CHAPTER THREE

Stigmatization in People Who Use Drugs: Causes, Consequences, and Intervention

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People who use drugs (PUDs), and especially those who meet diagnostic criteria for substance use disorder (SUD), are victims of stigmatization in almost all cultures (Corrigan et al., 2009). They are often perceived as dangerous, unpredictable, incapable of making decisions (Yang et al., 2017a), immoral, of weak character, and prone to commit crimes (Can & Tanrıverdi, 2015). This can have a detrimental effect on their health, contributing to a lack of resources and attention given for adequate treatment, among other negative health outcomes (von Hippel et al., 2018). Regardless of whether PUDs meet SUD criteria, the source of stigmatization always stems from the stereotypes and prejudices associated with drug use (Cassiani et al., 2019).

There is a high level of stigmatization towards PUDs in general (Yang et al., 2017), and even among health care personnel (Simmonds & Coomber, 2009). Similarly, it has been described that up to 75% of people in treatment for SUD report being stigmatized by their family members (Ahern et al., 2007). As a result, people with substance use-related problems often internalize such perceptions and behaviours towards themselves (Crapanzano et al., 2018), which becomes a key factor preventing them from seeking health services (Gupta et al., 2019), affects adherence to pharmacological treatment and psychotherapy (Luoma et al., 2014), can lead to relapse (Khazaee-Pool et al., 2019), and reduces the overall recovery rate (Hammarlund et al., 2018). Social stigma

itself can exacerbate the severity of mental health problems and constitutes an additional stressor affecting quality of life (Birtel et al., 2017; Vilsaint et al., 2020).

Despite the impact of the stigma associated with drug use, few reviews have analyzed this topic from a comprehensive perspective (Crapanzano et al., 2018). It is therefore necessary to explore the phenomenon of drug use stigma in greater detail (Yang et al., 2017). The following is a conceptualization of stigma, its types, causes, and consequences, as well as stigma reduction strategies that have shown to be effective. Publications in the Latin American context are the focus, as a region in particular need for this type of research.

Stigma Discrimination Complex (SDC)

Progress in stigma research requires a solid definition, and various theoretical perspectives on the construct of "stigma" have been proposed (Yang et al., 2007). Through a discussion of these different theoretical approaches, we will state our epistemological position in this regard.

In the 1970s, the Canadian sociologist Erving Goffman was the first to conceptualize stigma, referring it as a negative and deeply discrediting attribute built from the norms and values accepted by the society that generates actions of rejection and contempt towards those who possess such condition by those who do not (Goffman, 1970). However, research in the last 20 years has begun to explore the phenomenon of stigma in more detail (Pescosolido & Martin, 2015). In this vein, Link and Phelan (2001) complemented Goffman's initial concept by defining it as a process that involves five components:

1. Labeling: People tend to distinguish and label human differences.
2. Stereotyping: Dominant cultural beliefs sometimes link labeled individuals with undesirable characteristics and negative stereotypes.

3. Separation by labeling: People who are labeled are placed in different categories, leading to a separation between “them” and “us.”
4. Discrimination: Stigmatized people experience devaluation or social separation and a loss of status as a consequence of this separation and stereotyping.
5. Exercise of power: Stigmatization is related to inappropriate use of economic, political, and social power that legitimizes labeling, prejudice, and discrimination.

The contributions of Link and Phelan (2001) identify some conceptual categories linked to social stigmas—stereotype, prejudice, and discrimination—which are fundamental to understanding the phenomenon of stigmatization (Major & O'brien, 2005).

Stereotypes are a set of positive and/or negative (but generally erroneous) ideas, beliefs, or conceptions about a social group that biases the perception, memory, and assessment of the characteristics and behaviours of members of that group. In this way, an “impaired identity” is constructed based on an erroneous evaluation (Phelan et al., 2008).

Prejudices are emotional predispositions, usually negative, people have towards members of a social group whose characteristics are subject to stereotypical beliefs. In other words, negative stereotypes are considered as prejudices (Pescosolido & Martin, 2015).

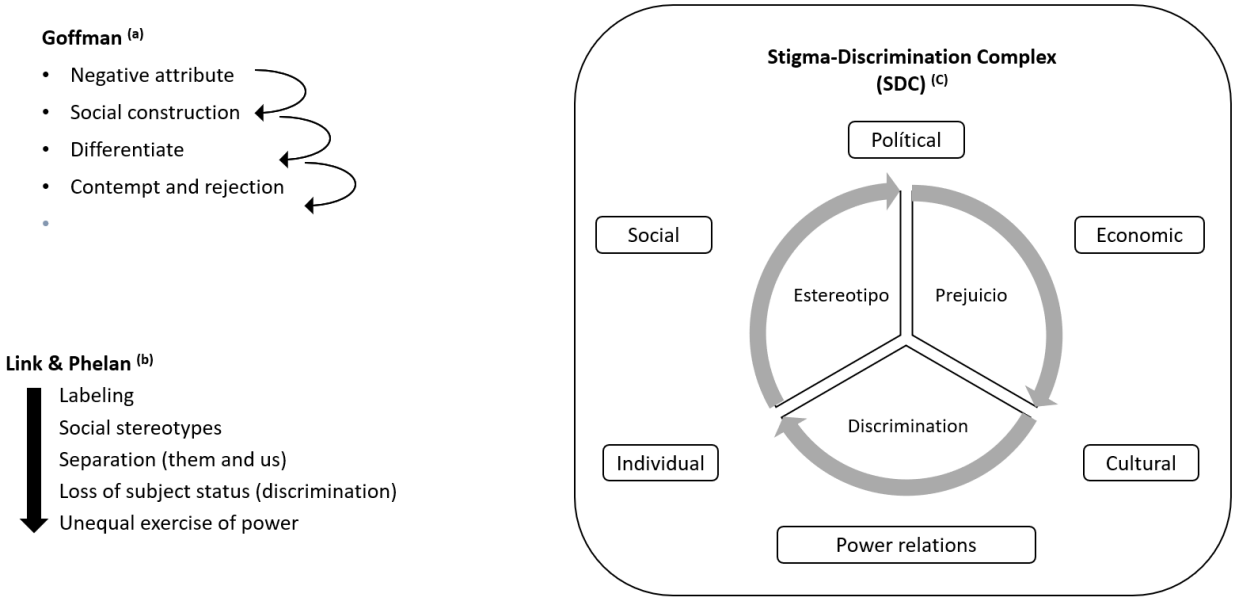
Discrimination describes actions and behaviours, usually measured in terms of social distance, towards members of the group linked to a negative stereotype (prejudice), and sometimes entail violations of their rights. Discrimination therefore can be considered the finale stage of the stigma-stereotype-prejudice sequence, where the resulting actions are taken (Campo-Arias & Herazo, 2015; Phelan et al., 2008).

Clearly, stigma, stereotype, prejudice, and discrimination are widely related and overlapping terms, the product of a complex sociocultural dynamic (Link & Phelan, 2001). It is

therefore necessary to not approach them linearly, but rather understand them as a complex network of relationships between concepts. Figure 1 shows the differences between the main theoretical positions on stigma.

Figure 1

The Main Theoretical Positions on Stigma



Notes. **(a)** From Goffman's point of view, stigma is presented in a linear way, deeply devaluing, degrading, and discrediting the person who carries it. **(b)** Link and Phelan's position also presents stigma as linear, consisting of five related components in a sequence. **(c)** From the SDC perspective, stigma is a network of complex relationships with individual, social, and structural aspects that are deeply interrelated and determine their forms of presentation and consequences.

The Stigmatization Process

The phenomenon of stigmatization occurs when a stereotype takes on a negative connotation (i.e., becomes prejudice) which, when validated by the hegemonic culture (Katz,

1991), leads to the violation of rights (i.e., discrimination) of the members of the stigmatized group (Arboleda-Flórez, 2005).

Traditionally, from attribution theory, stigma, stereotyping, prejudice, and discrimination are conceived as a complex sequence (Haghighat, 2001; Major et al, 2002) that led to the Stigma-Discrimination Complex (SDC) model. of the SDC groups these inseparable concepts, giving a more holistic view of the stigma phenomenon (Campo-Arias & Herazo, 2015; Pescosolido & Martin, 2015). This concept of stigma as a complex is consistent with other theoretical approaches such as the Framework Integrating Normative Influences on Stigma (FINIS; Pescosolido et al., 2008), which considers stigma to arise from several social and individual systems with close, dynamic and inseparable interconnections that point to a transdisciplinary and translational foundation.

Types of Stigma

Link and Phelan (2001) classify stigma into three levels: individual, interpersonal and structural. Individual stigma refers to self-stigma or internalized stigma, wherein the negative views of society are internalized by the person, whereas, interpersonal stigma (also known as public stigma) refers to the stereotypes that occur in the interaction between stigmatized and non-stigmatized people, which translate into actions of direct discrimination when considered acceptable by society. Structural stigma takes an even broader, considering macro-social forms of stigma such as those related to economic, political or ethnic factors (Hatzenbuehler, 2016). The main characteristics of these types of stigma are further described below.

Structural Stigma

Structural stigma has its origin in the concept of institutional racism, recognizing the role of transnational, and governmental institutions in legitimizing stigma and thereby restricting stigmatized people from accessing social benefits and opportunities to which they are entitled (Corrigan et al., 2004; Hatzenbuehler, 2016). In this sense, structural stigma evidence forms of exclusion and marginalization by relating the conditions of poverty and social condition (RIOD, 2019) with cultural and political norms. When these are institutionalized by dominant power groups, inequities for subjects who are socially disadvantaged due to stigmas associated with their ethnicity, sexual orientation, social status, mental health status (Hatzenbuehler, 2016), or drug use (RIOD, 2019), are exacerbated. There is exploratory evidence suggesting that, when stigma towards PUDs is coupled with other forms of prejudice such as ethnic-racial or gender, they are subject to marginalization and receive lower-quality health care (Corrigan & Miller, 2004).

It is important to highlight that stigmatization and its functions have historical and cultural bases, so understanding it demands a structural analysis insofar as the power relationship is constant in the process. Stigmatization thus presupposes processes of exploitation and oppression between social classes, related to issues of ethnicity, gender, and sexuality that lead to conditions of inequality (Ronzani, 2018). This process generates social imaginary of the "abject, rejected and loser" (Scambler, 2018), the result of an individualized and ahistorical ideal of human being, a situation that favors the legitimization of punitive, violent, and segregating policies by the State (Livingston, 2013). The above can be exemplified in the strategies of control and exclusion of impoverished people who live and circulate in specific territories, through actions justified by state agencies in the deteriorated identity of such subjects (Livingston, 2013; Scambler, 2018).

Public Stigma

Public stigma defines various shameful situations according to the terms that are tolerable or not, according to the set of norms and values accepted by a community and/or society (Goffman, 1970). In this sense, public stigma is the result of the interaction between the people who are victims of stigmatization and those who stigmatize them (Pedersen, 2009), and is represented in the transmission and assimilation in the general population of negative stereotypes about a particular group (París Pombo et al., 2009).

Difference and power play a fundamental role in public stigma, wherein one group is contrasted with another that is considered legitimate based on the social construction of a discrediting attribute (Goffman, 1970). Concerning drug use, there is a clear difference between people who use drugs and those who do not (Arribas, 2001). Moral, physical, and social stereotypes towards users of these substances (París Pombo et al., 2009) assume that PUDs are defined just by drug use (Arribas, 2001).

In public stigma, stereotypes that are rationalized as prejudices (Rengel Morales, 2005) cease to be individual characteristics and become general ones learned through the predominant culture (Corrigan et al., 2011). An unequal distribution of power between a dominant group and a lower status group (Link & Phelan, 2001), can cause the latter, to be devalued, underestimated and discriminated against by society (Ronzani et al., 2014). In the case of PUDs, this includes greater likelihood of succumbing to more drug use.

stigma, courtesy stigma, provider stigma, and stigma in the health field. Enacted stigma involves acting based on prejudice or discrimination against others based on a trait or condition, allowing the source to be identified (Pescosolido & Martin, 2015). Courtesy stigma, also called stigma by association (Östman & Kjellin, 2002), refers to someone who is not a member of a

stigmatized group living, working, or having a relationship (close or not) with individuals or groups that do (Pryor et al., 2012). Stigma by association is most common towards close family members and other relatives (Corrigan & Miller, 2004; Koro-Ljungberg & Bussing, 2009). Finally, provider stigma refers to stigma originated by individuals or institutions charged with caring for people with habitually stigmatized conditions (Li et al., 2007) whether manifested in the use of stigmatizing language (Sartorius, 2007) or the denial of care for people with mental disorders (Ross & Goldner, 2009; Schulze, 2007) or who use drugs (Tirado, 2019; Van Boekel et al., 2013).

Internalized Stigma

Internalized stigma the negative opinion the stigmatized person has about themselves as a direct result of public stigma related to their condition (Haghighat, 2001). Negative attributes conferred by the dominant group are internalized, assimilating it and applying it to themselves (Felicissimo et al., 2014) insofar as the assigned label (e.g., drug addict) occludes other components of their identity (RIOD, 2019).

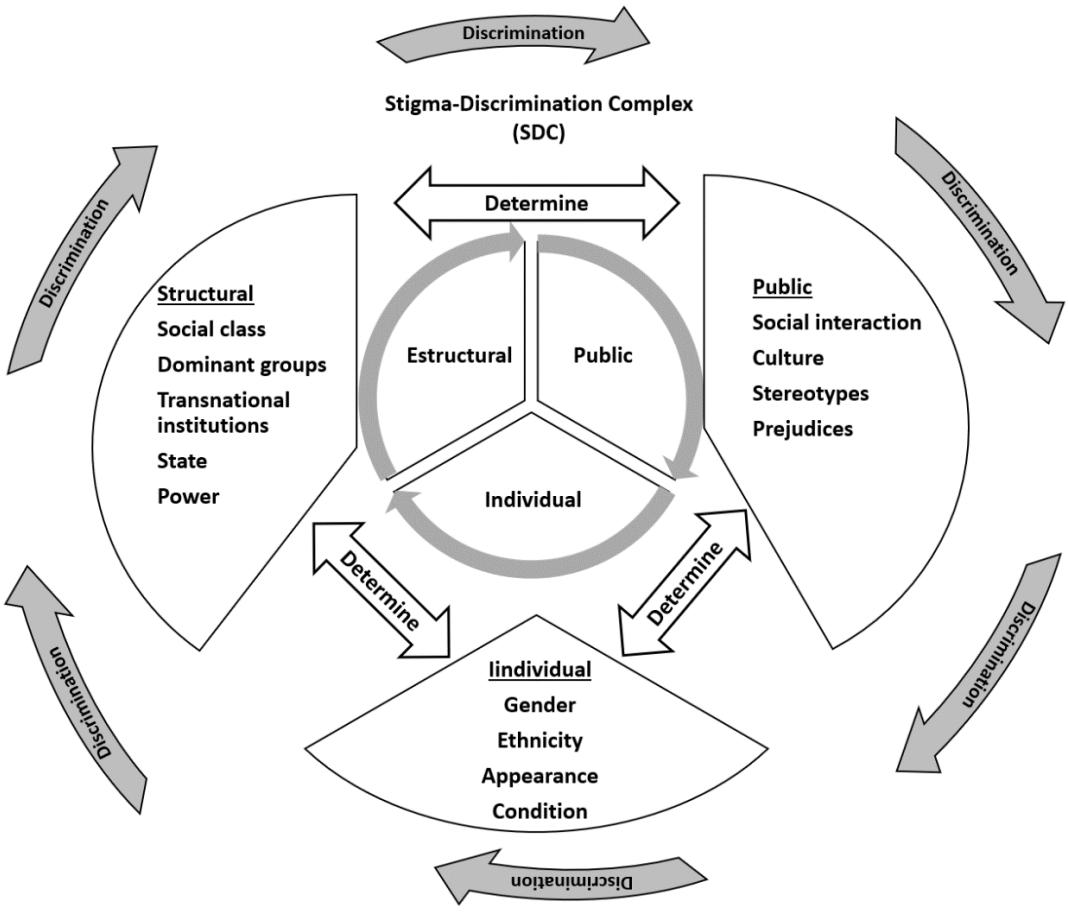
Internalized stigma has two variants, perceived and anticipated stigma. The former refers to victims' lived internal experience of prejudice and/or discrimination (Major & O'brien, 2005), while the latter corresponds to people's expectations of discrimination by others (Major & O'brien, 2005; Pilgrim & McCranie, 2013). In the case of PUDs, it is common to develop strategies of anticipation of rejection and devaluation to which they are subjected, which include concealment or avoidance of interaction with others to avoid being stigmatized (Ferreira et al., 2014).

Regardless of whether the emphasis is on micro-groups or macro-structural conditions, stigmatization has the primary function of exercising power and control through the simultaneous or subsequent occurrence of labeling, stereotyping, separation, loss of status, and discrimination

(Hatzenbuehler et al., 2013; Link & Phelan, 2001), legitimizing devaluation and social exclusion for presenting characteristics different from others (Corrigan & Watson, 2002). Consequently, the SDC is presented as a web of closely linked dependent and determinant relationships, so that their forms of presentation are not preceded by one another, nor in a hierarchical distribution. Therefore their consequences, regardless of their origin, cannot be reduced to a linear association, but rather to a circuit of interconnected causes and consequences (See figure 2).

Figure 2

The Stigma-Discrimination Complex (SDC)



Consequences

This section describes the different consequences that PUDs may face due to internalized stigma, public stigma, and structural stigma. Stigma, prejudice, and discrimination are not presented separately because they closely linked and inseparable concepts (Cox et al., 2012; Pescosolido & Martin, 2015)

Consequences of Internalized Stigma

Internalized stigma has multiple negative impacts on psychological and physical health, as well as on the social aspects of relating to others, work and home. This manifests as self-exclusion in drug users, a product of the rejection anticipation strategies they develop (Ferreira et al., 2014; Tirado, 2019).

Regarding the psychological consequences, people with SUD tend to hide due to shame about their behaviours (Mollá & Pastor, 2017). This is reflected in a loss of identity and hope, decreased self-esteem, self-concept, and self-efficacy (Felicissimo et al., 2014; Ronzani et al., 2014), as well as in feelings of guilt, anxiety, anger and self-reproach that interfere with their motivation to recover (RIOD, 2019). In terms of physical health consequences, the fear of being stigmatized can generate chronic stress, increasing the chances of developing stress-associated conditions (Link & Phelan, 2006). This fear can also drive them to further substance use in risky situations, which can cause or aggravate other health problems like sexually transmitted diseases, for example (RIOD, 2019).

Internalized stigma can also drive people with SUD to hide their condition for fear of being stigmatized, which makes them invisible to health systems (Mollá & Pastor, 2017) and causes

delays in seeking treatment (Vásquez, 2009) and difficulties in accessing health services (Paiva et al., 2014). Similarly, the stigma from health professionals towards PUDs also causes internalized stigma (RIOD, 2019), which can repel them from seeking care for fear of being recriminated, scolded and/or mistreated by health care personnel (Ferreira et al., 2014; Soares et al., 2011; Tirado et al., 2019), and lead to aggravation of their health problems (Ronzani et al., 2014).

Finally, in the social consequences related to internalized stigma, it should be noted that PUDs use different strategies of concealment and social distance, to avoid criminalization and stigmatization (See note 1) (Epele, 2007), or discrimination originating in the belief that they are incompetent, unreliable, or even dangerous (Link & Phelan, 2006). This limits their access to job opportunities, education and housing (Paiva et al., 2014), compromises their social networks, causes unemployment and loss of income (Link & Phelan, 2006), and can entail inequality in their civil rights due to rejection and exclusion (Herrera & Marín, 2015).

At this point, it is important to clarify that although the diagnostic criteria of SUD includes loss of functioning in the areas of family, work, and academic performance; when the disorder is compensated, these criteria are not met and the person can return to their work environment without any problem (American Psychiatric Association, 2013). What has been observed, however, is that some employers deny employment to individuals with a prior history of diagnosed SUD, even after they have recovered (Brouwers, 2020; Ottewell, 2019).

Consequences of Public Stigma

The process of building stigma is configured when those who deviate from what is socially assumed as acceptable are censured, and it becomes a biased and totalizing concept with the power to discredit the person who carries it (Arribas, 2001; Mollá & Pastor, 2017), as it is a constitutive

instrument of control and power (Parés Franquero, 2013). In this sense, the collective image constructed about drugs turns any user into a problematic individual not abiding by the norms and values of society (Herrera & Marín, 2015). When a PUD is understood only through the label of "drug addict," they are devalued and implicitly stripped of their social status as a citizen, excluding them from various common public spaces (Arribas, 2001).

This process of devaluation varies according to the type of substance, the cultural context, and the level of the person's drug use (occasional vs. SUD). Part of the cultural context includes whether they are understood from a punitive logic as criminals, or from a sanitarian logic as sick people to be treated (Cunial, 2015). In the punitive perspective, drug use is associated with violence, poverty, and crime, which translates into feelings of fear and collective threat (Mollá & Pastor, 2017), by falsely equating the consumer with a trafficker—or failing that with a criminal, because of the assumption that PUDs must commit illicit acts in order to finance their addiction (Cunial, 2015). From the sanitarian view, drug use is considered a disease (Organization of American States, 2013; Vázquez & Stolkiner, 2009) that must be diagnosed and intervened upon (Cunial, 2015), with the aim of correcting behaviours socially qualified as "deviant" or "abnormal" (Llinares Pellicer & Lloret Botonat, 2010).

The consequences derived from the stigmatization of drug users are reflected in the restriction of their social interactions, distrust, stereotypes, discrimination, and marginalization (Ronzani et al., 2014); and the imposed social branding limits opportunities for meaningful interpersonal relationships (Goffman, 1970). Marginalization implies the decision to disregard individuals who are outside the bounds of social acceptability (Arribas, 2001), while human classification according to degree of social belonging, implicitly justify the power to do so (Llinares Pellicer & Lloret Botonat, 2010). In this sense, the recognition of the individual as a

"drug addict" rather than a human being or a citizen limits their participation in public life and puts them at a disadvantage (Arribas, 2001; Llort A, 2013).

Consequences of Structural Stigma

Substance use disorders create barriers to health care access (Tirado et al., 2019), which recursively worsens their condition and further contributes increases these barriers (Li et al., 2009). Furthermore, if ethnic-racial and/or gender inequality factors are added to this, the risk of discrimination could also increase (Kulesza et al., 2016).

Historical and social context defines which groups, characteristics, and behaviours are stigmatized, and this process admits and justifies power relations of one group over another. Stigma therefore has an important social function since it naturalizes and gives rise to a series of symbolic or real punishments, often being the basis of criminal codes and public policies, as in the case of structural stigma (Livingston, 2013). In this way, processes of social exploitation and oppression are approved by identifying some groups as peripheral or undeserving of basic rights—either because of their social class, ethnic-racial identity, mental condition, or a behaviour like substance use (Ronzani et al., 2016).

In situating our discussion of the role of structural stigma in the field of substance use, it is important to highlight that there is something similar in the issue concerning economic, social, and cultural differences between countries around the world. Therefore, its understanding must consider regional and global issues, since the dominant discourse on drugs as an influence penetrating all spheres of society (Lobos, 2012; París Pombo et al, 2009) allows the dominant groups to deprive others (Llinares Pellicer & Lloret Botonat, 2010) by isolating them from the rest of the population. This is justified as a means of ostensibly avoiding "contamination" of the

dominant group (Herrera & Marín, 2015), since the other will always be perceived as a threat (París Pombo et al., 2009).

In consideration of the above, structural forms of stigma have an important impact in terms of exclusion, gaps in healthcare access, and perpetuation of social inequalities (Hatzenbuehler, 2016; Kulesza et al., 2016), wherein PUDs who also belong to other social minorities receive lower quality treatment (Kulesza et al., 2016).

On the other hand, the most vulnerable drug users (e.g., people with HIV, the homeless, people of diverse sexual orientations, and the poor) are not only rejected and discriminated against by health workers because of their condition, but sometimes denied care when arriving at a clinic or hospital. In some countries, such as Colombia, they must access healthcare in a particular way due to limitations of the health system to deal with this population (Tirado, 2019). The quality of the service provided to them can also be impaired, for example in the average consultation duration (Paquette et al., 2018). Similarly, structural stigma also has a gender component wherein women are more disadvantaged than men when faced with care in drug dependence services, in part because of the belief that women who use drugs are more promiscuous (Kulesza et al., 2016).

Finally, ethnic minorities, as well as young and poor men, are more likely to be detained by law enforcement agencies (Uprimny et al., 2014) and to receive harsher sentences for drug use (Kulesza et al., 2016). Coupled with the fact that prison systems lack appropriate treatment and rehabilitation programs for inmates (including treatment for dual pathology), this means that these individuals are not only limited in their chances of recovery once released (UNODC, 2011), but also limited in their access to employment, housing, medical care, and overall possibility of leading a sustainable life (Link & Phelan, 2001, 2006; RIOD, 2019).

In general, some impacts of stigma among PUDs are problems of health care access (Corrigan et al., 2014), reduction life expectancy, low educational level, unemployment (Silveira et al., 2015), increased risk of criminality, and poverty (Gronholm et al., 2017). Among the consequences of this impact is the attempt to hide their habits, and even more isolation, which exacerbates the problem (Luoma et al., 2013), and sometimes are even greater than the consequences of the actual drug use, placing them in a vicious cycle of stigmatization (Ronzani, 2018). On the other hand, such people may internalize negative attributes about themselves, decreasing their desire to seek help and causing low self-esteem, depression, anxiety, and other feelings of self-worthlessness (Li et al., 2009).

Up to this point, we have contextualized stigma in its different manifestations and described its multiple consequences for PUDs. Next, we present an overview of the research conducted in Latin America on the topic and then describe several evidence-based strategies for reducing stigma in this population.

Latin American Research on Stigma Towards People Who Use Drugs

Research on stigma toward PUDs in Latin America is still incipient. A search in the Latin American and Caribbean Center for Health Sciences Information—also known by its original name as the Regional Library of Medicine (BIREME)—for original and primary source research published in the last decade found 263 articles. Of these, 181 were discarded for not being relevant enough to the topic in their title or abstract, 30 for being reviews and 33 for being repetitive.

In the end, only 19 original articles on the subject remained, of which 13 were carried out in Brazil, nine are qualitative research and three are psychometric studies. This justifies the need

to continue research on this subject in our region with studies that include different methodological perspectives. Information on the main results of these articles is presented in Table 1.

Strategies for Reducing or Preventing Stigma

Considering the negative impact of stigmatization on PUDs, proposals for reducing it are presented from a general perspective. Such proposals seek changes in intrapersonal, interpersonal, and structural areas, and are developed to reach either victims of stigmatization or the general public (Ronzani et al., 2014).

There are three main categories of approaches for reducing stigma: protest, contact, and education. These can be carried out in various contexts, making visible the discussions on drug dependency and the social factors associated with it. They may also be able to inform the development of public policies and practice guidelines.

Table 1

Original Articles Published on Stigma Towards Drug Users in the Latin American and Caribbean Region

Article	Country	Design	Stigma type	Main results
Soares et al., 2011	Brazil	Cross-section	Social	Social distance was higher for cocaine addicts; no difference between alcohol and marijuana addicts
Oliveira et al., 2012	Brazil	Cross-section	Social	Professionals who stigmatize alcoholism engage in alcohol-directed practices as often as those who do not
Silveira et al., 2012	Brazil	Cross-section	Internalized	The unemployed have higher self-stigma
Silveira et al., 2013	Brazil	Cross-section	Internalized	Crack dependents internalize more negative evaluations of their condition and are less likely to seek/adhere to treatment.
Romanini & Roso, 2014	Brazil	Qualitative	Social	Crack users are only recognized because of the signals of the marks on their bodies and the identity of "crack users"
Paiva et al., 2014	Brazil	Qualitative	Social	There is strong stigmatization of drug use among health professionals, society, and drug users themselves
Soares et al., 2015	Brazil	Psychometric	Internalized	The Internalized Stigma of Mental Illness Scale (ISMI) showed satisfactory psychometric results as a tool for measuring internalized stigma in addicts
Vallim, 2015	Brazil	Qualitative	Social	Crack use increases exposure to health problems, violence, stigma, social isolation, discrimination and violation of rights
Silveira et al., 2015	Brazil	Cross-section	Social	Belief in recovery and perceived danger were associated with social distance

Article	Country	Design	Stigma type	Main results
				toward cocaine and marijuana addicts
Ritterbusch, 2016	Colombia	Qualitative	Social, Structural	Participatory Action Research (PAR) is useful to promote social inclusion practices and work against stigma and discrimination.
Abeldaño et al., 2016	Argentina	Descriptive	Internalized	Patients using alcohol alone showed more internalized stigma than users of multiple substances
Ronzani et al., 2017	Brazil	Psychometric	Internalized	The Brazilian version of the ISMI (ISMI-BR) scale was semantically equivalent to the original, culturally appropriate to the Brazilian reality, and reliable when tested for its psychometric qualities
Mora-Ríos et al., 2017	Mexico	Qualitative	Social, Structural	Social and gender inequality, violence, and abuse form a structural context of discrimination around addiction that are obstacles to treatment
Abeldaño et al., 2017	Argentina	Psychometric	Internalized	The ISMI scale adapted for people who use psychoactive substances is reliable and has an adequate factor structure
Ventura et al., 2017	Brazil	Descriptive	Social	The perception of drug users includes the stigmas that they are untrustworthy, ignored, and unintelligent
Camargo et al., 2018	Brazil	Qualitative	Social	Women who use crack suffer from social exclusion, marginalization, and difficulties accessing health services
Malvezzi & Nascimento, 2018	Brazil	Qualitative	Social	There are moralizing, prejudiced, and criminalizing attitudes towards alcohol use, mainly among the lower classes
Delgado & Brands, 2019	Ecuador	Cross-section	Social	Attitudes towards problematic alcohol users are positive, while those towards

Article	Country	Design	Stigma type	Main results
				problematic illicit drug users are ambivalent
Tirado et al., 2019	Colombia	Qualitative	Social	Health professionals' moral judgments and negative behaviours toward drug users are barriers to health care

Protest actions refer to social mobilization that is contrary to the classifying, stereotyping, moralizing, and discrimination of substance users or dependents. Discouraging the use of pejorative language to describe users and dependents is emphasized in this approach. Based on techniques that encourage contact, the aim is to promote positive interaction and exchanging of experiences with substance users as a methodology to make changing one's beliefs about users possible. Educational actions include presentations and discussions that aim to alter attitudes and behaviours at a community level, allowing the issue of substance use to be analysed critically (National Academies of Sciences & Medicine, 2016; Silveira et al., 2018). It is also still necessary to raise awareness among health professionals to change their moralizing view of drug use, which sometimes contribute to the stigmatization and exclusion of people with drug dependence (Silveira et al., 2018).

Actions should also be taken with stigmatized individuals and can be used in services that focus on dealing with the issue of dependency in an expanded manner. For example, support groups that promote autonomy and help to reconstruct their identity, self-esteem, coping skills and social integration stand out. Similarly, mutual support can increase treatment adherence based on the assumption that experiences will be worked on together, improving motivation for treatment, while actions aimed at building autonomy should be developed to provide a space for substance users and dependents to become active in their treatment processes (Ronzani et al., 2014).

Accordingly, we present a synthesis of some evidence-based strategies for stigma reduction taken from the recommendations of the National Academies of Sciences and Medicine (2016). See Table 2.

Table 2

Evidence-Based Stigma Reduction Strategies

Strategy	Target Audience	Action	Examples	Types of Stigma
Education	• General population • Stigmatizing groups • Stigmatized groups • Family members	Disclosure of anti-stigma information and content, support and group discussion	• Campaigns at different scales • Training • Acceptance andCommitment Therapy (ACT)-based groups	• Public • Internalized • Courtesy or affiliation
Contact	• Stigmatizing groups • Stigmatized groups	Promotion of positive contact between groups	• Stories of people who are stigmatized in trainings • Promotion of meetings between groups • Use of videos orinternet with people • Accompaniment and support for assistance in services	• Public • Internalized
Protest	• General Population • Stigmatizing groups • Stigmatized groups • Family members	Alteration and reinforcement of laws and public policies aimed at human rights and anti-stigma	• Publication of public documents • Organization of advocacy groups and promotion of social participation • Lobbying of politicians for changes in laws and public policies • Public protests	• Public • Internalized • Structural • Courtesy or affiliation

Evidence of effectiveness of stigma reduction strategies towards mental disorders is not yet the strongest in the area of mental health in general, however, there is a growing body of research in the area of alcohol and other drugs (National Academies of Sciences & Medicine, 2016). It is important to note that, regardless of which form of stigma is addressed, emphasis should be placed on developing and implementing strategies that consider the context in which individuals are embedded. Because the stigmatization process does not take place in a social vacuum, any strategy will have limited effect if it is implemented and thought of in a mechanical way without considering the social and historical determinants involved. Specific actions that do not account for the characteristics of the target audience tend to be less efficient since they do not consider the health, psychosocial and structural problems associated with dependency, so it is important to analyze the various potentialities existing in the different contexts. Finally, it is important to highlight that education, contact, or protest strategies, if not contextualized or planned more broadly, will have little impact or could even reinforce stigmatization or prejudice on certain groups (Silveira et al., 2018).

Conclusions

Stigma has multiple individual, social, and structural manifestations, and consequences. However, research on stigma towards people who use drugs is still incipient (Kulesza et al., 2016). Despite evidence showing brief interventions aimed at education and contact have positive effects on stigma in this population (Oliveira et al., 2012), there is insufficient evidence to conclude that such strategies are effective in reducing stigma towards these individuals (Tostes et al., 2020). This highlights the importance of advancing in the studies of these issues and the need to design not only interventions culturally adapted to the contexts and subjects in which they are carried out, but

also validation of instruments that allow the objective measurement of the phenomenon, in combination with qualitative research, allowing an in-depth understanding of the perceptions of the people who participate in the interventions.

Stigma reduction entails considering strategies that include multifaceted and multilevel interventions aimed at changing attitudes and beliefs about, and power relations with, the affected group (Link & Phelan, 2001). Strategies oriented to education, contact, and protest are the most recommended by the scientific literature on the subject so far (Tostes et al., 2020). Such strategies should be aimed at different audiences, and designed considering the particular context in which they occur so that their effectiveness can be tested with specific population groups. One group that requires a priority intervention are health professionals, due not only to the leading role they have in the care of people who use drugs (Tirado et al., 2019), but also the impacts that stigma has on patients from a clinical, psychological and social point of view (Felicissimo et al., 2014; Ferreira et al., 2014; Soares et al., 2011).

The stigmatization of people who use drugs is linked to social determinants associated with poverty, race, gender, unemployment, housing, schooling, and malnutrition, among others (Wilkinson & Marmot, 2003). In this sense, focusing on these factors enables a better understanding of the social vulnerability of substance use, and consequently can optimize the planning of actions and the care of users. Therefore, when considering the control function and power relations involved in the stigmatization process of drug users, it is strategic to understand how the determinants and social organization of countries and regions will impact on how such exclusion processes will be constructed.

Stigma as a process of devaluation goes against the idea of human dignity, causing humiliation and exclusion for victims of it. This is why the Organization of American States (2013)

has highlighted the importance of intervening in different forms of social exclusion such as unemployment, and access to health services.

This should be considered when proposing structural framework interventions to address the stigmatization of people who use drugs. Being a social construct linked to strategies of domination and unequal distribution of power (Link & Phelan, 2001), stigma translates into situations that reproduce social inequalities (Hatzenbuehler, 2016). Hence, it is critical states to foster conditions that favour equitable employment, education, housing, health, culture, sports, food security, citizen participation, and poverty reduction, among others.

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Note 1: Stigmatization is to be expected, since people who internalize stereotypes also anticipate or predict that they will be stigmatized in some situations, and engage in avoidance or concealment behaviours to cope.