Experiences of stigma within the substance using community in Richmond

By
Daniel Remedios

B.A., Kwantlen Polytechnic University

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We acknowledge and respect the Ləkʷəŋən (Songhees and Xʷsepsəm/Esquimalt) Peoples on whose territory the university stands, and the Ləkʷəŋən and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day.

Supervisory Committee

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By

Daniel Remedios

B.A., Kwantlen Polytechnic University

Supervisor: Dr. J. Barton (Bart) Cunningham, Professor

School of Public Administration, University of Victoria

Second Reader: Dr. Sarah Marie Weibe, Associate Professor

School of Public Administration, University of Victoria

Chair: Dr. Jennifer Hall, Adjunct Assistant Professor

School of Public Administration, University of Victoria

Abstract

Stigma faced by individuals who use substances is known to be a barrier to treatment as well as a roadblock to the implementation of progressive programs and policies that can increase the quality of life and care received. Stigma is often cited as one of the causes of individuals using substances alone, which relates to the cause of death due to overdose. The community of Richmond is an immigrant-majority city where the added layer of cultural and immigrant stigma towards substance addiction also hinders individuals from stepping forward and discussing their own substance use journeys. This study conducted a literature review on the current research on substance use addictions, with the key points being illustrated in the conceptual framework used. Based on the literature review, a conceptual framework was created to help identify the most common impact areas in which individuals who use substances are stigmatized. Semi-structured interviews were conducted with eleven people who use substances in the community of Richmond, and the interview findings were analyzed to identify key themes, which revealed that stigmatization occurs across various areas. These findings were corroborated by current research. The participants also offered their perspectives on stigma-reduction interventions across the different impact areas. Recommendations were based on themes from the literature review and participants' input.

Keywords: Addiction, Richmond, Stigma, Stigma Reduction.

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Dedication

To Kayla and Sebastian, thanks for putting up with the grumpiness over the years. It's all for you in the end.

To Naani, always.

Introduction

In the United States, according to the National Survey on Drug Use and Health, 48.8 million individuals met the criteria for a substance use disorder in 2024 (Substance Abuse Mental Health Services Administration, 2024). Of those, 27.9 million met the criteria for an alcohol use disorder and 28.2 million for an illicit drug use disorder. (SAMHSA, 2025). In Canada, 1 in 5 people (approximately 21%) will meet the criteria for a substance use disorder in their lifetime (Canada, 2023). Both the United States and Canada have experienced a striking increase in the use and addiction to opioids over the last decade. In Canada, death rates due to substance misuse have increased since 2019 (*CCENDU | Canadian Centre on Substance Use and Addiction*, 2023). In the province of BC, more than 15 thousand people have died due to toxic drugs since 2016 (CBC, 2024). People die by overdosing on both licit and illicit substances, stigma significantly contribute to this number. Since 2015, deaths due to unregulated substances have almost quadrupled in the municipality of Richmond (Coroners, 2025).

These statistics draw attention to the need for effective prevention and treatment. However, the stigmatization of people living with substance use addictions can be viewed as one of the major barriers preventing people from beginning or receiving the proper care or treatment (Bernot et al., 2019), etc. Specific language associated with individuals who have used substances can affect how they respond and engage with others, as they feel that words like “addict,” “drug users,” alcoholic,” “street person,” and ‘homeless” are laden with preconceived views that they are responsible for their ailment and do not warrant the same degree of help. This is supported by research on stigma of people with substance use disorders based on studies surveying the general public, health care workers, counsellors and mental health workers (Ashford et al., 2019; Goodyear et al., 2018; Kelly & Westerhoff, 2010; Kelly et al., 2016).

These studies suggest that the term “substance abuser” invoked negative perceptions and behaviour among practitioners (Kelly & Westerhoff, 2010). In comparison with a person who has had a car accident or brain injury, individuals with substance use disorders are seen as responsible for their own disorder and not capable or deserving of treatment.

Stigmatizing perspectives can also exist at individual and systemic levels, creating multiple obstacles for effective substance use disorder prevention and treatment. Despite an increased understanding around the topic of addiction during the recent opioid crisis, stigmatizing attitudes remain pervasive and continue to shape treatment modalities, policy frameworks, legal approaches, and funding allocation decisions (Barry et al., 2014). The 1980s drug war rhetoric continues to perpetuate moralistic and punitive perspectives toward individuals who use drugs, illustrating stigma's enduring influence and broad societal reach (Kulesza et al., 2017). Structural stigma creates significant barriers and challenges for these individuals who are actively trying to seek treatment or are considering seeking help (Ashford et al., 2019; McGinty et al., 2019).

The purpose of this project is to review the experiences of people with lived experiences with substance use disorders who are a part of the City of Richmond Community. The project will also aim to develop a deeper understanding of how their addiction affects them and how the larger community can help them reduce the negative long-term outcomes related to addiction. The City of Richmond has one the highest percentages of immigrants in Canada (60.3%), (Statistics Canada, 2021). This project will look for potentially unique interventions for the individuals who use within the city with the highest immigrant percentages in Canada.

In the initial sections of this report, background on the issue of addiction within the lens of people who use substances in Richmond is presented, as well as a review of the general literature on stigma. A framework is provided for the research and interview guide, which is used to

interview people who use substances living in the city of Richmond. The paper is intended to contribute to the general knowledge around the topic of stigma and stigma reduction for the population of individuals who use substances. The findings align with current research on the impacts and types of stigmas that people who use substances face. Recommendations have also been gathered directly from participants regarding their personal approaches to stigma reduction.

Background

The municipality of Richmond comprises approximately 209,000 residents, 80.3% of whom are visible minorities and 60.3% are immigrants, compared to the provincial average of 28% (Statistics Canada, 2021). Richmond has the highest percentage of immigrant population as well as the highest percentage of visible minorities across Canada. A city with a population makeup such as Richmond could need uniquely tailored responses, or preventative measures taken to support individuals from the community that use substances. According to reports from the Richmond Health Department and the British Columbia Coroners Service, the total number of deaths linked to toxic, unregulated drugs in Richmond in 2024 was 25. Additionally, in 2023, there were 28 deaths and 356 reported poisoning calls. The number of deaths due to substances just five years ago was 14, while ten years ago was only 3. These figures reflect the severe impact of substance-related incidents, highlighting the need for urgent interventions.

Over the last decade, there have been calls in Richmond to be more responsive to issues related to mental illness, subsidized housing, legalization, and decriminalization (Canadian Broadcasting Corporation, 2022). Some suggestions advocate treating substance use disorders like chronic health conditions. However, many people may still be unaware of recent scientific evidence, maintain moralistic views of substance use, or both (Kulesza et al., 2017). Such a feeling of public stigma might be one of the causes of a not-in-my-backyard (NIMBY) view of

substance abuse. As a result, some members of the public might be resistant to community-based services and lean towards punitive solutions over public health or harm reduction approaches (McGinty & Barry, 2020).

Despite significant efforts by the municipal government, regional health authority, and various health organizations to promote harm reduction and prevent addictive behaviours (Community Action Team, 2018), stigma remains one of the most prevalent challenges when addressing substance use and mental illness in Richmond. Stigmatization of people who use substances exacerbates the difficulties associated with addiction. Stigma manifests in various ways, including negative labels (e.g., "junkie"), exclusion from healthcare, and framing addiction as a criminal issue rather than a health concern (Goodyear, Haass-Koffler, & Chavanne, 2018). These practices not only prevent individuals from seeking help but also perpetuate the cycle of addiction by further isolating them from society (Centers for Disease Control and Prevention [CDC], 2013). The stigma associated with illicit substance use also creates societal and individual barriers to obtaining the services needed to stay safe, leading to an increase in risk-taking behaviours and a risk of death due to overdose. Reducing the stigma surrounding substance use is essential for increasing the likelihood that individuals will seek services and, ultimately, stay alive. Studies show that death due to overdose or substance use is influenced by the stigma that the individual who uses those substances faces (Earnshaw, 2020). By reducing public stigma, it in turn reduces the internalized stigma that substance-using populations face in Richmond (McGinty et al., 2020).

In 2018, various groups in Richmond, including Turning Point Recovery Society, Richmond Addiction Services Society, Vancouver Coastal Health, Richmond Consumer and Friends Society, tried to bring together individuals who used substances and hosted a series of dialogues

with different sections of the community (Richmond News, 2018). This team was titled the Community Action Team (CAT), and they connected with individuals from the substance-using community to empower them to speak to the larger community about their experiences as individuals who use substances. Separate dialogues also facilitated by the CAT, were held with the medical community, local business owners, and the public, during which individuals shared their experiences and answered any questions that arose (Anne Vogel Clinic, 2019). The final step of the process was to involve individuals in the substance-using community in creating any specific recommendations they had to share. Unfortunately, the Covid-19 pandemic occurred shortly after, and a lot of the momentum created by the CAT and the peers who used substances was halted and has still not resumed. Negative feelings regarding substance users continue in Richmond (Rantanen, 2025), and measures need to be implemented immediately regarding the false stereotypes surrounding the substance use community. This decrease in stigmatization can lead to decreases in deaths related to illicit substance use, increased uptake in harm reduction, and an increase in public awareness that addiction is tied to health as opposed to a failure of morals. Therefore, this study aims to explore Substance Users' first-hand perspectives on how they are currently treated by segments of the Richmond community and to provide suggestions and recommendations on how to address the concerns raised during these conversations. Due to the unique makeup of the Richmond population, the aim of this study is to explore if there could be any unique recommendations or methods gleaned from the individuals who use substances in the city and live in it as well.

Researcher Positionality Statement

I am the researcher of this study. I am also an immigrant, a person of colour, and part of a visible minority group. I am fortunate in that I live in Canada and have opportunities that others may not have had because I am physically and mentally well.

My interest in this issue is connected to the fact that I am an affected other living with a member of my family who is active in their addiction. I also work in a mental health and addiction education organization in Richmond. My organization is not involved in any aspect of this research study. However, because of my proximity to people who use substances, I am aware of the biases I may have when researching this topic. I have noted this in my ethics proposal and discussed it with my supervisor, Dr. Cunningham.

Literature Review

The Literature Review below summarizes the multifaceted nature of stigma that is experienced by people who use substances. Stigma is a complex social process that involves labelling, stereotyping, status loss and discrimination. Stigma manifests across multiple levels: healthcare professionals and services, societal, and internal. All levels can have profound consequences for health outcomes and impact the quality of life of people who use substances.

Stigma in the Substance Use Context

"Stigma refers to the social process of exclusion, where a person or group of persons is considered abnormal due to the presence of an attribute that is devalued by the broader social group" (Cama, Brener, Wilson, & von Hippel, 2016, p. 1664). Stigma is more than just a negative attitude, it is a social process that includes labelling, stereotyping, status loss, and discrimination through an unequal power dynamic (Link & Phelan, 2001). Stigma represents one of the most pervasive and harmful social processes affecting people who use substances, creating barriers to healthcare access, perpetuating health inequities, and exacerbating the harms associated with substance use itself. Substance use disorders are more stigmatized than any other health conditions since substance use is often seen as a choice, and repeated use is seen as poor ‘self-control’ (Kelly et al., 2016). In British Columbia, where the overdose crisis has claimed over 16,000 lives since the public health emergency was declared in April 2016 (BC Coroners Service, 2025), understanding the multilayered nature of stigma is essential for developing effective public health responses and compassionate care frameworks. The literature consistently demonstrates that stigma worsens health outcomes for people with substance use disorders (Livingston et al., 2012). Individuals report feeling judged and ignored, which leads to delays in accessing treatment or to the complete avoidance of healthcare settings (van Boekel, Brouwers,

van Weeghel, & Garretsen, 2013). Additionally, stigmatizing language in the media perpetuates harmful stereotypes, making it difficult for the public to view addiction as a treatable health issue (McGinty, Goldman, Pescosolido, & Barry, 2015). McGinty et. Al (2020) states that stigma is persistent, pervasive, and rooted in the belief that addiction is a personal choice, reflecting a lack of willpower and a moral failing.

Manifestations of Stigma and Its Consequences

Stigma manifests in the labelling of people, negative stereotyping, status loss, and discrimination. Rates of stigma are extremely high both in the public and in professions whose members interact with people with addiction, including health care professionals (McGinty & Barry, 2020). Due to associations with crime and violence, people who use substances are viewed as dangerous, unpredictable, and lacking self-control (Biancarelli et al., 2019). Public stigma can lead to an overall societal rejection of individuals living with addictions, and it contributes to and is perpetuated by structural stigma, which can be seen in discriminatory practices and policies that can be discriminatory in nature that can lead to suboptimal care for patients. (McGinty and Barry, 2020; Chang, Dubbin, & Shim, 2015).

Healthcare providers may view people who use substances negatively, mistrust their motives, and, in turn, limit the quality of care they provide (Biancarelli et al., 2019). Substances users report poor treatment with noted feelings of dehumanization when interacting health care facility staff**,** which aligns with findings that stigma contributes to underinvestment in addiction treatment infrastructure and suboptimal care for people with substance use disorders (McGinty & Barry, 2020). The belief is that this mistreatment likely stems from assumptions being made that substance users were 'purposely engaging in reckless behaviour' or using deception to seek pain medication. (Biancarelli et al., 2019). Even when substance users truthfully disclosed their

substance use, subtle changes in healthcare professionals' behaviour were noted (Biancarelli et al., 2019).

At a societal level, public stigma can lead to substance users being discriminated against when seeking insurance benefits, employment, and housing. Stigma can cause not-in-my-backyard (NIMBY) type resistance to community-based services and can shape public opinion that favours punitive rather than health-oriented solutions (McGinty & Barry, 2020). Even the language that society uses to address people who use substances can have devastating effects on individuals. Terms such as 'drug abuser', 'addict', 'junkie', among others, carry negative connotations (*RESPECTFUL LANGUAGE and STIGMA REGARDING PEOPLE WHO USE SUBSTANCES Background*, n.d.). Corrigan, Larson, and Rusch (2013) distinguish between public and self-stigma. Public stigma can be seen in stereotypes, prejudice, and discrimination; self-stigma occurs when individuals are aware of the stereotypes that describe the group they belong to, agree with them, and apply the stereotypes to themselves (Corrigan, Larson, & Rusch, 2013).

Societal stigma can lead to discrimination in employment and housing, and lead to resistance to harm reduction services and policies being adopted in the community. Stigma within healthcare services can lead to negative attitudes and mistrust that shows itself in poor treatment quality and experiences akin to dehumanization towards the person who uses substances, even if their need for medical care may not be related to their use at the time. This is shown to make the individuals who experience this stigma delay their care or even avoid it entirely, leading to possible negative outcomes or, in some cases, death. At the individual level, internalized stigma manifests in shame, diminished self-worth, and avoidance behaviours, including delaying

healthcare, concealing drug use from providers, and using substances in isolation, thereby increasing overdose risk.

At an individual level, self-stigma or internalized stigma occurs when people living with addictions internalize society's negative views (McGinty & Barry, 2020), and actions performed against them due to stigma are deserved (Fraser & Treloar, 2006). Even the anticipation of stigma can lead to a desire to hide one's use, which contributes to social isolation and high-risk practices, such as solitary use of substances, leading to possible overdose or death due to overdose. This internalized stigma can lead to feelings of shame and a lack of self-worth (Cama et al., 2016). In a study by Biancarelli et al (2019), substance users spoke on their internal feelings of shame and embarrassment about their use when seeking healthcare services, as well as "knowing" they would be discriminated against. Internalized stigma is correlated with a higher chance of depression, lower self-esteem, and a higher severity of substance dependence. This, in turn, is associated with a range of adverse outcomes, such as a higher suicide risk, overdose death, and transmission of blood-borne viruses (Cama et al., 2016). Internalized stigma may prevent users from seeking help or engaging with treatment or harm reduction programs. The participants in the Biancarelli et al. (2019) study employed four avoidance strategies as a way of avoiding the anticipated stigma: 1- delaying healthcare, 2 – not disclosing drug use, 3 - downplaying the need for pain medication, and 4 – seeking alternative sources.

Stigma-Reduction Interventions

Person-first language is a critical first step toward reducing stigma. Individuals should no longer be referred to as 'substance abusers', 'addicts', etc. Instead, 'substance user' or a person with substance use disorder should be the preferred language (McGinty & Barry, 2020). Individuals as well as health professionals should eliminate the use of negative and judgemental

language such as ‘substance abuse’, ‘addict’, ‘clean’, ‘junkie’, and ‘drug habit’, among others, to describe an individual’s use (McGinty & Barry, 2020). Emphasizing solutions and the success of treatments such as overdose prevention programs also reduces the negative attitudes related to harm reduction programs (McGinty & Barry, 2020). Stigma-reduction messages emphasizing addictions are related to societal or situational factors, as opposed to individual factors, have also been shown to help with overall stigma reduction. Public awareness campaigns are critical for changing societal views of addiction. Studies show that campaigns that frame addiction as a medical issue and promote empathy toward individuals with addictions have been successful in reducing public stigma (Barry et al., 2014). The media also plays a key role in shaping these narratives, and concerted efforts to accurately and compassionately depict addiction can lead to lasting changes in public perception (Pescosolido & Martin, 2015).

Research suggests that stigma can be reduced through educational initiatives targeting healthcare professionals. Programs that educate providers about the neurobiological connections to addiction and promote the use of person-first language have been shown to improve attitudes toward patients with substance use disorders (Goodyear et al., 2018). Harm-reduction approaches, such as needle exchange programs and supervised consumption sites, have shifted the focus from criminalization to treatment, resulting in a reduction of stigma (McGinty et al., 2015). In healthcare settings, people who use substances reached out to smaller community health centres or safe injection sites, with individuals noting that they were treated as 'human beings' (Biancarelli et al., 2019). A sense of belonging was also noted when health staff had lived experience with substance use, and substance users were more open and honest about their use and their needs, as the care received was perceived to be more understanding and non-judgemental. This is supported by the findings of Chang, Dubbin, and Shim (2015), who stated

that the success of interventions in healthcare settings can be effective through open and safe conversations about substance use. Even using language that reflects the medical nature of substance use and treatment such as speaking about addiction as a 'disorder' or referring to the individuals as 'someone who uses substances', separates the individual from the action of use. This language has help reduce the amount of stigma felt by the individual receiving services when speaking to a person using substances (*Stigma | Canadian Centre on Substance Use and Addiction*, 2025) (Kelly, Greene, & Abry, 2021).

The internalized stigma held by people who use substances can be just as challenging to address as societal stigma. Corrigan, Larson, and Rusch (2013) suggest that empowerment is a 'relevant and important mechanism for change.' Empowerment in the context of substance use emphasizes strategies on goals (what might be done) rather than prohibitions (what should not be done). The purpose of this method is not to take away stigma but to foster empowerment in the individual. A joint group identity among substance users engaging in treatment, mutual-help groups, and advocacy initiatives has been shown to increase self-efficacy among individuals who participated in these groups (Corrigan, Larson, & Rusch, 2013). A strong, supportive peer community is also critical to increasing empowerment to combat self-stigma. Peer networks operate without hierarchy, and all are encouraged to participate in ways that best meet their needs and interests (Corrigan, Larson, & Rusch, 2013).

Evidence-based interventions for stigma reduction at various levels show promise in reducing the harms derived from stigma. Educational initiatives targeting healthcare professionals that focus on the neurobiological aspect of addiction, as well as the promotion of person-first language in certain aspects, reduce the stigma that substance users feel. The creation of environments where patients feel treated as human beings also reduces the feelings of stigma

reported. Change in the language used is also a critical aspect for stigma reduction overall. Replacing stigmatizing terms such as ‘addict’ or ‘junkie’, among others, goes a long way in reducing stigma in societal aspects, as well as individual and internal aspects. Addressing internalized stigma within substance users themselves requires initiatives focused on empowerment. Peer support networks that help with participation in treatment, and non-judgmental, non-clinical support, can also help build empowerment and reduce internalized stigma.

Gaps in current research

Some gaps were noted during the literature review. A recent study in the city of Surrey claims that past traditional methodologies have excluded people who use substances from the meaningful aspects of developing research and have limited them to points of contact with other individuals who use substances. Jozaghi, Buxton, Thomson, Marsh, Gregg, and Bouchard (2018) claim to be the first study to employ a social network methodology in addressing the current overdose epidemic. Jozaghi et. al (2018) investigated the fact that the traditional methods, both qualitative and quantitative, do not engage people who use substances as researchers or collaborators due to stigma related to use. They propose a ‘community-based participatory action research (CBPAR)’ for the knowledge construction aspect of future research. Rather than using community champions as just individuals who seek out others with lived experience, they suggest that people who use substances be invited to all aspects of the research process, which includes research design, implementation, data collection, data entry, and dissemination of information (Jozaghi et al., 2018). This is done to ensure that outcomes reflect the true priorities and experiences of the affected population.

Current evidence indicates that diverse sources of information are needed to fully capture the complexity of addiction. Relying on just one source of information leads to significant biases and inaccuracies in the results shown (Souleymanov et al., 2016). Diverse sources of information that include self-reports, biological testing, CBPR, and qualitative interviews help add increased validity, reduce stigma in reports, and provide a clearer picture of the addiction as separate from the individual who lives with it (Berk et al., 2015).

Another gap in research is that there is limited research tied directly to the community of substance users in the city of Richmond. Eighty percent of the population is made up of visible minorities, and sixty percent are immigrants (Statistics Canada). Richmond is also a conservative community (Canadian Broadcasting Corporation, 2022), while there is a significant amount of research on the cultural aspects related to stigma, a look into the microcosm of the substance-using community in Richmond could bear relevant findings.

Looking at the context of stigma within the substance-using community, it is clear that reducing stigma itself is a complex yet critical aspect of helping reduce the risks associated with use. The literature review highlights the need for more research to address the role that stigma plays in the lives of people who use substances. As a result, a deeper understanding of stigma present in healthcare settings, public settings, and within the individuals themselves needs to be explored through effective research. This exploration is crucial for developing targeted interventions and policies that can effectively mitigate the adverse effects of stigma on individuals with substance use issues in Canada (McNeil, 2021).

Key concepts in a framework for understanding stigma and substance use

In response to the lack of substance use-specific stigma frameworks identified by Orpana et al. (2019), this conceptual framework draws on the literature reviewed to examine stigma at multiple levels. The framework focuses primarily on three forms of stigma: healthcare, public, and self-stigma, as identified by Davis et al. (2022). Drawing on Link and Phelan's (2001) conceptualization of stigma as a social process involving labelling and stereotyping, this framework identifies how stigma operates at a structural level in the lives of people who use substances, while addressing the dynamic that 'power over' plays as well in these interactions. It also identifies intervention points where stigma reduction efforts can be implemented.

This framework serves three primary purposes:

1- to map the multilevel nature of substance use stigma and examine relationships between structural and public, healthcare, and internalized areas.

2- to identify how stigma at different levels creates barriers to health and well-being.

3- to identify intervention points where stigma-reduction efforts can effectively disrupt harmful outcomes.

The framework supports Link and Phelan's (2001) social process model with the multilevel approach identified by Davis et al. (2022), while incorporating community-based principles from the City of Richmond's "Belonging Matters" training (2018), which emphasizes establishing shared understanding when addressing marginalization and stigma.

Table 1: Conceptual Framework of The Stigma Faced by People Who Use Substances

Area of Stigma/Concepts	**Reasoning**
Structural Context of Stigma	
The societal labelling and stereotyping that create an individual's unique view of stigma. Their thoughts on the labels that 'society' has placed on them due to their use of substances.	Establishes a shared conceptual foundation that the researcher can then use to try to empathize with the unique situation of the participant. It creates a greater understanding of how the participants' views on support have been moulded by structural stigma.
Area of stigmatization	
Perceptions of stigma in a healthcare setting: Experiences that individuals may have had at all types of healthcare settings, and how it affected their future attempts to reach out for support.	Develop an understanding of how participants who experience negative stigma in a healthcare setting, by learning of behaviours, words or experiences that may have been used against them in those scenarios.
Self-Stigma: The experience of the individual who uses substances themselves, and the labels they confer on themselves due to the structural stigma present in society.	Substance users themselves can struggle with internal stigma. This stigma can manifest itself in substance users being aware of the stereotypes present about them in society and agreeing with them. Self-stigma is dangerous because it causes users not to take part in crucial harm reduction strategies or not reach out for help when needed.
Public stigma: Referring to the perceived stigma that participants may have experienced in a social setting. This could include family settings, friend groups, as well as individuals coming together for the sole purpose of using substances.	Develop an understanding of how participants who experience negative stigma in a social setting by learning of behaviours, words or experiences that may have been used against them in those scenarios.
Stigma Reduction	
Healthcare level interventions: The participants' insights and observations on whether an experience in a healthcare setting helped them access care or think about their use in a non-judgemental way.	Develop an understanding of any behaviours, tools, or environments the participants may have experienced that could help reduce stigma in future healthcare settings.
Public level interventions: The participants' insights and observations about family, friends, or others that may have helped them reduce their use or practice harm reduction.	Develop an understanding of how social groups can impact stigma reduction and positive health outcomes for participants' use.

Self-stigma level interventions: The participants' insights into external influences on their own thoughts on their use and what can help others in their situation.	To understand if there is a common thread when it comes to helping individuals reduce the self-stigma they experience when they engage in use.

The first set of concepts in the framework addresses structural stigma in its various forms. Punitive drug policies, as well as cultural beliefs, can frame substance use as a moral failing, or even a personal choice, rather than a societal disease. (Kelly, et al., 2016; McGinty et al., 2020). Recognizing that experiences of stigma are subjective and can vary, the framework incorporates participants' own understanding and labelling of stigma experiences, following the approach used in the City of Richmond's 'Belonging Matters' training (2019), which emphasizes the importance of establishing shared definitions when addressing stigmatization.

The second set of concepts examines three primary areas in which stigma manifests: healthcare settings (including interactions with pharmacists, physicians, psychiatrists, and community organizations), public/social settings (encompassing family, friends, and peer substance use contexts), and internalized stigma (the individual's adoption of negative societal views). These levels are interconnected, with structural stigma creating conditions for public and healthcare stigma, which in turn contribute to internalized stigma.

Healthcare providers may hold negative attitudes towards individuals who use substances; they can mistrust their patients' motivations, even in cases where the individual is in need of treatment not related to their use (Biancarelli et al., 2019). Healthcare settings are also where individuals report being 'dehumanized' or receiving suboptimal care (McGinty & Barry, 2020). The stigma experienced by individuals in healthcare settings has been shown to lead to healthcare avoidance by individuals, which ranges from delaying healthcare to seeking

alternative sources to help self-medicate (Biancarelli et al., 2019), increasing the risk of related health complications, including overdose.

Another area in which the individual can experience stigma as a consequence of their use is in a public setting. Family and friends can place a considerable amount of pressure on the individual with the best of intentions, but waylaid interventions can often have detrimental effects. Understanding the stereotyping and discrimination that often happens against people who use substances in the context of public and social settings can be key in changing thoughts and attitudes towards people who use substances in our society. Public stigma can look like the false belief that people who use substances are dangerous and/or lacking self-control (Biancarelli et al., 2019). Public stigma can also materialize in strong NIMBY sentiment, which can impact community harm reduction services or public policy that may be beneficial for individuals who use substances (McGinty & Barry, 2020). It would be highly beneficial to understand the impact of public perception on the stigma experienced by an individual who uses.

A critical area of stigma found in the literature around substance use was internalized or self-stigma. Internalized stigma represents a critical dimension of the stigma process wherein individuals become aware of negative stereotypes about substance use, agree with these stereotypes, and come to believe that discriminatory treatment is deserved (Fraser & Treloar, 2006). A key piece of understanding around stigma is one of intersectionality and how self-stigma can impact perceptions of discriminatory feelings across all settings. The shame associated with internal stigma may drive individuals to use alone and dramatically increase their risk of overdose or worse (Papamihali et al., 2020). Understanding what messages are pushing individuals towards using alone can help reduce these high-risk behaviours.

The next area of focus is stigma reduction across the same three areas: healthcare settings, public settings, and internal settings. This area addresses positive protective factors that can be implemented to help reduce experiences of stigma. In the healthcare setting, client-first language focusing on respecting a person's choices improves the perception of care (Kelly, Greene, & Abry, 2021). This section will look at whether there are other behaviours or aspects of care that made individuals feel 'seen'. Replicating these behaviours across the healthcare system could lead to a large-scale reduction in feelings of stigma that individuals face.

When focusing on the public levels of stigma reduction, framing addiction as a medical or societal issue has been seen to influence attitudes towards people who use substances (Barry et al., 2014; McGinty & Barry, 2020). It would be beneficial to understand what stigma reduction through a public lens looks like, whether it be through an awareness campaign or a possible language change.

At the individual level, interventions focus on building empowerment and providing peer support to counter internalized stigma. Empowerment approaches that emphasize what individuals can accomplish rather than focusing on prohibition or restriction have shown promise in fostering self-efficacy without requiring elimination of stigma awareness (Corrigan, Larson, & Rusch, 2013).

Methodology and Methods

The study was conducted using a qualitative research design and used semi-structured interviews to explore the lived experiences of stigma among the people who use substances. The semi-structured approach was used due to the CBPR lens where the individuals were presumed to be experts in their own lives during the interviews. The 'stigma intervention' section of the interview guide was also created in this manner, 'Nothing about us, without us' (Jozaghi et al., 2018). Participants were interviewed one at a time, either in person, by phone, or via Zoom. An honorarium was offered to all participants through an e-transfer after the interview was completed. The interview questions focused on the participants' views on stigma, their experiences of stigma in healthcare settings, their experience of stigma in public settings, and their experiences of self-stigma. The participants were also asked for their recommendations on how to reduce stigma. The UVIC ethics department approved the questions. The HREB approval certificate number for this research topic is: 25-0078.

Research Design

A qualitative research design was used for this study since the topic of stigma can be broad and complex, yet incredibly subjective based on the individual who experiences it (Clingan, D'Ambrosio & Davidson, 2023). The qualitative approach enabled the study to capture the complex and nuanced perspectives of the participants through semi-structured interviews (Selseng et al., 2021).

Semi-structured, exploratory interviews were chosen for this study because they could uncover unanticipated information, issues, or ideas that the researcher may not have considered. This could lead to new avenues of exploration, which would be allowed due to the flexible format of the interview structure itself (Cohen & Crabtree, 2008)

Once the interviews were completed, the data was analyzed to understand the impacts of stigma on individuals using substances and their experiences of stigma in different areas of their lives, as directed by the literature review. A thematic analysis was also completed to compare the literature review and interview findings. The individuals' recommendations for combating stigma were also analyzed.

Research Procedures

Sample

Eleven semi-structured interviews were conducted. All were completed one-on-one. Five were held in person. One was held over Zoom. Five were held over the phone. A live transcription application was used during the interview to transcribe what was being said, and notes were taken throughout all interviews. All data and recordings were stored on an encrypted file on the researcher's desktop computer. All participants were selected by word of mouth.

The target population was individuals who have engaged with substance use within the city of Richmond. The goal is only to collect data from these individuals about their experiences. The population group is directly related to the topic of understanding the needs of people in Richmond community and reducing stigma around their substance-using. Inclusion criteria: Anyone 19 and over who has experience with using substances in the city of Richmond. English speaking.

- Exclusion criteria: Anyone under the age of 19. Anyone who does not have experience with using substances within the city of Richmond. Individuals who do not speak English.

The substance-using community in Richmond congregates at specific physical locations. As part of his work, the researcher is aware of these locations and knows a few of the individuals who are part of the larger community that uses substances. The researcher approached two of

these individuals and asked them if they would be open to participating in the study and if they knew any other individuals who would be open as well. The researcher gave the initial two participants his email and phone number, as well as physical copies of the invitation letter to pass on to other interested individuals. Six individuals reached out to the interviewer, and consent forms were sent after the initial conversation, during which clarifying questions were addressed. The invitation form was sent with the consent form, and the date of the interview and the method by which it would be held were confirmed. At the end of each interview, the participants were asked if they knew anyone else who would be a good candidate, and through this method, the last four participants also followed. After all the interviews were completed, the researcher asked the participants how they wanted to collect the $25 honoraria. Six selected an e-transfer, and the two in person said a coffee would be all they needed. The last three said they did not want it, and just sharing their stories was enough.

One of the limitations of this study is the smaller sample of participants interviewed for the thematic analysis of this paper. The aim with saturation was to instill confidence that the themes identified in any new data would not produce new categories (Glaser & Strauss, 1967). Hennink & Kaiser (2022) found that most datasets they reviewed in their systematic review reached saturation between 9 and 17 interviews, despite using different approaches to assess saturation. Similarly, Guest, Bunce, & Johnson (2006) published an article stating that theme saturation could be reached within 6 to 12 interviews. Although it is felt that the interviews conducted did illustrate saturation, the research is exploratory in nature with a smaller sample size and will require using a larger sample to encourage further research and practice.

Another limitation that was discovered during the coding process was that a majority of the individuals (8) who were interviewed were all further along in their recovery journey regardless

of the substance they were using. The interviewees would fall either in the ‘action’ or ‘maintenance’ stage if we were to use the six stages of addiction recovery as a model (*Transtheoretical Model of Change: The Cycle of Addiction*, n.d.). It is plausible that the responses, and recommendations could be different if the majority of interviewees were actively using at time or even in the relapse stage of their journey.

Design of Instruments

Implementation of the conceptual framework, the interview guide for this project focused on asking participants about their first-hand experience in areas related to their experience of stigma as an individual who uses substances, their experiences and interactions with members of the public, their experiences and interactions with medical and health professionals, and their thoughts on stigma-reduction initiatives. For example, participants were asked to describe an experience where they believed they were stigmatized when receiving care at a clinic. Participants were also asked to provide an example of a positive interaction with a medical professional. In addition, participants were asked to provide suggestions on how overall stigma towards people who use substances could be reduced in larger society.

In each area, the interview guide (Appendix B) included open-ended questions where the participants were asked multiple questions about how stigma impacted them. Interview questions were divided into the following sections: introductions, their experiences of societal stigma, their experiences of stigma from friends and family, their experiences of stigma from the medical community, their thoughts on internal stigma, and their thoughts on reducing stigma going forward.

Most sections of the interview followed a similar series of questions: What are some positive experiences you have had in said area? What are some not-so-positive experiences you have had? What were some of the feelings you were going through? And going forward, what can individuals do or change in their behaviour or words to ensure that future interactions are neutral or positive rather than negative? For the topic area of stigma reduction, the example of the, 'Stop Overdose' ad campaigns run by the province of BC (*HelpStartsHere*, n.d.), that consisted of ads on buses, on the radio, among other public spaces that represented photos and actor portrayals of people who use substances that featured the tagline "people who use drugs are 'real people'". The rationale for using the same example across all the interviews was to give the participants a common primer to begin speaking about the area, and they could then branch off to any other experiences they may have had.

Each interview consisted of approximately 13 questions and lasted between 40 minutes to an hour. A few were shorter, and a few were longer. Due to the personal nature of the topic, a few of the participants' responses strayed from the question at hand, but the core theme of the area we were speaking about was always present. Interviews were conducted between May 2025 and November 2025.

Method of Analysis

A grounded theory methodology was used to analyze the raw data, employing thematic analysis based on the conceptual framework. The grounded theory methodology was used as a way to reduce the researchers' preexisting biases with the subject matter of the project. By using this methodology, the focus would be to glean a theory from the data rather than starting with a preconceived hypothesis (Glauser and Strauss, 1967). The data was then coded to find themes within common responses through thematic analysis. Thematic analysis is the process of

searching through the data to identify themes or patterns that arise and eventually build these themes into a theory (O'Leary, 2017, p. 712). The analysis followed a hybrid approach that combined inductive and deductive coding strategies (Fereday & Muir-Cochrane, 2006). This dual approach allowed for a theory-driven examination of individuals' experiences of stigma, while also leaving space for emergent themes grounded in the participants' lived experiences.

Interviews were conducted in person, by phone, and via Zoom. Interviews were transcribed using a Live Transcribe app on the interviewee's phone. Notes were taken during the interviews, highlighting items of interest. After the interviews, the transcripts were reviewed to further understand the data and edit any errors that may have happened during the transcription process.

The transcripts were coded using the Coder application, a computer program that is used to help with sorting qualitative data for future analysis. Several rounds of coding were completed to fully identify the themes present within each area from the conceptual framework. Each area had themes coded, and both the positives and challenges that the individuals faced were identified. Recommendations for improving their experiences were also gathered.

Interview responses were manually coded within the Coder application. Some interview responses were double-coded. For example, *"You know what, we are doing it to ourselves. How can I expect them to have that much empathy for me, right, in that kind of situation from their perspective? The person that's thinking that hospital bed that actually just got into an accident? And they really need help, and then he got this junkie that needs some help in the corner, what's the doctor going to do?. They know they're getting scammed by junkies all the time. They're like, could I come in and get a script for some, like, painkillers, right? How do you win that battle? How do you stop that?"* was coded as 'self-labelling' and 'Internalizing others' judgement'.

Strengths and Limitations

Limitations.

This study has its limitations. The generalizability of this study is limited as the sample size is too small to represent the larger group of people who use substances in a meaningful way. While the request for participants in this study was distributed as widely as possible, most of the participants were on their recovery journey, with only three participants actively using at the time of the interview. Being in an active addiction is starkly different than any of the other stages on the substance use spectrum (Health Canada, 2022), and the depth and quality of the responses were apparent to the researcher. When looking at access to the interview, only individuals who frequented the common meeting spots for people who use in Richmond would have received the recruitment flyer, and only those with access to a computer and email would have received the recruitment email. As a researcher, I only speak English. Richmond is home to a majority of people who speak a different first language, and by not including Asian speakers in this study, I was not able to capture a true representation of the community of Richmond substance users. As a researcher, I found it hard to take notes while listening to the stories that the participants shared. I often found myself struggling to break eye contact or write down a point of interest while the person across from me was sharing an intimate and sensitive experience that they had. Personal biases could also have affected the data. Time and capacity restraints also limited the resources available to fully study the topic since only a limited number of participants could be interviewed and compensated for their time.

Strengths.

This study could help fill a gap in research on the location-specific experience of people who use substances in the city of Richmond. The semi-structured interview format allowed the

participants to use their voices and share rich data for the project. Collecting detailed information helps understand the needs of a marginalized segment of the population, that could provide insight for local organizations or even the local health authority. While the findings are limited in their generalizability, they could help shed light on a path for further research, and the suggestions gleaned from this study could be used to enhance the experience of people who use substances in the future.

Findings

This section presents the findings based on the interview guide that was derived from the conceptual framework. The findings are organized into six major areas and are discussed below. The six themes are participants' language and labelling, understanding of stigma, stigma across the health care system, stigma across public settings, internalized stigma, and stigma-reduction interventions. When reporting the findings, this project used the key below (Table 2) to refer to the number of participants who were included within each area.

Table 2: Key for Results

Word Used	Number of Participants
One	1
A couple	2
Some	3-5
Many	6-8
Majority	9-11

Language and Labels

Each interview began with trying to get the participants' understanding of what stigma really means to them. A story about a Richmond based substance user named Guy Felicella was used as a common starting point for all the interviews. Guy is a person from Richmond who used substances for thirty years. He overdosed six times during his active using years, has managed to ‘escape’ the grip of addiction, and is now a community champion and speaker for mental health and addiction supports (Felicella, 2025). Guy has tried to combat the stigma by trying to take back the word ‘addict’; he believes that people who use are addicts, and nothing can change who they are.

While the responses of the participants were split on the use of the word ‘addict’ to define themselves, all ten spoke to the importance of language used to describe people who use substances. The central themes that emerged from the interviews were around either the acceptance of the label of ‘addict’ or other verbiage with ‘harsh’ connotations, the outright rejection of any label placed on the individual by the larger society, a strong preference for client-first language, and the individual's autonomy being paramount to all.

Table 3: Language and Labels Themes

Feel I am being judged and have no choice (10)	• *It is up to the individual who has the lived experience to decide what language looks like for them. I don’t use ‘addict’ for myself.* • *I definitely think I view lot of the language around addiction is the same way I view a lot of racialized language. It's up to the individual to decide what best fits that. I personally am comfortable self-describing myself.* • *Have a conversation with me about why there could be concerns, and then give me the autonomy to decide*
Feeling of being defensive (9)	• *They don’t see the person you still are underneath it all. They just hear ‘drug addict’ and everything else disappears*

	• *when they talk about 'those filthy addicts'…Am I supposed to feel guilty…it makes me so immediately defensive*
Feeling of being dehumanized (6)	• *I don't know how to explain to people that we're all human beings and that people inherently have value. So sorry, even inconvenient people.* • *I can see my Humanity In my addiction, but then people will treat you as the whole as the symptom.* • *It feels like you're getting put back in a box all the time, even though you're like, that's not who or what I am*
Rejection of generalizing labels (5)	• *I would never consider myself a junkie, or I would never consider myself an addict, even though you know I was using heroin, but at the same time, I would also pride myself on the fact that I wasn't an addict.* • *I respect guy's work. I love what he does and … all his work is based around that self-identification as an addict, and he's comfortable with that word. Yeah, for myself. I, I don't identify as an addict.*
I embrace the 'Addict' label (4)	• *I would refer to myself as an addict, even though I'm in recovery now. …Those who followed the 12-step model… it's very common that you're always an addict, just in recovery.* • *If someone called me an addict, I don't take offence to that, but because I don't see the stigma attached to it, but someone else might*

As illustrated in Table 3, participants expressed that there is no single correct way to refer to someone living with a substance use disorder. All the interviewees stressed that while they may have personal opinions of the labels that society, or they themselves use, they did not speak for the individuals in the community at large. A shared theme among all the participants was that they felt that individuals were being judged and that they did not have the choice of what they are called comes first. A participant noted that it is up to the individual to decide what they want to be called: "It is up to the individual who has the lived experience to decide what that language looks like for them... Shared lived experience does not mean shared representation."

One participant was adamant that an addict is not a victim and that addicts have the autonomy to do what they choose, *"It starts here. The addict is not a victim. You are not a victim, that's a powerful one..sure, we have this addiction…but we're not victims"*. Another likened addicts to 'anarchists' of sorts, *"we're anarchistic. Don't tell me what to do...we aren't going to listen to some counsellor that's got book smarts that has a PHD, that's for sure. I am not talking to you unless you've been on the streets and done what I've done and seen what I've seen. You haven't identified with me"*.

A couple of participants spoke to individuals in the community who would not get help if it were not on their terms. They gain a sense of *"power"* about being known as individuals who use and can also *"keep up appearances of being part of society"*.

A second theme that most interviews touched on was the overall impact of stigmatizing language and labels. Participants were well aware that certain terms carry heavy stigma. Words like *'addict', junkie', 'drug user'*, especially when used in a judgmental way, can be reductive as a whole to the individual who hears those words; there is more to an individual who uses substances than just their addiction. *"They see 'addict' or 'junkie' before they see you as a person. Like all your other qualities… just disappear"*. Participants said that hearing labels like these made them feel 'written off'. Many shared that the word 'junkie' was particularly hurtful because of the implication of a failure of morals rather than a health issue. Some participants spoke to the internalizing of stigmatizing labels (to be discussed further on in this section), demonstrating just how powerful the words themselves can be.

Many participants advocated for humanizing and person-first language as the third theme in the interviews. An example, such as "someone who uses substances," was put forward because it focuses on the behaviour rather than the person as a whole. "It is up to the individual who has

the lived experience to decide what that language looks like for them...*shared life experience does not mean shared representation… in a peer space, remain neutral"*. Many of the participants saw person-first language as a way to see the person behind the struggle.

The word, 'Addict' itself was an interesting topic during the interviews. Five of the participants entirely rejected the 'addict' label on themselves, and five accepted the label and self-identified as addicts. Some participants outright rejected the label of 'addict' on themselves or on other individuals who use substances. *"For myself, I don't identify as an addict. ..some people that are currently using substances really aren't fond of that terminology.. it's not a term that I use personally, nor do I use it professionally in any way at all."* One participant agreed that they were an addict at one point in their lives, but not anymore, *"Hey, I was an addict…I'm no longer an addict."*

Just as many embraced the label, *"The principal being those who have followed the 12 step recovery model realistically that it's very prominent on the idea that you're always an addict, or you're always an alcoholic". "If someone told me an addict, I don't take offense to that, but because I don't see the stigma attached with it, but for someone who wouldn't have followed the same way they might."*

Regardless of whether the label of 'addict' is seen as stigmatizing or not, all the participants rejected labels being placed on them by others, *"What I object to is other people labelling me without my input…. or when society decides what I am - that's when language becomes a weapon."*

Understanding and Awareness of Stigma

Participants were asked to define stigma in their own words. Participants consistently described it as being reduced to just their worst behaviours. The described being stripped away of their dignity and made to feel less than. A few of the participants noted the cultural aspect of stigma.

Table 4 – Themes Related to General Stigma

Stigma as 'We are not human' (10)	• *Like we're less than human… they treat us like we're disposable, like our lives don't matter* • *They would just assume that I wanted drugs, not that I was there for help*
Stigma as Prejudice (10)	• *people that use substances they're mentally ill …People that use substances are not to be trusted, or probably out stealing from you and your children.* • *They are a lot of the times they're subject to abusive language…I think when you deal with a type of person consistently. Sometimes you automatically assume the next person is going to be exactly the same.*
Stigma because of malice and ignorance (4)	• *With stigma, it might not necessarily be malice. It's just because that's what you're taught.* • *Stigma is a preconceived idea of people, by society at large. It's, I wouldn't say lies, it's not knowing what's actually going on, it creates a negative concept of either the people, culture, or a system.*
Stigma because of culture (5)	• *I think a lot of stigma is linked to cultural aspects, most of the time. Most people in recovery were white…. you would see white people in the rooms. I'm originally Pakistani and I'm Muslim and so you know the amount of Muslim people I would see in recovery or trying to get recovery is very, very low, because of stigma.* • *I think education is always the key around it. It's usually the family's worried about what are people going to say and that's one of those things that is prominent in Asian cultures.* • *In the population of Richmond…when you talk to about addiction in the Asian community or awareness of mental*

	health, I just think that there's just a lack of understanding, or empathy for it

When speaking about the participants' feelings of experiencing stigma due to their substance use, all of them emphasized that stigma feels like they are 'boiled' down to one all-defining characteristic, their substance use, "Stigma is being reduced to your worst moment…and having that define you". A sense of dehumanization was also experienced in interactions with people in public, "people moving when they see me coming", "treat us like our lives don't matter". As shown in Table 4., the theme of identity reduction also came up while participants noted that stigma entails being seen as just an 'addict' and not as a whole person. While some participants could not easily verbalize what stigma was, all participants noted feelings similar to dehumanization and identity reduction.

When exploring the subject matter related to participants' awareness of the stigma around substance use, Table 4 also captured themes of prejudice and pre-judgment expressed by all participants in their interviews. Comments made by the participants involved assumptions being made about them prior to any significant interaction, or judgments being made when knowing only one aspect about the participant, their substance use: *"they don't see you as someone struggling with something; they see you as the problem itself."* The interviews alluded to the fact that there is a stereotypical image of what an 'addict' looks like in our society, and that image is imposed on all people who use substances, regardless of the person's actual character or circumstance. *"The person treats you shitty because of the situation you're in. It's just like they're just, you know"*. Common false assumptions such as people who use substances being *"lazy", "untrustworthy", "morally weak", "animals", "criminals", "dirtbags",* were mentioned in all interviews in some part. Many participants said they felt as if assumptions were made about

them and the type of person they were, almost before they could walk into the room. The theme of prejudice that was put forth from the interviews captured how our society views people who use substances, as a type of failure, a note that many of the participants also labelled themselves when they used.

Another theme that stood out when discussing participants' views on stigma was the distinction between ignorance and malice in the general population. Some participants identified a lack of understanding about addictions as contributing to the stigma against people who use substances rather than outright malice. Participants felt that people who may not have experienced an addiction in their lives would rely on harmful stereotypes to help them shape an idea of what people who use look like. One participant's quote regarding this stood out, *"A lot of the times stigma is ignorance, with stigma, it might not necessarily be malice. It's just because that's what society has taught you."* Another participant said that *"Judging a specific group of people without any actual exposure to them, or speaking to anybody and you make that that judgment based on it."*. This perspective that was held by many of the participants aligns with their later suggestions of education being one of the ways to reduce stigma in society. A participant noted that stigma is *"just human nature in a sense",* implying that if people do not actively work on their own prejudices and empathy, we can all become desensitized or judgemental over time.

Many of the participants self-identified as being Asian or South Asian; because of this, the cultural aspect of stigma was also a notable theme that came up in the interviews. A few participants noted a lack of representation at local AA (alcoholics anonymous) groups, *"I think there's a lot of cultural stigma, I'm still active in our Anonymous group…..and if I look at What the ethnicities that would attend…it's very different than Richmond"*

Participants described having expectations in their cultures about being ‘good’ members of society, and the shaming that they experienced when addressing their substance use. A participant noted that when their substance use became known, the reaction from family was *“what will people think? rather than how can we support you.”* Another participant said that there was a sense of *“letting down my parents…and the disappointment”* coming across in a sense of letting down ‘your’ community. A participant also mentioned that friends from similar cultural backgrounds told him that *“you’re hurting your family,* reflecting that for immigrant cultures any harms from their substance use affects the community’s branding at large rather than just the person using themselves. Another participant noted a lack of the Asian population in recovery houses in Richmond*, “the fear of you know judgment from that perspective, even when it comes to Asian people, you very rarely see Asian people in recovery. It's not because addiction is not a thing in our cultures, it's just the fact of the stigma”.* This theme underscored that stigma is not a monolith but has considerable nuances from individual to individual and community to community.

Public Stigma

When discussing the public or societal stigma that participants felt during the interviews, the themes around familial shame, loss of friendships, social network erosion, and larger community denial of use were brought up. Many of the participants described feeling ‘othered’ during their experiences with the public.

Table 5: Public and Social Stigma

Shaming of family (8)	• *It really affected me super greatly… definitely family…my family, where my mother knew, but kind of chose to turn a blind eye*

	• *I was using for a decade, and it should have been glaringly obvious to anyone* • *Knowing that my family knew …and didn't want to have conversations about it….felt very isolating,*
Friendships eroding (7)	• *So, my friend group started to drop off because there's this bizarre Behaviour. Like, why is ___ high on a Tuesday afternoon? What's happened in here, right? I didn't have any friends who looked at me without stigma* • *I would have friends be like, 'Can you like, not drink for me, just so that I know that you're, okay?' They were speaking more from a selfish perspective where…you have to do something for them*
New networks of peer users (4)	• *I found myself with a completely different social circle of folks who were substance users.* • *I just had a new best friend and places that we were going….and then just started using without having to go out … because why would you drink and then just go out* • *When they found out that I was in an act of addiction…I got the silent treatment… they were dismissive…I was not trustworthy…They didn't really want to be around me, and it was so isolating.*
Public Discrimination (4)	• *We push these individuals into modular housing, minimize their voices when they actually speak... They're going out there, and they live in tents…. They're making a mess, and they want to, you know, openly use on the streets* • *They think they're getting scammed by junkies all the time. …how do you win that battle? …look at them like dirt bags really.*
NIMBYism (4)	• *In Richmond, somebody needs to do like a massive public education, stigma, just like, seeps through just everything and everywhere…* • *It's because addicts are really crummy or shitty….people that usually bring the stigma on that say….they ruin my neighbourhood and breaking into cars. We should lock them up until it affects their family or someone they love.* • *Social problems don't happen here (Richmond)….if an addict exists, they're from Vancouver. But most of the addicts I've met… have been from Richmond….* • *Just bring back some Humanity to people and try to figure out because Richmond's been tough….but there's a very vocal minority of people who show up and yell and scream, and it's been rough*

One of the main themes that contributed to the area of public and social stigma for people who use substances is the theme of family shame. Many of the participants recounted painful experiences with family members when their substance use behaviours were disclosed to family members, willingly or unwillingly. Many participants described relatives responding with disappointment, shame and a few with rejection of the individual. One participant spoke about their sadness turning into resentment against a family member that did not address their use, *"and there's this secret that we're not talking about … why isn't she saying anything to stop it, you know? Yes, I'm an adult, but why isn't, why is nobody telling me? Hey, stop, this alright. That one's been really hard."*

Anger and silence were reported more frequently than support. Stigmatizing actions and conversations were reported in many of the interviews, and participants shared similar stories of being excluded from family gatherings. One participant heard from both family and relatives that *'you're hurting your family…..you're tearing this family apart'*. One participant touched upon there being preexisting conditions within families that they will not address, which added to their sense of familial stigma, *"I think you don't want to know when it comes to family. A lot of them are also sick …and they don't want to admit that he's a junkie or drug addict"*.

The messages from family were almost blaming the individual as well as shaming their actions. Overall, familial stigma would lead relatives to often distance themselves from the individual, which ironically left the participants more isolated and drove them to more substance use.

Closely tied to familial stigma, many participants also spoke to experiencing stigma in their friendship groups that led to a sense of social network erosion. Participants described close friends *"never saying anything directly…just slowly disappearing"* in all cases where the

participant noted friends pulling away, feelings of abandonment, and loss of support closely followed. Some mentioned that no one called or invited them out anymore, which also reinforced the idea that they were being abandoned due to their use, *"And I don't think I really noticed at the time, but once I was in an absolute substance use disorder state. Yeah, I, I do remember, just kind of reflecting and feeling absolutely abandoned by people. And, yeah, just completely worthless"*. Another participant also spoke to a sense of isolation and abandonment by friends, *"I got the silent treatment… they were dismissive…I was not trustworthy…They didn't really want to be around me, and it was so isolating."* A couple of the participants also mentioned that friends helped exacerbate familial stigma by saying*, "You know what you're doing to your family, right? You know what you're doing, your mother and father, right?" or, "You're hurting your family. Not that I'm hurting myself."*

Participants also mentioned more subtle behaviour changes in the individuals that did not leave, from a visible change in behaviour to overcompensate for any internal feelings, *"The worst is when people try to be nice but you can tell they pity you…that's almost harder to take than straight-up judgment"* to some expressing a morbid curiosity that would feel like a violation of the participants boundaries*, "someone will be like, oh have you ever like sold your body to do?...did you talk to gangsters to get your address"*. Many participants used the words *'alone'* or *'lonely'* when speaking to their loss of friendships during their times of substance use.

A third theme related to the topic of public stigma was that some participants created new networks related to their substance use*. "Friend groups completely shifted and changed". "I found myself a friend…who eventually turned into a friend that I only used with…and down the road that's all we did together…but at least they were there."* Participants expressed struggling with trying to get help for their use because it could have isolated them from this new social

network and left, *"it almost feels like an empty sort of fulfillment…we started using together, and then all we were doing was using together"*.

A fourth theme related to public and social stigma that participants spoke about was the stigma and discrimination received from members of the general public. Some participants shared incidents of discrimination by strangers, neighbours, or community members, *"People cross the street when they see me coming. Store owners watch me like I'm gonna steal something…"*. Participants also mentioned experiences of feeling like they were under constant surveillance. Some of the participants shared their feelings that Richmond is a close-knit community, and it would feel like once people knew of their situation, there would be 'whispers' anytime they were around. Some participants noted that there is a certain 'threshold' for stigma based on the substance being used. *"Alcohol and tobacco are totally fine, even though you can get addicted to alcohol or gambling, which can be just as bad"*. Participants seemed to think that the substance you were addicted to affected the 'level' of stigma you received from the general public.

Many participants spoke to the stigma on a community level, particularly the climate towards people who use substances within the city of Richmond. Participants felt that Richmond has a strong Not in My Backyard (NIMBY) stance when it comes to addressing mental health and addiction issues. A participant with insight into local services explained that Richmond is a relatively conservative community that often denies it has a drug problem. They recounted a recent incident where just proposing a survey about opening a supervised consumption site sparked intense public outcry, *"it was five days of people just yelling at council"* in opposition, with extreme reactions such as residents saying, *"I'm gonna stab myself with a needle if you put [a safe injection site] by my kids"*. Another participant sarcastically noted, "addiction? *We don't*

have that here…Richmond's too good". Some participants noted a cultural and language divide in Richmond, *"I think that there needs to be A lot invested, especially in Richmond. Yeah, there needs to be a massive investment in education and understanding, because there's this real cultural divide, and there's also a real language barrier.* And *"Flyers were targeting the Chinese community in Richmond it said the addicts are coming for your home like you're gonna die".* Many of the participants noted a lack of treatment centres and harm reduction organizations present in Richmond, with many of the participants having to go to downtown Vancouver or Surrey to get more intensive care for their addictions. "*In Vancouver, we have everything from …For people in Richmond, we don't even have like daybeds".*

Healthcare Stigma

Participants were asked to speak about their experiences with experiencing stigma from the medical community. Themes such as being treated as unworthy, judgemental communication, negative body language, and avoidance of future care were raised. Participants also shared experiences where they received care that was compassionate of their situation.

Table 6: Stigma in Healthcare Settings

Treated as drug-seeking/unworthy (7)	• *I had this comprehensive psychological assessment... All the recommendations were for stimulant medication. And my doctor completely shut it down... 'Absolutely not. You have a history of substance use disorder. We can't go down this road.'* • *He heard literally what I said, and just kept going on with what he probably thought was a script that, oh, here's another drug addict asking for help. I didn't want medication. I didn't want anything.* • *I had a client who had second-degree burns down his arms I had to take him to ER, he was a 83-year-old man…they would not give him painkillers*
Judgmental communication (8)	• *She suggested that I go jogging.* • *That doctor was actively stigmatizing me for having used substances. She could have explained to me that there could*

	be side effects with this medication …but because the stigma was there. It was an absolute no, and the door was shut, • *I had one doctor tell me that I had moral issues, like 'you have bad moral issues, you need to...' and I forget what he told me to do, but I had already basically started raging in my head* • *I would say there's always judgment, or maybe not understanding, where I'm coming from, or why I used to drink so heavily*
Negative body language (7)	• *I mean, she just looked at it. She was shaking her head. And you know, she had her lips pursed really tightly? It was just like, absolutely not. Like looking at me like I was crazy for even suggesting such a thing.* • *The person up front literally looked at me and kind of just took a deep breath immediately. I felt the energy…why are you judging me already?*
Stigma leading to avoidance of healthcare (7)	• *There's so much internalized stigma for myself…in how I perceived the initial stages of my substance use… so I didn't reach out* • *In the medical settings, it's very common to hear that given your history of substance abuse, I don't really feel comfortable giving you this medication or helping you in this way or because of this*
Compassionate Care (6)	• *It seems so simple, because I feel like they're treating you as an individual and like your use as something separate rather than being labelling you as one.* • *I had a doctor whom I was trying to lie to about…. So, I could help with my withdrawals from opiates…the individual caught on to my story and asked me about three or four questions, …and when I finally opened up in a vulnerable place…I felt alright.*

Many participants had experiences where healthcare providers assumed that they were seeking care only for drugs rather than as patients in need of medical care. This often led to their issues being undertreated or ignored. One participant shared their experience of seeking entry into a methadone program, and the doctor responded to their symptoms, saying, "Well*, that's what happens when you use stimulants"*. Another participant recounted going to multiple walk-in

clinics for help with their opioid withdrawal and being dismissed by one doctor, who told them that the problem was 'moral issues'. Participants felt that the medical professional saw them as addicts first and saw their health issues second, if at all. *"I've had experiences with doctors. They don't give you the, you know, they just treat you like crap in the hospital or something you're going in there for a detox, and they just treat you like an animal, which you know they see a lot of it"*. Even after years of being in recovery one participant that went in to a hospital for a nosebleed, "About five years ago my nose started bleeding, ended up the hospital...It was just profusely bleeding…. As soon as I said deviated septum. The person up front literally looked at me weird".

Nearly all participants who spoke about healthcare stigma, gave examples of medical professionals communicating in a judgemental or demeaning way. *"He writes a prescription but then goes on this lecture about 'lifestyle choices' and how I need to get clean before anything else matters. Like, dude, I know all that – I just need my arm fixed right now"*. Statements like these often made the individuals feel like they were being judged for their use. *"Two hours later, the Doctor comes in and is very dismissive. He said, 'These things happen, right? So, like, you should take care of yourself better. Maybe you know, like, you should try not putting things in your nose?"* A participant recalled a doctor telling him his 'morals' were at risk while essentially turning him away. A common feeling was that the medical professional was talking at them and not with them. This also included asking questions that the participants felt were irrelevant to the situation at hand.

In addition to language, some participants observed what they believed were subtle, and in some cases not-so-subtle, nonverbal cues from medical professionals. Participants described body language, facial expressions, and tone of voice when recollecting their experiences, *"His*

whole posture was closed off… arms crossed, leaning away from me. His face had this expression like he smelled something bad". "Their whole demeanour changed, she stepped back from the desk that I was leaning on once she heard why I needed help".

A critical theme that was discussed due to experiencing stigma from medical professionals was the avoidance of seeking further care or not being fully honest with care providers. A majority of participants shared at least one instance of them either not seeking further care for their needs or not being fully honest with a medical practitioner. A participant noted that they felt *"way more hesitant to seek help when I need it"*. Another participant noted that stigma *"literally prevents people from getting help".* Several participants linked stigma directly to future negative outcomes, one participant noted that earlier in their journey they tried to get help but felt so stigmatized and uninformed by providers that they relapsed and avoided doctors for a long time, *"a lot of it's more like a sensitive defensive, like, backed in the corner kind of things, I know, I need help. I'm trying to get help. I know that in this person's opinion, and like their recommendation, right now is being biased…they're not even being subtle. This person's recommendations are being biased based on an idea of what they think my substance use or my previous history of addiction looks like, or what they think anyone's addiction looks like, and it's actually not relevant to my needs at that moment. Why would I go back?"*

Many of the participants shared positive healthcare experiences that were stigma-free, in contrast to their other experiences. "*I had a psychiatrist who was like, 'If you engage in hallucinogens, you have a recorded history of schizoaffective disorder that could trigger that, just so that you're aware.' Very like, just information-based, not necessarily dictation."* A participant shared that an interaction they had with a medical practitioner who treated them if they had some other chronic health condition, *"I went through the detox program... I actually got*

to see a counsellor there, a free counsellor who made a huge difference for me. I got to do free acupuncture to help with cravings... being treated like a human and learning about the disease, learning about the element that you have. It would be similar if, honestly, it felt like if I was diabetic, then I was going to a dietitian". Another shared their experience of accessing treatment without judgement, *"I had an amazing experience there. I think I got treated with care with kindness. I didn't feel judged. I went through the detox program".* Commonalities among all positive experiences were being treated with respect and a sense of normalcy, the provider taking time to listen, and, when substance use was discussed, appropriate medical care and information were provided without bias. A participant shared that a nurse practitioner, *"asked about what I use, but it was just part of the whole intake…same tone as asking about allergies… she actually listened to my issues and treated me like a person…".* Participants shared being respected and treated as a whole person, which greatly increased the chances of the participants going back to the same doctor for future care. *"Tell me what I can do, not what you can't do for me."*

Internalized stigma

All participants not only faced external stigma but also struggled with internal stigma through believing society's negative views about people who use substances, as well as their own perceptions of self-worth because of their use. All participants spoke on themes related to self-worth, many spoke on internalizing other people's judgements, hopelessness, thinking of themselves as failures, and a loss of self-confidence. Many also spoke about self-stigma as a barrier to reaching out for support. Many participants also noted a hierarchy between individuals within the substance-using community that also contributes to internal stigma.

Table 7: Internal Stigma Themes

It is all my fault (10)	• *Yeah, I felt pretty, pretty worthless and pretty incompetent. And yeah, it was pretty bad.* • *Like when I was using, and when I realized that I couldn't stop, the self-loathing and hatred and shame was just insane. Yeah, it was such a heavy weight.* • *Ego is a big part of addiction, and that can manifest itself in many ways, you know, there's a traditional sense where people think that they're better than everybody else. But there's also moments where we think that we're worthless.*
I am inherently bad because I use (8)	• *It created a deeper and darker sense of myself and gave me the stigma that I was not worthy…. I wasn't worth friendship or attention.* • *Where did I come up with this concept? That I'm such a piece of junk, …I got that partly for my father, my mother, through my own experience and through family members,*
Hopelessness (7)	• *And when she shut it down, I felt I was just really hopeless* • *When are people ever gonna let this go, like, is this going to be something that's going to continue to affect my life? And I had like it created like a pretty dim outlook for myself.* • *I really believed that…I'm just gonna die in this situation? I'm never gonna get out of this, like? This is how I live now.* • *I've had experiences with doctors…they just treat you like crap in the hospital or something, you're going in there for a detox, and they just treat you like an animal*
I failed because I am an addict (4)	• *A whole lot of remorse for having ever used stimulants in the past because it was, like, wow, here's one more thing, like, I'm being punished for doing this thing that I've really worked hard because I used stimulants in the past* • *I just got a little fender bender, wasn't my fault. But I would contribute that to being an addict, any kind of bad luck, anything that would happen. I would immediately contribute to the fact that I'm a drug addict. This is what happens to drug addicts.*
Loss of identity and self-confidence (4)	• *But I gave myself trauma, telling myself that I was less than… I created my own trouble. Well, you'd have to break that identity of a person in addiction…which is hard.* • *And then I realized, I just didn't even know who this person really was anymore. I don't know why am I here?*
I do not deserve support (4)	• *I started creating this stigma around myself that, well, yeah. I use drugs, so, of course, nobody wants to talk to me. Of course, my family's not going to want to be a part of me* • *Because I'm an addict, I can't do this*

	• *My addiction was 'lighter,' do I even have the right to get support? Or speak for other people who have had much worse experiences?*
Hierarchy within the substance using community (7)	• *People who use cocaine would absolutely never think in a million years that they would be smoking fentanyl or injecting fentanyl... even within folks who are just kind of out there on the street using all kinds of substances* • *I have clients that will really openly talk badly about people that are in the same situations as them.* • *We should be supporting each other, not creating hierarchies and judging each other, probably because we've internalized all the external stigma. We turn on each other instead of standing together.* • *I know, one person uses in the car, the other person on the corner, but they're both doing the same thing….or like one person's employed, while the other person's like panhandling and there seems to be like a hierarchy there*

All participants talked about either self-blame or a sense of worthlessness when talking about their use, *"addicts are always always hating their life and not wanting to use. But it goes in and out, right. Our minds play tricks on us and tell us things that are not true."*

They talked about believing the worst about what larger society said about themselves. *"sometimes the worst part is when you start believing that stuff about yourself too"*. A majority of the participants spoke of feeling *'less than', 'not worth anything'*, and *'like an animal'. One* participant noted a difficult decision made by a doctor over a medical bed in the hospital, "*I've been treated like crap, like an animal, because of my use. Though I get it, there's a guy in for an accident, and there's just one bed, and then there's this junkie in the corner, what's the doctor supposed to do?*". One participant likened living with an addiction to a type of internal spiritual bankruptcy. "The talk, the self, all *the negativity. It's pretty hard to be successful with any relationships in your life. So, a lot of times it's not even the person's fault. We call it a spiritual bankruptcy,"* a bankruptcy that left him feeling *'hollow".*

A lot of the language the participants used about themselves seemed to mirror the labels that were placed on them by others in prior parts of the interview, *"I think your person in addiction, with that negative self-talk, has to pick it up somewhere, Whether through childhood, school, doctors, police wherever"*. Many participants spoke about moments of clarity during their times of use when they recognized that the negative talk in their heads was not their own. Some participants voiced other individuals' thoughts about them, *"you're a disappointment", "you're not trying hard enough", "you're an addict,"* and repeated thinking along those same lines about themselves. One participant noted a denial of sorts and noted that at times, *"I'm not like those other addicts",* but still spoke to a sense of self-shame and hate when speaking about their addiction. *"You see it portrayed in movies. You see, it portrayed all over the place, so that stigma's created in you almost before the person becomes an addict".*

Many participants brought up attributing any and almost all failures in their lives to their addiction, *"would immediately attribute that to the fact that I'm a drug addict. ...Any kind of bad luck…this is what happens to drug addicts".* Participants believed that they 'deserved' those bad things that happened to them because they were addicts. One participant shared that, *"I'll mess something up—could be anything, doesn't even have to be related to using—and immediately I'm like 'of course you screwed that up, what did you expect?"*

Some participants mentioned a loss of identity during their use. They were specific about when they started their use by mentioning *"before…I used to be"* or *"but who I've become…I used to be proud of myself…"*. Some participants noted that during recovery, they had some difficulty building an identity beyond "an addict" because once you are in an addiction, it can become "all-consuming*".* One participant remembered thinking that she didn't know who or what she was at the height of her use, *"what was my future actually gonna look like, I'm not*

gonna get through my schooling. Should I even apply for a job?”. A couple of participants mentioned *“not recognizing whom they were”* due to their use, as well as mentioning a *“past life”* with friends and family that had abandoned them.

Another theme that some participants spoke about was that internalized stigma created barriers to seeking further help. Participants believed they were either *“not bad enough”* or *“undeserving”* of help and support. Sometimes, I still feel almost guilty entering addict support spaces, because *my addiction never got that bad. Like, I never experienced homelessness through my addiction... These people with these stories, like deep heart and deep tragedy. I'm like, do I really belong here?”* Some believed that it would take too much to ‘cure’ them, *“I really believed that, like, this is how I'm gonna live forever”*. One participant noted the inconsistency of thinking patterns of people who use substance and are stigmatized against, *“Most common with anybody in addiction is the fact that there's no consistencies with anything you know. One minute, I thought I was better than everybody else, I would never consider myself a junkie, and the next I would find myself agreeing with the individuals that thought I was a dirtbag”*.

Hierarchy within the substance-using community was another type of internalized stigma that came up during the interviews. Participants were candid about there being a hierarchy about being ‘better than that person’ depending on the substance being used, *“People have Different levels of experiencing stigma based on the substances they're choosing to use as well”*. The method of use, injecting vs snorting vs smoking, was also seen as a hierarchy in participants' eyes. *“I wasn't one of these people that, was on the street, or stole from people. You know, I had a job.”* This was echoed by another participant, *“I wasn't one of these people that, You know, had a job somewhere, you know, stole from them or did something where I needed help.* One participant shared an experience they had about someone who stigmatized themselves and would

not access services due to it, *"I knew someone who was actively using fentanyl on a daily basis. But quote doesn't want to be around 'junkies', so we can't find him housing."*

Another participant shared their thoughts about the difference and similarities between individual users of different socio-economic classes, *"blue collar worker type dudes that jump off the skytrain, grab their bag of gear, you know, pipes, whatever, sometimes needles…but also, really looking down on the folks that were sitting there, doing it openly…. the only difference between you and them is that you have a place to go do this."*

Summary

During the interviews, participants discussed their experiences of stigma received from different facets of the community. They began by detailing what they believed stigma entailed and the labels that have been placed upon them because of their substance use. They shared their experiences of stigma from people in their public life, their experiences of stigma from the medical community and their experiences of internalizing their external experiences of stigma.

The language that is used to describe people who use substances is very frequently judgemental and stigma laden. It was noted that the underlying judgement attached to the language used mattered more than some specific words. While some are trying to 'take back' the word "addict", some find it deeply stigmatizing and harmful. There was some evidence to suggest that adopting the label "addict" could relate to the ideologies between different recovery programs or even cultures. But regardless of different philosophies of labels, the idea of individual autonomy was the one theme that all participants agreed upon.

Participants also spoke to the stigma they had received from members of the public and family circles. Participants often encountered shame, blame, and isolation from members of their

family and friend circles. This left many of them feeling “cut off” and alone. Friendships either dissolved due to their friends’ perceptions of people who use substances or felt distant. The participants found themselves with a new circle of friends that were often made up of other people who used substances. For Richmond specific context, the participants felt a strong NIMBY attitude towards them as well as a lack of visible support services that helped reinforce the stigma they felt.

In healthcare settings, participants reported experiencing both stigmatization from medical professionals as well as competent care. Many were treated as ‘drug-seeking’, and that resulted in inadequate care as well as perceived discrimination through judgemental communication and negative body language. Due to negative experiences, a few participants reported delaying healthcare visits as long as possible. Positive experiences shared by the participants involved being treated like a whole person, receiving practical advice, as well as non-judgemental support.

Internalized stigma revealed how people who use substances often suffer in silence due to the impacts of external stigma placed on them. Participants spoke about ‘hating themselves’, ‘feeling worthless’, and ‘like shit’. Some participants talked about how they did not believe their stigma was ‘bad enough’ and they had a “half-assed addiction,” which further prevented them from reaching out for help. Participants also spoke about an existing hierarchy within the substance-using community, which is also rife with in-group stigma.

Discussion and Analysis

This section discusses and analyzes the key findings from this research project. This section will also highlight the connection between the findings and current literature. Subsections have been created to align with the conceptual framework. Using a CBPR lens as well as the

exploratory nature of this project, suggestions for stigma-reduction interventions directly by individuals who use substances have been added under the recommendation heading at the end of the chapter. Overall, this project aims to add to the limited location specific research done within the city of Richmond.

Language and Labels

When asked about the impact that labelling and language had on them, the participants' definitions included themes that aligned with Goodyear, Haass-Koffler, and Chavanne's (2018) of stigma manifesting through language. The impact of stigmatizing language like 'junkie' and 'druggie', amongst others, was seen by participants as reducing them to just a behaviour rather than seeing the whole person. This reductive view of people who use substances is supported by Kelly and Westerhoff (2010), who demonstrated that referring to someone as a "substance abuser" elicited more negative views of that individual from people in the general public as well as the medical field. Goodyear et al. (2018) also found that focusing on person-first language when dealing with people who use substances helps reduce the stigma they face through labelling. The theme of adopting stigmatizing labels like the word "addict" also aligned with the Ashford et al. (2018) study, which found that individuals from the community would sometimes voluntarily take on the label through their healing process, much like the participants in current 12-step programs often do. The individual's autonomy to self-identify as whatever they choose was a consistent theme across all interviews on the topic of labelling and language. It can be seen as individuals taking back some of the agency in their lives. As one participant noted, "Addicts are anarchistic".

When speaking on the topic of stigma itself, much like the labels unfairly placed on them, participants talked about them being reduced to their worst behaviours. They were often made to

feel less than and alluded to stigma as a type of identity reduction. These definitions fit closely with Link and Phelan's (2001) understanding of stigma as a process that involves labelling, stereotyping, and discrimination through unequal power dynamics. Prejudice and pre-judgement were also spoken of when the participants tried to describe what stigma felt like, "*they just treat you shitty….you can tell they're not interested….it's just human behaviour".* The prejudice and assumptions that others place on people who use substances have been noted in a study by Biancarelli et al. (2019), where the participants were viewed as dangerous, unpredictable and lacking self-control even if this was not the case. Some participants expressed great empathy for people who stigmatized them by suggesting that the judgement and stigmatization from the public comes from a place of ignorance rather than malice, "*prejudging someone based on what society has told you…rather than speaking to someone (from that group)."* The argument was made that if members of the public were more educated about understanding the root causes of addiction, they would see it as a complex health problem rather than a moral failure. The sense of addiction as a moral failure was also brought about when speaking about the theme of cultural stigma. For the participants who identified as Asian and South-Asian, shaming their culture was seen as an "extra layer" of stigma. Kelly et al., and McGinty et al. both discuss how cultural beliefs frame substance use as a moral failing or a personal choice (2016, 2020).

Societal Stigma

Discussions on the topic of public and social stigma frequently brought up the theme of family dynamics. Participants often experienced rejection, estrangement, and, at times, topic avoidance by members of their family. Family shame was also spoken to by many of the participants. Messaging such as "*your actions reflect on your entire family*", and "*don't you know what you're doing to your parents",* was often mentioned by the participants. This is supported

by McGinty and Barry's (2020) study, which observed that stigma can lead to a societal rejection of a person living with an addiction. Participants also talked about losing friends and vanishing social circles once it was known that they were using substances. This sense of social erosion led to increased social isolation, but also led to participants having to "*find new friends to use with",* which created the formation of new 'friendships' that were only due to common use. However, many participants did note that they found these new friendships hollow and more damaging to their mental and physical health. This sort of 'social exclusion' has been supported by studies by Cama et al. (2016). Some of the participants also spoke to a type of structural stigma experienced as part of the larger Richmond community. Participants spoke of recent protests in mass against harm reduction proposals, supportive housing initiatives, and public substance use education reform. Their perspective on this type of stigma is supported by research done by Corrigan et al., who found that addiction is one of the most stigmatized health conditions in the eyes of the general public (2009). Ahern et al. (2007) found that people who use substances are seen as "*dangerous, unpredictable, and lacking self-control".* Barry et al., also noted that people in public believe that substance use addictions are a personal failing, that leads to calls for punitive measures rather than harm reduction (2014).

Stigma in Healthcare Settings

Much like stigma in public settings, all participants have experiences in health care settings. One of the consistent themes that was brought up was that participants were often treated as 'drug-seeking' by medical professionals who offered them care. One participant was honest about his dehumanizing experience when seeking help at the hospital, "*they just treat you like crap in the hospital…you're going in there for a detox, and they just treat you like an animal."* Other participants also noted a similar quality of care in their own lives. When asked about how

they knew they were being stigmatized, some also described subtle behaviours or words used by their healthcare staff. Participants spoke of healthcare workers conveying their messages in a judgmental tone or manner, some were told outright that they had "*moral issues"* or were told that *"you're addicted to substances, so no, I will not be prescribing you this medication".* Healthcare workers would also express their judgment non-verbally. Some nurses would not make eye contact with the individual, some would talk to them in an overly policing tone, some would exhale and shake their heads when participants would disclose their use. The themes elicited from this section and the experiences of the participants in healthcare settings align with the research surrounding stigma in medical settings. Biancarelli et al. (2019) found that people who use substances "know" they will be discriminated against when reaching out for help. This is supported by McGinty and Barry (2020), who found that rates of stigma within professions who interact with people with addiction are 'extremely high'. Biancarelli et al. (2019) also found evidence that subtle changes in healthcare professionals' behaviour were noted even when individuals truthfully disclose their substance use, creating a damned if you, damned if you don't type for scenario for people who use substances. Some participants reported delaying future healthcare appointments or deciding not to return to a certain doctor at all because of the care received. Unfortunately, their experiences are supported by the research of van Boekel, Brouwers, van Weeghel, and Garretsen, who found that stigmatizing treatment and care leads to individuals not accessing future care or delaying their next appointment further (2013). A positive that will be discussed in the recommendations section is that all the participants in this study noted at least one experience with a medical professional who provided them with compassionate and humanizing care.

Internalized Stigma

All the participants in this study had and, in some way, continue to have experience with internalized stigma. Internalized stigma is considered the most insidious form of stigma according to findings by Cama et al. (2016) and Fraser and Treloar (2006). The stigma that the participants received from family, the public, the medical and structural system manifested itself into internal stigma that led to feelings of worthlessness, self-hate, and self-blame. A participant spoke of their inner voice telling them that "*this is what addicts deserve".* Participants discussed how internalizing others' judgements influenced their own behaviour and actions. In some cases, this showed up as a loss of identity and self-confidence, others would attribute any setback or failure to the fact that they were an "addict". The research has shown that all of the themes related to internal stigma exist. Corrigan, Larson, and Rusch found that self-stigma occurs when individuals are aware of the stereotypes that describe the group they belong to, agree with them, and apply the stereotypes to themselves (2013). Feeling of shame and a lack of self-worth are found in individuals who hold the same negative perceptions of society toward themselves (Cama et al., 2016). One notable theme that stood out was that internal stigma can lead to individuals delaying reaching out for support or not reaching out at all. One participant thought that they were "*not a bad enough addict*" to reach out for support, another said that they were "*deserved"* how they were treated and "*Of course…no one would help"* them. Once again, their experiences are supported by research on internal stigma by the CDC (2013) and Fraser & Treloar (2006), who found that individuals often come to believe that the stigma performed on them is deserved and that self-stigma perpetuates the cycle of addiction by further isolating the individual from society. A theme that was less discussed to some extent was the presence of a hierarchy within the substance-using community itself. Participants described creating distinctions between themselves and others in the community based on either what substance

was being used (alcohol vs cannabis), the method of use (smoking vs injecting), perceived employment status (blue-collar worker vs panhandler), as well as the location of use (In my car/house vs out in the open). It was noted that some of the participants used similar stigmatizing language to describe the 'other' users, often it was language they disagreed with when used towards them.

There were no unprecedented findings through the analysis of the data from the participant interviews. The findings were consistent with the current literature on the stigma that people who use substances face and live with. The multilevel and structural nature of stigma still exists, and its impacts can be felt across the public, medical, and internal settings for people who use substances. It was evident that stigma at each level reinforces and perpetuates stigma in the other levels and creates barriers to help-seeking behaviours. Furthermore, as the current rate of overdose-related deaths shows, when people do not reach out for help, it can be fatal.

One possibility for future research relevant to the needs of Richmond would be to examine the impacts of translating labels and educational materials from English into the most common other local languages in Richmond.

Recommendations

In keeping with the exploratory nature of the interview process, participants were also asked for their recommendations for stigma-reduction interventions at the healthcare, public, and internal levels. Their responses were curated and three tables were created below using the ideas that were directly generated by the participants. Specific larger themes such as, 'overall harm reduction', or 'education' are expanded below the appropriate table.

Stigma-Reduction Interventions

When asked to provide recommendations on reducing stigma during the interview, participants offered their personal insights. They made recommendations at healthcare, public, and internal (personal) levels. All three larger themes have been broken down into subsections in the table below because of their importance to this topic.

Table 8: Recommended Healthcare Level Interventions

Person first/non-judgmental approach (10)	• *Being treated like a human and learning about the disease, learning about the element that you have... it would be similar if I was diabetic. Diabetics don't get judgment, you know?* • *She could have explained to me that there could be side effects with this medication explain to me what they were. She could have even gone so far as to say I'm not comfortable prescribing these, but she could have referred me to a psychiatrist who would have been able to do that.* • *Being able to go to that daytime facility and speak openly about the fact that I struggle with addiction and felt like I received compassion and got to speak to a counsellor…it was great.*
Harm Reduction (7)	• *When you show people you care about keeping them alive right now, not just if they get clean someday, that actually builds trust. That opens doors. I'm way more likely to listen to someone about treatment options when they've already shown me they value my life and humanity.* • *Oh, you're an alcoholic, so what's going on with you? Have you lost any motor functions? Do you understand this is only going to get worse? What are you looking for? What can we do for you now?*
Treating addiction as a health issue (4)	• *If the medical book is 800 pages, we get maybe 10 of those 800 pages on addiction. In the way it's written about addiction, they give you a little bit of symptoms, they talk about the drugs, and after that, that's it.* • *They don't know exactly what that person needs or what recovery looks like or whatever, so that's part of the problem.* • *With medication…If you do these things, and they can interact with your medications and create these side effects, just to let you know, and not telling you to stop or telling you the physical changes these meds will have on your brain*

Increase services in Richmond (4)	• *I took classes at __________ Services, where they actually taught me about addiction specifically, you've got to learn about relapse prevention…. it was like being treated like a human and learning about the disease learning about the element that I have.* • *But people who are in my peer group who are sharing their experiences with me, they'd be like, oh, I recently became unhoused... But there's only two places in Richmond they can go into and then the waitlist is super long…so now they have to leave the city.*

For healthcare level interventions, a person-first, non-judgmental approach was put forward by all participants. Viewing the individual as a "person" and giving them information that is relevant to their needs, without judgment and stigmatizing language, was paramount. Participants relayed positive experiences with health providers that made them feel "normal" and was a positive experience that kept them going back to the same provider for support in the future.

A harm reduction lens was also recommended by many of the participants, *"how do you dialogue with people in addiction? ...you can say, 'you are an act of addiction, do you know how many times you use? Do you see yourself reducing that amount of use in a day or a week? This medication doesn't work like that. You need just use a bit less…"*. One participant ended speaking about this theme with the following comment, *"not everything's about being sober. Sometimes, it's just about being alive"*.

Closely tied to harm reduction, the theme of treating addiction as a medical issue through education rather than seeing it as a moral failure was brought up by many of the participants. *"I don't need to know what I'm doing is harming me, I already know that…I need to know if what I'm being prescribed right now will harm me more"*. Participants also spoke to doctors who

either did not have appropriate information about treating addictions or just did not choose to treat, *"educate yourself a little more…I would love to see more information about Engaging addicts in Healthcare…the heavier users especially are treated like dog shit"*. Another participant spoke to doctors, learning empathy for the plight of people who use*, "I don't know how you can get a human being to care unless they care,…more education… show them videos".*

At a Richmond-specific level, there were calls from some of the participants for more significant services. A few pointed out the lack of treatment options for people in Richmond when compared to Vancouver. "*In Vancouver, we have everything, For people in Richmond, nothing".* People also mentioned more education for type programs, *"I think just education education, education",*to help combat the stigma that healthcare providers and the community place on individuals who use. Community information that tells professionals and individuals where they can go, was also mentioned, *"I think people need a lot of education and information out there about what substance use looks like. I think people need to know where to go for help".*

Table 9 Recommended Public Level Interventions.

Public awareness campaign feedback (4)	• *It reminded me that I'm not just my addiction.* • *We need way more information to go up to the public, just way more that, but it doesn't hurt* • *You know, maybe I do like the idea of the ads, maybe taking a bit of Shame away.. I think that's the power in that ad that you were talking about.*
Education (4)	• *The biggest part of stigma is not thinking that people have a choice. You know, 'why aren't they just choosing to stop?' If you address that part of it, it can help the person who is struggling with addiction to realize that it's bigger than us, you actually don't have a choice, you need help.* • *I didn't have even a way to explore if there might be help available. I could have gone into a Ministry office and they would have connected me with somebody to send me. It would have been so simple*

Peer support (6)	• *We aren't going to some counsellor that's got book smarts that has a PHD, that's for sure. I am not talking to you unless you've been on the streets and done what I've done and seen what, you don't understand my story.* • *I found myself sitting in these rooms, going, oh my God. I'm surrounded by some really unwell people….these are not people that I actually want in my friend group.*
Reframing addiction as a disease (4)	• *For many years, I was still using thinking that I was just an idiot… understanding that I have a disease would have helped.* • *When it comes to like talking about it…even just like psychology…it's a gentler way of putting it…seeing it like a disease.* • *People feel like they're alone. They're out there. They're unique. They're struggling with their drug addiction because of their circumstances, and they're still different than the other guy, they need to understand that this might be something common.*

Some of the participants recollected the 'Stop Overdose' ad campaign that ran in Richmond. Some felt that media campaigns could play an important role in educating people about the stigma they hold. *"It just humanizes it. I kind of would like to see, like, a little bit of that again. In Richmond, especially"*. One participant noted that it reminded them that they are "human" and a part of society. Though a few participants noted that individuals who are severely addicted and marginalized would probably benefit from the ads, with one participant wondering what the "actual impact" the ads could have.

A second significant theme to help with public stigma reduction is tied to the education of the general public. Some participants spoke that the reason they struggled with addiction was that they did not have enough information at home when growing up, *"because I didn't grow up in a home that struggles with any sort of substance use. I had zero, and I mean zero, knowledge of any supports that might be available".*

A third theme that spanned across reducing general stigma as well as internalized stigma was peer support. In terms of reducing public stigma, open peer support spaces were put forward, *“the whole point isn't to isolate Addicts. It's to integrate addicts into the community…a place that people who experienced addiction or substances can collect and converse and like, have that engagement”.* Many participants put forward the theme of showing the public that people who use substances are “a part of the community of Richmond”, whether they like it or not, *“Because we're gonna exist, no matter what…so we might as well know who shares our experiences.”. “I think Having resources out there, Community Outreach, and having people going out and helping people”.*

The last theme that also related to the reduction of stigma in the mental health community was pushing to reframe addiction as a disease. *“I'm a big fan of referring to addiction as a disease. And I think the biggest part of stigma is not thinking that people have a choice”.* Participants spoke of family members with treatable conditions, who were treated with nonjudgement from society, even though they may have contributed to their condition due to their past lifestyle.

Some participants also spoke about educating the public that some people may not have a choice when they use, *“addiction is about using against your will……and so the message is this person doesn't choose to be in this situation.”*

Table 10 Addressing Internalized Stigma

Peer Support (6)	• *Just coming from a place of curiosity…and letting the person answer, or speak for themselves or share their experiences.* • *To make addicts feel better socially. I think implementing more peer groups because we can't change the perception of non-users, but we can do is find community within our groups outside of AA and NA.*

Consistent compassion (5)	• *When it comes to like talking about it in the dictionary, even just like psychology, I think, addictions, yeah, it's actually, a gentler way of like putting it, like seeing it like before with disease and stuff like that.* • *You could get the sense that behind their questions…there was some care or concern or attached to it*
Meeting people where they are (4)	• *Most of the time you're probably going to get an angry addict. You're gonna get somebody who's, like, I know what I'm talking about.* • *They don't need your sympathy. They need your understanding. Understanding that you're going through a tough time. Practicing patience does wonders.* • *I had great doctors. I had people who said, Hey, you should try these services, but I didn't want to hear that at that time. I want to go get more drugs…but it's good that they do it because you just don't know the timing. I could have been totally willing at that moment to listen to that doctor and do everything right.* • *What that looks like is ego deflation.*
Practical support (4)	• *Their care came through… at least they were asking questions, like, what's going on, you know? How can we help? What is it that we can do better instead of just shutting me off?* • *Encouragement, even if a person just said they don't know anything about addiction, but they're there …It's more uplifting.* • *I would love to see a long-term single room occupant…something more medically inclined… But, we don't have the things to take care of you. So, go to Van.*

When discussing internalized stigma-reduction interventions, peer support was one of the first themes that many of the participants spoke about. Participants shared a sense of safety when speaking to someone about their own journey, "*my friend…feels like safer like talking to me because she knows I won't judge because I've also done some other things in the past"*. Another participant refused to speak to anyone who did not share similar experiences as themselves, *"You*

don't know what I've done, you don't know what I've been through, no amount of books will convey that….you need someone that has been through it".

Some participants spoke about having a sense of self-compassion during internal speak. *"Just because I had a problem with a substance doesn't mean that this is who I am as a person"*. Participants also spoke about not using stigmatizing language to refer to themselves, and opted for "softer" language such as "addiction as a disease" and "person who uses substances". One participant uses positive self-talk to help them get through rough times, "stepping back the disappointment talk or the 'you're failing' talk, and maybe just listening and offering a little internal encouragement".

A third theme that came up was practical support. Practical items were offered by many of the participants that they would have appreciated receiving themselves. Many of the participants pushed for just listening, *"Step back with the disappointment and just listen."*, *"maybe just asking people about their experience…, instead of just saying 'why would you do that?'"*. Open-ended questions that did not deny the autonomy of the individual were posed by many participants, *"How can I help?" "What's going on?"*, asking consistently in a non-judgemental way over time, so that, *"hopefully one day when the person walks in. And that's the day. And that's the day it finally clicks"*.

Current literature on stigma reduction

The participant's notes on person-first language are strongly supported by addiction research. Goodyear et al. (2018) found that using person-first language improves attitudes of health care providers towards individuals who use. Bake et al. (2022) found that using person-first language can also reduce stigmatizing attitudes in the general public. Even at an organizational level, it is

recommended that the adoption of humanizing language is key in reducing stigma (HQBC, 2025).

Harm reduction has been shown to increase quality of life in people with substance use addictions by decreasing some of the impacts of stigma (McGinty et al., 2015). McGinty et al. also noted that initiatives like needle exchanges and supervised consumption sites reduce the number of people who die due to overdose, and increase the chances of individuals reaching out for support due to readily available support services at these sites.

Educating both medical professionals as well as the community on the reality that addiction should be labelled as a medical affliction rather than a moral issue is a crucial step in stigma reduction (Goodyear et al., 2018). Studies by Sulzer et al. (22022) and Wakeman and Rich (2018) have been critical in pushing for medical providers, especially, to engage in education on topics of addiction and substance use to help reduce stigma towards people who use substances.

Peer-led supportive programs and robust community engagement are shown to have a strong impact on the internal and structural stigma that individuals experience. Corrigan, Larson, and Rusch (2013) focus on empowerment as one way to combat self-stigma. Joining a supportive community that can also empathize because of shared experiences can help counteract the feelings of isolation, shame, and worthlessness. Jozaghi et al. (2018) advocate for people who use substances to be involved in all levels of program creation and development to ensure that their voices are heard.

Conclusion

This project aimed to develop a better understanding of the topic of stigma and its impact on the substance using community in Richmond, B.C., and possibly compile stigma-reduction

interventions from the community itself. The need for this research was to reduce the number of overdose-related deaths occurring in the Richmond community over the past five years, as the evidence suggests that different types of stigma lead individuals to consume substances alone and, unfortunately, die alone.

The research comprised a literature review, a conceptual framework, semi-structured interviews and a review of the findings. According to the research, stigma is overwhelmingly present in all aspects of a person who uses substances in their life. Stigma is experienced structurally within the public and medical systems and professions, which in turn leads to an internalization of stigma within the person who uses substances.

One of the key findings from this project is that the cultural aspect of stigma is definitely present in the Asian and south-Asian communities that make up Richmond. The cultural stigma acts as another layer of stigma that is seen as harming the family's reputation in the community, rather than the individual who uses substances.

A finding that was strongly corroborated by the evidence in the literature review was the call to frame, addiction as a health issue when dealing with different populations. The framing helps individuals understand that addiction is not tied to a moral failure or a failure of willpower, but rather a health issue and needs to be understood and treated as such.

Another key finding was the pervasiveness of internal stigma where member of the substance use community themselves stigmatize others in their group. Type of substance, mode of consumption, and location of use were used as ways for individuals to 'other' other members of the community.

A key contribution were specific stigma reduction intervention strategies at each level as defined in the conceptual framework. This intervention strategies were put forward by the participants of the study themselves. Due to this the audience for this project could include the City of Richmond staff, member of the local health ministry, as well as members of the various community serving organizations in Richmond.

The project was exploratory in nature to understand a critical problem within the community of individuals who use substances in Richmond. There is little generalizability due to the sample size and the nature of the study.

Future research that could be region-specific could be to look at the impact of language, particularly the translation of educational materials to non-English main languages spoken by the population of Richmond. Research could also look into the nuances of how stigma is affected within the different cultural populations in Richmond. Overall, this project can open the possibility of more research that can be carried out within the lens of the impacts of addiction in a community as multicultural as Richmond.

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Appendices

Appendix A: Recruitment Poster/E-mail

Invitation Template

You are invited to participate in a study entitled "Stigma and its Effect on Substance Users in Richmond."

Hello (Name)

My name is Daniel Remedios, and I am a current graduate student at the University of Victoria. My supervisor for this study is Dr. Bart Cunningham. I am contacting you because you indicated you would be interested in participating in a study about the stigma surrounding substance users in Richmond. This study is part of the Department of Public Administration. You can reach out to Dr. Cunningham at bcunnning@uvic.ca for any further information about this study.

In the study, we are looking for people who have lived experience with substances. We are looking for volunteers for this study. We will gather experiences individuals may have had when accessing services from the health authority in Richmond, as well as smaller non-profits. We will also look into the effects of internal stigma on the individuals who are using themselves. The purpose of this project is to put forward recommendations directly from substance users to help improve their experiences with stigma within the community.

Your participation will be confidential, and no one will be aware of your decision to take part in this study, as it is anonymous.

The interview will take 40-60 minutes and involve questions about your experiences when working with health agencies in Richmond, including health professionals and your experiences

with the public. Based on your experiences, I hope to identify, with your help, some avenues to reduce the amount of stigma that users in the community face and increase the chances of people reaching out for help.

Your participation and your responses will be kept confidential. Each interview will be assigned a number code to help ensure that personal identifiers are not revealed during the analysis and findings.

If you are willing to participate, we will send you a date and time that suits you. We will also provide a copy of a consent form, which outlines our commitment to anonymity and confidentiality.

Looking forward to talking with you

Daniel Remedios

Appendix B: Participant Consent Form

Participant Consent Form

You are invited to participate in a study entitled, "Stigma and its Effect on Substance Users in Richmond."

My name is Daniel Remedios, and I am working on my project for my studies at the University of Victoria. My supervisor is Dr. Bar Cunningham, a Professor in the School of Public Administration who studies leadership, human resource management, stress and job satisfaction, and insight problem solving. He has been a visiting professor at Johannes Kepler University in Austria and has previously held visiting positions at the Czech Management Center, the California School for Professional Psychology in San Diego, and the Waikato Management School in New Zealand. He can be reached at: bcunning@uvic.ca or 250-721-8059.

Purpose and Objectives

The purpose of this research is to provide a fuller understanding of some of the impacts of stigma on the substance user community in Richmond. We will gather experiences individuals may have had when accessing services from the health authority in Richmond, as well as smaller non-profits. We will also look into the effects of internal stigma on the individuals who are using

themselves. The purpose of this project is to put forward recommendations directly from substance users to help improve their experiences with stigma within the community.

Importance of this Research

Generally, the research on stigma is based on ~~an inductive,~~ qualitative design where we ask a representative group of people about the problems they have observed or experienced. Based on these examples, we intend to develop recommendations from the substance-using community to encourage a more positive experience when accessing services in the community. If it is found that the people we interview share similar experiences when seeking services, we may share these recommendations anonymously with the VCH, the local health authority.

Participants Selection

We are asking people to participate who have lived experiences with substances in the community. We are looking for individuals who are 19 years or older.

What is involved

If you consent to voluntarily participate in this research, your participation will include the completion of an interview, which will take between 40 and 60 minutes. You will be asked questions about your thoughts on your views as someone who used/uses, and have a chance to add your views. Most interviews will take place over Zoom, although in-person interviews are also possible.

Inconvenience

Participation in this study may cause some inconvenience to you, including taking time away from your daily routines.

Risks

The interview will delve into personal experiences of feeling stigmatized due to using. Reliving this topic could cause some discomfort. To minimize this risk, please know that if I do notice your discomfort, I will check in with you and let you know that you are able to withdraw from the questions at any time. If you note that the discomfort is significant, I will be able to provide you with resources in our community that you can reach out to.

The interview will always take place in a private space that will not have members of the public walking through. But if this unlikely scenario does happen, the interview will be paused until the individual leaves, and if not, we will stop the interview, leave the area, and if you are still willing, we can continue it at another time.

If you choose to withdraw at any time during the interviews, your responses will be destroyed, and your comments will not be used in the research. Participants can contact the primary researcher (Daniel Remedios) if they have any questions or concerns about their participation before withdrawing from the research.

Benefits

Questioning interviewees is intended as a reflective exercise. A reflection on past experiences is generally a reliable way to gain information and is often helpful in developing ideas.

Voluntary Participation

Your participation in this research is voluntary. If you decide to participate, you may withdraw at any time without any consequences or explanation. If you withdraw from the study,

your data will be used only if you give permission. If no permission is granted, existing data will be destroyed.

Anonymity

Your name will be known to the interviewer, but your participation in this research will not be disclosed to other parties. After the completion of the project, your identity will not be associated with the data or the project. The interviewer and research team will not, under any circumstances, disclose your identity or participation in the project.

Confidentiality

Your confidentiality will be protected, and all data will be stored using the University of Victoria's secure and encrypted systems. Notes and transcripts will not refer to you by name, though you will be assigned an initialled designation or a number (e.g. 001) for working purposes.

Dissemination of Results

It is anticipated that the results of this study will be shared among academics. Only summary data or collective responses will be reported, and confidential and anonymous responses and findings will not be reported.

Disposal of Data

Initial notes and documents are temporarily stored in padlocked storage files or destroyed through a confidential shredding service. Electronic data might be archived and stored within the University of Victoria's secure storage systems.

Contacts

Daniel Remedios (main researcher) – leinadremedios@gmail.com

Dr. Bart Cunningham (Supervisor) – bcunning@uvic.ca

In addition, you may verify the ethical approval of this study or raise any concerns you might have by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

Name of Participant

Signature

Date

Verbal consent:

A copy of this consent will be left with you, and the researcher will take a copy.

Appendix C: Interview Guide

Interview Guide

Interview Guide

Introduction

The purpose of this research project is to understand how/if stigma has affected you in three different areas of your life overall. This project will seek to address certain aspects of stigma that relate to healthcare settings, public settings, and your personal internal feelings about what you experience.

The questions contained in this interview may be potentially emotionally distressing, because we may be speaking about experiences that you or someone close to you may have had. You can pause at any time during the interview, and time will be made available after the interview to debrief. There are also resources attached to the consent form provided in the initial e-mail. Keep in mind, you can end the interview or pull your information from the research project at any time.

"Guy Felicella's story: A lot of people who use have different terms that they kind of use for. Some people say substance users, some addicts, and there are other terms used. If you look at Guy F., he was a Richmondite who overdosed due to his use six times before starting this recovery journey. One thing he stands by is that he is an 'addict' and wants to be referred to as such. He doesn't want any soft language; he wants to be called an addict because that's who he is. Do you have any thoughts on his perspective?

General Stigma/Public Stigma

This section is to speak about your experiences with the general public, when they may have known that you were using a substance. The public could include your friends, family, or any group you choose to define.

- How do you think people in the community view people who use substances?
- Have you ever been labelled or called names because of your substance use? How did that feel?
- Do you feel like people judge you or make assumptions about who you are?
- What kind of assumptions do people make?
- Can you describe a positive experience with the general public when they knew you used substances?
- Can you describe a negative experience with the general public when they knew you used substances?

Healthcare settings

This section is to speak about your experiences with medical professionals. This could include pharmacists, walk-in clinics, and counsellors.

- How did the provider treat you or talk to you?
- Did you notice any changes in how you were treated after you disclosed your substance use?
- Have you ever been treated as if you were "drug-seeking" when you had legitimate health concerns
- How did you feel?

- What makes you feel that way?
- Do you have any ideas on how to make you feel better in those situations?
- Can you describe a positive experience with a doctor/clinician/or pharmacist when they knew you used substances?
- Can you describe a negative experience with a doctor/clinician/or pharmacist who knew you used substances?
- How did you feel?
- Do you have any ideas on how to make you feel better in those situations?

Internalized stigma

This section will deal with some thoughts that you may have when it comes to different experiences due to your use. Feel free to share as much or as little as you choose.

- What does stigma look like/feel like to you
- Has your substance use changed how you think about yourself?
- What are some stereotypes or negative beliefs about people who use substances that you've heard?
- What do you think are a few things that the public/healthcare professionals can do to change the way you feel
- Do you feel like there is a type of internalized stigma within individuals who use?

- Have you seen any ads in recent memory, labelling everyday individuals as users? Something like “This is Joe, he’s a father, a coach, and a drug user? Do you have any thoughts on those ads? And if you haven’t seen them, do you think campaigns like those are successful?
- Any final Recommendations?

This is the end of the interview. Thank you for your participation in this research project. As a reminder, you have the option to debrief if you feel that would be helpful. Also, a reminder that there is a list of resources available attached to the consent form if you feel you need more support later. If you change your mind about participating in this project, please connect with me via email, and I will delete any and all data collected the moment you rescind your participation.