stigma reduction to prevent opioid-related deaths specifically is implicit in most campaigns and in many cases stated explicitly. Campaigns are typically publicly funded through governments and public health organizations and target a general public audience. Finally, most campaigns depict PWLLE in some way and use these individuals' stories and identities to convey their message about the impact of stigma and the importance of reducing stigma. Given, the emphasis in most anti-stigma campaigns on addressing stigma as a risk factor for drug toxicity death, do campaigns also tend to represent people and groups who are most at risk of overdose mortality? The following key themes go deeper in analyzing 1) who these campaigns represent as PWLLE of illicit substance use, 2) how campaigns make connections (or not) between substance use-related stigma and other forms of oppression, 3) how stigma is defined as a concept and as a problem, and 4) the role of "recovery" in anti-stigma narratives.

2.5.2. Key Themes

1. Representations of PWLLE: Prioritizing White, middle class people who use(d) opioids as the subjects of destigmatization

Out of the total 1289 focal individuals identified across all 134 campaigns, 56% were represented as PWLLE of substance use or addiction[6]. Of these 727 people, the largest proportion were represented as actively using illicit substances (41%), followed by people represented as no longer actively using illicit substances and typically referred to as being "in recovery" from addiction (29%), people represented as having died of an overdose (22%), and people represented as "potentially" a PWUD (8%), typically to emphasize that anyone 'could' be a PWUD[7]. Since this study's key research questions

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[6] Nineteen anti-stigma campaigns did not represent any individuals and eleven campaigns that did represent individuals did not represent any PWLLE. This resulted in a total of 104 (out of 134) anti-stigma campaigns featuring 727 individuals represented as PWLLE of substance use or addiction (55.8% of all 1216 focal individuals across all campaigns) with an average of 7 PWLLE represented per campaign (median = 5, range = 1 to 33).

[7] A few individuals did not fit neatly into these categories including people who were represented as having briefly experienced dependence on prescribed opioids but never having experienced 'addiction' (coded as "person in recovery") and people who were

concern how the identities of PWLLE of substance use were represented in anti-stigma campaigns, subsequent analyses of representation will focus on these 727 individuals only[8]. Representation coding (see Appendix B for a detailed description of coding methodology) for PWLLE (race, class, gender, sexuality, age, disability status) is summarized in Table 2.3 and expanded upon in the following sections.

Table 2.3 Totals and percentages by representation category for all 727 PWLLE coded across 104 anti-stigma campaigns

Representation Category	Total	Percentage
Race		
White	526	72.4%
Indigenous	46	6.3%
Black	48	6.6%
Asian/Middle Eastern	33	4.5%
Latinx	2	.3%
Ambiguous non-White	50	6.9%
Unclear/Obscured	22	3.0%
Social Class		
Close to the Street	49	6.7%
Working Class	132	18.2%
Middle Class	511	70.3%
Upper Class	27	3.7%
Unclear	8	1.1%
Gender & Sexuality		
Men	415	57.1%
Women	305	42.0%
Trans / Non-Binary	7	1%
Non-Heterosexual	6	.8%

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represented as having died of substance use-related illnesses like necrotizing fasciitis (coded as people who “died of an overdose”).

[8] This 727 total includes 35 people primarily represented as service providers or friends/family members who also self-identified as having lived experience of substance use or addiction. Of the focal individuals who were not primarily represented as PWLLE, 21% were friends or family members of someone with current or former experience of addiction or (most frequently) someone who had died of an overdose, 22% were service providers or other ‘experts’ on addiction, substance use or stigma, 2% were represented simply as “supporters” of PWUD with no other obvious personal connection to substance use and 2% were represented primarily as “stigmatizers” depicted as mistreating PWUD.

Representation Category	**Total**	**Percentage**
Age Group		
Children (0-14)	6	.8%
Youth (15-29)	245	33.7%
Younger Adults (30-44)	317	43.6%
Middle-Aged (45-60)	119	16.4%
Older Adults (60+)	40	5.5%
People With Visible Physical Disabilities	6	.8%
Total	727	100%

Representations of Race. Of the 727 people represented as having lived or living experience of substance use, nearly three quarters were coded as appearing to be White. Small and roughly similar-sized minorities of PWLLE were coded as Indigenous, Black, Asian or Middle Eastern, or “Ambiguous non-White”. Only two PWLLE appeared to be represented as Latinx and twenty-two PWLLE were not represented clearly enough to be coded into a specific racial category (e.g., they were depicted only as a silhouette to preserve anonymity).

A follow-up analysis examined what ratio of PWLLE in each of the 104 campaigns that showed PWLLE were coded as White. One third (33%) of the anti-stigma campaigns exclusively represented PWLLE who were coded as White. Compared to 2016 census data[9] (72.9% White Canadian population, Statistics Canada, 2017), slightly over half (58%) of the anti-stigma campaigns that depict PWLLE in this review over-represented (i.e., had a White proportion that was greater than 72.9%) White-appearing PWLLE. However, no epidemiological statistics in Canada suggest that White people are over-represented or even proportionally represented in the population of people experiencing problems with substance use or at risk of drug toxicity. On the contrary, Indigenous people in Canada are over-represented nationally in hospitalizations for opioid toxicity (Carriere, et al., 2018) and over-represented in drug toxicity mortality rates in every province where such disaggregated data are collected.

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[9] Data from the 2016 census rather than the most recent (2021) census are used for contextualization purposes as this date more closely approximates the bulk of anti-stigma campaign release dates in this data set (2009-2020) and thus is a better reflection of population demographics at the time of campaign launch.

This becomes apparent when comparing federal and provincial racial demographic data from the 2016 national census with opioid toxicity data collected in the provinces of BC, Alberta, Saskatchewan and Ontario (Alberta Government and Alberta First Nations Information Governance Centre, 2017; First Nations Health Authority, 2019; The Institute of Clinical Evaluative Sciences and Chiefs of Ontario, 2017; Saskatchewan Coroner's Service, 2022). These four provinces have had the highest rates of opioid toxicity deaths in Canada from 2016 to 2020 (PHAC, 2023) and have also reported disaggregated data on Indigenous over-representation in drug toxicity deaths[10]. Analyses by province showed that Indigenous people have been represented as PWLLE and the subjects of destigmatization in campaigns unevenly across anti-stigma campaigns in Canada. For example, nearly half (21/46) of the PWLLE represented as Indigenous appear in just nine campaigns from BC, a province with both an over-representation of Indigenous peoples in drug toxicity deaths (FNHA, 2019) and a corresponding emphasis on including Indigenous PWLLE as the subjects of anti-stigma campaigns (e.g. nine Indigenous PWLLE appeared in three campaigns produced by BC's unique "First Nations Health Authority", six Indigenous PWLLE appeared in a single early campaign called "Stop Stigma. Save Lives." produced by BC's Northern Health Authority in 2017, in a region with a high concentration of Indigenous peoples).

Other jurisdictions in Canada stand out for their lack of inclusion of Indigenous people as PWLLE in anti-stigma campaigns, despite documented over-representation of Indigenous peoples in drug toxicity mortality and morbidity. In Saskatchewan, Indigenous people made up 56% of the 221 people who died of an apparent accidental opioid toxicity in the province in 2020. Yet, across six substance use-related anti-stigma campaigns in Saskatchewan from 2019-2020 only 5 (9%) out of 54 PWLLE appeared to be represented as Indigenous. In Alberta, where First Nations people have been found to have an opioid toxicity mortality rate 3.6 times higher than non-First Nations and an overall average rate of opioid-related emergency department visits (2011-2015) five times that of non-First Nations people (Alberta Government and Alberta First Nations Information Governance Centre, 2017), only 2 (2.4%) out of 85 PWLLE across 13 anti-

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[10] Not including the Yukon Territory which has had a consistently high drug toxicity mortality rate from 2016-2020 (ranging from 10.2 to 19.8, age-adjusted rate per 100, 000) but only a single anti-stigma campaign and no officially reported data on Indigenous over-representation (though see Connors, 2020)

stigma campaigns (2015-2020) appear to be represented as Indigenous[11]. In Ontario, a public health crisis stemming from addiction to prescription opioids and other drugs has been well-known in northwestern Indigenous communities since at least 2009 (Kanate, et al., 2015), with several First Nation communities declaring local states of emergency in response (e.g., Nishnawbe Aski Nation, 2009). Despite this, and recent reports that found First Nations people died from opioid-related toxicity at triple the rate for non-First Nations people in 2015 (The Institute of Clinical Evaluative Sciences & Chiefs of Ontario, COO, 2017) and that the Covid-19 pandemic had contributed to increases in First Nations opioid toxicity death rates twice those for non-First Nations people (COO & ODPRN, 2021), only seven PWLLE that appeared to be Indigenous were identified across Ontario's 30 anti-stigma campaigns that collectively feature 248 PWLLE. Taken together, it appears there is a systematic under-representation of Indigenous people in anti-stigma campaigns (other than in BC) despite evidence of disproportionate substance use-related harms in Indigenous communities. A similar trend has been observed in recent analyses of Canadian news media reporting on the overdose crisis (Johnston, 2020; Webster, et al., 2020).

Several campaigns included what I came to refer to as "diversity panels", that is, brief or background representations of an intentionally numerous and ethnically diverse group of people on a campaign website or as a part of campaign imagery. Individuals in diversity panels were not coded because they did not count as "focal individuals" and it was not always clear how these individuals' relationship to substances was meant to be understood. They provide campaigns a veneer of racial diversity. For example, a key campaign image in the "Learn their story. Stop the stigma." Campaign from Brant County Health Unit (September 2020) depicts a diversity panel of cartoon figures that appear to be of a wide variety of ethnic backgrounds. Most likely, individuals in a diversity panel such as this are meant to be interpreted as "potential drug users" to fit the narrative that anyone could be affected by substance use or overdose and "addiction does not discriminate" (see below).

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[11] A recent update to one Albertan campaign ("Critical Condition", City of Grande Prairie) included the addition of five short videos featuring Indigenous PWLLE and a new campaign ("Addictions don't discriminate", REACH Edmonton, 2021) included several Indigenous lived experience storytellers. However, these were released in 2021 and thus not within this review's inclusion window (2009-2020).

Representations of Social Class. Only a small number of the 727 PWLLE were coded as "close to the street" in terms of social class, with one in five coded as "working class", nearly three-quarters coded as economically privileged (i.e. "middle class" or "upper class") and six PWLLEcoded as "unclear" because there was not enough information from an individual's context, story or appearance to determine anything about their social class (see Table 2.3). Taking the distinction between "middle class" and "working class" to be a general marker of a social boundary between who may be associated with the stereotype of lower-income PWLLE and PWLLE that are more economically privileged, I examined what proportion of each campaign's focal individuals who were PWLLE had been coded as either "middle class" or "upper class". This analysis showed that two-fifths of these campaigns exclusively featured PWLLE coded as middle- or upper-class. Over half (53%) of the campaigns depicted more than three quarters of their PWLLE as upper class or middle class.

As with "diversity panels" depicting people of a wide range of racial backgrounds, a few anti-stigma campaign videos included blurred or long-range shots of street-based substance use or poverty as a backdrop to the focal narratives communicated through interviewees and their voiceover descriptions. For example, in the Hamilton Drug Strategy's "See the person. Stop the stigma" campaign (2019), individuals in the street-based B-roll scenes were typically not identifiable beyond the fact that they were homeless, poor, and congregating outdoors. Because these individuals were anonymized and not asked to speak, they were not considered "focal individuals" and thus not included in representation coding. While campaigns primarily focused on the stories and identities of economically privileged PWLLE, anonymous imagery of economically marginalized PWUD was sometimes used as a contrasting backdrop to stories of middle class experiences with substance use. Despite strong epidemiological evidence indicating that structural vulnerabilities around poverty, housing instability and low-wage work environments are significantly associated with overdose mortality and morbidity (BC Coroner's Service, 2022; Carriere, et al., 2018; Carriere, et al., 2021; ODPRN, et al., 2020; ODPRN, et al. 2021, 2022), most anti-stigma campaigns do not focus on these demographics when representing the subjects of potential destigmatization. Instead, they typically tell middle-upper class stories of "unexpected" addiction or overdose, eliding the structural context (e.g. economic inequality) that drives the bulk of substance use harms.

Representations of gender and sexual identity. PWLLE coded as transgender or non-binary were uncommon, appearing only seven times across all campaigns. Similarly, across all campaigns, only six PWLLE were represented as lesbian, gay, bisexual or queer. This finding is striking given evidence suggesting gender and sexual minority groups experience elevated risk of overdose morbidity and mortality (Goodyear, et al., 2020; Scheim, et al., 2017).

Of the 727 PWLLE represented across all campaigns, slightly more than half (57.1%) were coded as men. A campaign ratio analysis examining what proportion of PWLLE per campaign were coded as men revealed that a similar number of campaigns exclusively featured male PWLLE as featured none and the largest proportion of campaigns represented roughly equal numbers of male and female PWLLE. The percent of men amongst accidental apparent opioid toxicity deaths in Canada (2016-2021) has ranged from 72% (2019) to 77% (2017) according to the best available national data (PHAC, 2023). Using 72% as a conservative lower bound, three quarters (76%) of the anti-stigma campaigns under-represent male PWLLE compared to their representation in national accidental opioid toxicity death statistics[12]. As with the under-representation of Indigenous and lower-income PWLLE despite disproportionately high overdose mortality, anti-stigma campaigns tended to not reflect the disproportionate overdose mortality rate amongst men. However, this finding differs in that men are a privileged group whereas Indigenous and lower income groups are relatively disadvantaged. The simplest explanation appears to be that anti-stigma campaigns generally strive to achieve gender parity in representing PWLLE[13].

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[12] A comparison between the lower and higher bound of male percentages of apparent accidental opioid toxicity deaths and percentages of male PWLLE represented across anti-stigma campaigns in the seven provinces with available data and at the national level suggests that this trend of anti-stigma campaigns under-representing men compared to their representation in drug toxicity mortality broadly holds across most jurisdictions in Canada.

[13] It is also possible that there was a greater tendency to include women who use(d) drugs (WWUD) in anti-stigma campaigns because women were more likely to want to tell their stories (when using real people) and campaign creators felt female stories might be more compelling to audiences. A follow-up sub-analysis of representation of WWUD in these campaigns (Neufeld & Jarvis, 2022) found that in many cases campaign creators relied on tropes of feminized innocence in their portrayals of WWUD to build compassion with their audience, allowed WWUD lived experience narratives to frequently denigrate WWUD engaged in survival sex work, and in about equal amounts

Representations of age. Slightly less than half of all PWLLE were coded (based on reported ages, when possible, apparent age when not) as younger adults (30-44) and a further one third as youth (15-29). A small minority (16.4%) appeared to be middle-aged (45-60) and much smaller percentages as older adults (5.5%) and children (.8%). The two middle categories (youth and younger adults, approximate age range of 15-44) correspond roughly with the 20- to 49-year-old demographic that is often said to comprise most apparent opioid toxicity deaths in Canada (PHAC, 2022)[14]. These two categories combined make up 77.3% of all PWLLE represented across 104 anti-stigma campaigns. Additional analysis of ratios of this combined age group for each campaign reveals that 31% of campaigns exclusively depict PWLLE who were coded in the 15-44 age range.

While the over-representation of youth and younger adults amongst those dying of apparent opioid toxicity in Canada is well-known (Belzak & Halverson, 2018; PHAC, 2023), anti-stigma campaigns across Canada over-represent PWLLE coded as between the ages of 15 and 44 even more significantly. Census data indicate that in 2016 individuals aged 15-44 comprised 38.2% of the population (Statistics Canada, 2017), suggesting that 89.4% of campaigns over-represent this age demographic in representations of PWLLE compared to their share of the population. Furthermore, 58.7% of campaigns over-represent this age demographic compared to the highest percentage (70%, in 2021) of opioid overdose mortality reported by the Public Health Agency of Canada (2023) for the 20-49 demographic (a rough proxy for the 15-44 age group used in representation coding).

Representations of PWLLE in this age range were specifically centered in memorialization-type campaigns that typically featured parents and photos of their children lost to drug toxicity as well as several campaigns that specifically targeted youth addiction. For example, just seven campaigns identified as having at least one component designed specifically to communicate with youth at risk of addiction or

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challenged, or perpetuated the "good mother ideal" that condones child removal as a fitting consequence for any illicit substance use.

[14] This is sometimes reported as a highlighted finding in PHAC's regular updates on opioid toxicity deaths, though according to their own (2022) data the 30-59 demographic has captured a larger total proportion of apparent accidental opioid toxicity deaths at a national level than the 20-49 age bracket in every year this data has been collected (2016-2021).

overdose (e.g., “Just Talk PEI”, “Know More Opioids”, “Courageous Conversations”) accounted for 16% (40/245) of the youth PWLLE in the entire sample. Similarly, just six campaigns identified as “memorial” campaigns affiliated with national advocacy organization Moms Stop the Harm (e.g. “Overdose Can Affect Anyone”, “Niagara Area Mothers Ending Stigma Video”) accounted for 31% of the youth (76/245) and 15% of the younger adult PWLLE (48/317).

Representations of physical disability. Across the dataset only six PWLLE (.8%) were coded as having a physical disability (e.g., someone using a cane, wheelchair or other mobility aid) that was specifically named or visible in campaign materials. An additional twelve PWLLE described their experience of physical injuries or chronic pain as related to their substance use, either as a trajectory into prescription opioids and subsequent dependence (though see Feldman, 2017) or as a justification for ongoing opioid use (e.g., self-medicating pain). In these cases, representations of pain-related disability were integral to an anti-stigma message emphasizing how external factors had contributed to their trajectory into dependence on substances. This accords with surveillance data suggesting many people who experience opioid-related overdose are also receiving disability supports or have accessed healthcare related to pain management (BC Coroner’s Service, 2018; Martin, et al., 2020). In terms of representation in the national population, the Canadian Survey on Disability reports that as of 2017, 22% of the Canadian population aged 15 and up had at least one disability (Morris, et al., 2018). While many of these disabilities are not necessarily “visible” (e.g., pain-related, flexibility, mental health) this does suggest that people with disabilities are under-represented as PWLLE in substance use-related anti-stigma campaigns.

2. Addiction Does Not Discriminate? Colour-Blindness and the Absence of Intersectionality in Anti-Stigma Campaign Framing

Despite the clear history of intersections between substance use-related stigma and other forms of group-based oppression (e.g., racism, classism, sexism), close review of all anti-stigma campaign messages in the sample revealed that these intersections were not mentioned at all in 112 of 134 (84%) campaigns. Most frequently, substance use-related stigma was conceptualized and addressed within anti-stigma campaigns as if other forms of oppression were not relevant. A slightly larger number of campaigns (118/134 or 88%) make no mention of any inequities between social groups being relevant to issues with substance use or addiction. Indeed, this is an explicit commitment of many campaigns through a narrative that “addiction does not discriminate” or could ostensibly impact “anyone”. The narrative that “addiction does not discriminate” (including similar formulations such as “Overdose can affect anyone”, “Opioids don’t discriminate”, “All walks of life”, “Addiction does not have a single face”) appears as a central anti-stigma message or campaign slogan in 36 out of 134 campaigns (27%) and as at least one of several campaign messages (e.g. one interviewee makes a statement to this effect) in an additional 42 campaigns. Thus, a total of 78 campaigns (58%) employed some version of the “addiction does not discriminate” narrative as part of their anti-stigma message.

A close analysis of how the “addiction does not discriminate” narrative was operationalized both in campaign messages and imagery suggested that it was meant to establish shared identity between the audience and campaign subjects (or PWUD in general) by “challenging stereotypes” about what social categories are associated with substance use or overdose risk. In many cases, overdose risk was positioned as an equal opportunity or “colour blind” threat that therefore did not “discriminate” between social categories. An illustrative social media post from the Saskatchewan Union of Nurses’ “Making the difference: On the frontlines of addiction and crisis” campaign (April 2019) depicts the faces of four young people (three men and one woman) overlaid with the text “There is no ‘typical’ face to addiction. It doesn’t matter if you’re rich or poor. It’s a disease that cuts across race, class, gender, income, and social status.” Ironically though, all four individuals in the post appear to be White. An accompanying video entitled “Faces of Addiction” quotes Regina police chief Evan Bray saying: “we as a society tend to stereotype what we think someone with an addiction problem looks like and acts like, that’s not the case”. Bray’s quote highlights the key message of this ubiquitous “addiction does not discriminate” narrative: problems with substance use are not confined to those who fit the “stereotype” of someone who uses drugs. Whereas this narrative is often accompanied in anti- stigma campaigns by representations of PWUD who appear to be middle-upper class, healthy-looking and often White, stereotypical representations of PWUD are the mirror image of these representations: rough-looking, lower class and often racialized as non-White.

While not the norm, twenty-two campaigns (16%) included at least one mention (even if only once by a single individual in a campaign) of at least one additional form of oppression or exclusion that intersected with substance use-related stigma (i.e., intersectionality). Half of these mentioned an intersection with racism (mostly anti-Indigenous racism, e.g. how Indigenous PWUD face both racism and substance use-related stigma when accessing health care), ten campaigns mentioned how substance use-related stigma intersects with sex- or gender-related stigma (e.g. good mother ideal, sex work stigma, toxic masculinity), and smaller numbers mentioned an intersection with classism (7), mental health stigma (5), or the triple intersection of racism, sexism and substance use stigma (1). Sixteen campaigns (12%) included at least one reference to some form of group-based inequity related to problems with substance use, without going so far as mentioning a related system of oppression (e.g., racism, classism, sexism) as intersecting with substance use-related stigma. Half of these examples (7) referred to the over-representation of Indigenous peoples in overdose mortality with other inequities mentioned included concentrations of overdose or addiction problems among men (2), youth (1), people experiencing mental health challenges (3) or people experiencing homelessness (1).

3. Constructing Stigma Primarily as an Individual Problem

Nearly two-thirds of the anti-stigma campaigns (86/134 or 64%) appeared to define stigma primarily in a narrow social psychological sense as prejudice, stereotypes and discrimination that operate at the level of the individual. This “wrong ideas in the minds of individuals” definition of stigma is mirrored by an equally individualistic conception of how stigma is a “problem” for PWUD: the most common way stigma was represented as a problem in anti-stigma campaigns was as a “barrier to seeking help/treatment” (82 campaigns or 61% made this central, 92 campaigns included this problematization) or as contributing to increased overdose risk (15 campaigns or 11% made this central, 38 included it). Campaigns typically suggested that stigma heightens risk of overdose death by increasing “shame” or “isolation” and thus the chance that an individual will use drugs alone, overdose and die. Thus, the strong suggestion across most campaigns is that the negative attitudes towards PWUD held by bad individuals create barriers that are perceived to prevent people from informing others of their substance use (e.g., family members, friends), accessing support services (e.g. harm reduction, overdose prevention) or seeking treatment for addiction. Since stigma is represented most often as residing within the minds of individuals (rather than as embedded within policies and laws for example), an appropriate remedy would seem to be changing individual attitudes and behavior, increasing compassion, or challenging stereotypes about PWUD.

The dominance of this understanding of stigma across campaigns can also be seen in how the majority of campaigns (82%) target individual members of the “general public” (i.e., public stigma) while others target the attitudes of individual service providers who interact with PWLLE or the “self-stigma” of individual PWLLE (see Table 2.2).

Smaller numbers of campaigns constructed stigma in other ways, both in terms of how they define stigma and how they construct stigma as a problem. A sizeable minority of campaigns (22 or 16%) constructed stigma primarily in terms of the structural, historical or political dimensions of PWUD exclusion such as racist drug policies or drug criminalization. The majority (14/22) of the organizations who produced these campaigns emphasizing structural definitions of stigma were grassroots groups with heavy involvement of PWLLE. Several more campaigns included messages about “structural stigma” alongside a primary focus on individual attitudes, sometimes through their focus on changing stigmatizing attitudes amongst health-care providers who work with PWUD. Associated problematizations of stigma that were also more “structural” included substance use-related stigma as a barrier to taking political action (e.g., policy change) that could increase inclusion for PWUD (12 campaigns), a barrier to uptake of opioid agonist therapies (5 campaigns), and a barrier to uptake of the opioid antagonist Naloxone (4 campaigns). CCSA’s November 2020 #ChangeBeginsWithMe: Be an Ambassador For Change campaign stands out as the only social marketing anti-stigma campaign that constructed the problem of stigma almost exclusively in structural terms as a block to more inclusive drug policy in a variety of spheres (e.g. employment, health care etc.) and encouraged its audience to “take action” to change stigmatizing policies rather than change anyone’s individual attitude.

Less common stigma concepts and problematizations included that stigma is a problem because it diminishes the human right (and thus humanity) of people who use illicit drugs to control the decisions they make about their own bodies (22 campaigns, 16%) and that stigma is a problem because it is simply “morally wrong” (24 campaigns, 18%). Nine campaigns (7%) defined stigma primarily as “dehumanization” (e.g., campaign title or key anti-stigma strategy focused explicitly on asserting the humanity of PWUD) and seventeen campaigns (13%) primarily defined stigma as a “code of silence” around substance use in a given community (often rural or specific racialized communities) associated with anti-stigma strategies such as “starting the conversation” (13 campaigns) or “breaking the silence” (12 campaigns).

4. Stigma Reduction and the Addiction “Recovery” Imperative

Study CAB members suggested that each campaign be assessed in terms of how connected its anti-stigma message or framing was to the idea that PWUD should be seeking “treatment” for addiction or pursuing a life in “recovery” (i.e., no longer using illicit substances). Based on their own lived experience, study CAB members (all people who were currently using criminalized substances) anticipated that many anti-stigma campaigns might function as advertisements for addiction “treatment” or a “recovery” lifestyle (i.e., abstinence from all illicit substance use). They suspected that in many cases substance use-related stigma would be regarded as a problem primarily to the extent that it prevents people from pursuing this abstinence-based notion of “treatment and recovery”. CAB suspicions were correct as three quarters (75%) of all campaigns at least mentioned “treatment” and recovery as part of their anti-stigma message[15]. Thirty-two campaigns (24%) made recovery or treatment a central focus of their anti-stigma narrative. This meant that either the perspectives of people who are represented as being “in recovery” from problematic substance use were centered (e.g. “Possible Campaign”, Addiction Services of Thames Valley, December 2013), the campaign’s anti-stigma message consistently emphasized the importance of seeking addiction treatment or an assumed movement towards “recovery” (e.g. “On my way to wellness”, CAPSA, August 2020) or the key anti-stigma message was something like “recovery is possible” (e.g. “See your self(ie) in recovery”, Faces and Voices of Recovery Canada, September 2018). Furthermore, the treatment and recovery focus in campaign messaging was associated with the common construction of stigma as a “problem” primarily because it might prevent PWUD from accessing services or seeking support from others in their struggles with substance use.

Narratives about addiction treatment or “recovery” also played an important role within common stigma reduction strategies employed by campaigns. By implying a kind of “recovery imperative” that took for granted all or most PWUD’s desired movement towards eventual abstinence from illicit substances (Brookfield, et al., 2021), stigma is

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[15] In this coding, promoting access to the opioid antagonist medication Naloxone/Narcan or harm reduction services in general (e.g. opioid agonist treatments like Methadone or Suboxone, provision of new harm reduction supplies, supervised consumption sites) was not included in the concept of “treatment” or “recovery”

positioned as an unhelpful delay on the assumed journey away from substance use. This message was communicated most explicitly in the narratives of PWLLE who were represented as being “in recovery” or currently abstinent from substance use (27% of all PWLLE represented in campaigns) or by statements shared by the many “service providers” (21% of all focal individuals) who often had their perspectives highlighted in anti-stigma campaigns. In more than one quarter (27%) of campaigns, explicit slogans like “recovery is possible”, “treatment works” and “there is hope” were used to ostensibly reduce stigma towards (some) PWUD for whom abstinence from substance use is a realistic goal. Seven campaigns used this message as their primary anti-stigma strategy (e.g., Addiction Services of the Thames Valley’s “It’s Possible” campaign, June 2012).

This strategy was often intended to reduce PWUD’s “self-stigma”, presumed to be a barrier to seeking addiction treatment. However, another clear message of the “recovery imperative” in anti-stigma campaigns is that the public should not stigmatize PWUD because this prevents a transition out of substance use or addiction, not because it is simply wrong to stigmatize PWUD. The clear focus on addiction treatment and recovery narratives in many anti-stigma campaigns, especially those rooted in ideas of abstinence from all substance use, further excludes marginalized PWUD for whom many treatment options are inaccessible (e.g. expensive and exclusionary residential addiction treatment) or abstinence from substances is not a desirable or realistic goal (Boeri, et al., 2014; Hansen, 2017; Lyons, et al., 2015; Netherland & Hansen, 2017; Pro, et al., 2022; Robertson, et al., 2021). By constructing the only PWUD deserving of reduced stigma as those for whom abstinence is an achievable goal many anti-stigma campaigns may worsen stigma for racialized and lower-income PWUD impacted by structural inequities.

2.6. Discussion

This analysis of 134 Canadian anti-stigma campaigns offers insights into how campaign creators understand the nature of stigma, the problem of stigma and the stories and identities of PWLLE who are elevated as the subjects of destigmatization. It also sheds light on how substance use anti-stigma campaigns may ironically reproduce or exacerbate stigma, especially towards PWUD worst impacted by structural inequities and the intersections of racism, classism and other forms of oppression. As rates of opioid- and specifically fentanyl-related overdose dramatically increased across Canada in approximately 2017, substance use-related stigma was identified as a key problem, and anti-stigma campaigns were increasingly deployed in response. These campaigns were designed to address a problem of stigma most often constructed as creating barriers to seeking or receiving help for one's (assumed to be always problematic) substance use or increasing the risk of fatal drug toxicity through using drugs alone because of stigma-related shame and isolation. Campaigns were most often publicly funded, and have been broadly concentrated in regions where drug toxicity death rates are highest (e.g., BC, Alberta, Ontario). They also frequently relied on representations of the visible identities and personal storytelling of PWLLE to communicate their anti-stigma message.

Like trends uncovered in news and other media representations of the "opioid crisis" (see Daniels, 2018; Dertadian & Rance, 2023; Hansen, et al., 2023; Johnston, 2020; McLean, 2017; Netherland & Hansen, 2017; Revier, 2020; Webster, et al., 2020), anti-stigma campaigns often over-represent White, upper-middle class people compared to these groups' proportion of the total population in Canada and especially compared to representation amongst those who actually die of opioid-related drug toxicity. The one exception to this trend is men. Despite experiencing societal privilege through patriarchy, men are over-represented in overdose mortality and under-represented in anti-stigma campaign imagery, most likely because of a norm of gender parity when campaigns represent PWLLE (or a tendency to prefer female lived experience stories, see footnote 13 on p. 63). Nevertheless, this finding does highlight the need for more public health research to examine specific risk factors driving disproportionate rates of male drug toxicity mortality, including the specific interaction of stigma with "toxic masculinity" that may make it less likely for male PWUD to seek help for their substance use (Bardwell, et al., 2019). Encouragingly, the years since the end of this study's review window have seen the launch of several Canadian male-focused substance use anti-stigma campaigns (e.g., Health Canada's "Ease the Burden", 2021) as well more attention paid to the disproportionate harms of toxic drugs for men working in the trades (Gomes, et al., 2022).

In addition to over-representing privileged groups as PWLLE, many campaigns also suggest that social categories are uncorrelated with stigma or substance use by ignoring intersectionality or claiming that "addiction does not discriminate" and "overdose can affect anyone". The group boundaries drawn between different experiences and attributions for substance use are a part of a political and historical process of inclusion and exclusion of certain groups of people defined by certain types of substance use (Herzberg, 2020). Ironically, anti-stigma campaigns may help perpetuate the exclusionary divides between privileged and marginalized PWUD by emphasizing White, middle-upper class PWLLE in their representations, employing colour-blind and individualized constructions of stigma, and assuming a movement towards addiction "recovery" that is primarily accessible to those with existing social privilege.

2.6.1. Mobilizing New Subgroups of PWUD Who Do Not Deserve Stigma

The Social Identity Approach (SIA) frames stigma as a process of drawing and redrawing the boundaries of who is included and supported as a member of the ingroup (Reicher, et al., 2006; Reicher, 2007; Ryan & Reicher, 2018). Anti-stigma campaigns may contribute to the identity work of representing new subgroups of PWUD who are implied to be undeserving of stigma because they resemble the campaign's intended audience. By routinely over-representing White and middle-upper class appearing PWLLE, anti-stigma campaigns contribute to the perception that substance use-related stigma has recently and uniquely created negative impacts for racially and economically privileged subgroups of PWUD. This contrasts sharply with the dearth of humanizing portrayals of PWLLE represented as economically marginalized or Indigenous in mainstream campaigns. These trends in representation work to convince their general public audience that there is a new subgroup of PWUD at risk of overdose and stigma who, much like the audience, appear to be "normal-looking" people from middle- and upper-class backgrounds who are often also racialized as White. Portraying PWLLE in this way is meant to "challenge" historical stereotypes of "drug addicts" as people who are marginalized in terms of income, housing status, physical appearance, and racial identity.

While racial diversity was expressed in anti-stigma campaigns in complex ways (e.g., sometimes nearly all-White portrayals of PWLLE, sometimes superficially diverse in order to suggest that racial categories do not correlate with substance use-related outcomes), the systematic under-representation of Indigenous peoples as PWLLE deserving of destigmatization in mainstream anti-stigma campaigns stands out. It suggests an intentional mobilization of new understandings of the PWUD social category that does not include the racial group (Indigenous peoples) that has been (and continues to be) worst impacted by racialized substance use-related stigma and negative health outcomes (Campbell, 2008; FNHA, 2021; Marshall, 2015). Alarmingly, many anti-stigma campaigns are working hard to ensure that groups who have been historically marginalized through race- and class-based substance use-related stigma (and over-criminalization) are no longer centred in societal discourse about harmful substance use. This appears to be an attempt to build upon audience empathy for members of the dominant (White, middle class) group. An unintended consequence is the systematic exclusion of subgroups who have been most severely impacted by substance use-related stigma, criminalization, and harms such as death from toxic drugs.

The common claim within anti-stigma campaigns that social categories are irrelevant to the issue of substance use likewise supports the process of mobilizing new definitions of the social category of "PWUD" that treat privileged PWUD as different and superior to marginalized PWUD. The colour-blind anti-stigma strategies of "addiction does not discriminate" and "overdose can affect anyone" obscure structurally driven substance use health inequities to make room for the inclusion of privileged PWUD in narratives about overdose risk and substance use. This approach has been identified and critiqued in the context of news media representations of the drug toxicity crisis (Johnston, 2020; Netherland & Hansen, 2016) but it has not to date been identified in the context of anti-stigma campaigns. While a "colour blind" approach to stigma reduction may appear inclusive on its surface, it masks the very real group-based inequities in the stigma and health risks associated with substance use (Bonilla-Silva, 2006; Revier, 2020). By denying the importance of social categories (and structural inequities) in determining substance use-related outcomes, narratives like "addiction does not discriminate" can function to reproduce and perpetuate racism, classism, and other group-based divisions since they are never acknowledged, and as a result, never addressed (Netherland & Hansen, 2017). Rather than colour blind approaches that pretend substance use-related stigma is not intersectional and substance use-related harms are not driven by deep structural inequities, anti-stigma interventions should incorporate resistance to racism and classism and intergroup solidarity between privileged and marginalized PWUD. This may help address the complex phenomenon of substance use-related stigma more robustly with measures that are both more inclusive of all subgroups within the wider category of PWUD and more structurally focused on addressing the political and historical roots of substance use-related stigma rather than only its individual manifestations.

2.6.2. Troubling the “Recovery” Focus of Most Anti-Stigma Campaigns

While abstinence from illicit substances or “addiction recovery” is clearly a major theme and trajectory implied within anti-stigma campaign messaging, the concept of recovery is also sometimes used within campaigns as part of an anti-stigma strategy. A hopeful message that effective treatments for addiction exist may both change peoples’ perceptions of the extent to which PWUD deserve to be helped if recovery seems possible and reduce members of the general public’s desire for social distance with people in recovery (McGinty, et al., 2015).

However, as others have noted, there is a troublesome notion at the heart of this recovery-oriented approach to stigma reduction: we will only have compassion towards you and those like you if you demonstrate that you can leave your stigmatized identity behind. In this approach, PWUD as such are not really being destigmatized. Rather, they are offered a temporary reprieve from exclusion on the condition that they will soon abandon their present group and join the dominant group. Others have referred to this as a “repentance model” of destigmatization (Jones, et al., 1984) or pointed out how temporarily stigmatizing an individual for their behavior or identity can be a powerful form of social control when the conditions of destigmatization include coming under the authority of dominant regimes of power that compel one’s conformity to mainstream norms and productivity in a capitalist society (Tyler, 2020). Further critical analysis of how “recovery” narratives operate within anti-stigma campaigns may be warranted (see Costa, et al., 2012; Fomiatti, et al., 2019; Pienaar & Dilkes-Frayne, 2017; Woods, et al., 2019).

2.6.3. Limitations of this Review and Future Directions

While this review of anti-stigma campaigns in Canada was extensive and comprehensive it is possible that older substance use-related anti-stigma campaigns existed that were no longer available to find online, were never hosted online, or were not available in the memories or hard drives of any of the extensive contacts made throughout Canada in my search. However, it seems unlikely that the number of potentially missed campaigns would have been so large as to have meaningfully affected the patterns around PWLLE representation revealed through this analysis. Only a single anti-stigma campaign was identified in Quebec, however, two extended email exchanges (in English) with well-connected individuals working in harm reduction and drug policy in Quebec suggested the provincial government's PSA was the only example in the province of a widely shared public communication that broadly resembled an anti-stigma campaign.

The review was also limited in its generalizability as only Canadian campaigns were compiled and analyzed. An earlier, initial review of US campaigns (before US anti-stigma campaigns were abandoned as a focus) suggested both similarities (e.g., centering sympathetic White narratives, employing "addiction does not discriminate" narratives) and differences (e.g. more inclusion of Black and Hispanic PWLLE, even greater emphasis on addiction recovery) with Canadian campaigns. Future research could use similar methods to systematically analyze US-based substance use anti-stigma campaigns. While this review identified patterns in the identity characteristics of PWLLE as represented by anti-stigma campaigns, it could not offer further insights into what explains these patterns of representation. Future research could critically analyze the process of campaign development and sources of influence that led to specific anti-stigma strategies or patterns of representation, for example by reviewing internal documents that describe a campaign's design process (Greto & Neufeld, 2022) or interviewing people who contributed to developing a campaign.

Any approach to representation coding based primarily on visual assessments of individuals' identities is necessarily fraught and subject to subjective coder bias. While a process of standardizing coding definitions (see Appendix B), comparison coding (see Appendix C), and discussion and resolution of disagreements with another coder likely helped to bring more consistency to the representation coding, it remains possible that other coders would evaluate the identities of certain individuals' who appear in anti-stigma campaigns in different ways. However, it seems unlikely that potential disagreements of this nature would be so significant and systematic as to dramatically alter the results of the representation analyses reported here.

Finally, this study's representation analysis was somewhat limited by a coding approach that made it impossible to examine the overlap of PWLLE's social categories. For example, while it would have been interesting and relevant to explore the racial representation of all PWLLE who had been coded as "middle class" (e.g. What proportion of PWLLE coded as "middle class" were ALSO coded as "White"?) the coding approach used in this study (i.e. creating and comparing tallies of total number of PWLLE in each representation category for each campaign, see Appendix B) would not easily facilitate this analysis. In retrospect, an alternative coding approach (e.g., coding a screenshot of each individual PWLLE in each campaign with overlapping representation codes using software like NVivo) would have allowed for this type of analysis, and also facilitated different approaches to coding comparison.

This study's analysis should be understood as a preliminary description of substance use anti-stigma campaigns in Canada. Many further questions could be explored using the database of Canadian anti-stigma campaigns I assembled for this study. For example, the present analysis did not engage with questions of how anti-stigma campaigns may have changed since 2009. Future research could examine how campaign messaging and trends in PWLLE representation may have developed over time (e.g., Have White, middle-class appearing PWLLE been represented more often in more recent anti-stigma campaigns?). Future research could also involve more in-depth qualitative analyses that critically examine the language of addiction recovery narratives in anti-stigma campaigns, how different types of organizations (e.g., government, grassroots) frame the problem of stigma and its relation to drug toxicity death in their campaign materials, or how specific social categories of PWLLE have been represented (e.g. Indigenous PWUD). It is my hope that other researchers of substance use stigma and anti-stigma campaigns in Canada can explore these research questions using the database of anti-stigma campaigns produced through this research. As a means of knowledge mobilization, I have made the database of campaigns partially available online at www.antistigma.info as the "Anti-Stigma Archive".

2.7. Conclusion

While "stigma" is certainly on the drug policy agenda across Canada and anti-stigma campaigns are increasingly used to attempt to address the problem of stigma, it is important to ask how, and for whom, these campaigns are meant to challenge substance use-related stigma. Many anti-stigma campaigns appear to be working to rescue privileged (White, middle-upper class) PWUD from negative attitudes expressed by individual members of the public towards individual PWUD. These interventions seem unlikely to address generations of structurally embedded exclusion, dehumanization and denigration directed towards marginalized PWUD at the intersections of racism, classism, and other systems of oppression. Ironically, the patterns of representation and anti-stigma strategies used by many campaigns may only deepen the exclusion of marginalized PWUD.

Despite these overall findings, not all anti-stigma campaigns function in ways that ignore intersectionality, history, and the political aspects of stigma. A number of grassroots campaigns led by PWLLE and their allies framed stigma and the roots of the drug toxicity crisis in a wider political context, acknowledged the structural and intersectional realities of substance use-related harm, and sought to humanize PWLLE marginalized by race, class and other structural vulnerabilities. Close collaboration with marginalized PWLLE and drug user activist organizations in the development of future interventions to challenge stigma may represent a path towards more equitable and inclusive strategies for ending substance use-related stigma, exclusion, and dehumanization, particularly for those impacted most severely.

Chapter 3.

"It's Not Aimed at Us…I Guess We're Not Real People": How Marginalized People Who Use Drugs Perceive Two Canadian Anti-Stigma Campaigns

Substance use-focused anti-stigma campaigns started appearing en masse across Canada in approximately 2017 as the country experienced an unprecedented increase in drug toxicity deaths. These campaigns were largely predicated on the idea that public stigma (i.e. prejudice, discrimination, and stereotypes about PWUD held by the general public, Link & Phelan, 2001; Room, 2005; Tsai, et al., 2019) is a barrier that prevents PWUD (PWUD) from seeking help for problematic substance use (Gutierrez, et al., 2020) and may increase the likelihood of people using drugs alone, thus exacerbating their risk of death by drug toxicity. While well-intentioned, some of these campaigns have attracted criticism from long-time drug policy reform activists and PWUD who experience intersecting harms of substance use stigma, racism, and classism (Canadian Association of People Who Use Drugs, CAPUD, 2018; Coulter, 2018; Wadhwani, 2018). What underlies the criticism of substance use anti-stigma campaigns and how might such campaigns contribute to negative outcomes for marginalized PWUD?

While Chapter 2 of this dissertation provided a comprehensive review and critical analysis of trends across 134 Canadian substance use-focused anti-stigma campaigns (2009-2020), this chapter explores the potentially harmful impacts of anti-stigma campaigns for marginalized PWUD whose social identities (e.g., Indigenous, poor) make them frequent targets for substance use-related stigmatization. A concerning pattern observed across the campaigns reviewed in Chapter 2 was their focus on representing PWUD from groups (e.g., White, middle class) who have not been historically targeted by drug criminalization and who do not experience the worst substance use health inequities. Furthermore, key anti-stigma messages (seemingly intended to "challenge stereotypes" about what PWUD look like) that featured in many campaigns such as "addiction does not discriminate" or "overdose can affect anyone" often functioned to negatively contrast more stereotypical, marginalized PWUD with sympathetic representations of privileged PWUD. Thus, in their imagery and commonly used messages, anti-stigma campaigns frequently construct social categories of groups who deserve to have their substance use be the subject of destigmatization. They therefore also imply what groups of PWUD who do not deserve this.

Historians and drug policy scholars have argued that the work of separating PWUD who are seen as deserving of empathy from those who are seen as unworthy of such empathy has been a foundational and historical process underlying drug policymaking (e.g. the criminalization of certain substances associated with certain social groups) in both the United States (Herzberg, 2020; Hansen, et al., 2023) and Canada (Boyd, 2017; Carstairs, 1999, 2006; Malleck, 2015). The stigmatizing process of differentiating between sympathetic “victims” of addiction or overdose (typically White and middle class) and “criminal drug users” (typically racialized and poor) has likewise been documented repeatedly in critical analyses of news coverage and other mass media in the United States (Broome, 2018; Daniels, et al., 2018; Dertadian & Rance, 2023; Netherland & Hansen, 2016, 2017; Yankah, 2016). Research by Webster and colleagues (2020) has tracked a similar trend in Canadian coverage of the “opioid epidemic”. News stories have tended to emphasize accounts of “unexpected” PWUD who have died of drug toxicity (e.g., White, middle class) and frequently differentiate between these more privileged PWUD and their street-affected, lower-income “addict” counterparts (see also McLean, 2017). Webster and colleagues’ analysis also reveals how Canadian media reporting has often obscured the structural drivers and inequities at the heart of the drug toxicity crisis, for example by almost entirely ignoring the disproportionate impacts of drug-related morbidity and mortality in Indigenous communities in Canada (Firestone, Tyndall, et al., 2015; FNHA, 2022, see also Johnston, 2020).

In this chapter, I argue that many substance use-focused anti-stigma campaigns may ironically play a similar role in constructing the social categories of deserving and undeserving PWUD. I contend that this has negative implications for the marginalized PWUD that anti-stigma campaigns typically exclude from their representations and messaging. Little research has critically examined the potential for negative unintended impacts of health communication campaigns in general (Foster, 2017; Walsh & Foster, 2021) or anti-stigma campaigns in particular (though see Tyler & Slater, 2018). To address this gap, this study develops a social psychological account of how anti-stigma campaigns function to exclude (and harm) marginalized PWUD. It does this by examining the reactions and criticism that marginalized PWUD express after exposure to two high profile examples of typical anti-stigma campaigns that exclusively represent PWUD who appear to be from privileged social categories: the Province of British Columbia (BC) Government's 2018 "Stop Overdose" campaign and the federal government's (Health Canada) 2019 "End Stigma" campaign. This study asks how these anti-stigma campaigns might have ironically contributed to the broader societal exclusion and stigma experienced by marginalized PWUD.

To contextualize my approach to this question I first provide a brief overview of the social psychology of anti-stigma campaigns that seek to "challenge stereotypes" about the social categories (subgroups) of PWUD. In short, I argue that that this common approach of anti-stigma campaigns (e.g., representing White, middle class-appearing people as PWUD) attempts to construct a new subgroup of PWUD who do not deserve stigma by challenging the image of the prototypical marginalized PWUD. While this approach is rooted in good intentions (e.g. increasing the visibility of PWUD whose privilege allows them to hide their substance use, not perpetuating negative stereotypes associating PWUD with certain groups), I argue that the social psychology of intergroup relations suggests ways that marginalized PWUD may be harmed by anti-stigma campaign images and messages that ignore their identities, obscure their lived experiences and ultimately deepen their exclusion.

3.1.1. A Social Identity Approach to Understanding the Potential Harmful Effects of Substance Use Anti-Stigma Campaigns

In social psychology, the Social Identity Approach (SIA) (a combination of Social Identity Theory and Self-Categorization Theory, Reicher, et al., 2010; Tajfel & Turner, 1979; Turner, et al., 1987) argues that the contestation of group status differences is the central animus of intergroup relations. Indeed, the boundaries of social groups, the content of group identities and the positioning of individuals or subgroups within wider social categories are not fixed but matters of argument and contestation, sometimes involving the derogation of outgroups (e.g., through negative social comparisons) in order to bolster one's own group's status (Copes, 2016; Reicher & Hopkins, 2001; Reicher, 2007; Reicher, et al., 2010).

Broad social categories like "people who use drugs" are often made up of a diverse array of subgroups based on the intersections of other social categories (e.g., Indigenous PWUD) or other meaningful markers of subgroup identity (e.g. drug of choice, method of use, Sibley, et al., 2023). Within such a broad social category, subgroups may work together in solidarity or fight for dominance over others (Hornsey & Hogg, 2000; Neufeld & Schmitt, 2019). According to the SIA, a key concern amongst subgroups is their relative prototypicality within a wider social category (Hornsey & Hogg, 2000). Prototypicality refers to the extent to which representations of an individual subgroup are reflected in representations of the wider social category. In the context of substance use, dominant cultural imagery and long histories of criminalization and stigmatization directed specifically towards PWUD from marginalized social categories (e.g., racialized, lower-income) have meant that it is marginalized PWUD who are often seen as most prototypical of the wider PWUD category.

For example, people who inject drugs (PWID) in California's Central Valley area report becoming the target of abusive policing attention because they "look like a drug user", that is they "resemble the stereotypical presentation of what a PWID 'should look like' in the minds of police" (Friedman, J. et al., 2021, p. 5). Looking "like a drug user" in this context, means being perceived as someone who is marked by racialized identity, poverty, unstable housing, location in a "known drug use area" and general presentation as someone who is not able to maintain their physical appearance or personal hygiene (Friedman, J., et al., 2021). Analyses of relations between subgroups of PWUD are also consistent with the idea that the most marginalized subgroups of PWUD are seen as most prototypical of the wider PWUD category. For example, PWUD whose high level of substance use (i.e., dependence), and deteriorated physical appearance and health are often represented as more prototypical (e.g. "true addicts") than PWUD who can maintain a claim to being "functional drug users" (Copes, 2016). Research with people with "problematic substance use" who had recently discontinued addiction treatment revealed their perception that addiction treatment services are not meant for them (i.e. PWUD who may be able to hide their substance use, and who do not conform to negative stereotypes about disordered substance use) but rather designed for the "thieving junkie scumbags" (i.e. the most problematic, and most marginalized PWUD) who they felt were often seen as more prototypical PWUD (Radcliffe & Stevens, 2008). Qualitative evidence from a recent large-scale interview-based study with (mostly White) people who use (mostly) opioids (Sibley, et al., 2023) also suggests that the most marginalized PWUD who are labelled with the most pejorative terms (e.g. "Junkies", “Dopefiends”) are also often represented (by other PWUD) as engaging in the riskiest modes of drug ingestion (e.g. injection drug use) and the most “irresponsible” drug-using behavior (e.g. syringe sharing, Simmonds & Coomber, 2009) and that it is these PWUD who are often considered the most prototypical of the wider PWUD category (i.e. “real drug addicts”, Sibley, et al., 2023, p. 5). In sum, marginalized PWUD marked with the stigma of non-White racialization, poverty, the weathering effects of high levels of substance use, compromised health status, and risky substance use practices are generally seen as the most prototypical subgroup within the wider PWUD category.

The idea that marginalized PWUD are prototypical is often expressed in terms of stereotypes, for example the “stereotypical drug user” is poor, racialized and marked by a weathered physical appearance. Campaigns that set out to “challenge stereotypes” about PWUD by merely representing individuals from non-prototypical subgroups as PWUD (e.g., White, middle class, healthy-looking) in campaign materials are therefore challenging the prototypicality of marginalized PWUD. Yet there is a conundrum here. Due to the stigma of substance use, the wider superordinate category of PWUD is generally seen as a negatively evaluated group. According to the SIA, individuals should be motivated to avoid negatively evaluated social identities when possible, and certainly not fight for their subgroup to be most prototypical of a negatively evaluated superordinate category. What then might be a rationale for campaign strategies that attempt to construct privileged PWUD as more prototypical, and what might be the negative implications for the marginalized PWUD previously seen as prototypical?

3.1.2. Motivations for Challenging the Prototypicality of Marginalized PWUD

In the context of anti-stigma campaigns that emphasize representations of privileged PWUD, it is campaign creators (influenced by public health officials with an interest in reducing stigma as a means of reducing overdose risk) and not privileged PWUD themselves who are attempting to challenge the prototypicality of marginalized PWUD. A key concern of many anti-stigma campaigns appears to be making the invisible, visible. Whereas some PWUD are highly visible and publicly identifiable (i.e., those who “look like” a prototypical PWUD), many PWUD (especially those who are protected by the advantages of secure housing, stable income, good health, and intersecting privileged social identities) are more readily able to conceal their substance use from others. Many anti-stigma campaigns in Study 1 problematized this hiddenness of non-prototypical PWUD's substance use (and their invisibility as PWUD). Indeed, a common call to action within these campaigns is for members of the public to consider if their friends or family members (e.g., their “sister”, “neighbor”, “co-worker”) may in fact be concealing a problem with substance use and at risk of harm from an accidental drug toxicity, even if they do not “look like” a prototypical PWUD. Stigma is constructed as a barrier to these PWUD's ability to identify themselves, or be identified by those around them, as someone who may need support. Challenging the prototypicality of marginalized PWUD within the wider category of PWUD by representing privileged people as PWUD is thus employed as a strategy for making them more visible.

Challenging the prototypicality of marginalized PWUD may also be a way that campaigns attempt to address the stigma associated with substance use, by weakening the association of substance use with other stigmatized social categories. To the extent that some of the stigma of substance use is seen to *derive from* the association of substance use with stigmatized groups, breaking this association can itself be seen as a way of reducing substance use-related stigma. A close analysis of how the term “stigma” is used in many campaigns that challenge the prototypicality of marginalized PWUD by depicting privileged PWUD reveals this. In one example, a video testimonial from a woman represented as “in recovery” who appears White and middle-class explains the challenge she faced not being recognized as someone having a problem with substance use because she did not “fit what everybody's stigma and stereotype about what a person with a substance use disorder looks like” (#StigmaEndsWithMe campaign, CAPSA, 2020). This statement illustrates a wider trend across many anti-stigma campaigns where stereotypes about what a PWUD looks like (i.e., a marginalized person) are often thought of as an important *source* of the stigma associated with the PWUD category. This suggests another possible motivation for anti-stigma campaigns to challenge the prototypicality of marginalized PWUD by representing PWUD from more privileged social categories. The mere fact that they do not look like “those marginalized PWUD” is often considered to be an important anti-stigma strategy in itself.

In sum, the prototypicality of marginalized PWUD (i.e., the stereotype that “all PWUD are from marginalized social categories”) creates problems of invisibility and stigmatizing associations with marginalized groups for PWUD from more privileged social categories. Campaigns that exclusively represent PWUD as from privileged social categories attempt to overcome these problems by challenging the prototypicality of marginalized PWUD. While perhaps well-intentioned, several negative implications of this strategy are possible for marginalized PWUD.

3.1.3. Negative Implications of Anti-Stigma Campaigns for Marginalized PWUD

First, by failing to represent marginalized PWUD and by sharing the message that substance use problems can affect “anybody”, campaigns that focus on privileged PWUD obscure important intersections of oppressive systems (e.g. substance use stigma as an expression of anti-Indigenous racism, Goodman, et al., 2017) and substance use health inequities (e.g. disproportionate harms of substance use in Indigenous communities, Firestone, Tyndall, et al., 2015; Firestone, Smylie, et al., 2015; Marshall, 2015) affecting marginalized PWUD. Indeed, campaigns like this take the stigma associated with marginalized PWUD (e.g., the stereotype that “all marginalized people are drug users”) for granted and do not challenge it directly. Campaign creators often justify this strategy as rooted in a desire to not “confirm stereotypes” about marginalized groups being more likely to experience problems with substance use[16]. However, marginalized PWUD may perceive this effect of anti-stigma campaigns as ironically contributing to public ignorance or apathy towards their actual struggles with intersectional discrimination and disproportionate negative substance use health impacts. Rather than focus public attention on the real health inequities facing marginalized groups, campaigns like these redirect attention towards privileged PWUD.

Second, not having lower-income, Indigenous or other marginalized subgroup members represented in highly publicized and sympathetic depictions of PWUD may be perceived by marginalized PWUD as a form of social exclusion. This may in turn have a direct negative impact on well-being (Branscombe, et al., 1999; Fryberg & Townsend, 2008; Schmitt, et al., 2014). It would be an understandable response for marginalized

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[16] This observation is based on personal communications with multiple campaign creators in the course of data collection for Study 1. For example, a campaign creator in Saskatchewan reported that their campaign had intentionally not represented any Indigenous PWUD (despite Saskatchewan consistently reporting one of the highest rates of drug toxicity deaths amongst Indigenous people in Canada) so as not to perpetuate the negative stereotypes associating Indigenous peoples with problematic substance use (e.g. “the drunken Indian”, Frank, et al. 2000)

PWUD who do not see themselves, their identities, or experiences represented in a substance use anti-stigma campaign to feel ignored and perhaps even further dehumanized and excluded from society. It seems clear that if anti-stigma campaigns are constructing a new subgroup of PWUD who do not deserve stigma, then marginalized PWUD have not been included in this subgroup. This exclusion can be painful, especially as a reminder of how marginalized PWUD are excluded in other contexts. It also suggests that if anti-stigma campaigns are effective at reducing stigma towards PWUD, these potential benefits will not extend towards marginalized PWUD.

Finally, implicit in the contestation of subgroup prototypicality is a key intergroup strategy described by the SIA: outgroup derogation to promote the positive distinctiveness of a group (Tajfel & Turner, 1979). This can involve negative downward social comparisons in which one subgroup (e.g., White, middle-class PWUD) is contrasted against a subgroup of lower status (e.g. more stereotypical, marginalized PWUD). In the case of anti-stigma campaigns that emphasize representations of White, middle-class appearing PWUD, there is often an implied distinction made between the privileged PWUD (constructed as sympathetic victims, who share group identities with the public campaign audience) and stereotypically marginalized PWUD (who are constructed as members of deviant minority groups who do not deserve sympathy or destigmatization). This is implicit also in the suggestion that a key source of stigma associated with substance use is the association of the PWUD category with people from other marginalized and stigmatized social categories. PWUD may interpret this aspect of anti-stigma campaigns as “doing more harm than good” in that they may exacerbate their exclusion and dehumanization to the extent that the denigration of marginalized PWUD is required to rescue privileged PWUD from stigma.

Thus, anti-stigma campaigns that attempt to “challenge stereotypes” about the prototypicality of marginalized PWUD by representing privileged PWUD as the subjects of destigmatization may have harmful implications for marginalized PWUD by 1) obscuring important substance use health inequities and intersections, 2) making salient, or exacerbating, their exclusion from society, and 3) by setting up a negative contrast between marginalized PWUD and privileged PWUD in order to bolster the status of privileged PWUD in the process of constructing a new subgroup of PWUD who do not deserve stigma.

3.2. The Present Study

While this theoretical background provides some suggestion as to how marginalized PWUD may respond to substance use-focused anti-stigma campaigns, little is known about their actual responses. Some research has examined PWUD perspectives on drug use prevention campaigns (Kerr, et al., 2013; Marsh, et al., 2017; Ti, et al., 2017) and a recent study asked people with lived experience of substance use disorders (SUDs) to assess how (non)stigmatizing certain imagery was that depicted PWUD and related settings (e.g., drug paraphernalia, court, jails, Hulsey, et al., 2023). No studies have asked how PWUD perceive the content of substance use-focused anti-stigma campaigns. In particular, no research has examined the reactions of marginalized PWUD to the common anti-stigma campaign trope of representing privileged PWUD as prototypical of the wider superordinate PWUD category. This study fills this gap by employing a novel approach to engaging marginalized or "structurally vulnerable" PWUD[17] in group discussion-based analysis of mainstream anti-stigma campaigns. It uses a CBPR approach that centers the lived and living experience of PWUD experiencing structural vulnerabilities as an analytical lens alongside a critical perspective on substance use stigma.

3.2.1. Structural Vulnerability as a Lens for Critical Analysis of Anti-Stigma Campaigns

Whereas structurally vulnerable PWUD are often engaged in research to help design study protocols or increase the effectiveness of recruitment amongst hard-to-reach populations (Damon, et al., 2017; Boilevin, et al., 2018), it is less common for their standpoint and expertise as people who experience intersectional stigma to be engaged as a lens for interrogating government health communications. Standpoint Theory (Friesen, 2021; Harding, 1995) posits that the situated and structurally produced experiences of individuals, their "standpoints", function as a form of often unrecognized

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[17] "Structural vulnerability" is a social science term referring to how the location of an individual's social identities (e.g. health status, racialization, gender, class, etc.) within a social hierarchy makes them more or less vulnerable to social and health harms (Bourgois, et al., 2017). This term is also meant to draw attention to the social process of how inequality and its related structural violence are what make people or groups vulnerable (e.g. more likely to experience health inequities), not anything intrinsic to their personal character or negative attributes of their group identities.

expertise. Typically, the hardships of over-criminalization, group-based exclusion, intersecting forms of discrimination and manifold negative experiences associated with using illicit substances under prohibition are constructed as deficits within damage-focused research (Culhane, 2011; Tuck, 2009). However, when interrogating the nature of government-produced substance use anti-stigma campaigns, these experiences constitute a lens through which people may comment upon and unpack the complex messages and meanings of campaigns as well as their potential implications for the inter- and intra-group relations of PWUD. This study therefore adopts a strengths-based approach that elevates how structurally vulnerable PWUD critique two high profile, mainstream, government-produced substance use anti-stigma campaigns in Canada: the Government of BC's "Stop Overdose" campaign (Government of BC, 2018) and the Government of Canada's "End Stigma" campaign (Government of Canada, 2019b).

3.2.2. Study Context

The two campaigns chosen as the subject of focus group discussions were (at the time of data collection) recently released and high-profile examples of government-led substance use-focused anti-stigma campaigns at a provincial (BC) and national level. The Government of BC's Ministry of Mental Health and Addictions (2018) released its "Stop Overdose" anti-stigma campaign in January 2018 with large posters depicting stock photos of White and middle class appearing PWUD alongside a list of four attributes meant to humanize the campaign subject (e.g., "Cousin, student, drug user, friend") and portray their identity as a "drug user" as just one facet of their complex personhood[18]. The slogan "People who use drugs are real people. Get involved. Get informed. Get help" appeared above a URL (StopOverdoseBC.ca) that directed people to a website with further information on substance use stigma and its negative impacts, tips for family and friends to have "courageous conversations" to initiate a non-judgemental identification process with the suspected PWUD in their networks, and information on treatment and harm reduction resources in BC. Internal government

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[18] This aspect of the campaign worked to do two things: it marks the (previously unmarked) subjects of the campaign with the stigmatizing label of the "drug user" social category while at the same time communicating that this social category is not the most important aspect of the person. More marginalized PWUD who are routinely identified and marked as "drug users" based on their appearance (Friedman, J., et al., 2021) do not experience this same privilege.

marketing strategy documents accessed through a Freedom of Information request (see Greto & Neufeld, 2023 for a detailed analysis) reveal that a key goal of this campaign's imagery and messaging was to "challenge stereotypes" about PWUD by "removing focus from stereotypical portrayals of street-affected addicts" (Insights West, 2018, p.10). When later evaluating the efficacy of their campaign, BC government officials were especially interested in the extent to which exposure to campaign materials had decreased BC residents' agreement with the statement, "People who use illegal drugs are mostly homeless, poor and unemployed" (Insights West, 2019). The campaign's materials were widely promoted around the province, most prominently on public transit shelters (e.g., bus, light rail). At least two participants in each focus group reported having seen these anti-stigma posters before, most often on the bus stops.

The second campaign used was the federal government's (Health Canada) "End Stigma" campaign launched in June 2019 in the form of a 30 second PSA video[19]. The short video was aired on TV and as a pre-roll ad on social media (e.g., before a YouTube video begins). Given this less accessible dissemination strategy, this video was less familiar to participants (i.e., most were seeing it for the first time in the context of the focus group). Contrary to the Stop Overdose posters, this campaign featured the loved ones of people who had died of opioid overdoses and did not center representations of PWUD. In the video, ominous music plays as sombre voiceovers from a woman who has lost her husband, two parents who have lost their daughter, and a young man who has lost his friend recount their surprise to have lost someone close to them to an opioid overdose. They also recount the role that "judgement", "being made to feel invisible" and being "ashamed to talk about one's opioid use" may have played in their deaths. The clip concludes with a narrator explaining how "this story could be yours" while a map of Canada featuring tiny images of "Canadians of diverse genders, ages and ethnicities[20]" ("End Stigma" campaign official transcript, Government of

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[19] The initial version of the 30s PSA was refreshed in February 2021 to include a final scene featuring a young man wearing a medical mask in a doctor's office waiting room. This scene replaced the "diversity panel" and map of Canada.

[20] In my own review of this campaign (Study 1), we coded the wife as Indigenous, the parents as White, and the friend as Ambiguous non-White. All appeared to be "middle class". Focus group participants occasionally noticed that the wife from the video may be Indigenous and some thought the young man could be Asian. In only one focus group did anyone comment on the small images of "Canadians of diverse genders, ages and ethnicities" appearing at the end of the clip.

Canada, 2019b). The narrator states how eleven people per day were dying of an opioid overdose at the time (in 2019; in 2023 it was 21 people per day, PHAC, 2023) and ends the video with an emphatic plea to the audience to "Help end stigma" while a URL to a government website (Canada.ca/opioids) appears on the screen alongside the message "Get the facts". A series of Health Canada commissioned market research reports by Earnscliffe Strategy Group (2017, 2019) provided a basis for the campaign's direction by gathering information on public perceptions of opioids, people with "substance use disorder" and stigma from the Canadian general population. The July 2019 report (which included qualitative focus groups similar to those used in advance of the Stop Overdose BC campaign) included a similar recommendation to 'challenge stereotypes' about what PWUD look like: "Changing the image of the person [who uses drugs] who needs attention, understanding and care…[can] remind people that the individuals they envisage as the ones who have an opioid use disorder are much more like themselves than they currently think." (pp. 73-74). Thus, the emphasis on representing White and middle-class-appearing PWUD in both anti-stigma campaigns appeared to be motivated by a similar desire to challenge the stereotype that PWUD are prototypically people experiencing the structural vulnerabilities of racism, classism, and other systems of oppression. The exclusion of marginalized PWUD from these campaigns was therefore by design.

3.3. Method

3.3.1. Community-Based Participatory Research

To centre the expertise of structurally vulnerable PWUD in this study, I adopted a community-based participatory research (CBPR) approach. CBPR is a methodological orientation and set of commitments in research that strives to work collaboratively with members of the community that is the focus of the research (i.e., structurally vulnerable PWUD) to develop all aspects of the research project. This includes identifying and refining research questions, developing a research strategy (e.g., recruitment, inclusion criteria, method of data collection), recruiting participants, facilitating data collection, analyzing data and engaging in knowledge mobilization once results are finalized (Boilevin, et al., 2018; Damon, et al., 2017; Torre, et al., 2012). This approach is especially beneficial when working in heavily researched communities such as

Vancouver’s Downtown Eastside (DTES) neighborhood where high volumes of research (McKay, 2021) and negative experiences with researchers (Damon, et al., 2017; Goodman, et al., 2018; Neufeld, et al., 2019) have been the norm.

A CBPR approach to this study began through forming partnerships with three key organizations that are governed by and serve the needs of structurally vulnerable PWUD in the DTES: the *Vancouver Area Network of Drug Users (VANDU)*, the *Western Aboriginal Harm Reduction Society (WAHRS)*, and the *Youth Advisory Committee (YAC)* of the *BC Centre on Substance Use’s (BCCSU) At Risk Youth Study (ARYS)*. I made initial contact with staff at each of these organizations before attending board meetings of each organization to introduce myself as a researcher and sketch the outline of an early version of the study idea, asking for permission to collaborate with their members on various aspects of the project. Each of these three organizations agreed to support the project, most significantly through the formation of a community advisory board (CAB) and hiring of several Peer Research Assistants (PRAs) from within the membership of each organization.

3.3.2. Community Advisory Board (CAB)

In Spring 2019, I convened a CAB comprised of representatives from *VANDU*, *WAHRS* and the *BC Association of People on Opiate Maintenance (BCAPOM,* a subgroup of *VANDU)* to help guide the study’s development. All five CAB members had living experience of criminalized substance use and structural vulnerability produced by the intersections of their identities as PWUD and their other marginalized social identities (e.g., lower income, Indigenous, DTES residence). The five CAB members (Al, Earl, Samona, Laura and Boomer) were instrumental in collaboratively producing the study’s focus group guide, designing a recruitment strategy, providing initial feedback on a coding framework, and helping to interpret initial findings.

3.3.3. Focus Groups and Photo Elicitation

In consultation with the study CAB, focus groups (FGs) were determined to be an ideal form of data collection for this study. While one-on-one interviews are excellent tools for asking individuals about their health-related behaviors or personal lived experiences with stigma, a strength of FGs is their interactive dynamic where participants engage with and build upon the responses of other FG members (Braun & Clarke, 2013). The interactivity of FGs enabled participants to respond to the two focal anti-stigma campaigns in a way that made their shared identities with fellow FG members quite salient, often catalyzing rich discussions and critique that centred their frequent perception that PWUD like “them” (i.e., structurally vulnerable PWUD from the DTES) had been excluded from the campaigns. Furthermore, FGs can create a comfortable environment for participants to share their perspectives on a topic more readily than they might if they were not amongst their peers (particularly when FG members share experiences or identities in common) and may make it more likely they will provide authentic responses less influenced by the demand characteristics of a one-on-one interview (Braun & Clarke, 2013).

Focus groups employed a “photo-elicitation” approach in which imagery (anti-stigma campaign materials) is used as a prompt for individual reflection and group discussion (Glaw, et al., 2017; Harper, 2002; Harrison, 2002; Henwood, et al., 2012). Using imagery as a prompt in a focus group setting invites richer participant responses and sharing that can result in qualitatively different information from participants in data collection activities that do not use visual prompts (Harper, 2002). Using images as prompts can help clarify abstract concepts, focus participants’ attention, and reduce the fatigue sometimes associated with lengthy interviews based entirely in abstract conversation (Harper, 2002). Photo-elicitation was well-suited to the focus groups used in this study as individual responses to the imagery from one participant often elicited further, interactive discussion amongst fellow participants as people debated the status and identities of the PWUD depicted in anti-stigma campaign imagery they were examining as well as their wider implications.

3.3.4. Inclusion Criteria & Recruitment

Participants were required to be able to speak and understand English, be more than 14 years of age, use (or have used) illicit opioids[21] and have lived/living experience of

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[21] Current or former illicit opioid use was initially used as an inclusion criteria because funding for this study came from a large NIH grant (“An ethno-epidemiological study of the implementation and effectiveness of an innovative and comprehensive response to the opioid epidemic”) focused on the “opioid epidemic”. In practice all participants reported using a variety of illicit substances (e.g. stimulants, cannabis, etc.).

substance use-related stigma. To maximize the diversity of perspectives from subgroups of marginalized PWUD, I intentionally conducted focus groups restricted to participants who were: Indigenous (2 focus groups); cisgender women (1), cis-men (1), trans-women (1), youth (ages 19-24) (1) and two general focus groups recruited through *VANDU*. This focus group recruitment strategy was informed by conversations with the study's CAB, organizational partner staff (e.g., *VANDU, WAHRS, BCAPOM,* etc.), and study peer research assistants (PRAs). Partnerships with *WAHRS* (Indigenous focus groups), the *ARYS Youth Advisory Council* (youth focus group, six participants ages 19-24), and *VANDU* made these subgroup-specific focus groups possible. Participants were recruited primarily through staff at partner organizations and five PRAs employed by the BCCSU who invited people to participate from within their social networks. Two trained youth PRAs with lived experience working for *ARYS* supported the youth focus group. They helped adjust the focus group guide to better suit the youth population, assisted with youth participant recruitment and also co-facilitated the youth focus group with me. Thus, this study used a convenience sampling approach combined with a stratified sampling strategy to introduce purposeful diversity into the sample (Braun & Clarke, 2013).

3.3.5. Sample Characteristics

Forty-one PWUD contributed to eight focus group discussions. See Table 3.1 for a breakdown of sample characteristics. Participants could broadly be characterized as "structurally vulnerable" PWUD with over half the sample (63.4%) reporting an Indigenous identity, some representation of gender (4.9% trans-women) and sexual minorities (19.5%), more than half reporting at least one physical disability or mental health issue, a little over two fifths experiencing at least one overdose in the past year (five had experienced an overdose in the past 30 days), high levels of polysubstance use, and approximately one fifth experiencing some interaction with the justice system (arrests, jail/prison time) in the past five years.

Table 3.1 Study 2 Demographics

Participant characteristics		**N=41**
Age		*N* (%)
Mean		47.7
Range		19-63 years
Gender		
Cis-men		16 (39%)
Cis-women		23 (56.1%)
Trans-women		2 (4.9%)
Race/Ethnicity*		
White		17 (41.5%)
Indigenous**		26 (63.4%)
Black		1 (2.4%)
Other ethnicity (Japanese, French)		2 (4.9%)
No response		1 (2.4%)
Sexual orientation		
Straight		33 (80.5%)
Lesbian		1 (2.4%)
Bisexual		6 (14.6%)
Pansexual		1 (2.4%)
Living with…		
Physical disability		21 (51.2%)
Mental health issue		21 (51.2%)
Hepatitis C		14 (34.1%)
HIV/AIDS		4 (9.8%)
Substance use…	Lifetime	Past 30 days
Cocaine (Powder)	35 (85.4%)	22 (53.7%)
Crack cocaine (Rock)	35 (85.4%)	21 (51.2%)
Crystal Meth	29 (70.7%)	20 (48.8%)
Heroin	33 (80.5%)	32 (78%)
Opiates (other) (e.g., fentanyl)	30 (73.2%)	19 (46.3%)
Methadone	24 (58.5%)	12 (29.3%)
Solvents	13 (31.7%)	0
Marijuana	34 (82.9%)	24 (58.5%)
Alcohol	32 (78%)	18 (43.9%)
Other (e.g., psychedelics)	17 (41.5%)	2 (4.9%)
Experienced an overdose in the past 30 days		5 (12.2%)
Past year overdoses		17 (41.5%)
1 overdose		8 (19.5%)
2 overdoses		6 (14.6%)
3 or more overdoses		3 (7.3%)
Past 30 days consumption method		

Inject	28 (68.3%)
Smoke/inhale	34 (82.9%)
Snort	14 (34.1%)
Ingest/swallow	16 (39%)
Arrested in past 5 years	6 (14.6%)
Prison time in past 5 years (Range: “overnight in cells” to “18 months”)	7 (17.1%)

NOTES: *Participants could select more than one race/ethnicity, and all were reported here. **Indigenous included participants who identified as Métis, Inuit, a specific First Nation or simply as “Indigenous” or “Aboriginal.”

3.3.6. Data Collection

In Fall 2019, we conducted eight focus groups (ranging from 2-7 participants). A peer co-facilitator was present during each focus group to support participants if certain discussion topics or questions triggered traumatic memories or experiences and they required a break. Before beginning each focus group, participants were led through an overview of the study and provided written informed consent (Appendix D). They were then asked to complete a brief demographic questionnaire (Appendix E) that asked them to report various social categories (e.g., gender, race), health status (e.g. HIV/AIDS, mental/physical health concerns), substance use practices (e.g. lifetime use, mode of ingestion), lived experiences (e.g. overdoses, arrests), and perceptions of public stigma towards PWUD[22]. A semi-structured focus group guide (Appendix F) was used to facilitate group discussions. In the first approximately 5 minutes of each focus group, participants were handed a one-page coloured printout depicting the four anti-stigma posters used in the Government of BC’s initial January 2018 “Stop Overdose” campaign (See Appendix G).

Participants were asked to study these posters on their own and write down any initial thoughts or “gut reactions” to the images on the printout they had received[23]. After

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[22] The questionnaire concluded with the 4-item “awareness” subscale of an empirically-validated measure of perceived public stigma towards “opioid users” that was adapted to refer to “PWUD” more generally (Yang, et al., 2019). This sub-scale of the questionnaire asks participants to what extent they agree (1-5 Likert scale where 5 represents “Strongly Agree”) with statements such as “Most people believe that a person who uses drugs is dangerous”. The sample mean was 3.7 (range 1-5), indicating a high level of agreement that in general members of the public stigmatize PWUD.

[23] Inviting participants to write upon or mark-up the printouts of anti-stigma campaign materials functioned as an added prompt for participants to think about and develop critiques/comments on the materials they were reviewing. While I reviewed all marked-up materials closely before coding that focus group’s transcript, I observed that what

several minutes, participants were shown a 30-second PSA video from Health Canada's 2019 "End Stigma" campaign on a laptop computer and then handed a second one-page print-out depicting key screenshots from the clip (see Appendix H). Initial discussion questions asked participants to share their general thoughts on the materials they had just viewed as well as how they interpreted the campaigns' "message" and "audience". After an initial round of discussion, participants were invited to share some of their own stories of experiencing stigma related to their substance use, including stories of any overlaps (i.e., intersections) between substance use stigma and other systems of oppression that impacted them (e.g. anti-Indigenous racism). A second round of more critical discussion of the campaigns followed this story-sharing section with questions such as "what kinds of people who use drugs are NOT represented in these campaigns?" Focus groups concluded with an opportunity for participants to write or draw ideas for revising or improving the example campaigns and a discussion of suggestions for how to better address substance use stigma.

At the conclusion of each focus group, I gave each participant a $30 CAD honorarium. This was in line with community and BCCSU norms of respectful compensation at the time. Participants were also offered information on counselling, health care, harm reduction and other support services in the neighborhood. Participant consent forms were collected and stored separately from their marked-up anti-stigma materials and demographic questionnaires, all of which were stored in a locked filing cabinet in a locked office.

3.3.7. Reflexive Thematic Analysis

Analysis drew on the broad framework of Reflexive Thematic Analysis (RTA; Braun & Clarke, 2006, 2019, 2020, 2022). We employed a social constructionist epistemology (Braun & Clarke, 2013), treating participant responses as constructed within the interactive social context of both the focus groups and the structural vulnerabilities that shape their lived experiences. A critical realist ontology (Botha, 2021) was also employed, meaning that we consider participant perspectives and our findings from the study to have implications for real world contexts beyond that of the focus groups

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participants wrote on the printouts they almost always then shared verbally in the focus group. At times the markings on the images were helpful for interpreting the meaning of what they had said on the recordings.

themselves. Drawing on field notes written during data collection, collaborative discussions with PRAs, the project CAB and project supervisors, I developed an *a priori* coding framework to help guide initial close reading and analysis. Focus group audio recordings were transcribed, checked against recordings, annotated with initial observations, and then imported into NVivo 12 (QSR International, 2019) to enable data organization, coding, and analysis. Following the process for RTA, I used the initial *a priori* coding framework to code transcripts line-by-line, while simultaneously making additional notes, iteratively adding and developing new codes, adjusting code definitions, and continuing discussions with PRAs, CAB members, and supervisors as I developed candidate themes to summarize the data.

3.3.8. Ethics

Ethics clearance for this study was received from the University of British Columbia (UBC) Providence Health Care research ethics board (REB) under the BC harmonized ethics review process for a minimal risk study (it was also reviewed by Simon Fraser University's REB) on September 19, 2019 (File #: H18-03240).

3.4. Results & Analysis

The analysis is summarized in four themes which explore how participants 1) resonated with the narrative that drugs could affect "anybody" implied in the anti-stigma campaigns and felt this could benefit marginalized PWUD like them 2) perceived that the campaigns would do little to challenge the intersectional stereotyping participants often experienced where they were marked as "drug users" on the basis of their other social identities (e.g. poor, Indigenous), 3) reacted negatively to the observation that marginalized PWUD had been purposely excluded from the campaigns and that this constituted a threat to their prototypicality as PWUD, which they challenged, and 4) critiqued the campaigns for ignoring, and potentially even exacerbating, the substance use health inequities facing marginalized PWUD. All participants were assigned pseudonyms to preserve anonymity while avoiding the dehumanization of participant ID codes.

3.4.1. “You can’t tell who is a drug user”: Perception that campaigns might protect marginalized group identities from negative substance use-related stereotypes

A key finding from Study 1 was that versions of a narrative that “addiction does not discriminate” or “overdose can affect anyone” have been used frequently in anti-stigma campaigns across Canada. This “anybody” narrative was implied in both the “Stop Overdose” and “End Stigma” campaigns that focus group members analyzed. In many cases, participants initially responded positively to these campaigns, resonating with the implied message of the campaign materials that “anybody could be affected” by the risks of toxic drugs:

> Drugs can hit anybody, any race, any colour, creed…it doesn’t matter who you are, it can get you (Mark, Indigenous, 46, cis-man).

Participants often agreed with the implied message of the campaign images that drugs (and associated harms) “do not discriminate”. For many, the campaigns prompted them to share stories of rich people, employed people, celebrities and others who challenged the stereotype that it is only marginalized people (like the participants) who use drugs. For some participants, this narrative seemed to protect them from negative stereotypes that associated problematic substance use with their other social identities. For example, Mark (a 46-year-old, Indigenous, cis-man living in the DTES) shared:

> I don’t think you would know that before I came to the Downtown Eastside …the amount of money that I used to make. Nobody would have thought that I would end up down here [in the DTES] … I used to make 16 grand every six weeks and then it would have been 32 grand every six weeks if I hadn’t got injured…anybody, can end up down here…a Native person can be a hard-working class person but can still end up down here because of different circumstances.

For Mark, the “anybody” narrative helped explain his own transition into substance-use related challenges and poverty as a result of bad luck and personal circumstance rather than his fulfilling negative substance use-related stereotypes about Indigenous peoples. In this case, the individualizing effect of the “anybody” narrative, and the way it attributes the cause of problematic substance use to “circumstances” (e.g., an injury), is thought to be protective of his other marginalized social identities. By decoupling substance use outcomes from structural context (e.g., colonialism, historical trauma facing Indigenous peoples) and emphasizing the apparent randomness of developing substance use problems, the “anybody” narrative both obscures the social determinants of substance use health and helps to retain the positive distinctiveness of one’s other social identities. Indeed, close analysis of how participants framed their resonance with the “anybody” message of the campaigns suggests many saw the potential for the message and imagery of the campaigns to benefit marginalized PWUD like them by challenging the stereotype that all marginalized people (like them) use drugs:

> Oh, yeah, you get all walks of life. Because you can’t tell [who is] a drug user. (Jennifer, Indigenous, 63, cis-woman)
>
> This picture just goes to show that all walks of life do drugs, and you can’t stereotype drug users. (Robert, Indigenous, 55, cis-man)

The suggestion that you “can’t tell” or should not “stereotype” PWUD is a challenge to the way participants most often experienced the harms of stigma as an assumption of their drug use based on their other social identities (see Friedman, J., et al., 2021). The campaigns’ representations of non-prototypical (i.e., privileged) PWUD was (at least initially) perceived by many participants as a welcome *relief* from the public scrutiny, stereotyping, and stigmatization that they experienced as members of marginalized social categories who are often assumed to be PWUD.

3.4.2. “Automatically labeled as a drug addict”: Perception that the campaigns do not challenge the intersectional stereotyping participants experience as marginalized PWUD

Whereas participants tended to agree with the implied message of the campaigns that *“you can’t tell [who is] a drug user”* (Jennifer), the opposite experience of being *“automatically labeled as a drug addict”* (Lisa, Indigenous, 33, cis-woman) was the most common experience of stigma shared by participants. When asked to describe their experiences of stigma surrounding their substance use specifically, people often shared stories of how they were routinely stereotyped *as* PWUD based on other facets of their appearance and identity. For example:

> …a lot of people [assume] if you’re Native, you’re an alcoholic or a drug addict, you know, and that’s not true. (David, White, 61, cis-man)
>
> People think if you’re homeless you’re a drug addict. Not all homeless people are drug addicts. (Robert, Indigenous, 55, cis-man)

These accounts illustrate how participants experienced substance use stigma as intersecting with other forms of oppression, most often racism (i.e., stereotypes that associate Indigenous peoples with substance use) and classism (i.e. stereotypes that associate people experiencing homelessness and/or poverty with substance use). These accounts of intersectional stereotyping (i.e., beliefs that members of one social category, Indigenous/homeless, are likely to be members of another category, PWUD) were often challenged by participants, as they were in the quotes from David and Robert above. In participants' experience, assumptions about their substance use were almost entirely related to perceptions of stereotypes about their other social identities.

Whereas campaign images and messages suggested that PWUD at risk of drug toxicity are unmarked and undetectable people who are hiding their substance use from loved ones because of shame or embarrassment, participant stigma stories frequently constructed stigma as a "marking" process that flagged them for exclusion on the basis of their perceived substance use. This often involved being flagged as "drug seeking" in a health care setting and receiving substandard care (especially inadequate pain management) after being marked as a PWUD. For example, Lisa (Indigenous, 33, cis-woman) described being cut off from pain medication:

> I been taking T3's for years for my pain because they work, right? And the doctor cut me down from 20 to 15 to 12, and then totally cut me right off, when I'd been taking them for years for my knee pain. And when she first asked me, 'Well, where do you live?' and I said, 'Oh, well, I don't have my own place. I'm staying at Life Skills, the women's shelter just down the street.' 'Oh, so you're in the area. Okay, well, I'm going to have to cut you down.' I'm like – 'I don't even use drugs.'

Lisa perceived the disclosure of a particular social category (residence in a homeless shelter in the Downtown Eastside) as the trigger that initiated the stigmatization process, leading to her being cut off from access to an effective medication. A stereotype about poor or unhoused people who live in the DTES as being predisposed to substance use or addiction led the prescriber to assume that Lisa, as a member of these categories, was at risk of nonmedical prescription drug use or addiction. In response, the prescriber took automatic action to exclude Lisa from effective pain management. Stories like this shared by participants of being automatically marked and punished as "drug addicts" based on their other social identities contrast with the idea conveyed by the anti-stigma campaigns of invisible, privileged PWUD who need to be specially identified by their friends and family for the purposes of increasing support. Indeed, some participants used the language of stigma to comment on how the individuals represented in the campaigns were not obviously marked as visible PWUD, *"most of the time, when people see people like this [Stop Overdose subjects] there's no stigma"* (Christopher, White, 58, cis-man).

Being *treated as a 'drug addict',* even when participants felt this label did not apply to them (e.g., they were not using substances at the time), was another common feature of participants' stigma stories. This too highlighted how different their experience of stigma was from how stigma was conceptualized in the campaigns. For example, two participants in the youth focus group shared accounts of being identified and mistreated as "drug users" based on cues from their appearance or behavior that fit a member of the public's stereotype of someone who uses drugs (e.g., a passerby identifying a participant as a low-income person because she was panhandling, and misattributing a psoriasis-related skin rash to drug use). Stories like these reveal how participants' own identities as PWUD were often all too publicly visible, whereas PWUD who resembled the campaign subjects needed to have their identity as "drug users" highlighted in an anti-stigma campaign in order to become more visible.

Participants also shared how individuals who stigmatized them regularly made their (assumed) substance use a *totalizing identity*. For example, Ryan (No ethnicity shared, 55, cis-man) shared a story of having gained a reputation as a drug user from a young age in his small rural town that led to him being repeatedly pulled out of school to have his high school locker searched for drugs, frequently stopped by police in public, and stereotyped and mocked by employers on account of his 'reputation' as a drug user. He eventually left his hometown to avoid this stigmatized reputation. Recounting this story caused him to angrily express *"Yeah, you don't know what's going on, you don't know what battles the next person's fighting and you don't know what the fuck they [i.e., PWUD] look like."* Ryan later went on to summarize the message of the anti-stigma campaigns as attempting, *"To get people to stop looking down their noses at addicts because you don't know what an addict actually looks like."* Much like the first theme, participants like Ryan connected their experienced being marked as a person who "*looks like an addict*" with the campaign's message that a drug user might not match the common stereotype of a marginalized person. He hoped that the campaign's message might help him and people like him be less likely to be stereotyped *as* PWUD because of how they “look”. Yet all of the men in this focus group later agreed that whereas the Stop Overdose campaign inserted “drug user” as the third identity label on each poster (alongside other relational roles such as “sister”, “cousin”, “friend”), to suggest that this was not the defining feature of that person, marginalized PWUD like them would always be more likely to have “drug user” seen as their number one identity by others.

By sharing accounts of being automatically “marked” with the totalizing stigmatizing identity of being a “drug addict”, participants recontextualized their responses to the anti-stigma campaign materials depicting unmarked, privileged PWUD who are *not* marked by stereotypes as prototypical drug users. The “anybody” message of the campaigns challenged the stereotype that “all PWUD are marginalized”, but the challenge more often facing participants was the stereotype that “all marginalized people are PWUD”. Stereotypes linking marginalized social groups with problematic substance use are historically rooted and often particularly wound up in classist, racist and colonial systems of oppression (e.g., the stereotype of the “Drunken Indian”, Frank, et al., 2000; Maracle, 1994). As participants recounted their own experiences of stigma, and then considered the campaign imagery and messages further, they often came to express more clearly a perceived disconnect between their experiences and how (and for whom) the campaigns might “work” to address stigma. For example, Angela, a 43-year-old Indigenous woman who lived in the DTES, shared a story of an old acquaintance (also a marginalized person) who had once used illicit substances with a famous hockey player at a party. She used this story to illustrate her concern with a societal double standard that celebrates or ignores the substance use of wealthy celebrities while vilifying poor and racialized people for their (often assumed) substance use. To Angela, this highlighted the key inequity in the experience of substance use stigma that campaigns’ message left unaddressed, *“anybody can do it but, people down here [i.e., marginalized PWUD in the DTES] shouldn’t be judged as much as they are”.*

3.4.3. “Real people like us”: Responding to the exclusion of marginalized PWUD by contesting subgroup prototypicality

Despite some initial suggestions that the campaigns were a welcome intervention that might help take some of the pressure off the form of “marking” stigma many participants experience, this positive reception of the campaigns did not last long. Across all focus groups, and without interviewer prompting, participants observed that PWUD “like them” had not been included in the representations of PWUD in either campaign[24]. Overwhelmingly, this exclusion was negatively perceived by participants, and understood as more, and unsurprising, evidence of the continued exclusion of marginalized PWUD from society. When asked in each focus group if people saw themselves represented in the campaign imagery most participants reported that they did not identify with the "drug users" depicted in the anti-stigma campaigns. A similar question asking participants to explain who they felt was *not* included in the campaigns frequently produced this kind of response:

> I: Who would you say is not included in these photos?
>
> Ryan (No ethnicity, 55, cis-man): Not any of us.
>
> Steven (White, 42, cis-man): Someone like us.
>
> Andrew (White, 55, cis-man): Anyone like us, yeah.

These participants, all poor, cis-men who used opioids, constructed an ingroup identity (i.e., "us") as the kind of PWUD that most people would associate stereotypically with the DTES neighborhood where they lived (i.e. marked by their visible poverty, poor health, etc.). Participants frequently described the campaign imagery as featuring people from an outgroup that did not include them. This outgroup was often referred to as "healthy-looking", "White", members of "mainstream society", as illustrated in these three excerpts:

> I: Who would you say they're choosing to show?
>
> Mark (Indigenous, 46, cis-man): Middle class. High class.
>
> Angela (Indigenous, 43, cis-woman): Mediocre. Everybody. I don't know.
>
> John (Indigenous, 42, cis-man): Not the Downtown Eastside.

> Straitlaced people are included and uh, the typical…everyday drug user like um, that we know, out of the Downtown Eastside, maybe they're not

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[24] Since the Stop Overdose images were presented first, and more explicitly pictured individuals represented as PWUD (compared with the End Stigma video, which focused on the parents, a partner, and a friend of people who had died from drug toxicity), most participants commented on the Stop Overdose posters when discussing the perceived exclusion of PWUD "like them".

> included?... They look like normies…They look too uppity. (Robert, Indigenous, 55, cis-man)

> They're White people who use…They look too healthy… (Lisa, Indigenous, 33, cis-woman)

These quotes demonstrate a general trend of participants describing the subjects of the anti-stigma campaigns as members of privileged social categories (e.g., White, employed, middle-upper class) that excluded marginalized PWUD like them. This observation was often expressed critically, even angrily. For example, Karen (Indigenous, 54, cis-woman) critiqued the Stop Overdose images as *"Too yuppy looking…Everybody looks too yuppy and too clean"*, engaging in a negative upward comparison and contrasting their apparent class status (yuppie, i.e., upper-middle class) and physical appearance or hygiene (clean) as better than her own.

Critiques of the *authenticity* of the campaigns' representations of PWUD were common throughout the data as well. For example, Lisa's quote above does not merely construct the campaign subjects as looking "healthy" but "too healthy", drawing a contrast with the visibly compromised health status of many marginalized PWUD with high levels of substance use. It was very common for participants to question whether the people pictured in the Stop Overdose campaign were truly drug users, frequently referring to them derisively as "actors" or observing that *"none of these people actually look like they do drugs"* (Andrew, White, 55, cis-man). To many participants, the veracity of the campaign subjects' substance use was in doubt (i.e., they were seen as non-prototypical PWUD) because they were missing the visible signs of marginalization that many participants associated with a significant level of substance use, and drug user prototypicality:

> Daniel (White, 60, cis-man): Where's the person with the sore, on his face? …or the abscess…Where's the person with the missing tooth? (general laughter, brief)
>
> Julie (White, 53, cis-woman): Yeah, yeah. Or the crooked back, or the scoliosis?

This exchange was preceded by Karen (Indigenous, 54, cis-woman) explaining her perception that the campaigns were simply *"targeting rich people…they're not talking about anybody that's down here [in the DTES] that are really lost,"* indicating how the bodily marks described by Daniel and Julie were indicators of class, not just health status. Many participants noted how the campaign subjects' bodies were unmarked by the signs of serious, long-term substance use and the associated entrenched poverty many of them experienced. People often described their own physical appearance, in contrast to the clean-cut look of the campaign subjects, as "disheveled" (Jason, Black, 57, cis-man) or "weathered" (Michael, White, 57, cis-man).

The Stop Overdose campaign's slogan that "PWUD are real people" caused Andrew (White, 55, cis-man) to joke that he had *"never met anyone who wasn't a real person."* But this soon expanded into a thoughtful exchange between participants in the cis-men's focus group on how PWUD like them were frequently stereotyped, dehumanized and *"treated like cartoon characters…like they think we're not real"* (Jeffrey, White, 48, cis-man). Further reflection on how people "like them" were excluded from the campaign's representations of PWUD led Andrew (White, 55, cis-man) to conclude cynically *"It's not aimed at us…I guess we're not real people."*

But ironically, "real people" was also one of the most common phrases used by participants to describe themselves (i.e., marginalized PWUD associated with the DTES) as more authentic in their substance use and experience of stigma than the "actors" who appeared in the campaigns. Like Andrew's comment that *"we're not real people",* participants often perceived the campaigns' fixation on PWUD who appeared to be from privileged social categories as a challenge to the prototypicality of marginalized PWUD like them in the wider PWUD category. Participants reacted to this threat with the resistance strategy of explicitly claiming the label of "real" drug users for themselves. This was most common when participants made suggestions around who *should* have been included in the campaigns. For example:

> If it were up to me, I would most definitely use real people…like people from down here [i.e. the DTES] (Joseph, Indigenous, 39, cis-man)

> I: What types of PWUD would you say are not included in these images?
>
> Karen (Indigenous, 54, cis-woman): Real people like us. (Laughs)
>
> [*general laughter and "yeahs"*]

Importantly, it was rare for participants to suggest that the White and middle class-appearing actors in the two campaigns should be completely replaced with PWUD who appeared to be marginalized. In fact, many participants initially welcomed the representation of privileged PWUD in the campaigns and recognized people whose privileged status enabled them to hide their drug use from others as worthy of compassion and support[25]. Instead, participants often recommended that the campaign should have increased the diversity of who was represented as PWUD. Most commonly suggested was an approach to representing PWUD that reflected the substance use health inequities (i.e., prioritizing members of groups experiencing disproportionate impacts of substance use health harms) many felt the campaigns had ignored. For example, Laura (White, 37, cis-woman) explained how she felt it was "incredibly hurtful" that the campaigns had apparently excluded Indigenous PWUD:

> I think they probably left [First Nations PWUD] out because they…probably felt it would be gauche to put a First Nations person on that campaign cause then everybody would be like "oh of course you put a First Nations person there"…But they should have cause that's…a huge demographic that's struggling with substance use.

Here, Laura intuits a common anxiety felt by campaign creators (i.e., not wanting to perpetuate racist stereotypes associating Indigenous peoples with substance use) that drives decisions about representation. But she also recognizes the need to address an important health inequity (i.e., disproportionate negative impacts of substance use facing Indigenous communities, Firestone, Tyndall, et al., 2015; Marshall, 2015) that is driven by anti-Indigenous racism (and associated substance use stigma, Goodman, et al., 2017) by acknowledging, and even representing, Indigenous PWUD in an anti-stigma campaign meant to increase sympathy for PWUD.

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[25] At times participants also responded less kindly to campaign representations of privileged PWUD. For example, some participants associated people who looked like the PWUD represented in the campaigns with 1) "stigmatizers" who looked down on marginalized PWUD and had treated participants badly and 2) "weekend warriors" who were described as entering the DTES neighborhood to buy drugs before returning to their privileged homes in the suburbs. These characterizations of privileged PWUD were often made with disdain, highlighting the anger some participants felt at the injustice of unequal treatment of privileged versus marginalized PWUD that the campaign materials reminded them of.

Indeed, rather than simply advocating for a campaign that would replace privileged PWUD with representations of more obviously marginalized PWUD, many participants described an inclusive anti-stigma campaign strategy that would represent *"every part of the spectrum"* (Melanie, White, 24, cis-woman) of substance use:

> Like somebody that's homeless, somebody that's a businessman, somebody that's like on the street, in an SRO, a lawyer…Because they're saying that these people [i.e., campaign subjects] are sisters and moms and brothers but they're still saying that we're scum [i.e. marginalized PWUD]. (Melanie, White, 24, cis-woman)

> What might have been interesting too is you have folks like this represented, and this is a drug user, and then you have a picture of a homeless person, this person doesn't use drugs, right? (Shannon, White, 61, trans-woman)

Shannon's idea in particular ties this theme back to the issue raised in the first and second themes: Whereas the images and messages of these campaigns were meant to challenge the stereotype that "not all PWUD are marginalized" a major challenge facing participants was the stereotype that "all marginalized people are PWUD". By representing a person who fit the stereotype of a prototypical PWUD (i.e., a homeless person) explicitly as someone who does not use drugs Shannon wondered if this might better address the challenge of people who appear marginalized being *"automatically labelled as a drug addict"* (Lisa).

3.4.4. "Works for everybody but us": The double standard of mainstream anti-stigma campaigns perceived to ignore (or exacerbate) substance use health inequities

Finally, participants commonly interpreted the implied messages and especially the representation of privileged PWUD in the anti-stigma campaigns as perpetuating a "double standard" where the substance use of elites is tolerated and the serious health inequities impacting marginalized PWUD are ignored. The perception that the potential destigmatizing effect of the campaigns would not benefit "people like us" was common across focus groups:

> I: If, if it did work, who do you think it would work for if it did help reduce stigma?
>
> [*all answer at once*]
>
> Andrew (White, 55, cis-man): Well it's …
>
> Ryan (No ethnicity, 55, cis-man): Works for everybody but us.
>
> I: Yeah?
>
> Steven (White, 44, cis-man): The great massive, the straight people out there…
>
> Ryan: These aren't aimed at us man.
>
> I: Yeah.
>
> Andrew: No, it's not at all. Totally not, it's not about us and it's not aimed at us.

Many participants went so far as to describe how they felt campaigns such as these depended upon the continued stigmatization of marginalized PWUD and contributed to the worsening of inequities. These participants did not see their exclusion from these anti-stigma campaigns as an unfortunate oversight or simply another example of being ignored by government policy makers. Rather, participants felt that the exclusive focus on non-prototypical, PWUD and privileged (hidden) experiences of substance use in both campaigns sent a clear message to the general public that marginalized PWUD more similar to the participants were not worth helping, humanizing, or destigmatizing. For example, Shannon (White, 61, trans-woman) expressed a concern that the Stop Overdose campaign:

> …kind of transmits the message that "see these, you know, middle-class folks, they could be drug users too", and maybe… we can help these folks out. But at the same time, we've washed our hands of the people on the street.

The apparent prioritization of middle class PWUD *"when the people that are really dying from it are in the Downtown Eastside"* (Lisa, Indigenous, 33, cis-woman) was a common analysis of the campaigns by participants. A wider narrative of special media and political attention paid to the White middle-class-associated prescription opioid crisis[26]

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[26] As many have observed, legally procured prescription opioids were in fact only ever a very small contributor to the crisis of opioid addiction and mortality, which has (especially

was a frequent reference point for participants expressing their frustration with the potentially harmful implication of the campaigns. Participants often interpreted the apparent White middle-class status of the campaign subjects through reference to the (expensive) prescription opioids they imagined they were using. Some even expressed how they felt that people who (only) used illicit prescription opioids (perceived to be upper class) were the real target of the campaigns:

> Karen (Indigenous, 54, cis-woman): It's basically a form of genocide ... hiding the gentrification that's happening around here [i.e. in the DTES]. That's what I feel it is. They never mention it. They just said "opioids". It could be any opioid, could be just pills or whatever. I think that's the only people they're targeting in here, people that pop pills. *Not people that really use drugs.*
>
> Daniel (White, 60, cis-man): [*background*] Oxycontin.
>
> Julie (White, 53, cis-woman): Yeah, Oxycontin

When asked who the campaign might help, Daniel (White, 60, cis-man) shared that he felt it was *"not gonna help Downtown [Eastside] people"* or address the kind of stigma that he and his community faced: *"It may help the rich suburbanite who started smoking pot in high school and now has graduated to opiates, Oxycontin for example. … Mother's prescriptions. (chuckles)."* Participants like Jason (Black, 57, cis-man) and others shared that the posters reminded him of how *"The first time somebody died in the 'burbs, it became…an epidemic".* Jason reported how many of his friends in the DTES had died of drug toxicity before this so-called "epidemic" was identified in suburban communities, and his perception that the deaths of his friends had received no recognition or concern from politicians or the media. Many participants framed their response to the campaign materials in terms of a wider perception that mainstream

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in recent years) been almost entirely driven by illicit heroin, fentanyl (and analogues, e.g. carfentanil), and the mixture of illicit substances (e.g. alcohol, opioids and benzodiazepines) (Rose, 2018; Satel, 2018). The "Whiteness" of the crisis has also been a matter of debate as it was initially observed and widely emphasized in media reports that opioid addiction (and mortality) was newly touching White communities where it had previously been less visible (Case & Deaton, 2015; Cicero, et al., 2014). This trend has subsequently been critiqued for ignoring substance use health inequities facing low-income and racialized communities that were always present (e.g. Friedman, et al., 2022; James & Jordan, 2018; Netherland & Hansen, 2016, 2017; Hansen, et al., 2023).

society did not care about the impacts of the toxic drug crisis on marginalized PWUD like them. In this context they saw the campaigns as an attempt to rescue privileged PWUD from stigma by negatively contrasting their identities with those of marginalized PWUD:

> Steven (White, 44, cis-man): There is this certain segment of the population out there that’s gonna say "good, let them die, it’s less welfare money".
>
> Ryan (No ethnicity, 55, cis-man): Yeah, and then their kid goes and dies, [*imitates snivelling rich person*] ‘Oh but he was a good boy, he wasn’t like a drug addict",’ well yeah he was! yeah he was.
>
> Steven: And that’s when, that’s when they’ll learn when one of theirs dies.
>
> I: In some ways do you see that kind of story reflected in these photos?
>
> Ryan: Your fucken right.
>
> Steven: Well no, "he’s not a drug addict, he just takes a few pills a day."

Several participants in different focus groups shared a related concern that despite an over-representation of Indigenous PWUD experiencing the harms of substance use (e.g. death from toxic drugs) the campaigns did not clearly represent Indigenous PWUD and seemed to ignore this important inequity. For example:

> “What I think they’re portraying here is that the middle class upper, non-Indigenous person here um…can be…a person that uses drugs and that should not be stigmatized against. But the stigmatism against a Native person is portrayed in a whole different, fucking different sense than anything else. And it’s not in here. That Native people are people and that we shouldn’t be judged the way that we’re judged…They’re trying to reduce stigma, is trying to reduce the stigma against everybody else except for…Native people.” (Mark, Indigenous, 46, cis-man)

A small number of participants went even further to frame stigmatization towards Indigenous people and marginalized PWUD as *useful* for the government. These participants felt that to the extent that these anti-stigma campaigns may help to further public ignorance of, or even perpetuate, substance use health inequities this could only benefit governments that depended upon the fracturing of oppressed communities. For example, John (Indigenous, 52, cis-man) shared his disbelief that the government truly wanted to end the stigma around substance use, which he felt would *“always be there”* because of his perception that governments benefit so much from the continued stigmatization and criminalization of marginalized PWUD:

> John: They [i.e. governments who made these campaigns] have to have [us] divided from first class to low class. It makes society. It makes everything. If you get caught for drugs, that gives pay to lawyers. That pays the judge. That pays the security guard. That pays the sheriffs. That pays the cops. We [i.e. PWUD] make society….It’s never going to stop.
>
> I: So when you see two campaigns like this, by the federal government and the provincial government, saying we’re trying to reduce stigma towards PWUD, what do you think about that?
>
> John: They’re not going to do it. [*incredulously*]
>
> I: [*laughing*]
>
> John: Fuck! They’re trying to just fucking… split us apart to see which one’s are going to fucking be in court and which ones aren’t going to be.”

3.5. Discussion

This study used a community-based, participatory, and qualitative research approach to examine the reactions and analysis of marginalized PWUD who were given an opportunity to engage in group-based discussion of two mainstream anti-stigma campaigns. Analysis of participants’ discussion provides insights on the potential negative implications of a widely-used approach to substance use-focused anti-stigma campaigns: representing non-prototypical PWUD in order to “challenge stereotypes” about the social categories of PWUD.

This analysis finds that marginalized PWUD had complex reactions to the two anti-stigma campaigns. Participants often initially resonated with the campaigns’ message that individuals from any social category (even unexpected ones) could be affected by the harms of toxic drugs, hoping that this message could reduce the public scrutiny they often faced as people who “look like drug users” by broadening public conceptions of what a drug user looks like. But participants’ somewhat positive initial reaction was soon followed by cynicism that the campaigns could truly challenge the type of intersectional stigma that they faced, and anger that the campaigns had so blatantly excluded PWUD like them. Participants also commonly expressed resistance to the campaign’s suggestion that privileged PWUD are prototypical of the PWUD category, by (re)asserting their own prototypicality. It was important to participants to contrast themselves with the campaign subjects by identifying as “real drug users” who bore the marks of stigmatized drug use, contrary to the unmarked faces and bodies of the White and middle-class appearing PWUD represented as the objects of destigmatization in the campaigns. Finally, participants expressed their concerns that by ignoring important substance use health inequities (e.g. over-representation of Indigenous and poor PWUD amongst those who die of drug toxicity) and implying a negative contrast between privileged and marginalized PWUD, the campaigns may have the harmful effect of exacerbating inequities and worsening the intersectional stigma that participants experience. Ultimately, this analysis suggests that marginalized PWUD who interact with anti-stigma campaigns that seek to “challenge stereotypes” about what PWUD look like (i.e. their visible social identities) by centering the identities of privileged PWUD may experience them as exacerbating the societal exclusion, stigma, and health inequities experienced by PWUD who are made structurally vulnerable by their intersecting marginalized identities (e.g. poor, Indigenous).

Few studies to date have adopted the Social Identity Approach (SIA) to examine the identities and intergroup relations surrounding PWUD and substance use-related stigma. Simmonds and Coomber (2009) provided one early example. They drew on concepts from Social Identity Theory (Tajfel & Turner, 1979) to make sense of how some PWUD are both the recipients of intense stigma from the public and yet also seek to maintain positive distinctiveness by engaging in negative downward comparisons towards other PWUD more marginalized than them (e.g. PWUD who are homeless, “junkies” who used heroin rather than steroids). They also noted how their participants’ (injection drug users recruited from a harm reduction service, majority White men who were economically and socially marginalized, though mostly not homeless) wanted to avoid being seen as prototypical of the wider PWUD category as this was to them a negative identity. Prototypicality, to them, meant association with PWUD who were most severely marginalized (i.e. “junkies”). More recently, Sibley and colleagues (2023) used the SIA to explore how rural PWUD (mostly White opioid users) engaged in social categorization when describing the intragroup dynamics within the wider PWUD category. Their participants described various subgroups delineated by drug of choice (e.g. opioid users vs. stimulant users), modes of ingestion (e.g. smoking vs. injecting), income generation strategies (e.g. petty crime vs. legal employment), gender, age, and recovery orientation (e.g. abstinence vs. harm reduction). Like Simmonds and Coomber (2009), Sibley and colleagues also observed their participants' concern with using identity management strategies (e.g. negative downward social comparisons) to distance themselves from the most marginalized PWUD (e.g. injection drug users) who were also seen as the most prototypical PWUD. In both cases, an SIA analysis was used to demonstrate how some PWUD attempted to distance themselves from the most marginalized PWUD in order to maintain their positive and distinct social identities.

Contrary to these past studies, in the present study. marginalized PWUD appeared to embrace, and even defend, their prototypicality. Importantly, the context, and participants, in the present study differed in significant ways from both prior studies. Whereas past studies interviewed PWUD who could disidentify with more marginalized subgroups of PWUD (i.e. they were relatively privileged), the participants in this study did not engage in negative downward social comparisons towards other PWUD perceived as more marginalized than them. Furthermore, whereas most participants in both prior studies were White PWUD, more than half the sample in this study identified as Indigenous. By asking participants to respond to anti-stigma campaign materials representing people with more privileged social identities (e.g. White, middle class) as PWUD who did not deserve stigma this set up an intergroup context in which participants often identified themselves, not just as individuals but as a group (e.g. "people like us"), as having been excluded from the campaigns. Participants reacted negatively to the campaigns, perceiving the exclusion of marginalized PWUD like them as an injustice, and further evidence of their wider exclusion from society. Participants also frequently questioned the authenticity of the "actors" in the campaigns, and expressed their skepticism that the campaign subjects had truly used drugs, used "hard" drugs (e.g. street heroin, fentanyl), experienced serious addiction, or endured the kind of dehumanizing stigma that participants were all too familiar with. Rather than working to distance themselves from some more marginalized subgroup of PWUD, participants experienced the anti-stigma campaigns they were asked to review and analyze as a threat to their collective prototypicality as PWUD. In response, PWUD in this study seemed to assert the value of their prototypical status as “real drug users”, at least in the context of comparison with a more privileged subgroup of PWUD.

Valuing one’s prototypicality within a negatively evaluated social category is a somewhat surprising finding that not only contrasts with analyses of intragroup dynamics amongst PWUD (Sibley, et al., 2023; Simmonds & Coomber, 2009) but more broadly SIA studies of subgroup concerns within wider superordinate categories (Hornsey & Hogg, 2000; Wenzel, et al., 2007). What explains this? One possibility is that participants felt the injustice of exclusion from PWUD prototypicality in the campaigns because they saw that they were being excluded in a context where being made the “face” of the wider PWUD category might have some benefits. Participants seemed to understand that these campaigns were working to construct a new subgroup of privileged PWUD who did not deserve stigma. Participants observed they were excluded from this new subgroup, and thus locked out of the potential benefits of destigmatization. While both campaigns ostensibly targeted stigma towards the wider category of PWUD, it was clear to participants that whatever potential destigmatizing benefits the campaigns might produce would not apply to marginalized PWUD like them, given their obvious exclusion. But importantly, participants in this study resisted this exclusion, mocking the campaigns’ suggestion that these were “real PWUD” and bolstering their own ingroup pride as “real drug users” who bore the visible marks of long-term drug use and other stigmatized identities. More research could examine the conditions under which disadvantaged subgroups within a stigmatized social category fight to remain prototypical of the wider category, despite its overall negative evaluation. Research could also more directly examine contexts in which prototypicality in a stigmatized category is desired by subgroups, for example when subgroups perceive this prototypicality may facilitate their access to resources like material support or sympathy. Research on ingroup projection (e.g. Wenzel, et al., 2007) has examined how subgroups within positively evaluated superordinate categories (e.g. Canadians, Europeans) are motivated to be seen as prototypical of the wider group, but less research has examined the fight for subgroup prototypicality within broader superordinate categories that are generally seen as stigmatized (e.g. PWUD).

3.5.1. Anti-Stigma Campaigns as a Tool For Divisive Social Categorization Amongst PWUD

This analysis took for granted the conflict between privileged and marginalized PWUD implied by the anti-stigma campaigns and analyzed by participants. However, it is also important to problematize this conflict and interrogate its political function. As John (Indigenous, 52, cis-man) emphasized in his description of the politicized function of substance use-related stigma in society *("…they're trying to split us apart")*, stigma often operates all too effectively at creating divisions between groups that could operate in solidarity with each other (Friedman, et al., 2021). This perspective positions stigma as a tool used by governments and political leaders to categorize and divide people (Fraser, et al., 2017; Link & Phelan, 2014; Parker & Aggleton, 2004; Reicher, 2007; Tyler, 2020). This view of the function of substance use stigma is an important context for understanding the potential role of substance use-focused anti-stigma campaigns in the wider context of PWUD intragroup relations.

While the anti-stigma campaigns examined in this study were ostensibly directed towards reducing stigma towards all "PWUD", in practice, participants saw them as focusing attention on a privileged subgroup of PWUD. These PWUD were constructed via the campaigns' sympathetic messaging and imagery as deserving compassion and support, and not deserving stigma. This observation suggests that this common genre of anti-stigma campaigns (i.e. centering privileged PWUD) may fit in with the wider history of legal, cultural, and even corporate practices that separate classes of PWUD from each other. As Herzberg (2020) points out in his historical analysis of both drug market developments and subsequent changes to relevant regulatory frameworks (e.g. criminal drug laws, drug quality controls), the history of drug policy shows a pattern whereby people with other marginalized identities (e.g. poor, racialized) have had their substance use criminalized and punished and people with privileged identities (e.g. White, middle class) have had their substance use medicalized and treated (see also Dollar, 2019). Hansen and colleagues (2023) document how innovations in the pharmaceutical industry (e.g. marketing of Oxycontin and Buprenorphine to primarily White doctors and patients) have both exploited, and exacerbated, the racial and class divides between people whose substance use is stigmatized versus normalized. Analyses of media representations of the "opioid overdose crisis" also show how the categorization of PWUD who deserve (White, middle class) or do not deserve (Indigenous, Black, Brown, poor) public sympathy or support is mobilized (Dertadian & Rance, 2023; Johnston, 2020; McLean, 2017; Netherland & Hansen, 2016; Webster, et al., 2020).

Rather than emphasizing the common struggles of stigma or health risks faced by all PWUD, campaigns that centre the identities of privileged PWUD, and draw implicit negative contrasts with marginalized PWUD, work to fragment the broad social category. Given the angry responses of participants (e.g. their strong negative feelings of exclusion from the campaigns), they may even foment animosity between different groups of PWUD who could potentially work in solidarity for social change that would benefit all PWUD. As Friedman and colleagues (2021) point out in their conceptualization of how stigma operates in a system, breaking the potential for solidarity within groups is a key stigma tactic often used by those with power to disrupt meaningful resistance to oppression (see also Neufeld & Schmitt, 2019). Ironically then, anti-stigma campaigns like those centred in this study could in some cases worsen the situation of marginalized PWUD by deepening the intersectional marginalization they experience because of negative implied contrasts with their other stigmatized identities (e.g. poor, Indigenous) and by disrupting the potential for broad-based solidarity between all PWUD.

3.5.2. Who Are These Anti-Stigma Campaigns Really For, and Who Might They Actually Benefit?

One possible interpretation of the two anti-stigma campaigns examined in this study is that they were never intended to provide any benefit for marginalized PWUD. As interventions, they were designed to reach a broad mainstream audience (i.e. general population in BC and Canada) and purposely represented campaign subjects who shared identities with that imagined audience (i.e. predominantly White and middle-class-appearing). This strategy of representing PWUD with identities that resemble those of the target audience serves to maximize the potential impact of the campaigns and encourages everyday citizens to see the role of stigma in the worsening drug toxicity crisis as a problem that could be impacting those close to them, and which they may have some personal responsibility to address. Stereotypical, marginalized PWUD, marked by the visible signs of deteriorated health status and other stigmatized identities, were purposely excluded given the campaign creators' likely correct intuition that these

PWUD would be unsympathetically perceived by the campaigns' audience given their widely accepted dehumanization.

A potential justification of this approach from campaign creators is that it will not matter if marginalized PWUD are represented in an anti-stigma campaign's imagery, so long as the campaign overall has the desired effect of reducing public stigma towards PWUD. This suggests that "a high tide lifts all boats", and in this case the ends (public stigma towards PWUD decreased) may well justify the means (excluding marginalized PWUD). Despite study participants' protestations that it hurts to be excluded from mainstream anti-stigma campaigns, will the effects of a campaign strategy that emphasizes PWUD whose identities put them in a sympathetic and relatable light for audiences not ultimately benefit even marginalized PWUD?

Little research has examined this hypothesis directly, but historical examples from drug policy reform advocates cast some doubt. Whereas in earlier eras of the War on Drugs media frequently portrayed the supposed dangers of illicit drugs and the people who both use and sell them in racist and classist ways (i.e. non-Whites, lower income, Boyd & Carter, 2010; Murakawa, 2011; Reinarman & Levine, 1989, 1997), more recent portrayals of White, middle-class appearing PWUD in news media and anti-stigma campaigns such as those examined here may seem like an uncontestably positive development. While shifts in public perceptions of the identities of people at risk of substance use-related harms (White, middle class) may seem to bode well for reducing stigma towards all PWUD and building support for progressive drug policies that could benefit everyone, historical examples show that utilizing White and middle-class privilege as a strategy to reform drug policy has typically only benefitted White and middle-class people, often at the expense of structurally vulnerable, racialized and low-income PWUD (Hansen, et al., 2023; Herzberg, 2020; el Sabawi & Oliva, 2022).

For example, long-time drug policy reformer and scholar Jules Netherland recounts (Hansen, et al., 2023) how suburban White parents of children who suffered from epileptic seizures that could benefit from medical marijuana joined a long-running movement of lower-income, racialized PWUD advocating for cannabis decriminalization in New York. Highlighting how some constituents are constructed as mattering more than others, their movement's advocacy finally gained traction as lawmakers, who had ignored calls from racialized people to address the racial injustices of marijuana criminalization, paid attention to the heart-wrenching stories of innocent, young, White children who could benefit from medical marijuana. A bill was eventually passed that primarily benefitted the White children and left behind the marginalized PWUD who had begun the movement (Hansen, et al., 2023, pp. 66-70). In another example, Schlussel (2017) catalogued how many campaigns for the legalization of cannabis in the U.S. emphasized "White individualism" (i.e. depicting White, middle-class appearing "good" people as deserving of legalized recreational cannabis) in order to build public support for this policy reform. Schlussel found that this campaign strategy was associated with eventual legalization regimes that did nothing to address the racial injustices of cannabis prohibition and made it more challenging for the racialized groups who have borne the brunt of cannabis criminalization to benefit from the legalized cannabis market. While it may seem strategic to attempt to generate some change in public perceptions of PWUD and (hopefully) movement in drug policy reform by centering the sympathetic stories of White, middle-class PWUD, the changes that result often do not benefit all PWUD (Hansen, et al., 2023, see also Seelye, 2015). Thus, participants in this study's intuitions may be correct that being excluded from the subgroup of PWUD who campaigns construct as uniquely deserving of stigma reduction due to their privileged identities will ultimately harm them by exacerbating their exclusion from society.

3.5.3. Towards More Inclusive Anti-Stigma Campaigns? Recommendations From Marginalized PWUD

Rather than advocating for the wholesale replacement of privileged PWUD with marginalized PWUD in anti-stigma campaign representations, participants more often suggested that the campaigns simply should have shown more diverse examples of PWUD. Specifically, participants recommended representing PWUD with privileged social identities (like those in the campaigns they viewed) alongside PWUD who appeared more marginalized (more similar to participants). In contrast with the artificial diversity observed in many anti-stigma campaigns from Study 1 (e.g. a "diversity panel" of stock actors from diverse ethnic backgrounds represented as PWUD), participants recommended a more meaningful approach to diversification that would intentionally represent PWUD from groups disproportionately harmed by substance use health inequities (e.g. Indigenous, poor). Participants felt this approach could both help to draw awareness to substance use health inequities (e.g. disproportionate impacts of drug toxicity in Indigenous communities) and also work to counter the intersectional effects of substance use stigma, racism, and classism. An anti-stigma campaign launched in Brockville, ON in May 2021 used an approach like this. Employing a similar design as the Stop Overdose posters, this campaign purposely showed both PWUD who appear to be from more privileged social categories and those who appeared to be more marginalized (Vandermeer, 2021). Several participants also specified how anti-stigma campaigns could focus less on simply representing the identities of PWUD and instead focus on challenging negative behavior-based stereotypes that paint all drug users as lazy, dangerous, irresponsible, or dysfunctional. As Tara (White, 22, cis-woman) suggested, *"Maybe let people know we aren't all scumbags and there are good people that use, by giving like a small story or snippet of what good they've done in the community."*

Several times throughout the focus groups participants expressed how a more inclusive anti-stigma campaign might have been produced if the campaign had been co-developed with a diverse group of people with lived and living experience (PWLLE) of substance use, including those from more marginalized subgroups of PWUD. While the Stop Overdose BC campaign creators claimed to have worked with PWLLE (Regan Hansen, Ministry of Mental Health and Addictions, personal communication, June 14, 2018), close analysis of internal campaign development documents suggests there was limited real engagement (Greto & Neufeld, 2023). Indeed, reports from Vancouver drug user activists (e.g. the Canadian Association of People Who Use Drugs, CAPUD) suggested that while they had been briefly consulted on the campaign materials shortly before its January 2018 launch their consultation had been rushed, and highly tokenistic (CAPUD, 2018; Wadhwani, 2018). This lack of meaningful PWLLE engagement, but also a wider structural critique of the inadequacy of anti-stigma campaigns to address the roots of substance use stigma in drug policy (policy controlled by the very governments now launching anti-stigma campaigns), underlaid CAPUD's fierce public criticism of the Stop Overdose campaign.

3.5.4. Limitations and Future Directions

This study has several limitations. First, participants were recruited from a small set of DTES-related organizations and networks, limiting the potential generalizability of these findings to PWUD in other areas. Indeed, the unique nature of Vancouver's DTES and organizations such as VANDU, WAHRS and BCAPOM may have influenced participant responses. Given the long history of activism and organizing by PWUD in Vancouver's DTES (see Boyd, et al., 2009; Boyd & MacPherson, 2018; Kerr, et al., 2006) and participants' connection to these organizations via recruitment, it is possible that participants represented a uniquely empowered and class-conscious group of PWUD (see also Culhane, 2011). This may partially explain the unusual finding of participants defending their status as prototypical PWUD whereas in other contexts PWUD have been more motivated to avoid being seen as prototypical (Sibley, et al., 2023; Simmonds & Coomber, 2009). Familiarity amongst participants with the language of drug user empowerment and ingroup pride as marginalized (and politicized) PWUD may have contributed to participants' critical reaction to the anti-stigma campaigns. Marginalized PWUD from less politicized communities may have responded differently.

Second, despite purposive sampling to include youth, trans-women, cis-women and cis-men focus groups, as well as intentional questions in each focus group asking how participants' experience of those identities intersected with substance use stigma, participants across focus groups primarily discussed race and class-based identities when reflecting on the anti-stigma campaigns. For example, only when I asked participants in the trans-women focus group if they felt it was important that anti-stigma campaigns include trans representation did this come up as a topic of discussion. Shannon (White, 61, trans-woman) replied that it was, but also recognized that there were only four posters. She explained how she knew the campaign could not represent individuals from all possible social categories, suggesting that the exclusion of trans PWUD was implicitly expected and accepted. Nevertheless, Shannon did comment on the Stop Overdose campaign's perceived lack of diversity by saying *"they could have done a whole lot better than this"*. Identities related to class and race appeared most salient to participants when contrasting their own identities with those of the campaign subjects. While history and participants' experiences do suggest that substance use stigma has perhaps most often worked as a tool of racism and classism, this emphasis amongst participants should not be taken to suggest that substance use stigma has not also been weaponized as a tool to control, dehumanize and otherwise harm women, gender and sexual minority groups, sex workers, youth, and other structurally vulnerable groups.

3.6. Conclusion

In summary, marginalized PWUD in this study felt that substance use anti-stigma campaigns that seek to challenge the prototypicality of marginalized PWUD by representing imagery of privileged PWUD may contribute to the stigma and exclusion that they experience. This study's findings align with the criticism expressed towards substance use anti-stigma campaigns by activist groups, yet also deepen those criticisms by providing a social psychological analysis of how challenges to marginalized PWUD's prototypicality may ironically exacerbate the substance use health inequities (e.g. disproportionate impacts of drug toxicity in Indigenous communities) and intersectional stigma (e.g. racism, classism) they face. This analysis of anti-stigma campaigns suggests the need for more thoughtful approaches to anti-stigma interventions that consider both the intersectional nature, and structural roots, of substance use stigma.

Chapter 4.

General Discussion

Unregulated and ever more potent illicit drugs have killed increasing numbers of Canadians in recent years. From January 2016 to March 2023 (PHAC, 2023) approximately 38, 514 individuals have died from apparent opioid-related toxicity in Canada. This crisis of deaths from toxic drugs is unprecedented in Canadian history, as is the response from governments, public health organizations and other stakeholders. In the past, national crises surrounding a perceived or actual rise in illicit drug-related harms (e.g. addiction, crime, blood-borne infections, drug toxicity death) in Canada were met with moral panics around the threat that PWUD may pose to respectable mainstream society (Boyd, 1984; Boyd, 2017; Giffen, et al., 1991; Malleck, 2015). More recently, organizations as wide-ranging as the Canadian federal government, small groups of concerned university students, the City of Hamilton, private for-profit addiction recovery centers, radical drug user activist groups, the provincial government of BC, and national organizations created by the parents of young people who have died from toxic drugs (e.g. Moms Stop the Harm) have taken up the cause of addressing stigma towards PWUD. Substance use-focused anti-stigma campaigns have exploded in popularity in the past 7 years. According to the national review reported in Chapter 2, just 19 substance use-focused anti-stigma campaigns could be identified across Canada from 2009 to 2016, whereas from 2017 to 2020 there were 115. This turn towards attempting to address substance use-related stigma, rather than doubling down on discrimination and exclusion towards PWUD, appears to be a welcome break from divisive prohibition drug policies which have sought to criminalize, punish, and dehumanize PWUD.

As this dissertation has argued however, the recent spate of substance use anti-stigma campaigns in Canada raises many questions about how, and for whom, these ubiquitous interventions are meant to do their work. The first study in this dissertation, a large-scale and comprehensive review of 134 substance use-focused anti-stigma campaigns launched in Canada from 2009 to 2020, identified a disproportionate emphasis on White and middle-upper class-appearing PWUD as the subjects of destigmatization. This study also showed how anti-stigma campaigns in this review frequently constructed the problem of stigma (e.g. overly individualistic and rarely focused on structural stigma), employed anti-stigma strategies (e.g. “addiction does not discriminate”, obscuring substance use health inequities), and assumed journeys of addiction recovery (e.g. the imperative towards eventual abstinence from all substance use, a goal not desirable or attainable for many marginalized PWUD) that worked to exclude the identities, concerns and lived experiences of marginalized PWUD. The second study in this dissertation, eight focus groups conducted with marginalized PWUD who analyzed two mainstream anti-stigma campaigns, highlighted the potentially harmful implications of campaigns that center White and middle-upper class appearing PWUD, while ignoring the intersections of oppression (e.g. racism, classism) and substance use health inequities facing marginalized PWUD. Participants in this study felt strongly that such campaigns confirmed a double standard in which privileged PWUD are constructed as uniquely deserving of compassion and negatively contrasted with the marginalized and “stereotypical” PWUD whose exclusion and dehumanization is implicitly taken for granted.

Both studies reported in this dissertation are tied together by a community-based participatory research (CBPR) approach (including a single CAB comprised of marginalized PWUD from DTES drug user advocacy organizations) and theoretical influences from critical perspectives on substance use stigma and the Social Identity Approach (SIA) to intergroup relations. The CBPR approach ensured that both studies were grounded in the concerns, experiences, and perspectives of marginalized PWUD (i.e. CAB members, peer research assistants). The SIA, and critical perspective on substance use stigma, helped move understandings of the nature of substance use stigma in both studies beyond mere negative interactions between individuals (Allport, 1954; Goffman, 1963) to consider how anti-stigma campaigns are implicated in the construction of new subgroups of White, middle-upper class-appearing PWUD who are meant to be seen by mainstream public audiences as similar to them, and not deserving of stigma. The practice of governments and public health authorities using anti-stigma campaigns to redraw group boundaries around which PWUD are seen as not deserving of stigma illustrates how stigma can sometimes be understood as a process of people with power marking marginalized groups as different, and worse, for the purposes of their exclusion from the dominant ingroup (Link & Phelan, 2014; Parker & Aggleton, 2003; Reicher, 2007; Tyler, 2020). Ironically, substance use-focused anti-stigma campaigns may under some circumstances act as tools of further stigmatization towards the marginalized PWUD that they frequently exclude.

4.1. Novel Contributions to Knowledge: Relevance for Health Communication Researchers and Substance Use Stigma Scholars

This dissertation makes novel contributions to knowledge in two key areas. First, substance use-focused anti-stigma campaigns are an almost completely unexamined form of health communication (understandable, given their relative novelty) and this dissertation provides the first known large-scale, in depth, and critical analysis of anti-stigma campaigns in any country. While a small number of studies have evaluated the effectiveness of substance use-focused anti-stigma campaigns (e.g. Kennedy-Hendricks, et al., 2022), no studies have critically examined the content of these campaigns or examined how campaigns represent PWLLE, how they define stigma, or the potential implications of these representations for the marginalized PWUD they exclude. A few examples of critical examinations of health communication campaigns in other areas exist (e.g. HIV/AIDS prevention PSAs in India, Khan, 2014; mental health-related anti-stigma campaigns, Tyler & Slater, 2018, Walsh & Foster, 2020), but no studies have examined the content of substance use focused anti-stigma campaigns. Similarly, while several studies have asked PWUD to respond to substance use-related health communication campaigns (e.g. “anti-drug” prevention campaigns, Douglass, et al., 2017; Kerr, et al., 2013; Ti, et al., 2017), no studies have asked PWUD to respond to substance use-focused anti-stigma campaigns, despite their growing popularity. Given the novelty of this arena, this dissertation’s findings will be of interest for critical health communications scholars who study anti-stigma campaigns, scholars who study substance use stigma and its reduction, and social scientists who are broadly interested in stigma reduction interventions.

Second, this dissertation presents a novel analysis of substance use-related stigma as tied up in the construction of subgroups of PWUD who are seen as more or less deserving of public compassion versus stigma. I advance the argument that anti-stigma campaigns may sometimes work to exacerbate stigma towards marginalized PWUD by excluding them from representations of a newly constructed subgroup of PWUD (White, middle-upper class) that is framed as not deserving of stigma and as a challenge to the prototypicality of marginalized PWUD. By conceptualizing substance use stigma through the lens of the SIA (e.g. Reicher, 2007) and other critical perspectives on stigma (e.g. Tyler's 2020 updating of Goffman's classic 1963 sociological account of stigma) this dissertation provides fresh language and conceptual tools to describe stigma that other scholars who focus on stigma towards PWUD may find novel and useful. Reicher's (2007) reconceptualized SIA to stigma (or prejudice) describes it as a practice that has more to do with how powerful people work to (re)define the boundaries of ingroup categories (who "us" includes, and who it excludes) than it does with merely how "we" think or feel about "them". Similarly, Tyler (2020) conceptualizes stigma as a tool wielded by the powerful to mark marginalized groups for surveillance, capture, and control. Both ways of thinking about stigma foreground the context and history of group-based exclusion and draw attention to how stigma produces benefits for stigmatizers (e.g. scapegoating marginalized groups, bolstering ingroup cohesion in response to the threat of stigmatized outgroups). This dissertation's application of this analysis of stigma to the context of substance use stigma and substance use-focused anti-stigma campaigns provides a novel contribution to knowledge that may be useful for developing rich analyses of substance use stigma, how it operates, how it may be reduced, and how anti-stigma campaigns may at times ironically contribute to the exclusion of marginalized PWUD.

4.2. Mobilizing Knowledge and Moving Forward on Anti-Stigma Interventions

A key goal of this CBPR project was to create conversations, data, analysis, and findings that were of interest, relevance and value to people who are stigmatized for their substance use. As an action-research project, CAB members and I hoped that our work together developing this dissertation's two studies and subsequent critical analysis of anti-stigma campaigns would contribute to the development of more inclusive, and ultimately more effective responses to the harms of stigma towards PWUD amid the drug toxicity crisis (Boilevin, et al., 2018). Whereas initial plans for knowledge mobilization from this project would have involved in-person collaborations, sharing recommendations and co-presentations of findings with CAB members, the unexpected hurdles of the Covid-19 pandemic made virtual collaboration with marginalized PWUD more difficult. My subsequent move from Vancouver, BC to St. Catharines, ON in 2021 has also made ongoing close collaboration with the CAB a challenge.

Nevertheless, I developed two key knowledge mobilization resources based on findings from this dissertation. The first is an online “Anti-Stigma Archive” (www.antistigma.info) that catalogues all 134 anti-stigma campaigns from Study 1, archives key materials and weblinks associated with each campaign, and provides a description along with a system of tagging based on how campaigns were coded (e.g. “uses addiction does not discriminate narrative”, “represents exclusively White PWLLE”). At present (December 2023), it also includes entries for nineteen campaigns that were launched after 2020 and thus were outside the review window of Study 1. The archive is fully searchable by key words and campaign tags and could serve as a jumping off point for substance use stigma researchers with an interest in expanding on some of the analyses begun in my dissertation project. It could also serve as an inspiration for anti-stigma practitioners who wish to explore specific types of anti-stigma campaigns (e.g. Indigenous-focused campaigns) or identify and avoid common issues with past campaigns. This resource will eventually be accompanied by some critical commentary and summaries of the findings from this project.

The second key knowledge mobilization component produced from this study is a series of recommendations for anti-stigma campaigns and substance use-focused anti-stigma interventions more broadly. These are reviewed in the next section, before the dissertation concludes.

4.3. Recommendations for Future Substance Use Focused Anti-Stigma Interventions

In the course of conducting the research for this dissertation (e.g. contacting many anti-stigma campaign creators across Canada, speaking with many marginalized PWUD about stigma) and especially as more public health organizations across Canada reached out to ask me to share my research with them, it became clear that one useful outcome of this dissertation project should be a set of recommendations for more inclusive, and potentially more effective, anti-stigma interventions. However, over time as I read more literature on anti-stigma campaign (in)effectiveness, became more attuned to the perception of many marginalized PWUD that anti-stigma campaigns might actually make things worse for them, and learned about more structurally oriented conceptualizations of stigma (and structural interventions to address it), I began to think about recommendations for anti-stigma interventions differently. Thus, the recommendations deriving from this project are presented in two parts. The first provides recommendations for those who wish to continue making anti-stigma campaigns, yet do so in a more inclusive way by avoiding some of the pitfalls identified in this dissertation (e.g. White, middle-class fixation). The second provides recommendations for those who want to think more strategically about addressing substance use stigma in their context, with an eye towards more structurally focused and intersectionality-conscious approaches.

4.3.1. Reverse Engineering Exclusion: Suggestions for More Inclusive Anti-Stigma Campaigns

As Study 1's analysis illustrated, not all diverse subgroups of PWLLE are represented in proportion to their share of relevant populations or negative impacts of substance use. For example, Indigenous PWUD are disproportionately impacted by drug toxicity yet rarely appear in anti-stigma campaigns. Study 1 illustrated the extent of this problem and Study 2 explored the potential negative implications of excluding marginalized PWUD from anti-stigma campaigns. A natural antidote might simply be to follow the advice of Study 2 participants and work more closely with marginalized PWLLE to co-design anti-stigma campaigns that represent imagery of PWUD who come from both marginalized and privileged social categories. But this approach does not consider the potential reasons for why campaign creators so consistently prioritized White, middle class PWUD in the first place. What might explain the observed pattern of over-representing White- and middle-upper class-appearing PWLLE in anti-stigma campaigns, and how could the pattern of excluding marginalized PWUD from representations be reversed? While empirical evidence to answer this question is beyond the scope of this dissertation[27], several possible explanations were identified in a series of personal exchanges with campaign creators across Canada. These suggest several potential routes to the pattern of anti-stigma campaign representation critiqued in this dissertation. These routes also

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[27] Though this could be a focus for future research. For example, a series of interviews with campaign creators who were involved in creating an anti-stigma campaign that prioritized representations of White, middle-upper class PWUD could explore their rationale for using this representational strategy.

provide some ideas for how campaign creators could overcome these factors that may have shaped an exclusionary pattern of PWLLE representation to pursue more inclusive representation in future campaigns.

First, campaigns may be designed to reflect an imagined audience and purposely represent individuals as PWLLE who creators feel may share social identities with this imagined audience. This is a key tenet of a marketing approach called “identity-based messaging” (Rank-Christman & Henderson, 2019). The purpose of this approach is to trigger an ingroup bias effect that increases audience sympathy towards the individuals depicted in the campaign because they are part of the same social group. In many campaigns, this may explain the focus on White, middle-class appearing PWLLE because campaign creators believe this group represents the widest swathe of their “general public” audience. A similar effect is in evidence in the handful of campaigns that focused on reaching specific racialized communities (e.g. Punjabi and Chinese-speaking, First Nations communities). These campaigns exclusively depicted members of those communities as PWLLE. However, by focusing on ingroup members only, this strategy misses an opportunity to explicitly challenge the intersectional racism and classism inherently wound up with substance use-related stigma.

Strategies for challenging substance-use related stigma that are not intersectional might ultimately increase support for drug policies and responses that are only beneficial for fellow ingroup members (e.g. wealthy Whites, Allen, et al., 2020; Hansen, et al., 2023; Hatcher, et al., 2018), and may even exacerbate harms for marginalized PWUD (e.g. drug-induced homicide laws that help further the War on Drugs and exacerbate racial inequities in the carceral system, Drug Policy Alliance, 2017). Campaign creators using this justification to represent campaign subjects as fellow ingroup members with the campaign audience should be reminded that this approach may naturalize the intersectional stigma experienced by racialized and lower-class outgroups. Instead, identity-based messaging campaigns could represent a mixture of marginalized and privileged-appearing PWLLE while at the same time emphasizing shared ingroup identities between campaign subjects and audiences that are more inclusive of a wider swathe of the public (Reicher, et al., 2006; Ryan & Reicher, 2018). For example, residents of a city (e.g., Vancouverites), Canadian or provincial identity, or relational identities like those used in the Stop Overdose BC campaign (e.g., sister, cousin, friend, hockey fan). As marginalized PWUD in Study 2 often pointed out, drug users like them were *also* someone's sister, cousin, friend, hockey fans, co-workers, and so on.

Second, some campaign creators may shy away from including racialized or economically marginalized PWLLE in campaign representations out of a concern for not perpetuating negative substance use-related group stereotypes such as "homeless drug addicts" or "drunken Indians". This was confirmed to me in personal communications as a potential pitfall campaign creators had actively tried to avoid (e.g., not representing Indigenous people in a substance use focused anti-stigma campaign) on several occasions. Troublingly, this frequently seemed to be a decision made on behalf of the groups these negative stereotypes impacted (e.g., Indigenous, poor) by members of advantaged groups (e.g. White, middle class). While critical research on stigmatizing drug prevention campaigns and news media reporting on drug crises has documented a repeated trend towards contributing to the racist, classist demonization of marginalized groups vis a vis their alleged substance use (Hartman & Golub, 1999; Marsh, et al., 2017; Netherland & Hansen, 2017; Scheibe, 2017; Taylor, 2008; Ti, et al., 2017), anti-stigma campaigns represent an opportunity to *challenge* these perceptions. Campaign creators' reluctance to include representatives of groups who have been historically stereotyped negatively for their substance use seems like an ironic continuation of this trend rather than a kindly reprieve for marginalized communities. Arguably it is those who bear the worst effects of substance use health inequities and the intersections of multiple systems of oppression with substance use stigma who could most stand to benefit from inclusion in sympathetic constructions of PWUD as not deserving stigma.

Some research has suggested that in experimental vignette studies intersectionally marginalized individuals (e.g. poor, pregnant compared to middle class and single) indeed elicit less sympathetic stigma ratings compared to socially privileged PWUD (Kennedy-Hendricks, et al., 2016; Wood & Elliott, 2020). But ignoring intersectionality altogether, or only emphasizing privileged PWUD (as is sometimes recommended to anti-stigma communicators, see McGinty, et al., 2015; McGinty & Barry, 2020), is not a robust solution. This approach takes for granted the racism and classism that is so tightly wound up with substance use-related stigma, leaving it unproblematized and unaddressed. More research and advocacy should address the intersecting challenges of substance use-related stigma and other forms of oppression simultaneously. An important step towards allaying campaign creators' fears about perpetuating negative stereotypes about marginalized groups and substance use through anti-stigma campaigns would be for them to actively seek out partnerships with members of these groups who could in turn inform their efforts. Meaningful, respectful, and ethical engagement with PWLLE of substance use (Boilevin, et al., 2018; Greer & Ritter, 2019) that is rooted in collaborative relationships and not exploitation can be an excellent bulwark against inadvertently creating campaign materials that may unintentionally exacerbate stigma towards marginalized PWUD by excluding them.

Third, a tendency towards representing PWLLE as “middle class” specifically may in part be explained by the high number of campaigns that use photos submitted by the family members of PWUD who have typically died of a drug toxicity. When family members are in control of how their loved one is represented, they understandably rarely choose imagery that depicts the person as they were when they died (i.e., often at their most marginalized). In some memorial style anti-stigma campaigns, there was sometimes a clear disjunction between how an individual who died of drug toxicity was represented in the campaign (e.g., as middle class) and their social class (e.g. homeless, very low-income) when they died. For example, a post from Toronto-based Twenty-Twenty Arts’ (August 2020) anti-stigma campaign “Weathered” featured a photo of a young woman named Alexandra who appeared healthy, happy and middle class, yet an accompanying comment from her mother declared, “The last time I found her on the street, I hardly recognized her”. Whereas Alexandra was represented as middle class in her campaign image, the implication of her mother’s comment was that when she died, she was possibly homeless, in poor physical condition and did not resemble the photo her mother selected for the campaign. This tendency towards memorializing people who have died of a drug toxicity in a positive way and with a photo that captures happier (and less economically marginalized) times in their life (Revier, 2020; Bowman, 2018) may partially explain why so many individuals who appear in anti-stigma campaigns as people who have died from toxic drugs are represented as middle class. This tactic relates to the anti-stigma strategy of humanization as overdose memorial photos are often “meant to challenge stereotypical depictions of addiction by offering a more recognizable, and therefore humanized, face” (Revier, 2020, p.8). Campaigns could challenge this tendency by encouraging the submission of photos that capture both the good times and the challenging times in a person’s life who was lost to drug toxicity. This may help avoid creating the false impression that deaths from toxic drugs disproportionately impact people who appear to be middle or upper class.

An inordinate focus on middle-class appearing PWLLE in campaigns may also be explained in part by the ease of using stock actors or photos from online libraries when creating anti-stigma campaign materials. While stock photo libraries are easy to use and give campaign creators significant control over representing ethnic diversity (though often in a superficial way) and gender parity, the typical stock actor is represented as a middle-class, healthy-looking and sharply dressed person. Respectful, humanizing images of stock actors who are represented as unhoused or lower SES are comparatively difficult to find. Thus, even if anti-stigma campaign creators wanted to use a mixture of stock images that were from a variety of economic backgrounds to represent PWUD this may not be easy to do given the limitations of stock image libraries. A solution here is to prioritize using images of “real people” (an expressed preference of focus group participants in Study 2 who routinely decried the “actors” in the two anti-stigma campaigns they viewed) with whom campaign creators have established respectful relationships with and who offer to have their image and story used in the campaign (though see Costa, et al., 2012 for some cautions on the ethical implications of publicly sharing marginalized peoples’ lived experience stories).

A final explanation for the emphasis on White and middle-class appearing PWLLE in anti-stigma campaigns may be that campaign creators (who tend to be White and middle-class themselves, based on my personal communications with many such campaign creators across Canada) draw on their existing social networks to identify potential PWLLE who feel comfortable telling their story about stigma and substance use in a campaign testimonial. To the extent that peoples’ social networks often reflect their own social identities, this may help explain the over-representation of White and middle-upper class PWLLE who agreed to share their stories in anti-stigma campaigns. Furthermore, when a person privileged by race and class admits to the stigmatizing identity of being someone who uses or has used illicit substances, they are not confirming a negative stereotype about their group. Rather, they are “challenging stereotypes” (e.g., that PWUD are all from marginalized social categories), often congratulated for their bravery, and will not be vilified as “another drunken Indian” or a “homeless drug addict”. The higher status of their group memberships insulates White, middle class PWUD from the worst, intersectional experiences of substance use-related stigma, making it easier and more socially acceptable for them to “share their story”. This challenge to more inclusive representations may be overcome through the development of meaningful partnerships between the White and middle-class dominated public health, government, harm reduction and treatment organizations (Godhkindi, et al., 2022) that often produce anti-stigma campaigns, and organizations that represent the interests of marginalized PWUD (e.g., drug user unions, Indigenous health organizations, 2SLGBTQIA advocacy groups). When trust is established between these groups, marginalized PWUD may feel more comfortable and supported to tell their stories publicly. Another way forward here may be through fostering intergroup solidarity between socially privileged PWUD, and their families and more marginalized communities affected by the dehumanization, over-incarceration and disproportionate impacts on health at the intersections of racism, classism and substance use-related stigma (Hart, 2022; Rieger, 2020). Using anti-stigma campaigns to highlight stories of connection, relationship and solidarity work between these groups would both draw attention to the racism, classism, colonialism, and other systems of oppression that drive the drug toxicity crisis, but also to how differently positioned PWUD from different class or racial backgrounds nevertheless face similar risks from the unregulated, toxic illicit drug supply that is produced by drug criminalization. Examples of solidarity between, for example, Indigenous and White mothers who have lost children to drug toxicity (Rieger, 2020) show what is possible when some of the historical targets (e.g., Indigenous peoples) and beneficiaries (e.g. White people) of prohibition drug policy unite in shared grief to drive policy reforms that may truly help all PWUD.

4.3.2. From Anti-Stigma Campaigns to Structural Interventions to Address Substance Use Stigma

While current trajectories suggest that governments and public health organizations will continue to create substance use-focused anti-stigma campaigns (and perhaps these could be made more inclusive), research examining the effectiveness of substance use-focused anti-stigma campaigns has been limited and produced mixed findings. The few studies and reviews of interventions to reduce stigma towards people with substance use disorders (SUDs) or PWUD specifically (Gür & Yilmaz, 2023; Livingston, et al., 2012; McGinty & Barry, 2020; National Academies of Sciences, Engineering and Medicine, NAS, 2016) have demonstrated only limited success, with many examples of small or non-significant intervention effects (though see Kharpal, et al., 2021 for four promising evaluations of Canadian anti-stigma interventions). Substance use-focused anti-stigma campaigns (i.e. mass media advertising like those examined in this dissertation) have rarely been evaluated, though several high profile evaluations of anti-stigma campaigns are currently underway in the United States (Bonnevie, et al., 2022; Krug, 2022; Lefebvre, et al., 2020) and a recent randomized clinical trial found that exposure to a combined visual and vignette campaign depicting a patient with OUD predicted reduced stigma amongst health care professionals in the United States (Kennedy-Hendricks, et al., 2022). While not a rigorous evaluation of campaign impacts, national polling in Canada suggests that the recent onslaught of substance use-focused anti-stigma campaigns described in Chapter 2 has at the very least not been associated with significant nation-wide reductions in public stigma towards PWUD. In 2017, 2019 and 2021, Health Canada commissioned three national phone surveys to be completed by Earnscliffe Strategy Group on "opioid awareness, knowledge, and behaviors for public education". Findings from the third wave (Earnscliffe Strategy Group, 2022) suggest there was virtually no change in nation-wide levels of stigma towards people with an opioid use disorder[28] from 2017 to 2022, despite 115 substance use-focused anti-stigma campaigns launched across Canada from 2017-2020.

While the effectiveness of anti-stigma campaigns at reducing stigma towards PWUD may not yet be clear, a bigger concern may be the potential for unintended negative effects of anti-stigma campaigns for marginalized PWUD. As this dissertation has argued, it is possible that at least some anti-stigma campaigns (e.g., those that center representations of privileged PWUD and exclude marginalized PWUD) may at best create feelings of exclusion for marginalized PWUD and at worst exacerbate the stigma marginalized PWUD experience by negatively contrasting them with more privileged PWUD. As argued in Chapter 2, substance use anti-stigma campaigns frequently represent PWUD and convey powerful messages to their audiences that frame definitions of the nature of stigma, the drug toxicity crisis, and the subgroups of PWUD who are deemed to be deserving of stigma reduction, or not. As argued in Chapter 3, anti-stigma campaigns that construct White, middle-class appearing PWUD

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[1] The samples for all three waves of the poll were weighted to reflect the demographic composition of the Canadian population. However, they cannot be considered generalizable to the Canadian population in a statistical sense because they were not a random sample but were drawn from the pool of people who had self-selected to be a part of the contracted marketing firm's national panel.

as uniquely deserving of compassion (excluding marginalized PWUD from this construction) may in some cases inadvertently work to exacerbate substance use health inequities and intersections of racism, classism and other systems of oppression that interact with substance use stigma.

Other unintended harmful effects of common substance use anti-stigma campaign strategies have been noted by recent research. For example, the ubiquitous anti-stigma message that “addiction is a disease” has been roundly critiqued by critical researchers and theorists (Hall, et al., 2015; Hart, 2017, 2020; Hammer, et al., 2013; Lie, et al., 2022). Most recently, Kelly and colleagues (2020) used a nationally representative, vignette-based, cross-sectional survey to determine that use of the term “chronically relapsing brain disease” to characterize a person with an OUD (compared to other terms like “disease”, “brain disease”, “problem”, and “disorder”) was most strongly associated with respondents being least likely to blame the person for their addiction, but also less likely to believe the person could recover (i.e. decreased prognostic optimism), more likely to recommend the person will require continuing care, and more likely to believe the person is dangerous[29]. Other risks of anti-stigma campaigns include perpetuating narratives that actively stigmatize marginalized groups of PWUD. For example, in a separate analysis of the campaigns from Chapter 2 I found that many female PWLLE narratives expressed in campaigns implicitly supported the “good mother ideal” that reserves special scorn for mothers who use drugs (Boyd, 2019; Campbell & Herzberg, 2017; Nichols, et al., 2020) and routinely normalized stigma towards women engaged in sex work (Neufeld & Jarvis, 2022). The heavy reliance of many anti-stigma campaigns on highlighting the personal lived experiences of real PWUD may also create additional risks including having their reputation publicly tarnished, their trauma carelessly revisited and their pain exploited for the gain of campaign creators (see Costa, et al., 2012; Tyler & Slater, 2018).

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[29] Similar concerns have been raised in the realm of mental health anti-stigma campaigns that emphasize “biogenetic” explanations such as how mental illnesses are diseases “like any other”. This common anti-stigma approach has been found to spur some support for mental health treatment yet exacerbate the desire for social distance from people with a mental illness and heighten perceptions of how dangerous people with a mental illness are (Pescosolido, et al., 2010; Walsh & Foster, 2021).

4.3.3. Strategic, Intersectional, and Structural Interventions: Towards Ending Stigma for All PWUD

Addressing substance use stigma in a manner that is both effective and equitable is clearly a challenging task fraught with complexity and at least the possibility of doing more harm than good, despite best intentions. A final set of recommendations compiles insights gained throughout the course of both studies in this dissertation, as well as the input and analysis of CAB members, organizational partners, and feedback from the many anti-stigma practitioners (e.g., public health promoters who have developed their own anti-stigma campaigns) I have met in the course of sharing the knowledge generated through this dissertation project. These recommendations have been summarized elsewhere in a shareable, accessible, and plain language format document titled “So you want to reduce stigma towards people who use drugs?” The document summarizes key takeaways from the dissertation studies (to situate anti-stigma campaigns in context) along with recommendations for more inclusive, strategic, and structural anti-stigma interventions (which may or may not include anti-stigma campaigns). This document (Neufeld, 2022) is accessible online and appended to the dissertation as a final appendix (Appendix I). It has been widely shared with public health organizations in Ontario and beyond. It has often been circulated in conjunction with my frequent knowledge mobilization presentations I have delivered to public health units and substance use policy organizations in Canada. I briefly summarize the key recommendations in a linear progression of five steps (F.I.R.S.T.) to follow when designing an anti-stigma intervention and conclude with four principles to guide equitable, intersectional, and structurally focused anti-stigma work.

Given the importance (and complexity) of conceptualizing stigma, I suggest that anti-stigma interventions first *focus* their definition of the problem of stigma, ensuring they have a clear understanding of what they mean when they say that stigma is creating a problem for PWUD in their context. With stigma clearly defined and operationalized, I recommend that people engage in an *investigation* of how stigma shows up in their community, paying special attention to groups that may be especially targeted, and harmed, by substance use-related stigma. While still at an early stage of designing an intervention, it is essential for anti-stigma intervention creators to *reach out* to a diverse mix of PWLLE of substance use and stigma in their context, treating them respectfully and paying them for their time, expertise, and collaboration on determining next steps for the intervention. Once a collaborative partnership that includes meaningful leadership of PWLLE has been established, the group can *strategize* around feasible and effective approaches to intervening on stigma as they have come to understand it as a problem in their context. Who is the audience? What kind of stigma change is desired? How will the change be produced and how will you know if change has occurred? This might involve a process of *tailoring* an intervention observed elsewhere (e.g., an anti-stigma campaign, a speaker's bureau workshop, peer programs) to fit the parameters of the context, for example to reflect the limitations of funding, organizational capacity, or meaningful levers of change in the local environment. These recommendations resist being prescriptive about specific methods, formats, or strategies for addressing stigma. Instead, they invite people who are interested in devoting resources to anti-stigma work in their community to engage a local process of gaining deeper understanding of how stigma creates harms in their own specific context, collaborating effectively with PWUD who are most impacted by stigma, and working strategically to maximize the efficacy of often limited resources.

Four principles for guiding equitable, intersectional and structural anti-stigma work complement these steps:

Remember History. Learning both local and national histories of how systems of oppression (e.g., racism, classism, colonialism, sexism, etc.) have helped shape the context of drug policy, criminalized marginalized communities, and created substance use health inequities is a useful means of drawing attention to the intersectional nature of substance use stigma. This can help anti-stigma practitioners be more mindful of not exacerbating intersectional stigma with careless interventions. This practice also helps to remind we that stigma itself has a history, has benefitted some people as it has harmed others, and that it can be changed.

Prioritize Policy. A strategic approach to addressing the harms of substance use stigma places attention on arenas where stigma change is both feasible and consequential. While it may be hurtful for an individual PWUD who struggles with stable housing to experience the interpersonal disgust and dehumanization of a member of the public calling them a "dirty junkie" as they walk past them on the sidewalk the benign intake policy at the local hospital that flags individuals who "look like drug users" for exclusion on the assumption that their medical complaints are not legitimate and they are “drug seeking” is likely far more deadly. Building on this dissertation’s critical conceptualization of stigma as rooted in practices of social categorization that construct some PWUD as deserving of compassion and others (i.e., marginalized PWUD) as worthy only of further exclusion, this principle prioritizes policy change over attitude change in anti-stigma efforts. This puts an emphasis more on stigma “machine-breaking” (Tyler, 2020) efforts that seek to identify how stigma operates as a system of social control (Friedman, S., et al., 2021) and work to interrupt the everyday categorization processes that mark marginalized PWUD as different, and worse. In this sense collective action or advocacy that aims to work towards the decriminalization of drugs (Scher, et al., 2023), expungement of drug-related criminal records (Policy Options, 2019), or conducting stigma audits and equity walk-throughs to identify exclusionary practices that turn PWUD away from life-saving medical care (Bennett & Larkin, 2018; EQUIP Healthcare & Community Addictions and Peer Support Association, 2023; Knaak, et al., 2020; Livingston, 2020; Sukhera & Knaak, 2022) are seen as potentially more useful anti-stigma interventions than anti-stigma campaigns that merely target public stigma.

Practice Inclusion. In response to the pattern across anti-stigma campaigns (observed in Study 1 and explored more deeply in Study 2) where privileged PWUD are routinely constructed as different and better than the marginalized PWUD that many anti-stigma campaigns exclude, practicing inclusion means working against this divisive approach. This entails practicing inclusion of both marginalized and privileged PWUD through anti-stigma organizing, collaboration and intentional representation of diverse PWUD in anti-stigma interventions. In order to practice inclusion, differences between PWUD with widely varying lived experiences (e.g., wealth, poverty, racism, White privilege) that have shaped their trajectories with substance use-related harms, entanglement with criminalization and lived experience of stigma must first be recognized. Colorblind narratives that “overdose can affect anyone”, while in some ways true, may often stand in the way of recognizing how structural inequities create very different experiences of drug toxicity risk (Collins, et al., 2019). These differences must be recognized and actively acknowledged for anti-stigma interventions to be truly inclusive and responsive to different experiences with substance use-related stigma.

Build Solidarity. A final principle for equitable anti-stigma practice involves the work of building solidarity between marginalized and privileged PWUD. As this dissertation has argued, the history of entanglements between racism, classism, colonialism and the criminalization and stigmatization of PWUD has been marked at every turn by the reification of divisions between different kinds of PWUD. This categorization process of deserving and undeserving PWUD, marginalized and privileged PWUD, medicalized victims and criminalized addicts has been documented in the historical evolution of drug prohibition (Boyd, 2017; Herzberg, 2020; Malleck, 2015), news media representations of the opioid epidemic (Johnston, 2020; McLean, 2017; Netherland & Hansen, 2017; Webster, et al., 2020), and with the research reported in this dissertation on anti-stigma campaigns that center White, middle class PWUD. As Study 2 participants' often angered reactions to the privileged PWUD they saw in the anti-stigma campaigns indicate, relations between marginalized and privileged PWUD are often fraught with feelings of deep injustice, from both sides of the divide. Marginalized PWUD feel incensed that PWUD from privileged backgrounds appear to enjoy the benefits of a double standard approach that treats their substance use with more leniency, compassion, and less blame. Likewise, privileged PWUD have often pointed out how they are not the same as the stereotypical "addicts" who they define in terms of chaotic drug use, irresponsibility, and danger (e.g., the #patientsnotaddicts movement to separate "legitimate" users managing chronic pain with opioid medication from "illegitimate" users of illicit opioids, Zwarenstein, 2018). Equitable anti-stigma interventions may require that PWUD from both marginalized and privileged social categories resist the impulse to denigrate each other, find common ground in shared risks from the potent and unregulated toxic illicit drug supply, and work together in solidarity for an end to stigmatizing prohibition policies that harm all PWUD. In the closing words of VANDU's Manifesto for a Drug User Liberation Movement, "Drug users unite to fight for justice and liberation!" (2010, p. 3)

4.4. Conclusion

Substance use-focused anti-stigma campaigns in Canada have proliferated in recent years in tandem with rising drug toxicity-related deaths. Close review of the content of these campaigns reveals that Canadian anti-stigma campaigns (2009-2020) have tended to centre the identities of White, middle-class appearing PWUD, ignore the well-documented substance use health inequities affecting marginalized PWUD, construct stigma primarily as an individual-level concept (frequently ignoring structural stigma), and often imply that abstinence-based addiction recovery is desirable or attainable for all

PWUD. These campaigns often obscure wider histories and present realities that point clearly to the intersections of racism, classism, and other forms of oppression with substance use-related stigma. In the view of marginalized PWUD in and around Vancouver's DTES neighborhood, campaigns like BC's "Stop Overdose" or Health Canada's "End Stigma" that center the identities of privileged PWUD convey a painful double standard where the substance use of privileged people is met with compassion, and the substance use of marginalized people continues to be met with blame, scapegoating, and criminalization. Far from ending stigma for all PWUD, many anti-stigma campaigns appear to focus on constructing privileged PWUD as uniquely undeserving of stigma, ignoring, or even potentially exacerbating, the societal exclusion that marginalized PWUD have always experienced.

Despite their unclear efficacy and potential for harmful unintended effects, the sudden popularity of anti-stigma campaigns as an intervention in the drug toxicity crisis indicates they will continue to be utilized. The findings of this dissertation suggest ways that these campaigns could be made more inclusive and reduce their potential to harm marginalized PWUD. They also point towards ways of thinking about substance use stigma, and how to address it, that may be more adequately equipped to address the structural roots of stigma in policy and law, as well as the longstanding intersections between substance use stigma and other systems of oppression.

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Appendix A.

Study 1 – Detailed Search Strategy and Inclusion Criteria

Anti-stigma campaigns in Study 1 were identified through a variety of search strategies over an extended period spanning from approximately June 2019 to October 2020, with a highly dedicated effort to this search applied from June to August 2020. Anti-stigma campaigns were identified initially across all states, provinces and territories in Canada and the United States, yielding over 300 examples of unique anti-stigma campaigns. However, this data set was subsequently constrained to only the Canadian campaigns identified (134 in total) in order to make analyses more manageable and better connect study results and analyses to the political and historical drug policy and epidemiological context of Canada and its provinces and territories. The review was primarily completed by the dissertation author, with some campaigns identified with the help of volunteer undergraduate RAs who assisted on the project. All campaigns were reviewed before inclusion by the dissertation author.

Detailed search strategy. An initial search strategy used a multi-pronged approach to cast as wide a net as possible and identify substance use-related anti-stigma campaigns at a national level and in each Canadian province and territory. First, several anti-stigma campaigns were identified by asking CAB members and various colleagues working within the harm reduction and drug policy field if they knew of examples of campaigns or materials that had been developed with the purpose of reducing stigma towards PWUD and shared widely. Second, each of the websites identified as connected to these initially identified campaigns was searched thoroughly and often revealed links and connections to other anti-stigma resources or campaigns which were then recorded. Third, a more systematic approach was employed using Google to search each province and territory for the online evidence of substance use stigma related campaigns (e.g. “Alberta+stigma+campaign”). This was the most fruitful search strategy and often revealed news articles, official press releases, or the campaign website. Fourth, in jurisdictions where no campaigns had been identified using the aforementioned methods more specific searches were made of the websites of provincial/territorial or local municipal governments or public health/health departments for search terms such as “stigma”, “opioids” and “campaign”. These terms were usually sufficient to reveal any efforts a given organization had made towards reducing stigma and sometimes revealed campaigns that had not appeared in higher level Google searches. Several campaigns were identified by searching for the terms “stigma” and “campaign” within lengthy policy documents, opioid action plans or year-end reports published by various government or non-profit organizations. Other campaigns were identified by searching through these entities’ social media (especially YouTube channels and Facebook pages) where anti-stigma campaign materials are often shared, even if they have not been publicized through press releases or in internal reports. A fourth strategy involved directly contacting (primarily by email, occasionally through phone or Zoom) government departments, non-profit organizations and grass roots organizations to inquire if they had themselves developed any anti-stigma campaigns targeting stigma towards PWUD or if they knew of any such campaigns within their jurisdiction (they often did). This tended to be a highly effective strategy as well and often helped to clarify whether some more ambiguous materials that had been identified had in fact been widely shared and intended to reduce stigma. Direct contact with individuals also often resulted in the full extent of campaign materials being shared, especially when a campaign had primarily been conducted offline (e.g. physical posters, brochures, billboards, transit ads) or was no longer actively “in-market” (e.g. digital social media ads, radio PSAs) and more specific details being provided on start dates, dissemination strategies and campaign goals. A final strategy to identify anti-stigma campaigns across Canada involved contacting well-placed individuals and organizations across Canada with a comprehensive understanding of the harm reduction, drug policy and anti-stigma landscape in Canada. These organizations included *Health Canada*, the *Canadian Centre for Substance use and Addiction*, the *Canadian Public Health Association*, *Canadian Students for Sensible Drug Policy*, the *Mental Health Commission of Canada* and the *Public Health Agency of Canada*, the *Canadian Drug Policy* Coalition, the *Ontario Drug Policy Research Network,* as well as numerous officials from provincial and municipal governments and health authorities. These conversations proved extremely helpful towards the end of the review to confirm that no major campaigns had been missed. Several organizations generously shared environmental “scans” they had completed to assess what existed in terms of addiction / overdose awareness or anti-stigma materials across the country which enabled cross-checking with the database for the present study. The review was concluded when each major jurisdiction where campaigns could exist (i.e., provinces, territories and at a national level) had been thoroughly searched and contact had been made with at least one knowledgeable person in each jurisdiction.

As each campaign was identified for possible inclusion, key details were recorded in a large spreadsheet, with each “campaign” having its own row. Data initially collected included the campaign location (e.g. British Columbia), regional level (e.g. provincial), the name of the campaign (e.g. “Stop Overdose”), the primary organization(s) that developed the campaign (e.g. the BC Ministry of Mental Health and Addictions), start date (and occasionally termination date), a brief description of the contents of the campaign, hyperlinks to example material from the campaign, information on how the campaign or materials have been disseminated, any contact info associated with the campaign, any official website associated with the campaign (e.g. www.stopoverdose.gov.bc.ca), links to any official press releases or local media stories that had accompanied the launch of the campaign and any additional related media (e.g. an opioid action plan document that mentioned the campaign, an evaluation of the campaign) or notes to contextualize the campaign.

Limitations of the search strategy. It is possible some anti-stigma campaigns were missed, especially if they were small and not widely or publicly promoted. For example, several small or grassroots campaigns were identified through random chance I happened to learn of an individual’s substance use-focused anti-stigma campaign they had personally created or led. Many more of these types of campaigns could have been created locally and not identified through this search. This may be increasingly true the farther back in time a campaign was created as online traces of such campaigns may simply be removed as online hosting expires or an organization periodically declutters or reorganizes its web domain.

For example, in early 2021 one of the final campaigns added to the database was identified from the Canadian Mental Health Association’s branch in Durham, Ontario. This campaign (originally launched in November 2018) featured a single dedicated web page (a landing spot and press release that social media posts could drive traffic towards for the campaign’s audience to learn more information on the harms of stigma and supportive actions they could take) and a short series of Facebook posts that in turn were simply adaptations of national materials and campaign messaging from the Canadian Centre on Substance Use and Addiction's (CCSA) 2018 campaign materials for their annual "National Addiction Awareness Week". This campaign, though small, was included because the materials had been sufficiently adapted as to no longer resemble the imagery produced and shared by CCSA (e.g. CMHA Ontario had used new visuals). I contacted someone at CMHA Durham to ask for more information on this campaign and a similar adaptation from the year prior. They provided a response with some additional information, including the explanation that they had received the materials from CMHA Ontario, a wider body, but appear to have been one of the only local chapters that shared these materials publicly. Subsequent visits to this campaign's dedicated microsite revealed that this email interaction had likely spurred the organization to "clean up" its website as these campaigns were soon deactivated and no longer available at their former URLs. This illustrates the temporary and contingent nature of digital campaign materials and thus the potential limitations of this primarily online search strategy.

Inclusion criteria and exclusions. Once all possible materials had been identified and recorded in the study database, a more stringent set of inclusion criteria was applied. To be included in the final dataset each campaign needed to 1) clearly aim to reduce stigma towards PWUD as at least one of its goals 2) have been shared widely and 3) have enough materials available for coding. This sometimes included longer videos (e.g. 30 minutes plus) that had been developed with an express goal of challenging stigma or increasing compassion towards PWUD and were also widely shared and promoted, sometimes within specific audiences (e.g. health care providers, first responders). One off, stigma-focused events, workshops or trainings were not included unless they also had a widely promoted "campaign" component (e.g. local expressions of anti-stigma campaigns developed in conjunction with National Addictions Awareness Week or International Overdose Awareness Day; video series developed specifically to complement in person workshops/trainings that were also shared publicly). Several campaigns primarily took the form of interactive "exhibits" that were viewed in person. These campaigns were included but only coded when enough materials were made available to be able to assess how individuals had been represented in the campaign or if some components of the interactive experience had been recorded and more widely shared online.

Several campaigns that had been identified in the initial search were excluded because individuals affiliated with the campaign specifically confirmed they had not been shared widely or promoted as a campaign and/or stigma reduction was not a specific goal. In some cases where large comprehensive campaigns that had multiple objectives (e.g. providing naloxone information, general opioid awareness, substance use prevention) had clearly distinguishable anti-stigma components, only those components were included and coded in the dataset (e.g. Health Canada's "Know More" interactive displays and online modules). Upon closer examination, several campaigns that were initially flagged for inclusion were excluded because they focused primarily on reducing "mental illness" related stigma and not substance use stigma directly. Any campaigns that featured a mixture of mental illness and substance use / addiction related stigma were included but only individuals who were portrayed as experiencing addiction or substance use were coded for representation as PWLLE. Several campaigns primarily featured "user-generated" materials (e.g. campaign supporters take a selfie with a supportive message and post on social media using a campaign hashtag) and these were included but not coded for representation given the generally unclear relation of individuals to the category of substance use or the very high volume of individuals represented (e.g. "#RecoveryAlly", CAPSA, September 2013). Finally, several campaigns exclusively featured text-based posters or animated videos that provided education on stigma and substance use but did not feature any individuals so were included but not coded for representation.

Inclusion criteria. One-off, anti-stigma focused events, workshops or trainings were generally not included unless they also had a widely promoted "campaign" component (e.g. video series developed specifically to complement in-person workshops/trainings that were also shared publicly). In some cases where large comprehensive campaigns that had multiple objectives (e.g. providing naloxone information, general opioid awareness, substance use prevention) had clearly distinguishable anti-stigma components, only those components were included and coded in the dataset (e.g. Health Canada's "Know More Opioids" campaign included multiple interactive displays and online modules but only the "stigma" module was included in this review). Several campaigns were excluded because they focused primarily on reducing mental health-related stigma and not substance use stigma directly.

Appendix B.

Study 1 Detailed Campaign Coding Framework

Once all campaigns had been identified, I collaborated with the project's CAB and my PhD supervisors to develop an initial coding framework to describe each campaign in a systematic way. This coding framework was revised and adapted as coding proceeded to better capture the nuances of the dataset as they were becoming clear. The coding framework was designed to be able to answer the study's key initial research questions regarding what stigma reduction strategies are common, how anti-stigma campaigns conceptualize the problem of stigma and most importantly, how the identities of focal individuals featured in anti-stigma campaigns were represented on key variables. In addition, the coding framework captured systematic information on how many campaigns had been produced in specific jurisdictions, when campaigns were released, how they had been promoted, target audiences, content delivery formats and what types of organizations had developed campaigns. To code each campaign, I carefully re-examined all the recorded information on each campaign's entry in the database and then carefully reviewed all widely shared materials associated with each campaign.

Basic information. Key details were initially recorded about each campaign including its official name, location (e.g. province), launch date, the primary organization(s) that developed the campaign and a brief description of the campaign including links to campaign website or materials.

Campaign typologies. A system of typologies of campaigns was developed as part of the coding framework to categorize each campaign's content type, delivery type, intended reach, intended audience, substance focus, extent to which stigma is central to the campaign, and organization type. These typologies were created iteratively as more examples of campaigns were reviewed.

Content type. Five "content types" were identified as "curated stories" (real people's stories are presented through a combination of images and quotes or video interviews), "share your story" (members of the public are invited to submit or upload their own story of addiction or recovery to a web platform), "dramatized stories" (campaign content is communicated through actors dramatizing the lives or issues surrounding substance use stigma), “images and messages” (individuals, typically stock actors, are represented alongside generic campaign slogans or messages) and “education only” (facts and text that are not accompanied by any representations of individuals).

Delivery type. Four “delivery types” were identified as “social marketing” (public service announcements, physical posters, billboards etc.), “web-based only” (videos, digital ads or social media posts exclusively promoted online), “longer documentary” (videos over 10 minutes long that were widely promoted), and “interactive experience” (online or in-person interactive exhibits or experiences intended to introduce viewers to the realities or perspectives of PWUD and the issue of substance use stigma).

Intended reach. This code captured how far the campaign materials were intended to reach and reflected dissemination strategy as well. Types included “national”, “province/territory wide”, “county/regional district” (e.g. a regional health authority that encompasses several cities), “city/municipality”, “organization/field specific” (e.g. internal campaigns targeting specific health care providers such as pharmacists) and “specific community” (e.g. Indigenous communities in a given province).

Intended audience. Audience types included “general public”, “family and friends of PWUD”, “PWUD themselves” and “service providers” (e.g. health care providers, first responders, employers).

Substance focus. This code captured if a campaign was focused on a specific substance and included “opioids”, “stimulants”, “fentanyl specific”, “meth specific”, “other drug specific”, “methadone or other OAT” and “drugs or addiction generally”.

Stigma focus. This code captured the extent to which a campaign was focused on “stigma” reduction per se. Some campaigns were “entirely” focused on stigma reduction (e.g. they were referred to exclusively as an “anti-stigma campaign” and may refer to “stigma” in the campaign name), other campaigns had a “mixture” of goals with stigma reduction being one of several key objectives (e.g. other goals include naloxone awareness or substance use prevention) and other campaigns had stigma reduction “included but unclear” (e.g. appeared to be primarily an awareness campaign but individuals who helped develop the campaign explicitly confirmed an objective of the campaign was to reduce stigma).

Organization type. This code captured the type of organization that developed the campaign and includes codes for “federal government”, “provincial/territorial government”, “county government”, “city/municipal government”, “researchers/university”, “professional association” (e.g. Canadian Pharmacists Association), “regional health authority”, “public health department”, “justice department”, “large non-profit” (i.e. national or provincial level and well-funded), “small non-profit” (i.e. smaller scale and limited budget), and “grassroots group” (e.g. people with lived experience, students).

Representation coding and determining “who counts” as a focal individual. Representation coding proceed by first identifying all “focal individuals” within each campaign. A focal individual was defined as someone who had their identity, story, or expertise highlighted in a campaign image, video, audio clip or written narrative or someone who was represented as having a meaningful interaction with that person. For example, if a doctor who treats people with SUDs was interviewed in a video and video footage showed them interacting with patients as they described what it is like to provide health care for PWUD, both the doctor and their clients would be considered “focal individuals” even though the clients (who were being represented as PWUD) did not speak or tell their story for the camera. Focal individuals sometimes also included people who appeared in a video shot or post depicting a photograph (e.g. a family photo showing a person who had died of an overdose alongside their children or other family members). In anti-stigma videos where groups of individuals were shown only briefly (this was often a way of briefly inserting a sense of “diversity” or magnitude into a video) these scenes were recorded in campaign notes but not coded for representation. Similarly, crowds or background individuals in B-roll footage or unspecified individuals in family photos depicted in videos were not considered focal individuals (though these too were recorded in campaign notes, for example if they featured scenes of anonymous street-based PWUD). Individuals represented in archival or news media clips within anti-stigma videos (e.g. Ronald Reagan shown in archival footage declaring a war on drugs) were similarly not considered to be focal individuals. In posters or billboards where certain individuals were represented as too small or unclear to determine how they were being represented in relation to the issue of substance use stigma, these were not considered focal individuals. Finally, individuals represented exclusively on campaign affiliated website banners or other pages of the website but not included on widely disseminated campaign material were not considered focal individuals.

All focal individuals in a given campaign were coded on the basis of how they appeared to be represented on seven demographic categories: relation to substances, race/ethnicity, class, gender identity, whether someone was represented as non-heterosexual, age and any visible or identified physical disabilities. These social categories were prioritized based on the structural stigma and vulnerability to overdose risk that is heightened amongst those facing racism, classism, gender-based oppression, heterosexism, ageism and ableism (Collins, Boyd, et al., 2019).

Importantly, "representation" was understood as a decision that had been made by campaign creators. Who to show, how to identify them (e.g. through video title texts, social media quotes, personal identifying information provided by a campaign subject themselves, dress, appearance, etc.), what parts of their story and identity to include and what parts to obscure were understood as non-random decisions campaign creators had made. For this reason, our interest was not in identifying campaign subjects' "true identities[30]" so much as using deductive reasoning within the context of a given campaign's available materials to make as accurate as possible of a guess as to how each person would be "read" by those viewing campaign materials. Thus, coders attempted to guide representation coding with the questions "How is this person meant to be seen by the audience?" and "What pieces of information would guide a typical audience member's social categorization of this individual?" Therefore, while representation coding of this nature is inherently subjective, our approach constituted an attempt to "think like the audience" guided by several considerations or "clues" described under each category below (and collaborative discussions when discrepancies in representation coding were identified, leading to the resolution of subjective

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[30] For example, if someone featured in a campaign was "really" Indigenous but could pass as White and no information provided within the campaign could reasonably be used to suggest the person in question had Indigenous ancestry, that person would be coded as "White". For all intents and purposes this is how they were being "represented" by the creators of the campaign (e.g. if the campaign creators were aware of the person's Indigenous ancestry, but chose not to highlight this in their representation) and how they would have been perceived by the audience.

disagreements and a harmonized ‘compared coding’ used in all final analyses presented in the main text).

Relation to substances. Individuals in anti-stigma campaigns were typically represented as having one of five relations to substances: “overdose decedents” (i.e. people who have died of an overdose, typically depicted in family-submitted video or photos and sometimes represented in a photo within a photo, for example a grieving mother holding a photo of her deceased child), active PWUD, people in recovery, friends and family of PWUD/people in recovery, service providers (anyone who is being featured in an anti-stigma campaign because they have specific experience or insights to share on stigma or substance use more generally, often health care providers, first responders, academics, policy makers, employers or community leaders). Less common but included nonetheless to capture their occasional appearances are “non-users/potential users” (sometimes included to either illustrate how you “cannot tell” who a person who uses drugs is just by looking at them or to raise the spectre of possible substance use), supporters (campaigns that entirely feature “supporters” were not coded for representations, but in a few cases one or two supporters” were included alongside primarily PWLLE of substance use so they were coded in those cases), and stigmatizers (i.e. individuals who are represented as expressing stigma towards PWUD).

In determining how to code each individual into one of the above categories a key question was asked, “What is the primary role of this person in this campaign?” This helped distinguish how to code someone who may fall into multiple categories. For example, a service provider introduced with their title and service provider role in an anti-stigma video who primarily speaks to the issue of stigma from their perspective as a service provider but later on in the video reveals that they are also a person in addiction recovery would be coded primarily as a service provider, not a person in recovery (though this was always recorded in the coding notes). The primary reason they were included in the video was to offer their perspective as a service provider, which is why they were represented as such when they were introduced and not as a “person in recovery” (many people who are primarily featured to speak from their lived experience of substance use were introduced with titles such as “person in recovery” or “person with lived experience”). It was sometimes difficult to determine if an individual with lived experience was being represented as in active use or in “recovery”. Clues that guided coding included if they spoke about their substance use in the past versus in the present, mentioned treatment or recovery processes they had experienced and more generally the scene in which they were represented (e.g. someone being interviewed in a dirty street environment and depicted as disheveled was more plausibly being represented as in "active use" than someone being interviewed indoors and depicted as clean cut).

Race/ethnicity. Individuals were coded as being represented as "White", "Black", "Latinx", "Indigenous", "Asian/Middle Eastern", "Ambiguous Non-White" or "Unclear". This is of course not an exhaustive list of possible racialized categories and subjectively assessing "race" by apparent phenotype is a highly fraught activity reliant almost entirely on visual stereotypes of what members of racial/ethnic categories "look like" (Norton, 2018; Revier, 2020). Nevertheless, this approach approximates how people typically categorize on the basis of race in everyday life and maps onto how race is represented and interpreted in the context of representations of the overdose crisis in news media for example (e.g. Johnston, 2020). Coding representations of race and ethnicity was sometimes assisted by self-identifications within campaign materials (e.g. an individual identified themselves as Indigenous or their First Nation affiliation was included as part of their title text introducing them) but often not. The "ambiguous non-white" category was used when an individual did not appear to be phenotypically "White" but their ethnic background was not made apparent. The "unclear" category was only used when there were no visual signs of an individual's racial/ethnic categorization (e.g. no skin or hair was visible, they were shown in silhouette to maintain anonymity).

Class. Individuals were coded with regard to apparent class status in four key categories. "Close to the street" was used to code people depicted as currently or recently homeless, engaging in a street-based illicit drug economy, and who appeared to be somewhat dirty, unkempt or poorly clothed. "Working class" was used to code people depicted as clearly lower-income, with dishevelled appearances or in unkempt settings, but also including people represented as working in trades or manual labour positions especially the oil and gas sector[31]. "Middle class" was used to code people depicted as

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[31] Importantly, social class is not only about income. While some of the PWLLE represented as working in the oil and gas sector or other potentially lucrative trades professions described high incomes and periods of heavy substance use (e.g. "hidden" or "high-functioning" addiction) amidst grueling long hours at difficult manual labour jobs

well-dressed, “normal” everyday people who did not appear to be economically marginalized or what one would typically imagine as a stereotypical lower-income PWUD. In many cases, people coded as “middle class” PWLLE were clearly stock photos meant to depict “everyday people” (e.g. “PWUD Are Real People”, Durham Region, June 2019) or photos of individuals who had died of an overdose submitted by friends or family members of the deceased (e.g. “Overdose Can Affect Anyone”, Moms Stop the Harm, August 2020). People coded as “middle class” typically appeared relatively clean cut, potentially working in the service sector, engaging in middle class activities like expensive hobbies or costly holiday travel, and especially people depicted as living in their own homes rather than a semi-public space such as a community service provider’s offices. People coded as “upper class” were depicted in high-income, high-prestige occupations such as doctors, lawyers, professors, chief of police/fire department, mayors, CEOs, minor celebrities, public figures etc.). Individuals coded as “upper class” were also typically shown to be well-dressed (e.g. wearing a suit and tie).

As with race/ethnicity, coding for class was highly subjective, fraught and difficult to assess based on visual representations alone. However, a few considerations guided this coding including the surroundings an individual was depicted within (e.g. streets, community centres, their own home), any titles or jobs associated with an individual, physical appearance to a certain extent (e.g. someone with many missing teeth, a weathered face, unkempt hair was plausibly being represented as close to the street) and any leisure activities associated with the individual (e.g. someone described as having a love of travelling and snowboarding is plausibly being represented as at least middle class). Class was often but not always represented as overlapping within families. For example, if an individual overdose decedent was represented as middle class and depicted in a family photo with their young children it could be assumed that their children were also being represented as middle class. However, in cases where a person in active substance use was being represented as close to the street and their concerned family member was also included in the campaign but represented as middle class there was no overlap within families. Oftentimes an individual represented as a person in recovery with a middle-class family background would share their story of a descent into street-based substance use where they “lost everything” for a time, and

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their demeanour, language and appearance contributed to the decision to code these individuals as “working class”.

therefore decreased in class status temporarily (see Robertson, et al., 2021). In these cases, the individual's present situation was used to assess their class status: "How are they being represented *now*?". If an individual's class status was truly impossible to assess (e.g. a small photo with no contextual surroundings, no accompanying description of any aspects of their life) an additional code was sometimes used: "class unclear".

Gender identity. Individuals were coded as "Men", "Women" or "Transgender/Non-Binary". The transgender/non-binary code was only applied if there was a clear reason to suggest an individual identified in this way (e.g. they referred to themselves as trans, they spoke specifically about trans issues from the perspective of their lived experience).

Heterocoding. A single code ("non-heterocoded") was used to record when an individual was represented as gay, lesbian, bisexual or queer (e.g. they self-identified as "queer", a family member mentioned their same-sex partner).

Age. Age was coded using five age ranges, "children/early teens" (approximately 0-14), "youth" (approximately 15-29), "younger adult" (approximately 30-44), "middle aged" (approximately 45-59) and "older adult" (60+). The boundaries of these age-ranges were subjective and difficult to discern but were occasionally assisted by individuals' self-identifications in anti-stigma videos (e.g. "My name is Rob and I'm 47") or the identifications of others (e.g. memorial photos or posts that emphasized what age an overdose decedent was when they died). In general, this coding was assisted by visual signs of aging such as wrinkled facial skin, greying hair along with life stage indicators (e.g. mentions of children, grandchildren, retirement) and signs of youth such as clear complexion, school or career status (e.g. high school, college).

Apparent physical disability status. A single was used to record if any individuals within a campaign were represented as having a visible physical disability (e.g. a wheelchair, cane, blindness).

Stigma Concepts and Stigma Reduction Approaches. In a final section of the coding framework, each campaign was assessed wholistically for how it connected to the concept of addiction "treatment", how it conceptualized "stigma", if there were any intersections or inequities noted between substance use stigma and other marginalized identities, how it conceptualized the “problem” of stigma and what stigma reduction strategies the campaign employed.

Connection to addiction treatment. Each campaign was coded in terms of how connected encouragements for PWUD to seek treatment for “addiction” were to the anti-stigma message. Campaigns were coded as either “treatment is not mentioned” (e.g. campaign messaging focuses entirely on reducing stigma without trying to change or “treat” PWUD), “treatment is mentioned but not central to the campaign messaging” (e.g. one or more individuals featured in the campaign talk about treatment or treatment resources or admonitions to “get help” are prominently displayed on campaign materials) and “treatment is a central focus of the anti-stigma message” (e.g. only the perspectives of people who are in recovery are represented and they all emphasize the importance of seeking treatment or the key anti-stigma message was something like “recovery is possible”). This code was especially important to CAB members who anticipated that many anti-stigma campaigns would function as recovery advertisements or that stigma would be regarded as a problem primarily to the extent that it prevented people from pursuing treatment and recovery and ceasing substance use. This perspective ignores the reality that not all substance use is problematic, and treatment/recovery may not be possible or desirable for all PWUD (Castillo, 2018)..

Stigma concept. Each campaign was coded for how campaign materials in general constructed or defined the concept of stigma. Codes here included “prejudice/stereotypes in your head” (i.e. stigma is defined using dominant mainstream definitions from social psychology), “structural/political/historical issue” (i.e. stigma is located at a structural level as embedded in institutions or derived from specific historical and political practices of group-based exclusion), “dehumanization” (i.e. stigma is primarily depicted as treating PWUD as less than human), and “societal silence” (i.e. stigma means primarily that addiction or substance use is not talked about out in the open). The final category, “societal silence” was added after realizing this was the operative definition of stigma at work in several campaigns that sought to “break the silence” on addiction. These campaigns suggested contexts where stigma’s primary experience was that of silence and secrecy around addiction or substance use in a given context more so than explicitly poor treatment of PWUD.

Intersections and inequities. This code was initially used to indicate whether or not a campaign had mentioned, at any point, that stigma towards PWUD intersected with other forms of oppression. If coded as “yes” a brief description was also provided. Examples could include individuals who said that substance use stigma was worsened by lower class status (e.g. homelessness), an accomplice to anti-Indigenous racism or rooted in historical injustices such as the racist exclusion of people of Asian heritage. This code was later expanded to also capture mentions of any group-based inequities related to problematic substance use, for example elevated rates of drug toxicity death in Indigenous communities in Canada.

Problem of stigma. This code was used to record a typology of how stigma was framed as a problem in a given campaign (Bacchi, 2009, 2018).. Examples of identified “stigma problems” included that stigma was a “barrier to seeking help/treatment”, that stigma “increases overdose risk”, that stigma was an “affront to human rights”, that stigma is “morally wrong” (often applied when a campaign emphasizes personal stories of significant mistreatment and characterizes an appropriate response as angry disbelief), that stigma is a “barrier to OAT” (e.g. Methadone, Suboxone) or that stigma is a “barrier to Naloxone”. Multiple “stigma problems” could be applied to a given campaign as campaigns sometimes conceptualized the problem of stigma in more than one way. In these cases, the primary or focal “problem of stigma” was coded first in the list.

Approaches to stigma reduction. This code was used to record a typology of anti-stigma strategies employed in a given campaign. Approaches identified and coded for included “sharing personal stories of hardship or loss” (i.e. in order to elicit empathy), “challenging stereotypes” (e.g. campaigns that seek to demonstrate that unlikely individuals might struggle with substance use too and often suggest that “addiction does not discriminate”, “overdose can affect anyone” or “everyone is impacted”) “education” (e.g. “stigma is wrong for these reasons”), “reframing addiction concepts” (e.g. repeating the narratives that “addiction is a disease, not a moral failing”, “addiction is not a choice”, or “addiction is a social issue”), emphasizing that PWUD have “other identities too” (e.g. that they had family roles such as a “sister” or “mother”), emphasizing that PWUD are “a part of our community” (e.g. emphasizing ingroup inclusion of PWUD in a city or area), emphasizing that PWUD are “human beings/lives worth saving” (i.e. specifically countering dehumanization by asserting the humanity of PWUD), “changing language” (e.g. campaigns that primarily emphasize using non-stigmatizing, person-first language), “start the conversation” (e.g. campaigns that encourage friends and family members with loved ones who use substances to find compassionate, non-judgemental ways of supporting them, often providing guides for bringing up difficult topics related to substance), “break the silence” (e.g. campaigns that specifically aim to challenge societal silence on an issue or shatter the misconception that substance use/addiction does not happen in a given community), “normalizing substance use” (e.g. campaigns that emphasize how normal and non-problematic most substance use is or seek to recontextualize problematic substance use along a continuum of normalized and less problematic substance use, might also emphasize the human rights of PWUD), “PWUD have something to contribute” (e.g. campaigns that show PWUD or people in recovery in a positive way as skilled, talented and valuable members of communities), and “treatment works/recovery is possible/there is hope” (e.g. campaigns that emphasize how addiction is treatable and PWUD can change). Often, multiple approaches were utilized in a given campaign but typically one approach was used as the primary anti-stigma strategy (e.g. often reflected in the name of the campaign) so that approach was always listed first.

Notes. A final column allowed for open-ended notes to be recorded providing additional context on a given campaign, specifying certain unique features of the focal individuals (e.g. an individual was represented as a service provider but also identified as a person in recovery), or noting when additional diversity had been indicated in a campaign by briefly showing a panel of diverse faces or including B-roll footage of street-based drug scenes.

Appendix C.

Study 1 Coding Comparison Analyses

As representation coding especially (and to a certain extent stigma concepts and stigma reduction approaches coding as well) is subjective, an additional coder (an undergraduate research assistant) was trained to provide a secondary coding for all campaigns. I compared this coder's independent coding with my own coding for each campaign and any discrepancies were identified, discussed, and ultimately resolved through regular meetings or comparisons of coding notes. Since representation coding took the form of discrete, numeric, frequency counts (compared to the other more qualitative codes, which allowed multiple codes per campaign) they alone could be compared using statistical methods. To maximize sample size (and as necessitated by the coding system used), coding comparisons were calculated using comparisons of all focal individual frequency counts, not just those identified as PWLLE.

Independent representation coding was compared between the two coders in several ways (Table C.1). First, independent frequency counts for each coding category (e.g. people in recovery, White people, younger adults) and for each coder were imported into SPSS (IBM Corp, 2021) as unique variables. Two-tailed, bivariate correlation coefficients were calculated to assess the association between the two coders' independent frequency counts. All but one (Latinx) of these correlations were statistically significant and only seven (out of 31, 23%) had correlations below $r=.7$. Lower correlations between independent frequency counts appeared to be associated with coding categories that were either infrequently used (e.g. only 8 people identified as Latinx out of 1287) or more ambiguously defined (e.g. "Ambiguous non-White"). Discussions to resolve discrepancies between independent coders were more commonly associated with categories such as "Ambiguous non-White", "Working class" (typically vs. "Middle class"), or "Older adults" (typically vs. "Middle-aged").

A second approach to coding comparison was to calculate the absolute difference between each coder's independent frequency count for each variable. This yielded two additional statistics. First, "perfect initial agreement" reflected the proportion of campaigns where the absolute difference between independent coders' frequency counts was zero. These percentages ranged from 100% (identifying “Stigmatizers”, which was both uncommon and straightforward) to 36% (identifying people who appeared to be “Middle-aged”, as this category was both frequently used and more open to subjective interpretation and disagreement between coders) with only 10 variables below 80% perfect initial agreement. Other notable values here include 58% perfect initial agreement on coding focal individuals as White (a lower value, likely reflecting the large number of White individuals across the data set and in many individual campaigns, making initial perfect agreement less likely), lower percentages for “Working class” (54.5%) and “Middle class” (47.3%) (reflecting some of the ambiguities in subjectively coding social class in the “mid-range” between very poor/marginalized and upper class), and lower percentages as well for “Younger adults” (36.6%) and “Middle-aged” (35.7%) (likely reflecting both the high number of subjects in each category and some ambiguity in subjectively categorizing campaign subjects into these mid-range categories).

A final measure of coding comparison was the mean absolute difference between independent coding frequencies for each variable. For only three variables was this value greater than one (“Middle class”, “Younger adult” and “Middle-aged”) and in each case the increased absolute mean difference is simply yet another reflection of how mid-range categories were more ambiguous and subject to coding discrepancies.

Table C.1. Coding comparison statistics for two independent coders and all focal individuals across 134 anti-stigma campaigns

	Pearson's R	P-value	Total # (final coding)	% Perfect Initial Agreement	Mean Absolute Difference *(SD)*	Notes
Total[1]	.992	<.001	1289	80.4	.46 *(1.2)*	
Role (.7-1.00)						
OD decedent	.997	<.001	161	97.3	.06 *(.41)*	
PWUD	.957	<.001	296	75.9	.54 *(1.12)*	
Person in recovery	.954	<.001	190	80.4	.37 *(.93)*	
Friend/family	.937	<.001	266	88.4	.27 *(1.07)*	
Service Provider	.991	<.001	285	82.1	.24 *(.56)*	
Potential PWUD	.847	<.001	45	91.1	.24 *(1.03)*	
Supporter	.696	<.001	22	93.8	.19 *(81)*	Small # (sometimes less clear)
Stigmatizer	1.00	.000	24	100	-	Small # (but very clear)
Race (-.04-.99)						
White	.994	<.001	954	58.0	.60 *(.8)*	
Black	.892	<.001	65	90.2	.14 *(.48)*	
Latinx	-.037	.7	2	91.1	.09 *(.29)*	Small #, often ambiguous
Indigenous	.956	<.001	89	86.6	.18 *(.49)*	
Asian/Middle Eastern	.937	<.001	67	88.4	.15 *(.49)*	
Ambiguous Non-White	.616	<.001	84	60.7	.58 *(.86)*	More ambiguous
Unclear Race	.802	<.001	29	90.2	.13 *(.46)*	

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[1] This row indicates the degree of correlation in our initial assessment of how many focal individuals were included in each campaign. Disagreements were sometimes due to miscommunication from the first author over what materials were included in a given anti-stigma campaign. In several cases these discrepancies were due to more subjective disagreements on which individuals 'counted' as focal individuals within a campaign. Agreements of this nature were always resolved first before proceeding with coding comparison, so we were working with the same total number of focal individuals in each campaign. In these cases the coder who had missed some focal individuals would independently code these individuals for demographic representation before we would proceed with coding comparison.

	Pearson's R	**P-value**	**Total # (final coding)**	**% Perfect Initial Agreement**	**Mean Absolute Difference *(SD)***	**Notes**
Class (.38-.97)						
Close to the street	.920	<.001	52	85.7	.21 *(.59)*	
Working class	.748	<.001	167	54.5	.88 *(1.43)*	This may reflect some ambiguity and the need for more discussion when identifying markers of 'working class' status
Middle class	.967	<.001	935	47.3	1.11 *(1.65)*	
Upper class	.871	<.001	128	79.5	.40 *(1.03)*	
Class unclear	.378	<.001	12	88.4	.18 *(.59)*	Very small number
Gender (.87-.997)						
Men	.997	<.001	641	91.1	.12 *(.42)*	
Women	.997	<.001	640	91.1	.12 *(.42)*	
Trans	.870	<.001	8	98.2	.02 *(.13)*	Small # but fairly clear
nonHetero	.648	<.001	7	95.5	.05 *(.26)*	Small # at times more ambiguous or harder to notice
Age (.68-.95)						
Children	.954	<.001	51	95.5	.07 *(.35)*	
Youth	.905	<.001	273	63.4	.75 *(1.59)*	
Younger adults	.887	<.001	499	36.6	1.25 *(1.61)*	
Middle aged	.899	<.001	355	35.7	1.21 *(1.22)*	

	Pearson's R	**P-value**	**Total # (final coding)**	**% Perfect Initial Agreement**	**Mean Absolute Difference *(SD)***	**Notes**
Older adults	.683	<.001	100	66.1	.56 *(.94)*	May reflect some ambiguity in subjectively differentiating between "middle aged" and "older adult"
Person with a disability	.659	<.001	7	96.4	.04 *(.19)*	Small # and not always clear

Appendix D.

Study 2 – Informed Consent Form

A Community-Based Participatory Research Project to Examine Representations of PWUD in Anti-Stigma Campaigns

Informed Consent Form

It is important that you understand this study before signing the consent form. We will read this consent form to you so that you understand what this study involves. Please ask us to explain any words or information that you do not understand.

WHO IS CONDUCTING THIS STUDY?

Researchers with the British Columbia Centre on Substance Use, University of British Columbia and Simon Fraser University are conducting this study.

Principal Investigator: Dr. Ryan McNeil (UBC/BCCSU)

Co-Investigator/PhD Student: Scott Neufeld (SFU/BCCSU)

British Columbia Centre on Substance Use

t: Ryan: ####### Scott: #######

e: Ryan: ###### Scott: ####

WHO IS FUNDING THIS STUDY?

This study is being funded with internal funding from grants awarded to Dr. Ryan McNeil. Scott Neufeld is supported by a SSHRC doctoral Vanier scholarship.

WHY ARE WE DOING THIS STUDY?

Reducing stigma towards PWUD is important in the midst of the opioid overdose crisis. This study explores how PWUD respond to two recent campaigns intended to help reduce stigma towards PWUD. We hope to identify ways to improve anti-stigma campaigns by learning from the perspectives and insights of PWUD themselves.

WHY AM I BEING INVITED TO TAKE PART IN THIS STUDY?

You are being invited to take part in this study because of your experiences as someone who has been stigmatized for using drugs. We would like to discuss these experiences with you.

It is up to you to decide whether you want to take part in this study. By taking part in this study, you do not give up any legal rights. If you do not want to take part in this study you will still be able to take part in other studies conducted by the BC Centre on Substance Use. You also will not be denied support from any of our community partners. Even if you agree to take part now, you can change your mind later. You do not have to give us a reason why. We may also decide to withdraw you from the study if we feel it is in your best interest. In that case, we will destroy all of your study files and remove your text from the transcript of the focus group you were in.

HOW IS THIS STUDY DONE?

If you agree, you will take part in a recorded group interview or “focus group”. Someone trained in qualitative research will lead the focus group. Qualitative research involves collecting information about people's experiences and views through discussion. Before starting the focus group, we will ask you for some information about you. For example, we will ask your gender and age, your level of substance use and if you have overdosed before. This helps us keep track of who we have spoken to. Your answers to any questions are up to you. You do not have to answer any questions that you do not wish to answer. You do not have to tell us why.

If you choose to end your participation midway through the focus group, what you have said up to that point in the focus group will still be transcribed and included in data analysis unless you specifically tell us otherwise. If you would like to remove your contributions from the study altogether, anything you contributed during the focus group will not be transcribed from the audio recording of the focus group. None of your words will be included in data analysis or publication of any research findings. Any information you gave us will be immediately destroyed and will not be stored.

The focus group will last about 60 to 90 minutes. We will ask you to share your opinions and observations on images from two anti-stigma campaigns, describe your experiences with stigma related to drug use, and share your ideas for ways of addressing this stigma. We will ask you questions like:

- What are your gut responses to these images of PWUD in an anti-stigma campaign?
- Could you share a time when you felt like you were being stigmatized or discriminated against for using illicit substances?

The interview will be recorded and later typed out (transcribed) by someone on our team.

IS THERE ANY WAY THAT TAKING PART IN THIS STUDY COULD BE BAD FOR YOU?

Some questions are very personal and might make you feel uncomfortable or upset. Remember, you are not required to answer any questions that make you feel uncomfortable. You may also leave the focus group at any time if you are feeling uncomfortable. If you need a break, a peer researcher can step outside with you for a few moments to check in. At the end of the interview, we will provide you with a list of agencies or people you can contact for follow-up support. We can also help to arrange for an appointment if you would like to speak to someone about how you are feeling.

WHAT ARE THE BENEFITS TO TAKING PART IN THIS STUDY?

You will not directly benefit from taking part in this study. However, what you share will be used to try to improve attempts to reduce stigma towards PWUD. We will also use our findings to advocate for increased respect and inclusion for all PWUD.

WILL YOU RECEIVE ANYTHING FOR TAKING PART IN THIS STUDY?

We will offer you $30 at the end of the focus group to compensate you for your time. We will offer you $30 even if you decide to withdraw from the study during the focus group.

HOW WILL YOUR PRIVACY BE PROTECTED?

We will keep all information collected from you confidential. We will store your information in a locked filing cabinet in a secure office at the Hope to Health Centre (611 Powell) or BCCSU Qualitative Team Research Office (717 E Hastings). To protect your personal identity, only the lead researchers (Dr. Ryan McNeil and Scott Neufeld), focus group facilitators, and the person who transcribes the interviews will listen to the recording of the focus group. We will remove any identifying information from the transcripts. Notes made during or after the focus group will not include identifying information. The only computer files that might contain information identifying you are the recordings of your interviews. We will keep copies of these audio files on a password-protected and encrypted network drive accessible only from BC Centre on Substance Use computers and work locations. These files will be kept for possible use in future research. Your name or other identifying information will not appear on any publications or reports produced by the study. Only the research study staff will have access to all the information over the course of the study.

Research records identifying you might be inspected, in the presence of Dr. McNeil, Scott Neufeld, by someone from the Providence Health Care / University of British Columbia Research Ethics Board to monitor our research. However, no records that identify you by name or initials will leave the research office. We will destroy all of your files five years after we publish the study findings.

In addition, please note that all people in British Columbia are legally required to contact the Ministry of Child and Family Development if they have reason to believe that a youth under the age of 19 is being abused or harmed in any way. If information of this kind is disclosed during the research interview, we will report this information to authorities with the Ministry of Child and Family Development.

WHO CAN YOU CONTACT IF YOU HAVE QUESTIONS OR CONCERNS ABOUT THE STUDY?

If you have any questions about the study, you can contact the Principal Investigator, Dr. Ryan McNeil, at ####.

If you have any concerns about your rights as a research participant or your experiences while taking part in this study, you may contact the Research Participant Complaint Line in the University of British Columbia Office of Research Ethics at #### or #### (Toll Free: #####).

PARTICIPANT CONSENT AND SIGNATURE

By signing this consent form, you acknowledge that:

- this study has been explained to you and all your questions have been answered;
- you understand that taking part in this study is voluntary and you are free to refuse to take part or withdraw from this study at any time;
- the potential risks have been explained to you and you understand the benefits of taking part in this study;
- you understand that your study files will remain confidential and no information will be released that would disclose your personal identity unless required by law;
- you understand that by signing this form you have not waived your legal rights nor released the researchers, sponsors, or involved institutions from their legal and professional duties; and,

Your signature below indicates that you have read this form or have had it read to you. Your signature indicates that you consent to take part in this study. You understand that you will be given a signed and dated copy of this consent form.

Signature of participant

Signature of Principal Investigator or Designate

Appendix E.

Study 2 - Participant Information Questionnaire

FOCUS GROUP COVER SHEET

Interviewer:____

Date and Time:____

Filename: ____

DEMOGRAPHICS – DO NOT TURN ON AUDIO RECORDER

1. **What do you identify your gender as?**

☐ Man ☐ Woman ☐ Transgender Woman
☐ Transgender Man ☐ Other:________________________________

2. **How old are you?** __________________________

3. **What do you identify your race or ethnicities as? (check all that apply)**

☐ White (Caucasian) ☐ Indigenous / Aboriginal ☐ East or Southeast Asian
☐ South Asian ☐ Black / African-Canadian ☐ Other________________

4. **What do you identify as your sexual orientation?**

☐ Straight ☐ Gay ☐ Lesbian
☐ Bisexual ☐ Two-Spirited ☐ Other:_______

5. Do you live with a... (check all that apply)

☐ Physical Disability? If yes, please describe:

____

____

☐ Mental Health Issue?
If yes, please describe:

____

____

6. Are you currently living with HIV/AIDS?

☐ Yes ☐ No

7. Are you currently living with Hepatitis C?

☐ Yes ☐ No

8. Which of the following substances have you used in your lifetime?

☐ Cocaine (powder)
☐ Heroin
☐ Solvents
☐ Other:____
____
☐ Crack Cocaine (rock)
☐ Opiates (other)
☐ Marijuana
☐ Crystal Methamphetamine
☐ Methadone
☐ Alcohol

9. Which of the following substances have you used in the past <u>30</u> days? (Check all that apply and <u>Circle</u> drug of choice)

☐ Cocaine (Powder)
☐ Heroin (Down)
☐ Solvents
☐ Other____
☐ Crack Cocaine (Rock)
☐ Opiates (other)
☐ Marijuana
☐ Crystal Meth (Jib)
☐ Methadone
☐ Alcohol

10. How often are you currently using your <u>drug of choice</u>?

☐ Daily ☐ 3-4 times per week ☐ One or fewer times per week

11. How often are you currently using <u>other drugs</u>?

☐ Daily ☐ 3-4 times per week ☐ One or fewer times per week

12. Are you on an opioid agonist or maintenance program?

☐ Methadone ☐ Suboxone ☐ Dilaudid ☐ Heroin

13. Have you experienced an overdose in the <u>past 30 days</u>?

☐ Yes ☐ No

14. Over the <u>past year</u>, have you experienced:

☐ 1 overdose ☐ 2 overdoses ☐ 3 or more overdoses ☐ N/A

15. After your overdose(s), were you administered naloxone by any of the following:

☐ Family Member or Friend	☐ Peer (Someone who uses drugs)	☐ Social Services Worker
☐ Paramedic	☐ Nurse	☐ Other__________________

16. (If applicable) What type of drug did you think you used when you overdosed? (Check all that apply)

☐ Cocaine (powder)	☐ Crack cocaine (rock)	☐ Crystal Methamphetamine (jib)
☐ Heroin (down)	☐ Fentanyl	☐ Other Opioids (extra-medical)
☐ Speedball	☐ Other:________________	

17. Which methods have you used to consume drugs in the past 30 days? (Check all that apply)

☐ Inject ☐ Smoke / Inhale ☐ Snort ☐ Ingest Swallow

18. (If you have not injected in past 30 days) Have you ever injected drugs?

☐ Yes ☐ No

19. Have you been arrested within the past five years?

☐ Yes ☐ No

20. Have you served time in prison within the past five years?

☐ Yes ☐ No ☐ (If yes) Length of sentence: ______________

21. How many times have you been evicted within the past five years (since 2014)?

______

Please indicate your level of agreement with the following statements:

22. Most people believe that a person who uses drugs cannot be trusted

Strongly Disagree	Somewhat	Unsure	Somewhat	Strongly Agree

23. Most people believe that a person who uses drugs is dangerous

Strongly Disagree	Somewhat	Unsure	Somewhat	Strongly Agree

24. Most people believe that a person who uses drugs is to blame for their problems

Strongly Disagree	Somewhat	Unsure	Somewhat	Strongly Agree

25. Most people believe that a person who uses drugs is lazy

Strongly Disagree	Somewhat	Unsure	Somewhat	Strongly Agree

Appendix F.

Study 2 - Focus Group Guide

A Community-Based Participatory Research Project to Examine Representations of PWUD in Anti-Stigma Campaigns

<u>DIRECTIONS</u>

Thank you for agreeing to share your experiences as someone who uses drugs. As we discussed during the consent process, today you will be taking part in an approximately 45 to 75-minute focus group about your experiences as someone who uses drugs as well as your perceptions and experiences of recent images from public service announcements related to the overdose crisis. Please note that this focus group interview will be audio recorded and later transcribed or written out. Before we begin, please remember that everything that you share with us is confidential, and your information or identity will not be shared with anyone unless required by law. Also, please keep in mind that there are no right or wrong answers to these questions, and you do not have to answer any questions that you are not comfortable answering.

<u>FOCUS GROUP INTERVIEW GUIDE – START RECORDING</u>

Initial Image Responses

We're going to start by looking at a few depictions of PWUD in two recent ad campaigns related to the overdose crisis. (*Hand out sheets with four "Stop Overdose" campaign images and "End Stigma" Health Canada campaign images*). Has anyone seen these images before? *(show of hands.)* Whether or not you've seen them before, I want you to take a good look at these images now and think about what comes up for you as you do...we'll discuss our gut responses to these images all together in a few moments but for now please feel free to write or draw a few comments on the images as your initial responses come to you. I will be collecting these later on and looking at what you wrote, so I encourage you to write something! *(Provide two minutes – take some notes on peoples' reactions, facial expressions etc. while they are doing this first exercise – remind people to do this quietly, and on their own, only if people are talking etc.)*

Alright, you can stop writing. I wanted to also really briefly show a video where the images on the second page come from. (Show end stigma clip, 30 s). Now I want to hear from people...

1. What was your gut reaction to these images when you first saw them? *(could be here in the FG, or first time they saw them in public...)*
    - Why do you think these images make you feel like that?
    - Do others resonate with that response to these images? *(Describe level of agreement in the room for the recording)*
    - What else are these images bringing up for people?
2. *(After initial round of discussion/gut reaction)* Who do you feel are these campaigns' audiences? Who are the campaign creators hoping will see these?
3. What do you feel these campaigns are trying to tell their audience?
4. What do you think the people who developed these campaigns are hoping people will think when they see these images? What kinds of "change" do they hope might take place for people who see these images?
5. In general, what do you think these campaigns, with these images, are trying to achieve?
    - Do you think it was/will be successful?
    - What would that success look like?

(Wrap up section) So as some of you may know, these images with the different coloured backgrounds were created for the provincial government's "Stop Overdose" campaign and the video is part of a campaign by the Government of Canada. One goal of these campaigns is to "reduce stigma towards PWUD". So, as PWUD these campaigns are meant to help reduce stigma towards you.

Experiences with Stigma and Representations of PWUD

Now I want to stop looking at these images for a few moments and have some discussion of how you have personally experienced stigma for using drugs.

6. Could someone share a time when they felt like they were being stigmatized or discriminated against for using illicit substances? *(ask for a few others)*
    - How did you respond to or resist that treatment?
    - When was a time you were treated well, or without stigma, as someone using drugs?
7. How do you think people who do not use drugs typically imagine a person who uses drugs?
    - What do THEY think PWUD are like?
    - What are some common stereotypes about PWUD that exist in society?
    - What do you have to say in response to those stereotypes?
8. Intersectionality: How does your experience as *(Insert relevant identities from select FGs: e.g. women, trans folks, Indigenous, racialized, etc. but also more privileged identities, e.g. men (masculinity) etc.)* result in a unique experience of stigma as someone who uses drugs?

Representations of PWUD – Second Image Analysis

Drawing on your experiences and perspectives as PWUD from a variety of backgrounds, I want to spend a bit more time “analyzing” these images. Flip the pages with the campaign images back over. I’m interested in what you can tell me about what these images might be saying about drugs and the people who use them:

9. How do these images represent, or portray, PWUD?
    - Is that representation accurate?
    - What are the implications of this (mis)representation?)

10. What types of PWUD do you feel are included in these campaign images?
    - How often do you think these people use drugs?
    - What kinds of drugs do they use?
    - What kinds of backgrounds or identities do you associate with the people depicted in the campaign images?
11. What types of PWUD do NOT seem to be included in the representations we see in these campaign images?
    - What are some different categories of PWUD we can think of?
    - Which ones are/are not represented here?
12. Do you see yourself, or other members of your group *(reference stigmatized identities specific to FG...e.g. women, indigenous, trans, other racialized etc.)* represented in these campaigns?
    - Do you think these campaigns will help reduce stigma towards you and other members of your group (e.g. Indigenous people, trans folks etc.)?
    - Why or why not?
13. What kinds of PWUD might these campaigns help to reduce stigma towards?
14. What kinds of PWUD might they NOT help reduce stigma towards?
15. What would you say is the wider message these campaigns' imagery is sending about illicit drugs and the people who use them?
16. Sometimes the way our message is interpreted by others is different from what we meant to communicate. In the case of this campaign and these images, could there be a difference between the intended message and the received message? What is it?

17. One of the goals of these campaigns is to reduce stigma toward PWUD. How do you think people have responded to these campaigns? Do you think they have/will achieve their goal? How and why?
18. How do you think these (mis)representations of PWUD might be harmful?
    - How might they deepen stigma around certain types of PWUD?
    - Are there other ways these campaigns might be harmful?
19. What is the message these campaigns are sending about the overdose crisis in general? What are the potential harms or benefits of that wider message?

Ideas for Revising the Anti-Stigma Campaigns and Addressing Stigma/Inequality Facing PWUD More Generally

Given our discussion about the images from these two anti-stigma campaigns, I want to give you a chance to revise or edit these images based on your own ideas of what needs changing, or what could work better*. (Hand out a clean copy of the four stop overdose images and 4 end stigma health Canada campaign images).* The first time we did this, we were just writing what we noticed. Now, we're writing what we would change. Feel free to cross out text, write something else, or just put a big X through the entire thing and write a new idea for how to reduce stigma towards PWUD on the back of the page. Once again, I'll be looking closely at what you write or draw on these images later, so do your best to express yourself as completely as you can. *(Provide approx. 5 minutes)*

20. Could a few people share a bit about what they wrote or drew on the images?
    - Why did you cross that out?
    - What would you put in its place?
    - What is some better language to replace that?
    - How did that piece you crossed out make you feel?
    - How did it feel to mark up this poster?

21. What would you say to the people who created these images or developed the “Stop Overdose” (BC) or “End Stigma” (Canada) campaigns?

22. What are your views on awareness or anti-stigma campaigns as interventions in the overdose crisis in general?

23. What are other approaches you might suggest as ways to reduce stigma towards PWUD?

    - How do you think stigma can be reduced?
    - Do peoples’ minds change? Do laws and policies change? In what order?

24. How important is “stigma” as a focus of intervention in the overdose crisis? In the midst of the ongoing criminalization/prohibition of drugs?

25. Are there other areas of potential intervention in the overdose crisis that are more important than stigma? What are they? How might those be addressed?

26. Is there anything we missed that you would like to mention or discuss?

Before we wrap up, here are a few key points I’ve written down from our discussion today that seem to me like they summarize what we’ve been talking about (*Read*).

27. Do those key points accurately reflect what we discussed today?

Appendix G.

Study 2 - BC Government “Stop Overdose” Image Prompts

Appendix H.

Study 2 - Health Canada “End Stigma” 30s PSA Video Screenshots

Get the facts at Canada.ca/Opioids

Source: https://www.canada.ca/en/health-canada/services/video/end-stigma-campaign-described-video.html

Appendix I.

Knowledge Mobilization Document

So you want to reduce stigma towards people who use drugs...

F.I.R.S.T. let's...

FOCUS your definition of the problem. What do you think "stigma" is? Is there a more specific term you can use here like discrimination (unequal treatment), prejudice (negative attitudes), stereotypes (inaccurate or harmful beliefs) or social exclusion that better describes the lived experience of people using illicit drugs in your context? How exactly might public attitudes, stigmatizing policy or internalized stigma be...

- Creating barriers for people who use drugs to seek help or access supports?
- Increasing the risk of overdose and overdose death?
- Preventing the implementation of changes in drug policy (organizational, municipal, federal etc.) or social supports that could save lives and reduce harm?

INVESTIGATE how stigma is showing up in your community. What is the history of stigmatizing policy and practice towards people who use drugs? Are there social groups who are disproportionately impacted by the harms of drug policy in your context? How have people who use drugs from different walks of life been harmed and excluded in *different ways* in your community? Where is this still happening today?

REACH OUT to people with lived and living experience of substance use related stigma. Make sure to respect their time and expertise. Ensure you are reaching a diversity of people and recognize that experiences of stigma may differ in important ways based on social position. How can your anti-stigma intervention (and the voices and stories you choose to elevate through it) represent a diversity of experiences of stigma and substance use? Drug policy and the criminalization of drugs in Canada have affected specific communities in very different ways over time, with a disproportionately negative impact on marginalized groups including low-income and racialized communities. Instead of saying “we’re not like them”, can you work to build solidarity across diverse lived experiences of stigma and substance use?

STRATEGIZE in partnership with people who are most impacted by substance use related stigma on what an effective and respectful anti-stigma intervention could look like. What form will your campaign take? Who will be the target audience for your campaign? What will success look like and how will you measure it?

TAILOR your intervention to your specific context. What is the most effective thing you can do with the resources you have to combat substance use related stigma? Posters on bus stops? Social media storytelling? Protests at city hall? Writing letters to politicians demanding decriminalization and safe supply in Canada?

Contextualizing Anti-Stigma Interventions

For a long time, stigma towards people who use drugs was not a concern for researchers or policymakers. Because of this, we still know very little about what actually “works” to reduce stigma towards people who use drugs. The little research that does exist is only starting to consider the complex ways that substance use related stigma intersects with racism, classism, and other forms of oppression. Much of the discussion around substance use related stigma treats stigma as if it does not have a long and ugly history as a tool of racism and classism. It focuses on changing wrong attitudes inside of peoples’ heads rather than interrogating the sources of stigma or how stigma is expressed through discriminatory and harmful policy.

Nevertheless, anti-stigma campaigns are exploding in popularity across Canada and the United States. A recent review has identified 134 anti-stigma campaigns targeting substance use related stigma that were launched in Canada from 2009-2020. Most of these (86%) have been released since 2017. But marginalized people who use drugs have been facing, and resisting, stigmatizing attitudes and policy that target their communities long before the most recent wave of the overdose crisis. Many are asking, **who are all these recent campaigns really for?**

The vast majority of people with lived or living experience (PWLLE) of substance use who appear in these 134 Canadian anti-stigma campaigns do not belong to groups that have been the historical targets of substance use related stigma and drug criminalization. Approximately 72% of the PWLLE represented in anti-stigma campaigns appear to be White. Of the 104 campaigns that showed individuals, 33% *exclusively* featured White-appearing PWLLE. Similarly, across all campaigns approximately 74% of PWLLE appeared to be represented as middle or upper class and 40% of the campaigns *exclusively* showed middle-upper class PWLLE. **Why?**

Many campaigns seek to "challenge stereotypes" about who might be at risk of an overdose by depicting people from social groups that are not typically stereotyped AS "drug users". Representations of White, middle-upper class PWLLE are often paired with colour-blind messages like "opioids don't discriminate" or "overdose can affect anyone". This narrative ignores how other forms of group-based oppression intersect to produce substance use related inequities (e.g. the over-incarceration of people with addiction and mental health problems in Canada, the over-representation of low-income and Indigenous peoples in overdose deaths). Worse, this narrative is sometimes paired with a negative downward comparison, "these (good) drug users are not like those (bad) drug users". This approach may help privileged people who use drugs by creating a new category of "deserving" drug users for whom stigma is seen as inappropriate, while normalizing and preserving the exclusion and dehumanization of racialized and low-income people who use drugs.

Towards Ending Stigma For ALL People Who Use Drugs

Remember History: Recognize the intersections between substance use related stigma, racism, classism and other forms of oppression. Try not to develop interventions that exacerbate intersectional stigmas by ignoring them. Don't let your privilege blind you to history.

Prioritize Policy: Changing stigmatizing policy that actively harms people who use drugs may be more important than targeting the public attitudes of individuals. Don't confuse mean comments with structural exclusion. Better yet, sometimes an effective way to change minds might be to change policy! For example, it might be easier to convince the public not to see people who use drugs as undeserving criminals if we decriminalized simple possession of currently illicit substances.

Practice Inclusion: Don’t make anti-stigma work about separating “us” from “them”. Instead, recognize the connections between different experiences of stigma and trajectories into substance use. How does the demonization of marginalized drug users that has been normalized for generations contribute to the shame a White upper class person feels using drugs alone in their nice house? What interventions can help end stigma and reduce drug related harms on both ends of that spectrum?

Build Solidarity: Find ways to make your anti-stigma work foster connections between different experiences of substance use related stigma. Could you elevate the stories of Indigenous communities dealing with pain from intergenerational trauma with opioids? Respectfully allow people experiencing homelessness to share their experiences of substance use and stigma in a way that transcends stereotypes? Encourage privileged folks to share about their experiences of addiction without perpetuating narratives of deserving and undeserving people who use drugs?