DECIDING MATTERS
Rethinking Power

Tackling Stigma for Drugs & Alcohol in Scotland Report

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Introduction, Background & Purpose

Tackling stigma on drugs and alcohol co-design workshops are a part of supporting a national mission to reduce drug related deaths and harms in Scotland. Scottish Government have commissioned Deciding Matters to deliver a series of workshops, identifying where changes to services and public perceptions in Scotland can tackle stigma experienced by people with substance use.
Deciding Matters hosted a series of seven full-day workshops over the course of 2024 and into 2025 with up to 20 people who have lived or living experience of substance use - either their own or a loved one's - who want to inform a set of recommendations that can tackle stigma and meet identified needs through influencing services, media, education, or public behavioural change. Participants received input from a range of experts and took part in conversations and activities hosted by neutral facilitators.
The workshops aimed to design:

- A national programme to challenge public stigma.
- A voluntary scheme to tackle structural stigma within organisations and institutions.

The recommendations from these workshops have been shared with the Scottish Government, along with feedback from a range of professionals and service providers. The Scottish Government will use all of this information as the basis for recommendations for a national programme of work to tackle public stigma and a Scotland-wide-pledge for organisations and services to tackle stigma related to drugs and alcohol.

National Mission in Scotland Background

Stigma towards people affected by problem substance use, either through current or past use, being in recovery, or as a family member, is increasingly recognised as a significant factor in the current public health crisis in Scotland. It is a cross-cutting priority of the National Mission and was identified as one of the key drivers of drug related deaths and harms in Scotland. In a sector that can be divided and with a divergence of views on resolving the current crisis, there is a strong and united call that the stigma directed at people affected by substance use, and the services which support them needs to be addressed.

In 2020 the Scottish Drug Deaths Taskforce published *A Strategy to Address the Stigmatisation of People and Communities Affected by Drug Use*; in winter 2021/22 Scottish Government ran the campaign Let's End the Stigma of Addiction alongside publishing the Drug Deaths Taskforce developed Stigma Charter; in July 2022 the final report of the Drug Deaths Taskforce Changing Lives was published.

Evidence cited in the development of each of these as well as broader evidence available on understanding and successfully challenging stigma was used in the developing of the Stigma Action Plan published in January 2023 as part of the *Drug Deaths Taskforce response: a cross government response.*

The Stigma Action Plan included commitments to:

- Turn the principles of the Stigma Charter into action by coproducing the specifications for an accreditation scheme and commission its delivery from the third sector and the community of people with lived and living experience;
- Implement a national programme to tackle social stigma by coproducing interventions to tackle social stigma and commission the set up and delivery of a national programme from the third sector.
- Review policies and workings internally within Scottish Government, interrogating internal policies and removing barriers for people affected by substance dependency.
- Put lived and living experience at the heart of everything we do.

Executive Summary

Without tackling stigma we won't reduce the number of deaths!

The key priority for the co-design panel is for Government, services and the public to acknowledge and tackle stigma which is a direct driver of the ongoing crisis causing preventable deaths and ruining lives.

The co-design panel made up of 20 experts by experience came together numerous times over 2024 and 2025 to draft a series of recommendations for a national programme to tackle drug and alcohol stigma as well as design actions for a national pledge.

The co-design panel ask that the Scottish Government…

- provide adequate funding and resourcing to address the drug and alcohol health crisis in Scotland
- demonstrate commitment to actively listening to, and enacting, recommendations from those with lived and living experience
- ensure public services are available to all, regardless of geography

- treat addiction holistically and recognise intersectionality

The co-design panel ask that public health services…

- provide trauma and anti-stigma training and awareness raising tools to upskill staff across all public services.
- treat people as individuals and recognise their intersectionality
- ensure all services are connected and in place for an individual (meeting needs such as housing, education, employment, food).
- regularly review training and language to ensure trauma-informed and de-stigmatising approaches
- provide access to naloxone training for staff
- provide equal access to services
- provide mental health and health screening

The co-design panel ask that media campaigns…

- educate the general public on drug and alcohol use
- engage with organisations and individuals in a respectful, collaborative and transparent way
- not use stigmatising language
- promote recovery-orientated care
- see the person

The co-design panel ask that the public…

- understand that anyone can be affected by drugs and alcohol
- acknowledge drug and alcohol use as a health crisis
- acknowledge the varying levels of addiction and how it will affect everyone differently
- normalise and encourage conversations around drug and alcohol use and recovery throughout the community

Full outputs and recommendations can be found in the main body of this report.

National Programme to Tackle Stigma for Drug and Alcohol use in Scotland

The following campaign actions are clustered into groups, with each group anticipated to be enacted at approximately the same time. The clusters range from immediate implementation to long-term goals:

Immediate implementation

- SG needs to commit to transparency; sharing exactly what they are going to do, who is responsible, when it will be done, all as a follow-up to this process. This needs to be shared in a timely manner.
- SG should adopt a policy (working towards legislation) that addiction is a protected characteristic: people are not refused access to any services on the basis of addiction (includes employment, housing, education, health (physical and mental screening), benefits, policing etc.). Rights should be presented at point of access.

- Services should have a person-centred approach. Service users' rights should be openly embedded and emphasised at the first point of contact as well as what services are available and what the individual is entitled to. Services should function with kindness and provide a welcoming, comfortable, non-judgemental environment. If a service does not deliver a person-centred approach this should be acknowledged and corrected. This should be monitored and evaluated on an ongoing basis based on service-user feedback.
- Minimum unit pricing profits should be used to fund substance resources instead of profit for suppliers.

- Review and retrain ADRS workers with ongoing reviews on their understanding of stigma, and differences between the different drugs people might take ensuring there is a better understanding of drug use, levels of addiction and types of addiction (opiate, cannabis, prescription drugs), and issues regarding class and classism.
- Ensure engaging with ADRS results in support rather than punitive actions taken against the service user. E.g. currently have driving licence removed, using OST (opiate substitute treatment) as carrot and stick with treatment being stopped if engagement isn't deemed enough. Where actions do have to be taken for safety, clearly explain the decision and the process.
- Ensuring ADRS spaces are safe to access without police and security presence which is off-putting to service users, understanding of relation between legal system/prison system and impact on health support access. "Safe" defined by services users not workers.

- All public service staff should be trained in trauma-informed practice (including GP receptionists, hospital porters, police etc.). Training should be included as part of induction processes with regular reviews and ongoing training opportunities.
- E-learning module trauma-informed training should include real-life stories and examples.
- NHS24 should have substance use options as well as mental health options.

Long-term goal	• There should be a 24 hour helpline available to signpost to different substance use resources in different areas. This helpline would be delivered by and informed by experts from experience. • There should be an online platform for people to submit anonymous questions and receive honest answers. The platform should ask users to specify their age before entering (e.g. are you over 18) to provide age appropriate responses/signposting. • In-person trauma informed training designed and delivered by people with lived experience • Widely accessible naloxone training
	• Not prioritising service users who may receive a prescription over those who would need other forms of support.
	• There should be clarity for services users as to which services work collaboratively and share information. There should be clarity over where information is shared voluntarily versus mandatory reporting and the reasoning for this. • SG should publish the true costs of not prioritising recovery in society – financial impacts and societal impacts including hospital appointments, prison services, treatment centres and loss of life. • It shouldn't matter where you live or what your local health agency is, you should have the same access to high quality care. SG and NHS needs to reduce variation in provision across different localities. All first points of contact (such as GP surgeries, A&E) should have a "navigator" to signpost service users to appropriate resources.
	• Experts from experience should have access to opportunities to share their stories when and if they want to as part of relevant processes (e.g. service reviews, staff team training). These opportunities should not be forced or tokenistic and should be appropriately compensated. • Recovery groups should emphasise peer support, including experts from experience delivering workshops and shaping programmes, from creative opportunities to structured projects and coaching. • There should be easy ways for service users to provide feedback on services and interactions with staff.
	• Having holistic and informal support available equally across the country, in the form of drop-ins and cafes open during out-of-office hours, with support for access (such as travel passes, childcare, etc.). These services should be appropriately resourced with well paid and trained staff. There should be an audit of services currently available to be able to target support and funding.
	• Educational programmes for young people, both those in school and those in alternative programmes (e.g. college, employability funds). This education will focus on stigma across a range of topics including gender, ethnicity, sexuality, disabilities, drugs and alcohol and how they interconnect.
	• Service directorates (justice, housing, health, education) need to hold their own reviews of stigma and develop internal processes to strengthen the supports available. These processes need to be led by experts from experience.

See Appendix 1: Campaign Timeline

National Programme Message to Use in Media to Tackle Stigma for Drug and Alcohol use in Scotland

 **Core message**	**"Addiction doesn't discriminate. Do you?"** A provocative question designed to prompt self-reflection and challenge stigma.
 **Target audience**	• General Public • Aimed at challenging preconceptions and unconscious bias around addiction
 **Secondary messages**	**"Which one of these people is an addict? They all are."** *– Addiction doesn't have a look.* **"Being human means needing help sometimes."** *– Normalising addiction as a human experience.*

 **Visual concepts**	**1. The Line-Up (Poster & Video Series)**
	• **Visual**: Usual Suspect Poster. A stark, high-contrast image of six people in a classic police *line-up* format.
	• **Characters**:
	  ○ A judge
	  ○ A nurse
	  ○ A construction worker
	  ○ A police officer
	  ○ A young student

- A retiree

- **Tagline**: "Which one of these people is an addict? They all are." *Addiction doesn't discriminate. Do you?*

2. Mirror Visual (Second Poster)

- **Visual**: Three people who look nearly identical (e.g., same age, gender, clothing), standing shoulder-to-shoulder with neutral expressions.
- **Tagline**: "You can't see addiction. You can see people."

- **Concept**: Close-up portraits of each "line-up" person. They look directly into the camera.
- **Voiceover**:
  - "I'm a nurse. I struggle with addiction."
  - "I'm a police officer. I'm in recovery."

Video campaign: 30-60second clips	○ "I'm a judge. I carry naloxone." ○ "Which one of us is an addict? We all are. Because addiction doesn't discriminate." • **End Screen:** "Do you?" [Website URL] + QR code to info/support resources
 **Usage and distribution**	• Billboards, bus stops, subway ads • Posters in libraries, clinics, and schools • Digital ads with click-through to support resources • YouTube pre-roll ads • Instagram Reels/TikTok/Meta • TV ad slots (optional if budget allows)
 **Formats and methods**	• **Outdoor Advertising**: Billboards, transport stops • **Digital Media**: Paid social media campaign across Instagram, Facebook, YouTube • **Print**: Posters for GP surgeries, libraries, schools, recovery cafés • **QR Code**: Leads to a website with real recovery stories, info on addiction, rights, and where to find help • **Hashtag**: #SeeThePerson #AddictionDoesntDiscriminate
 **Outcomes and calls to action**	• Increase public awareness of addiction as a health issue • Challenge public assumptions and stereotypes • Link to support services, the Charter of Rights, and harm reduction tools • Encourage empathy and reduce stigma in daily interactions

National Pledge Goals for Services & Organisations to Tackle Stigma for Drug and Alcohol use in Scotland

In order to raise awareness of stigma of drug and alcohol use, to mobilise public interest and encourage discussions and genuine commitment from organisations. We ask organisations and government/s in Scotland to pledge to agree to do the following.

Raising awareness, training & education

We pledge to:

1. Integrate our stigma friendly logo and campaign material.
2. Boost the existing naloxone campaign.
3. Develop and increase awareness of human rights.
4. Utilise the tackling stigma campaign as a prominent resource to build awareness.
5. Ensure our staff use destigmatising language through review of our existing organisational policies and making feedback mechanisms more accessible.
6. Ensure that everyone in our organisation undertakes anti-stigma and trauma-informed training.
7. Measure learning and development through compulsory training modules for staff.
8. Ensure that people have access to support and signposting where appropriate.

Commitment & accountability

We pledge to:

1. Provide public updates and evidence on how we have achieved the goals in the pledge including an overview of what we have done for our organisation (to who are we proving/evidencing? Examples in appendix of how updates can be publicised).
2. Identify a person/advocate (stigma champion) who is responsible and accountable for our organisation. They will ensure the pledge is delivered and human rights are upheld.
3. Encourage and be open to hiring people with lived experience to apply for jobs with us (connect to workforce).
4. Use an awards system in our organisation to celebrate success of change organisationally and individually for employees who are recognised for their contributions.

Partnerships and Community Engagement

In order to bring people together to foster community and share purpose for our National Pledge to tackle stigma, community organisations, leaders, stakeholders and government should pledge to:

We pledge to:

1. Seek out ways to join partnerships and develop collaboration to address stigma.
2. Engage key seldom heard groups as part of pledge delivery (young people, LGBTQ+, BAME groups etc).
3. Share best practice across sectors and organisations.

Guiding change with measurable goals

In order to influence changes and resource allocation, guiding government and organisations to prioritise issues. Governments, organisations, leaders, and stakeholders should pledge to:

1. Ensure and support this as a multi-directional pledge where organisations are working together.
2. Treat every person with dignity and respect in line with the charter of rights. Ensure that from your first point of contact within the service all staff will show a caring trauma-informed attitude. (charter of rights – what we mean by dignity and respect).
3. Create networks of stigma champions locally and nationally to share best practice and highlight areas of improvement.
4. Set out the ways in which our organisations will deliver these pledges through a transition plan and a clear timescale.
5. Make the charter or rights readily accessible and integrated into our service or organisation.
6. Engage more with people who use services to understand what change needs to happen from their perspective.
7. Ensure that when someone asks for help, they get the help first time.

Scottish Government Pledge Goals

We pledge to:

1. **Ensure that addiction is a protected characteristic**.
2. **Utilise existing partnerships and strengthen collaboration with third sector partners**, where they are directly involved in policy reform.
3. **Ensure continued funding is allocated to our national campaign** and wider messaging on tackling stigma for drug and alcohol use.
4. **Lead a review of hiring practice and vetting to ensure more people with lived and living experience of drug and alcohol use can be employed**. Use people with lived and living experience to do this.
5. **Measure sign-up rate annually on a national level and raise awareness through participating in a national collaborative call for evidence.** Publicly report on what people are experiencing and undertake actions in response to this.

6. **Incentivise take-up of the pledge through prioritisation of public funding to organisations committed**. This encourages an accountability mechanism for change.
7. **Encourage local authorities to increase community led funding models**, such as participatory budgeting, to ensure money is put into the services based on local need.
8. **Implement watertight rent controls and ensure that addiction as a protected characteristic applies to both public and private sector housing provision**.
9. Offset the impact of disproportionate benefit sanctions of people with drug and alcohol use in a similar way to the proposed two child cap universal credit reforms.

Workforce & Private Sector Pledge Goals

We pledge to:

1. **Undertake inclusive hiring practices.** This includes guaranteed interviews for those disclosing substance use such as with the disability confident scheme.
2. **Implement a proportionate amount of mental health first aider/s** for our organisation, specifically incorporating trauma-informed and anti-stigma practices.
3. Ensure our employees are enabled and comfortable to disclose drug and alcohol use/addictions through providing an inclusive and safe environment to disclose.
4. **Celebrate good practice through agreeing to be part of a list of champion** organisations that are inclusive to employing people who have or have had alcohol or drug use/addictions or convictions.
5. **Increase public awareness of our tackling stigma campaign** through placing posters and information for customers and staff.
6. **Include anti-stigma and trauma-informed training as part of new employees' inductions**, developed by external consultants with lived and living experience of drug and alcohol use.
7. **Join our national network of stigma champions** working with local/regional services and communities to support the pledge and tackle stigma.

Health Services including Mental Health, Addictions services, GPs, Hospitals & Pharmacies Pledge Goals

We pledge to:

1. **Include a no wrong door policy in our service**. **Stop treating mental health and addiction as separate issues.** Services need to consider holistically 'not why the person has the addiction, it's why the person has the pain' for example, these are symptomatic of each other and both need treated in equal measures. It should not matter whether the person comes in with a mental health or an addiction issue, the person will receive help and not be passed from pillar to post. Do not use a person's addiction to deny mental health support. This ensures there is quicker action when someone needs help.
2. **Provide the charter of rights to all patients** so that people know exactly what their rights are on arrival.
3. **Ensure our staff and patients understand legal duties around patient rights and responsibilities.** Patient rights 2012 and 2022, human rights and MAT standards. Staff undertake mandatory training and are responsible for informing people of advocacy support and how to complain if they are unhappy.
4. **Ensure our services are inclusive by embedding mandatory anti-stigma, trauma-informed, suicide prevention and charter of rights training**. **Ensure our buildings are all psychologically trauma informed**. We know trauma can be the foundation of mental health issues. Incorporate a range of therapies tailored to the individual. All staff in health and GP practices including admin staff should receive continual development training around stigma, discrimination, language and access and training in Harm Reduction.
5. **Staff should have local knowledge of where they can send people to get support**. GPs should have and build awareness to patients of other local resources such as peer workers, conversation cafes, Andys man clubs, Let's get connected app, Dundee recovery app.
6. **Develop a person centred approach – see the person, not the issue**. Treat the issue as its presented.
7. **Staff have a better understanding and training in why people may present in different ways when seeking help** – e.g. aggressive/depressed/hyper/sad. There needs to be a clear parameter for unacceptable behaviour to protect staff and people who use services. Give people an option to return at a different time if their behaviours are too extreme. Set people up for success – give support even if they are presenting as intoxicated.
8. **Involve the persons support network or a peer-advocacy worker in their care** within health and mental health services. People who have accessed services have a better understanding of how to support someone, people in healthcare with experience can humanise healthcare. They don't have to be "lived/living experience". This could include who the individual wants supporting them in providing health/mental health and advocacy.
9. **Each person who comes in for help should have direct access to advocacy.** Our organisation will identify roles and responsibilities and nominate who is responsible for advocacy and ensure each person receives help the first time they ask. This is because there is often a small window of opportunity when people are in a position where they are willing to accept help.
10. **Include a feedback mechanism** for our service through an anonymous system. Services would be able to implement change based on feedback on how people feel about the service they are receiving, implementing change based on feedback. Involve those with experience of the service in the design and implementation of that change.

11. **Humanise healthcare and embed conversation cafes into the 5 medical schools in Scotland** through compulsory training within curriculum for trainee medical professionals to attend peer support groups and fellowships to create connections and understanding. Professionals should attend community groups such as conversation cafes.
12. **Look to learn and share best practice with health boards and other services**.
13. **Undertake and adhere to the pledge goals from the private sector/workforce section**.
14. **Improve methods and knowledge of how addictions can become a prescribed medication (social prescribing**) for example prescribed Valium rather than street Valium so that people are not without medication for days or on waiting lists. This will also reduce crime and harm.
15. **Develop and adhere to minimum thresholds**. This includes people being able access addiction services the same as any other place – there are no locked doors and pharmacists do not have separate doors/queues for addiction services.

Housing (council housing, private landlords and housing associations) Pledge Goals

We pledge to:

1. Provide trauma-informed, addiction awareness and stigma training that is informed and delivered by people with lived experience to front-facing housing association staff.
2. Provide signposting to existing local support services and networks**.**
3. Ensure tenancies are secured and tenants are not kicked out of their homes when going through rehab or extended hospital stays.
4. Implement a duty of care and inform people of their tenancy rights.
5. Include reforms of effect on loss of DWP support on remand prisoners and psychiatric in-patients who lose benefits and tenancies.

Education Pledge Goals

We pledge to:

1. Ensure our directors of education take responsibility for the delivery of pledges.
2. Integrate anti-stigma teachings into teacher training.
3. Refresh substance education to avoid stigmatising the use of alcohol and drugs. Introduce anti-stigma and harm reduction lessons into personal social education (PSE) in secondary schools to open up relevant conversations with young people.
4. Put relevant tackling stigma campaign materials in and around schools.

5. Introduce mandatory training to all pastoral care staff as stigma champions to support young people affected by substance use.

Social Care Pledge Goals

We pledge to:

1. Integrate anti-stigma training into existing training and inductions.
2. Foster a person-centred approach based on unique client needs and social situations.
3. Support people with trauma-informed care in a way which respects boundaries and understands the role of advocates.
4. Ensure our service/organisation is working on tackling stigma in collaboration with other agencies, for example health and social care partnership, sharing learning and best practice.
5. Ensure help is available within clear, realistic timescales which are readily communicated.
6. Integrate anti-stigma approaches in our provision of support for families, taking into account the families views in the care of the person we're supporting.
7. Incorporate tackling stigma campaign information as part of existing local peer support groups and drop-in services.
8. Ensure anti-stigma is at heart of self-directed support models.

Policing Pledge Goals

We pledge to:

1. **Set up or provide custody-based recovery with peer workers**. This will provide more awareness of substance use withdrawals to support people. Encourage engagement with addiction/recovery services and build more awareness of substance use withdrawals to support people.
2. **Educate our police on issues with release and/or health support. Police should release people to a place of safety.** For example, Police should have local knowledge of support services, health services and housing to sign-post people. Police should build awareness, better understanding and acceptance that not everyone who uses substances engages in criminal activity. Ensure police do not withhold medication as a tactic for gaining information.
3. Police Scotland should encourage the training and roll-out of naloxone and nyxoid with naloxone champions within the Police force.
4. **Provide Harm Reduction Training as part of ongoing CPD.** This will provide awareness of where to access Harm Reduction supplies i.e. IEP, fails, to advise people how to access. Peer support working along with Police for e.g. overdose calls.

5. Develop strong community liaison across all localities.
6. Ensure lived and living experience is not a barrier to working with or alongside police with appropriate risk assessments in place.

Prisons Pledge Goals

We pledge to:

1. **Create and provide a through care plan 6 weeks prior to release**, with input from appropriate and recognised third sector parties in each local authority.
2. Ensure our prisoners have access to the MAT (Medicated Assisted Treatment) standards and charter of rights.
3. **Compose a list of support methods and resources in every locality**, including GPs, housing, recovery cafes, benefits, citizens advice, peer mentoring opportunities, advocacy support, gate pickup, liberation packs, job centres, harm reduction, rehab support, mental health support, family involvement to repair/improve relationships prior to liberty, access to community psychiatric nurses, twelve step recovery programmes, and relevant charities that will help prisoners on release.
4. Promote peer mentoring and recovery communities in every prison.
5. **Provide access to training to improve understanding for our prison officers** of mental health, drug use, stigma, trauma-informed care and importance of empathy. This training should be attached to annual development.
6. **Provide more training and awareness for people in custody** short and long term to support themselves and others that includes first aid, mental health first aid, wellbeing, harm reduction, SMART facilitator training, ASSIST, twelve step programmes.
7. **Ensure our prisoners have access to the medications that they need**, and information of all treatment options, and provide a written justification if denied, as detailed within MAT Standards.
8. Get addiction nurses and nurses to **work in collaboration** in our prison.

Approach & Methodology

Process Delivery

The co-design process for Tackling Stigma for Drug and Alcohol use in Scotland was a collaborative, iterative approach that centres the voices of people with lived and living experience. Each workshop builds upon the insights gathered in the previous one, creating a layered understanding of stigma and how it manifests across services, communities, and society. The process began by identifying key

issues and personal experiences of stigma, followed by exploring the groups most affected, and then examining how systems and structures contribute to stigma. Later workshops focused on shaping solutions, messages, and public awareness strategies, ensuring that all ideas and outputs are grounded in real-life experience and informed by those most impacted. This progressive structure ensures that the project remains participant-led, continuously refined by feedback, and ultimately results in actions and messages that are meaningful, effective, and community-driven.

Workshops & Purpose	Place/Date	Workshop Aims	Deciding Matters Team	External Input
Workshop 1: Introduction; Hopes/Fears; Experiences of stigma; Role of media & public realm in stigma; Vision Statement.	Saturday 27th April, Quaker Meeting House, Edinburgh.	• Understand Scottish Government's plans and how these recommendations will be taken forward. • Understand the work undertaken so far by Scottish Government on Drugs and Alcohol Policy • Understand different types of anti-stigma national campaigns such as SeeME mental health. • Identify where stigma exists at an individual level, group level and systemic level. • Identify the priority challenges the Tackling Stigma Programme might face e.g., can't address everything in Scotland. • Produce a set of vision statements they wish to see Scottish Government, services and the public take forward for change.	• Annie • Kevin • Rachel • Alex	• Julie Allison, Scottish Government • Christina McKelvie, Minister for Drugs and Alcohol Policy of Scotland • Patty Lozanzo Casal–SeeMe Scotland • Carolyn Wood, mental health support person – running mindfulness exercise
Workshop 2: A day in the life of scenarios; Mapping most stigmatising areas and places in Scotland &	Saturday 15th June, Merchants House, Glasgow.	• Been informed by the research team on the national research on tackling stigma for drugs and alcohol in Scotland. • Have developed and prioritised 8-10 solutions for positive change per table (potentially 30 solutions in total). • Have developed and prioritised 3 sets of national programme messaging and methods per table to	• Annie • Kevin • Rachel • Alex	• Millie Dixon – Research team, Scottish Government • Julie Allison, Drug & Alcohol Policy, Scottish Government – running mindfulness exercise

solutions for change.		test with the research team over the summer (potentially 9 sets of national programme messaging/methods/target audiences in total).		
Workshop 3: Refining our Campaign; Developing our solutions and actions for change.	Saturday 14th September, The Grassmarket Community Hub, Edinburgh.	• Been informed on what's already happening in Scotland on drugs and alcohol policy, the gaps in Scottish Government, services and budgets. • Review and develop workshop 2's solutions for positive change using any gaps in Scottish Government's work to develop potential solutions in more detail. • Been informed by the research team on the general public's attitudes on drug and alcohol stigma and their feedback on national messaging. • Have prioritised 3 sets of national programme messaging and methods using the feedback from research team's focus groups	• Annie • Kevin • Alex	• Clare Wood – Research team, Scottish Government • Alison Crocket, Drug & Alcohol Policy, Scottish Government - policies underway
Workshop 4: Defining success for a national pledge that addresses stigma; Developing national pledges for different sectors	Saturday 9th November, The Grassmarket Community Hub, Edinburgh.	• Review the outputs from workshops 2 & 3 including the national campaign messaging final survey that will go to a communications strategist. • Been informed on what's already happening in Scotland on anti-stigma training, drugs and alcohol policy, the gaps in services from Scottish Drug Forum perspective. • Start developing ideas for a Scotland national pledge to tackle stigma for drug and alcohol use including overarching indicators of success. • Start developing specific clear achievable goals for each service area (5-8 overarching pledge goals per service area): housing, mental health, health, education, policing, prisons, social care, and private sectors e.g., supermarkets, with regards to	• Annie • Kevin • Rachel	• Wez Steele – Scottish Drugs Forum • Austin Smith – Scottish Drugs Forum • *No Scottish Government attendance

		how they could each undertake actions to tackle and reduce stigma for drug and alcohol use.		
Workshop 5: Integrating Charter of Rights into recommendations ; Refining pledge goals for health/mental health & workforce/private sectors.	Saturday 1st February, The Social hub, Glasgow.	• Review the outputs from workshop 4 • Been informed on what's already happening in Scotland on the Charter of Rights and how this could be connected to our National Pledge for Services • Refine ideas for a Scotland national pledge to tackle stigma for drug and alcohol use including overarching indicators of success. • With input and support from topic experts, refine specific clear achievable goals for workforce and private sectors and mental health and health services (5-8 overarching pledge goals per service area): with regards to how they could each undertake actions to tackle and reduce stigma for drug and alcohol use.	• Annie • Kevin	• Jason Wallace – Scottish Drugs Forum - Charter of Rights (Supporting with overarching Pledge Goals) • Stuart Henderson– Scottish Government (Supporting with Workforce & Private Sector Pledge Goals) • Dan – Health Improvement Service (Supporting with Health & Mental Health Pledge Goals) • Linda Hunter – Scottish Government (Supporting with Health & Mental Health Pledge Goals)
Workshop 6: Refining National Programme Campaign & National pledge goals for services/governments.	Saturday 15th March, Quaker Meeting House, Edinburgh.	• Review & refine ideas for a Scotland national pledge to tackle stigma for drug and alcohol use including overarching indicators of success.	• Annie • Rachel	• *No Scottish Government attendance

Additional Workshop 7: Refining National Programme Campaign & National Pledge Goals for services	Online through Zoom	• Reviewing and refining the draft national pledge goals • Reviewing and refining the draft national campaign	• Annie • Rachel	• Julie Allison, Drug & Alcohol Policy, Scottish Government
Workshop 8: Refining the Draft Final Report, Creating Media Content, Feedback & Accountability	Saturday 31st May, The Social Hub Glasgow	• Reviewing and refining the draft final report, adding resources • Creating participant media content of stories, experiences and messages for public and government • Feedback on process • Accountability & next steps for Scottish Government to action	• Annie • Rachel	• Julie Allison, Drug & Alcohol Policy, Scottish Government • Doreen Grove, Head of Open Government, Scottish Government

Inception & Planning

We are aware that this work is part of a much wider tackling stigma programme, including cross-cutting areas such as mental health, housing, supporting families, justice, and the role of healthcare services in improving existing challenges in Scotland. We recognise that by engaging people with lived experience and the public we are aiming to support Scottish Government achieve the ambitious national outcomes of reducing drug deaths and improving the lives of those most impacted by drugs and alcohol.

Deciding Matters utilised existing frameworks including Scottish Government's Participation Framework to identify relevant guiding principles which will underpin our design and delivery of this process, alongside strong working knowledge of successful participatory processes. Deciding Matters has a strong commitment to working with individuals who have lived experience. We recognise the invaluable insights and expertise that these individuals possess, and we firmly believe that including their voices in our work is essential for creating effective and impactful solutions.

Deciding Matters held a kick off meeting with SG Tackling Stigma policy team to understand specific requirements and clarifying and agreeing requirements and ways of working:

- Reaffirming the purpose, scope and parameters of the co-design process.
- Clarifying roles and responsibilities, including who needs to be involved in the design process.
- Agreeing expectations and ways of working.
- Logistical arrangements.
- Key next steps.

Recruitment & Participants

Scottish Government led the recruitment of the co-design panel, with support from Deciding Matters. Deciding Matters created a recruitment pack which included the project background and purpose, an overview of workshops, information on how to register interest, and FAQs. Individuals who were interested in taking part were asked to complete an online expression of interest form and it was made clear that 20-24 respondents would be selected with the intention of having a final panel with diverse representation. Of the 92 respondents, 24 were invited to take part in the full process. Of these 24, 20 then attended the workshops. The four who dropped out cited reasons including change in circumstance and inability to commit to a year-long process. Attempts were made to bring the number of participants back up to 24, but after the first workshop it was determined that the group worked well together and to not add new personalities. These participants were diverse in geography, age, and gender. Respondents were all of similar ethnic backgrounds, while attempts were made to reach diverse audiences (such as recruiting through a range of network channels), recruitment was not successful with regards to racial diversity. This could be due to a number of reasons, such as the additional stigma faced by those of minority ethnic groups compounded with drug and alcohol stigma may have presented to many perceived boundaries to engage. All respondents had either direct or indirect experience with drugs and alcohol and the associated stigma, whether it was from personal experience or through friends and family.

For full demographic breakdown please see Appendix 2: Participant Demographics

Accessibility & Inclusivity

We recognise there are several challenges in Scotland in tackling stigma and reducing drug deaths including the stigma and discrimination surrounding drug use and addiction which can cause significant barriers to people getting effective treatment and support. For example, increasing public awareness is needed to challenge stereotypes and misinformation. We recognise the historical policy focus on criminalisation and enforcement rather than public health and harm reduction strategies and limited access to evidence-based interventions such as supervised consumption facilitates and naloxone access – although this is slowly changing in Scotland with better recognition on the issue. Other challenges we recognise are the lack of funding and resources for treatment and support services for individuals and families affected by drug and alcohol use, health inequalities, socio-economic factors, education, employment, and housing. Scotland also faces the challenge of building better integrated and coordinated services and ensuring collaboration between sectors such as healthcare, social services, education and housing to address the multi-dimensional challenges of drug addiction.

The primary objective of this co-design process is to leverage the valuable insights and perspectives of individuals who have experienced drug and alcohol harms first-hand and/or second hand. By involving them in the design process, we aim to develop solutions that address their needs, improve support systems, and reduce the negative impact of substance harm.

Deciding Matters utilised the following principles of co-design to involve and engage participants into the Design Team to create more inclusive and user-centred solutions.

1. **Inclusion and diversity.** Ensuring that a diverse range of stakeholders are involved in the design process. This includes individuals from different backgrounds, cultures, abilities, and perspectives. By including a variety of voices, co-design aims to create solutions that are representative and relevant to the needs of the entire community.
2. **Collaboration and shared decision-making.** Emphasise collaboration and shared decision-making among all participants. Designers and stakeholders work together as equal partners, valuing each other's expertise and contributions. This principle fosters a sense of ownership and empowerment, as decisions are made collectively, and everyone's input is considered.
3. **Empathy and understanding.** This process will emphasise the importance of empathy and understanding towards the experiences, needs, and aspirations of all participants. Designers strive to develop a deep understanding of the context and

challenges faced by stakeholders, allowing them to create solutions that are truly responsive to their needs. This involves active listening, conducting research, and engaging in meaningful dialogue to build empathy and trust.

4. **Iterative and flexible process.** The process is iterative and requires flexibility. It involves multiple cycles of prototyping, testing, and refining ideas based on feedback from participants. This iterative approach allows for continuous improvement and ensures that the final solution is well-adapted to the unique needs and preferences of the user group.
5. **Creativity and innovation.** DM will encourage creative thinking and innovation and provide a space for participants to think outside the box, challenge assumptions, and explore new possibilities. By fostering a collaborative and open environment, co-design enables the exploration of diverse ideas and promotes innovative solutions that may not have been considered in traditional design processes.
6. **Transparency and communication.** The process should promote transparency and effective communication throughout. Clear and open communication ensures that all participants are well-informed and have a shared understanding of the project goals, progress, and outcomes. This principle also includes providing regular updates, seeking feedback, and involving stakeholders in decision-making processes to maintain transparency and accountability.
7. **Sustainability and long-term impact.** DM has emphasised the sustainability and long-term impact of the solutions being designed. The process should consider the social, environmental, and economic aspects to ensure that the solutions are not only effective in the short term but also contribute positively to the community in the long run.

Human-centred and trauma-informed approach

- **Choose a venue that is comfortable and confidential**, where participants can freely express themselves without fear of judgment or stigma. We aimed to consider factors such as lighting, seating arrangements, and privacy. We also tried to offer a quiet room if participants need to leave at any time for a breather.
- **Develop a trauma-informed approach,** to recognise that individuals with lived experience of substance abuse and trauma may have unique needs and triggers and we will educate ourselves on trauma-informed practices to better understand and respond to their potential challenges. This includes being aware of potential triggers, using empowering language, and providing options for participants to opt-out or take breaks if needed. Our team including associate facilitators will all undertake training where necessary to be fully prepared to respond to potential challenges.

- **Promote a non-judgemental atmosphere of acceptance** by emphasising that everyone's experiences and perspectives are valid. Participants were encouraged to share openly without fear of criticism or blame and establish conversation ground rules that promote respect, active listening, and confidentiality throughout the workshop.
- **Offer peer support** through encouraging the formation of peer connections and support networks among participants by setting up and facilitating smaller group activities that promote bonding, such as icebreakers or pairs exercises. Peer support can create a sense of belonging and validation, as individuals can draw strength from shared experiences.
- **Bring in professional support**. In similar processes we have brought in mental-health professionals that are available during the workshop. For this process we had on offer a mental health professional available if participants felt they needed them. These professionals can offer individual support if someone becomes triggered or needs additional assistance.

Outputs - Workshop 1 Summary Report

Please note that this summary of discussions aims to provide an overview of the issues mentioned, but it may not encompass all the nuances and complexities of each discussion and situation.

Discussion 1: Hopes & Fears

Hopes ♥	Fears 😞
Participants highlighted a list of hopes that they see as essential in making progress for tackling stigma for drugs and alcohol in Scotland	Participants highlighted a list of concerns and fears that they see as essential in making or blocking progress for tackling stigma for drugs and alcohol in Scotland.
• **Change the language**. The focus is on changing the language and removing stigmatising terms like "alcoholics" and "addicts" from the glossary. • **See the person.** The aim is to see individuals as people and create a seed for change in order to achieve a fairer Scotland, where there are no more deaths due to addiction. • **Less judgemental society**. Society should become less judgmental, enabling those who are struggling to feel	• **Perceived lack of action**. Efforts to address addiction are slow and limited to bureaucratic processes without resulting in real change or reaching the communities affected. • **Insufficient support**. There is currently not enough help and support available for individuals and families affected by addiction, and that support is only provided if the individual seeks it themselves.

comfortable asking for help without shame. Support for families is important.

- **Trauma-informed communication**. It is crucial to speak to the person directly, not just a screen or notes, and to ensure consistency and shared experiences. Understanding trauma from a young age and highlighting positive pathways are essential.
- **Services should work together**. There should be no segregation for people seeking help.
- **Increasing public awareness and reducing drug deaths are priorities**. The process should be empowering and show that positive change is possible.
- **People in jobs should genuinely want to be there**, and the public perception of those suffering from addiction needs to change. Lived experience should be at the centre of this transformation, and learning from others is important.
- Opening minds to negative consequences and prioritising compassion are key.
- **Psychologically and trauma informed campaign**. The campaign should be psychologically informed, focused on trauma, and convey the message that substances are symptoms.
- **Kindness should be emphasised** from top to bottom, and the **word "love"** should be brought back for everyone.
- **Avoiding stereotypes are crucial.** Understanding and addressing stigma nationwide and an awareness built of our judgements.
- **More acceptance and understanding are needed.** Stigma reinforces feelings of shame and guilt.
- All people, regardless of their background, should be able to socialise in society.

- **Deteriorating situation**. The situation is getting worse, with no legal grounds or enforcement mechanisms to drive meaningful change.
- **Scepticism of intentions.** Participants are very concerned that the current efforts are just empty words without actual implementation or consideration of trauma-informed approaches.
- **Lack of listening and understanding**. Individuals feel unheard and undermined, with their personal experiences being overlooked by policymakers and experts.
- **Impact on mental health.** Emotional distress and difficulty in recovering from re-sharing stories, the sessions and discussions are mentioned, indicating the toll it takes on individuals' well-being.
- **Lack of resources and funding**. There is a shortage of funding and resources, leading to a lack of positive impact and an inability to do what is necessary.
- **Pessimism about change.** There is a belief that change will not happen or will be slow, resulting in continued stigmatisation and lack of access to public services.

• **Bring back hope.** The goal is to leave with a sense of hope, educate more people about the damage of stigma, minimise drug-related deaths, and make positive changes in society. • **Policymakers have strong understanding of actions required**. It is important for policy makers to understand what needs to be done and for there to be positive outcomes, including changing views on addiction, providing help for families, and improving the justice system. • Additionally, accepting border cafes in the community is a part of the desired changes.	

Discussion 2: Experiences of Stigma

Lack of support and understanding from the prison service	• Individuals in prison often face a lack of support and are seen as lesser, without consideration of the underlying reasons for their incarceration. • This lack of support can lead to individuals coming home with more trauma, exacerbating their existing challenges.
Police attitudes towards overdose cases	• There have been instances where police officers have stated that they wouldn't use lifesaving medications on someone who has taken an overdose. • This attitude raises concerns about the value placed on the lives of individuals struggling with substance use.
Public services using derogatory language	• Some public service providers use derogatory language, such as referring to individuals with addiction issues as "junkies." • This language contributes to the stigma surrounding substance use and can further marginalise individuals seeking help.
Assumptions and lack of understanding in healthcare settings	• There are cases where individuals with medical issues are assumed to have taken drugs, disregarding explanations provided by their families. • Police officers speaking disparagingly to professionals working in roles related to helping individuals, without realising the professionals' lived experience, can be damaging.

Negative connotations associated with "lived experience"	• The term "lived experience" is sometimes associated with low qualifications and wage, which can undermine the value and expertise of individuals who have personal experience with addiction.
Stigma leading to reluctance in sharing experiences	• Many individuals hesitate to share their lived experiences with addiction due to fears of stigma from friends, employers, and colleagues. • This fear of judgment can prevent individuals from seeking support and perpetuate the cycle of stigma.
Impact on family members	• Family members of individuals with addiction often face judgment, denial, shame, and ignorance. • Children of parents with alcohol use may experience name-calling and stigma due to their family situation being known.
Trauma and stigma leading to loss of family members	• The experience of trauma and stigma can contribute to the loss of multiple family members, further compounding the hardships faced by individuals with addiction.
Assumptions based on appearance	• Individuals may be wrongly assumed to not experience challenges related to addiction based on their appearance, leading to a lack of support and understanding.
Staff assumptions and limited time for service users	• Staff members may not have time for service users due to assumptions, which can hinder the provision of appropriate support.
Lack of support for individuals with substance use coping with trauma	• Volunteers in organisations like Rape Crisis have hesitated to report victims (to the Police) using drugs or alcohol, as substances can be used as a coping mechanism for trauma. • The lack of support to address trauma can perpetuate the cycle of substance use.
Challenges in accessing help:	• Individuals in crisis often face complex paperwork and bureaucratic hurdles when seeking help, which can delay or deter them from receiving the support they need.
Substance use not seen as a health problem	• Drug and alcohol addiction is often not viewed as a health issue, leading to a lack of appropriate support and treatment options.
Limited support for childhood trauma leading to substance use	• There is a lack of support to address childhood trauma, which can contribute to individuals turning to substances as a coping mechanism.
Cumulative trauma	• Traumatic experiences can build upon each other, further exacerbating the challenges faced by individuals with addiction.
Rumours, judgment, and the need to change appearance	• Some individuals have to relocate and change their appearance to escape rumours and judgment associated with their addiction.

Ignored calls for help	• Individuals may reach out for help but are often ignored, which can further isolate and discourage them from seeking support.
Denial of help for individuals with mental illness using drugs to cope	• Individuals who experience mental illness may turn to drugs as a coping mechanism but are then denied help due to the assumption that their substance use is the primary problem.
Segregation at the chemist	• Some individuals who use substances may face segregation at pharmacies, highlighting the need for a more inclusive and supportive approach to accessing medication.
Seeking services outside the local area to avoid judgment	• Some individuals travel to chemists in other areas to avoid judgment and stigma from their local community.

Discussion 3: Impacts of Stigma

1. How does or could stigma impact us individually?
2. How does stigma impact us as a group? (a group could mean geographically, demographically, socially, family, etc).
3. What are some current public perceptions of people who are affected by drugs and alcohol use?

Individual Impacts

Below is a summary of some of the ways stigma has impacted participants on a personal individual basis.

Lack of access to services	Being judged for being on drugs and told to wait for help, missing the window of opportunity.
Sense of shame	Feeling embarrassed and being your own worst critic.
Isolation	Feeling and being isolated, lacking community support.
Stigma and self-esteem	Stigma lowers self-esteem, reinforces shame and guilt, and creates in and out groups.
Reluctance to seek services	Barriers and reluctance to seek help, toxic and unhealthy thoughts.
Self-stigma	Feeling not good enough, shame/guilt, impacting mental health and preventing help-seeking
Employment prospects	Stigma affecting employment prospects and leading to a self-fulfilling prophecy
Loneliness and self-loathing	Being labelled, internalising feelings, and feeling down.

Repeated explanation of situation	Having to repeatedly tell their story, recreating trauma.
Lived experience and policy makers	Lived experience being viewed differently, despite having knowledge and understanding
Impact on confidence and self-worth	Doubting oneself, low self-esteem, and lack of confidence.
Vilification of drug addiction	Annoyance at the vilification of people with drug addictions
Believing negative perceptions	Impacting confidence and self-worth.

Group Impacts

Below is a summary of some of the ways stigma has impacted participants as a group (a group could mean geographically, demographically, socially, family, etc).

Loved ones and families	Loved ones changing their behaviours to avoid impacting their family, even when it is not necessary, such as refraining from drinking in front of someone. Families being treated as an afterthought in the context of addiction. Friends and family feeling embarrassed or ashamed due to the stigma surrounding addiction. Label stigma extending to family members, further exacerbating the impact.
Intersectionality	Blaming issues solely on drugs and alcohol without considering intersectionality and multiple diagnoses.
Shared experiences	The group SFAD brings people together and strengthens them through shared experiences.
Appearances	Questioning why we judge others based on their appearance.
Institutional stigma	Institutional stigma and a lack of awareness about trauma. Stigma leading to the group being ostracised from society.
Queer community	The queer community relying on substances as a response to public stigma and queer phobia, highlighting the intersectional nature of the issue.
Risk of suicide from stigma	The presence of self-stigma and public stigma increasing the risk of suicide.
Recovery spaces	Resistance to recovery spaces and the shunning of such spaces slowing down progress.
Generalising assumptions	Generalising assumptions made about individuals dealing with addiction.
Geographic inequality	Disparities in access to resources based on location, creating a "postcode lottery" effect.
Politicians	Elected officials prioritising resources for addiction services based on perceived deservingness, which can perpetuate inequality.

Public perceptions

Below are some issues participants raised on current public perceptions of people who are affected by drugs and alcohol use.

People can't change when in fact people can go on to live amazing lives	Stigma and stereotypes exist around individuals who have experienced change, particularly in the context of medical records and substance use. Society creates stereotypes that people can't change.
Media and pollical factors	These stigmas are perpetuated by certain forms of media and political factors.
Service co-ordination	There is a lack of coordination among services, resulting in a failure to refer individuals to the appropriate help.
Identity and categorising	Stereotypes can blur the lines of identity, leading to the overlooking of those who do not fit into certain categories. For example, there are assumptions that people who use drugs and alcohol are in poverty, poor health, in the justice system, poor education, violent, crime, bad associates, bad family, poor upbringing, lazy, on benefits, untrustworthy.
Medical system	The medical model often dismisses other contributing factors and creates a hierarchy. Very few relate drug and alcohol use to mental health.
"Recovery" implications	The term "recovery" in substance use can be stigmatising as it implies that certain adversities are necessary for change. Recovery is also sometimes seen as a trend, undermining its significance.
Intersectional approach	There is a need for a more intersectional approach to understanding and investigating these issues.
Naloxone	Naloxone, despite being widely available, still faces stigma.
Public bodies	Publicly funded bodies may have the right rhetoric, but their actions may not align.
Negative public attitudes	Negative attitudes and judgments contribute to the perception of individuals as "wastes of space." These individuals are often viewed as lesser, criminals, and drains on society.
Connection between mental health	It is important to recognise the connection between substance use and mental health. Very few people connect these together.

Discussion 4: Role of Media & Public Realm in Stigma

1. What role does the media have in shaping public opinion and perpetuating or tackling stigma? How and what can be controlled by the media? How and what can't be controlled by media?
2. What else shapes public perspectives and public attitudes? Consider the public realm, how people's attitudes are shaped, historical factors, education systems, familial systems, social groups, power dynamics, contact and engagement, services, events...
3. What influences public perceptions and behavioural change more?

Participants highlighted that **media**, **word of mouth, education, Scottish culture,** and **use of language** can play a significant role in shaping attitudes and perceptions towards addiction and substance use and these are five of the biggest influences in changing public perceptions and behavioural change. Overall, the media's portrayal of addiction and substance use can greatly influence public opinion and perpetuate stigma. It is essential for media organisations to approach these issues responsibly and provide accurate and empathetic representations.

Below is a summary of key points:

Use of language	• Media often labels people as "addicts," which contributes to the stigma surrounding addiction.
Images being shared without consent	• Negative comments and images shared without consent on social media further perpetuate stigma.
Alcohol advertising	• Advertising of alcohol, including finding ways to promote "0%" options, can normalise excessive drinking. • Constant advertisement for alcohol can be triggering for individuals struggling with addiction.
Glamorising addiction	• Media sometimes glamorises addiction, especially when it involves celebrities. • Films and social media platforms like TikTok can glamorise drug and alcohol use.
Misinformation	• Incorrect portrayals of how to deal with overdosing can spread misinformation.
Angled lensed or misrepresented portrayals	• The media tends to focus on symptoms rather than addressing the root causes of addiction. • Media often focuses on social or recreational drug use and ignores the realities of addiction. • Media representations of recovery can be unrealistic, leading to misconceptions about the process.

Political agendas	• Drug-related deaths and statistics are often used as political tools rather than giving a platform to lived experiences.
Sensationalist storytelling	• The media can be intentionally divisive and sensationalise drug-related issues for specific emotive purposes. For example, "war on drugs" was fuelled by the media. • Bullying and sensationalism in media narratives reinforce stereotypes and justify mistreatment of certain groups. • Sensational stories about addiction sell, while nuanced perspectives are often overlooked.
Actions and improvements:	
Promote responsible behaviour and accurate information	• The media can play a role in promoting responsible behaviour and providing accurate information about addiction • Poor education and cultural factors contribute to the stigma surrounding substance use. For example, Scottish economy/culture is around alcohol and whiskey. • The media has the power to control beliefs and shape societal attitudes towards addiction.
Social influencers	• Social influencers can have both positive and negative impacts on public perceptions of addiction.
Government accountability	• Government accountability and advocacy groups can influence stigma and promote harm reduction.
Increase in empathy, education, and services	• Lack of empathy, understanding of services, and education contribute to the perpetuation of stigma.
Personal stories and word of mouth	• Word of mouth and personal stories can help break down barriers and challenge stigma.
National TV campaigns	• Media has the potential to provide positive education and reduce stigma through national TV advertisements.

Discussion 5: Campaigns in the media that aim to address stigma

1. Reflecting on these examples (in presentation), how effective do you think media campaigns are in addressing and reducing stigma around these social issues?

2. What strategies do media campaigns take to challenge public perceptions and attitudes towards stigmatised topics?
3. Do media campaigns help with meaningful discussions about stigmatised topics in society?
4. How can media campaigns be improved to have a more lasting impact in reducing stigma and promoting social change?

Participants looked at some media campaigns in the current public realm including HIV anti-stigma, SeeMe mental health and NHS drug and alcohol anti-stigma campaign. The group discussed how the effectiveness of various media campaigns addressing social issues depends on various factors. Overall, participants highlighted that to develop or improve media campaigns in Scotland, it is crucial to encourage reaching out for help, stimulate conversations, involve the right people, be present in various platforms, and incorporate positive recovery stories. Ultimately, the media's role should be to foster critical thinking, challenge assumptions, and prompt meaningful change through dialogue and action.

Here are some key points participants highlighted as important to consider:

Scare tactics vs empowerment	• Scare tactics can sometimes backfire and lead to blame and stigma, as seen in the HIV campaign that wrongly targeted gay people and drug users. Empowering campaigns, such as carrying naloxone to save lives, can have a positive impact.
Wide reach and targeting	• Campaigns need to reach a wide audience to be effective. However, it is also important to target specific groups who are most affected by the issue.
Funding and expertise	• Adequate funding and involvement of experts in campaign planning and execution can enhance their effectiveness. • Attention should be given to diverse perspectives and not solely rely on job titles.
Genuine dialogue and conversation	• Media campaigns should prompt hard conversations and dialogue between people. Creating spaces for genuine dialogue and allowing people to share their stories can be powerful.
Balance and relatability	• Striking the right balance between shock value and relatability is crucial. Campaigns should stimulate conversations and debate while being based on truth and providing hope.
Representation of lived experience	• Involving people with lived experience in campaign development and delivery can bring authenticity and increase effectiveness. Their insights can help shape messaging and highlight the impact of stigma on accessing healthcare.
Acceptance as a health condition	• It is important for social issues like addiction to be accepted as health conditions rather than moral failings. This shift in perception can reduce stigma and promote understanding.

Tailored campaigns and methods	• Different audiences may require different approaches, and campaigns should consider a rights-based approach. Incorporating sanctions, if necessary, can ensure accountability.

Discussion 6: Vision Statement

The following table is a vision statement collated from the group on recommendations that should be taken forward by government, public services, media and public in order to tackle stigma for drugs and alcohol in Scotland.

Our vision is that to tackle stigma for drugs and alcohol in Scotland...

The Government will...	• Provide robust funding and engaged dialogue which are necessary for addressing addiction. • Really listen to those affected by addiction. • Integrate the campaign into wider training and induction programs. • Frame substance use as a normal response to abnormal circumstances. • Include a section on the self-medication hypothesis in the campaign. • See the person, not just the addiction. • Provide support for public services to provide appropriate care is essential. • Be honest about the severity of the drugs and alcohol issue in Scotland. • Ensure human rights is at the forefront of the approach. • Outdated legislation should not be relied upon, and progress should be made. • View addiction as a health crisis, not just a legal issue, is crucial. • Demonstrate commitment to resolving the issue. • Consider decriminalisation and legalisation. • Actively listen, take action, and provide safe supply. • Provide better resources and the use of existing legislation to regulate services are needed. • Provide evidence-based policies and allocating resources where needed. • Evaluate the effectiveness of commissioned organisations is essential.

	• Ensure stigma towards people who use drugs and alcohol is avoided. • Work with individuals who have experienced stigma. • Collaborate with those who have lived experience. • Consider secondments for local government into local services. • Make programs accessible to everyone and ensuring non-profit services are available. • Involve local government in community groups and giving a platform to the people is important. • Ensure collaboration between different government sectors, such as criminal justice, health, and social care, is crucial. • Tackle the wider issues surrounding addiction should be a focus. • Provide more recovery spaces.
Public services will... **Healthcare, social care, education, etc*	• Provide clear directions and guidance for individuals seeking recovery from addiction. • Implement education programs that target young people to raise awareness about addiction and its consequences. • Embed addiction awareness campaigns and support systems within the school curriculum. • Address the issue of inaccurate data on drug-related deaths and ensure accurate recording and analysis of such data. • Recognise and prioritise the individual behind the addiction, providing personalised support and treatment. • Proactively reach out to individuals in need of support, ensuring they don't have to always seek it themselves. • Provide timely intervention and support to individuals struggling with addiction. • Ensure that individuals' basic needs, such as housing and food, are met to support their recovery journey. • Create programs and systems that set individuals up for success, rather than perpetuating cycles of failure. • Maintain regular communication with individuals in recovery to provide ongoing support and guidance. • Have peer-based advocates and supporters available to offer help and guidance to those in need. • Offer programs that support individuals in reducing their substance use and promoting harm reduction. • Centralise addiction services and resources to ensure better coordination and accessibility.

	• Use language and approaches that do not stigmatise individuals struggling with addiction. • Avoid making individuals retell their personal stories repeatedly, respecting their privacy and dignity. • Provide more training for professionals working in addiction and recovery services. • Offer training on overdose prevention, including the use of naloxone. • Ensure easy access to naloxone, a medication used to reverse opioid overdoses. • Respect individuals' rights regarding their personal data and provide clear opt-in and opt-out options. • Employ more individuals with lived experience of addiction to enhance empathy and understanding in the workforce. • Foster a culture of openness and honesty, reducing fear and stigma surrounding addiction. • Address and tackle stigmatising language commonly used in relation to addiction. • Ensure the right to access healthcare under the AAAOR (Availability, Accessibility, Acceptability, and Quality) framework. • Increase availability and speed of access to rehabilitation services. • Provide safe spaces for individuals to use substances, reducing the risk of harm and overdose. • Integrate mental health and addiction services to provide comprehensive support. • Incorporate individuals with lived experience in the development and delivery of services. • Increase advertising and support services for families affected by addiction. • Adopt strategies to address addiction-related issues in the night-time economy. • Provide more resources and support for young people struggling with addiction.
Media campaigns will...	• Engage in the campaign in a respectful and collaborative way. • Fundamentally change the language used on substance use. • Promote more recovery-oriented care. • Change the language that they use. • Promote positive recovery stories. • See the person. • Use multiple platforms (social media, TV, in person). • Reduction and cessation of vilification of people who use drugs. • Be honest. • Acknowledge how many people are affected and don't be judgemental.

	• Share full nuance of the situation. • Understand and share recovery journeys. • Don't want dark, dingy campaigns. • Make message hopeful and relatable. • Use better language. • More information on overdose. • Educational. • Targeted. • Show that it can affect everyone and anyone. • Use QR codes and make accessible. • Information. • Interactive. • Stop glorifying alcohol/drugs. • Show what can actually happen. • Humanise.
The public will... **Public society, perceptions, communities etc*	• Be supported to think critically and challenge their pre-held beliefs and where they come from and do this with compassion. • Be able to access safe houses if they've used psychological drugs. • Understand drug use and levels of addiction. • Be kinder to people who use. • Know when to spot the signs of when someone needs help. • Be educated. • See the person. • Understand that they can help fix these issues. • Understand how everyone will likely be affected by substance use. • All contribute to reducing stigma. • Be educated. • Have compassion. • Love.

	• Tolerance. • Listen. • Less-fear. • More involvement in community. • Campaign for support for people. • Get involved. • Talk about it. • Normalise and encourage conversation. • Culture change needed.

Outputs - Workshop 2 Summary Report

Discussion 1: A day in the life of scenarios/persona's

The following scenarios/persona's informed by research were presented to the design team:

1. ***Sarah**, who is a mother wants to get healthcare support for her child from her GP but is frightened to speak to her GP for fear of losing her child because of her substance use.*
2. ***Ben** makes an appointment to see mental health support worker. When he tells the support worker that he uses substances, the support worker refuses to provide mental health support until he stops using substances.*
3. ***Megan** tries to shop in their local shop and is followed around in the store by suspicious staff, refused entry to the shop or even barred because of their lived experience of substance use.*
4. ***Jo** starts using methadone as part of her recovery. When she goes to get her prescription, she is asked to wait in a different queue and is treated differently from other customers in the pharmacy.*
5. ***Jennie** works as a nurse in a high dependency hospital ward. The ward treats a lot of patients with substance use issues and there's lots of disrespectful chat among healthcare staff about these patients. But when the woman revealed that her own child had substance use issues, staff attitudes started to change.*
6. ***Mike**, a teenager receives so much abuse at school because his brother has living experience of substance use, that his mother decides to send him to a new school and change his name so teachers / pupils in the new school don't know who he is.*

Your lived experience

Participants highlighted areas in which they resonated with the scenarios from their own lived experience to start thinking about the main areas in which stigma needs to be tackled.

- **Pharmacy:** Participants felt stigmatised by being required to use a separate entrance or booth, especially in small communities where everyone knows each other. There was also stigma around different treatments (e.g., take-home vs. supervised medication).
- **Hospitals & Mental Health Services:** Some staff were perceived as distant or unapproachable. Physical barriers and impersonal treatment (e.g., being made to watch a DVD) made services feel unwelcoming and dehumanising.
- **Mental Health & Substance Use:** There was a lack of integrated support for those using substances, and concerns about being treated poorly or not supported when disclosing issues.
- **Social Stigma:** Fear of judgment and stigma in small communities, especially around drug or alcohol use, both during use and while in recovery (e.g., visible withdrawal symptoms).
- **Employment & Parenting:** Fear of losing children or being suspended from work when disclosing substance use.
- **Systemic Issues:** Perceived lack of awareness of rights and a tendency to shift blame between different levels of government.

Ideas for change

Participants highlighted a list of areas from the scenarios and their own lived experiences in which there could be positive change around these stigmatising and negative experienced.

- **Systemic Failures:** Confusion and lack of coordination between drug and alcohol services and mental health services create a harmful cycle for individuals needing help.
- **Judgment and Stigma:** People are often judged based on appearance or behaviour (e.g., being upset), leading to denied care or criminalisation.
- **Support Gaps and Misinformation:**
    - Many people fear losing their children if they disclose substance use.
    - There's a lack of awareness that other professionals (e.g., school nurses, health workers) can provide support before reaching the GP.
- **Changing Attitudes:** While social services are becoming more understanding, fears and misconceptions still prevent people from seeking help.

Key Solutions:

- Public Education & Awareness:
    - Increase visibility of drug and alcohol users in media to humanise their experiences.
    - Share rights and principles openly in all service spaces (e.g., GP waiting rooms).
    - Have real conversations with people who have lived experience to break down stigma.
- Service Improvements:
    - Ensure continuity of care and adopt a “no wrong door” approach where people can choose the support they need.
    - Involve advocates or supporters in appointments to help people feel safer and more empowered.
    - Make existing advocacy services (like NHS ones) more visible and accessible.
- Cultural and Structural Change:
    - Employ more compassionate, well-suited staff.
    - Create a more flexible, tolerant approach (e.g., not requiring people to be completely sober to receive help).
    - Address class-based inequality alongside other protected characteristics.
    - Reduce criminalisation and controlling practices in support services.
- Empowerment and Rights:
    - Help people know and exercise their rights without fear.
    - Encourage self-advocacy and ensure it’s safe to speak up.

Short Term Ideas for Change	Long-Term Ideas for Change
Community Engagement:	**Policy and Structural Reform:**

- Services actively visiting cafes and safe spaces like recovery cafés.
- Conversation cafés in universities and community venues.
- Pop-ups in DWP offices and local hubs for signposting and support.
- One-stop shops and visible, accessible services in the community.
- Peer support and buddy systems to guide people through services.

Training and Awareness:

- Annual training for NHS and public services on addiction and stigma.
- Promote awareness of existing feedback systems like Care Opinion (but simplify them).
- Cross-sector weekly check-ins (e.g., police, housing, food banks) to identify community needs.
- Enable individuals to share their stories once—better data sharing and communication.
- Empower people to know and assert their rights.

Improved Access and Communication:

- Immediate wraparound support in schools.
- Simplified "Yellow Pages"-style directories for services and advice.
- Use of healthcare passports to streamline care.

Stigma Reduction:

- Legislate standards of care, rights, and accountability (already in discussion in Scotland).
- Make addiction a legally protected characteristic.
- Require cohesion and data sharing between all relevant services.
- End the criminal-first approach to addiction; prioritise care and recovery.

Service Transformation:

- National "one-stop shops" with integrated services and peer support.
- Full restructuring of support systems to prevent trauma and reoffending.
- Legal frameworks to regulate workforce behaviours and eliminate institutional stigma.
- Improve coordination between mental health and drug/alcohol services.
- Ensure addiction is recognised and protected (e.g., as a protected characteristic).
- Legislation and standards to hold services accountable for stigma and inequality.

Empowerment and Leadership:

- Establish national peer groups and embed lived experience across all levels.
- Enforce adherence to a national charter of rights.
- Co-design services with people with lived and living experience.
- Include lived experience in designing, delivering, and evaluating services.

• Public bodies required to address stigma to receive funding. • Mandate kindness, respect, and compassion in public service behaviour. • Reduce institutional and professional stigma (especially in healthcare and justice sectors). • Promote respect, compassion, and curiosity asking, "Why are they like this?"—over judgment. • Education and regular training for all public service workers. **Education:** • Mental health and substance education in schools and GP training. • Short-term sober spaces (e.g., sober raves) and safe social events. • Increase access to education, financial support, and rehabilitation (especially post-prison). • More flexible, inclusive employment and education pathways (e.g., not penalising CV gaps).	**Sustainable Education:** • Mandated, continuous professional development for all relevant services. • Mutual learning partnerships between government and grassroots communities.

Discussion 2: Mapping the most Stigmatising Areas in Scotland & Solutions for Change

'Shoot for the moon' ideas for change

🚀 Integrated Person-centred Service Improvements:

- Provide appointment cards to reduce missed appointments and prevent suicide.
- Immediate peer support referrals by GPs.
- Mandatory training in trauma, addiction, and stigma for all public sector staff every 2 years.

- Mental health and addiction services must operate as one integrated team.
- Holistic, trauma-informed, and personalised care should be the standard.
- Support staff (including peers) should be cross-trained in addiction, mental health, and trauma.

🚀 Community-Based Actions:

- Weekly multi-agency community meetings to catch what's "slipping through the cracks."
- Recovery hubs and community centres in every area.
- Use social media to roll out a national stigma-reduction campaign.
- Establish weekly community meetings with services, GPs, and stakeholders.
- Build community hubs and increase amenities for children to prevent future addiction.
- Foster stronger local connections to reduce isolation.

🚀 Voice, Advocacy and Accountability:

- Create peer networks within ADPs.
- Peer-led audits and advisory roles in Alcohol and Drug Partnerships (ADPs).
- Lived experience should guide all policy and service delivery, including at cabinet/government level.
- Community voices—not just national organisations—should shape strategy.
- Appoint ministers with accountability—resign if no improvement in one year.
- A national strategy to address stigma is needed, supported by social media and public campaigns.
- Advocacy, reporting, and accountability mechanisms must be improved for people using services.
- Public services must treat addiction as a complex mental health issue rooted in trauma, not moral failure.

🚀 Policy & Structural Reform:

- Legal decriminalisation of drug use.
- Make addiction a fully integrated part of national mental health services.
- Make the drugs/alcohol portfolio a cabinet-level role with lived experience at the centre.
- Double funding for addiction and mental health services.

- Invest in education, housing, and poverty reduction.
- Move away from relying on charities—government must take responsibility.
- Coordinate national/local/regional strategies based on need and harm hotspots.
- Use existing legislation (Fairer Scotland Duty, Public Bodies Act, etc.) more effectively.

Decriminalisation, Legislative & Systemic Overhaul:

- Fully implement the Christie Commission principles.
- Devolve more powers to Scotland and apply laws like the Fairer Scotland Duty meaningfully.
- End charity dependence; properly fund and staff public systems.
- Addiction should be treated as a health issue, not a criminal one.
- Police should not respond to overdoses—appropriate, non-criminal emergency services should.
- The prison system and justice responses need complete overhaul to avoid re-traumatisation.

Cultural and Educational Change:

- End class-based and institutional discrimination—reduce poverty and inequality.
- Education in schools, GP surgeries, and colleges must be lived-experience-led, not police-led.
- Promote long-term leadership and workforce development in areas of greatest need.

Holistic Public Health Vision:

- Eliminate the need for food banks.
- Eliminate unpaid/invisible care roles.
- Create a national stigma strategy and a just, compassionate health-first approach to addiction.

Most marginalised groups	Key Issues

• Women, especially ethnic minorities and older women. • Prisoners and people living in rural or deprived areas. • LGBTQ+ community. • People who don't speak English as a first language. • People with disabilities. • Homeless individuals. • Children and teenagers (with specific concerns about drug use). • Men from Black, Asian, and Minority Ethnic (BAME) backgrounds. • Those experiencing poverty and social isolation. • Individuals affected by domestic violence. • Queer community and families with children in care. • Lonely adults, especially related to alcohol use.	• Services often focus on young men, leaving other groups underserved. • Lack of targeted approaches for males in deprived areas despite higher risk. • Invisible poverty and inequality in rural and certain urban communities. • Need for education led by people with lived experience. • Importance of providing practical and emotional support, especially for children and families. • Impact of relationship breakdowns, social isolation, and community-wide challenges. • Importance of resourcing services adequately (staffing and funding). • Need for wrap-around support and activities for young people.

Mapping the most stigmatising areas and places in Scotland	Solutions for Change
• **Deprived areas** and people living on the **margins** face the most stigma. • **Statutory institutions** (e.g., NHS, police, education) often reinforce stigma through lack of understanding or systemic barriers. • **Pharmacies**, **media**, and **employers** contribute to stigma through practices, assumptions, or portrayal. • **Governmental engagement** seen as superficial or political, not meaningful.	1. **Increase Community Outreach** a. Use assertive ADP workers, GPs, police with lived experience to build trust and connection. 2. **Better Education and Awareness** a. Provide cross-generational education on the effects of drugs and alcohol. b. Create national awareness campaigns with a recovery-positive message. 3. **Improve Service Access**

• **Alcohol advertising**, **minimum pricing**, and **criminalisation** of drug use were seen as ineffective or counterproductive. • **Teenagers and public substance use** reflect worsening conditions due to lack of early intervention. • Public discussion of **grief**, **harm**, and **bereavement** is stigmatised or avoided. • People in addiction are **judged for their behaviour** instead of being supported through it. • Class divides are **normalised**, and services do not reflect the needs of all groups (e.g., older people, women, people of colour). • **Lack of trauma-informed care** and **person-centred support** in statutory services. • **Peer workers** face stigma within services despite lived experience. • Support for **people leaving prison**, those **on prescriptions**, and **housing support** is often inadequate.	a. Self-referral/non-referral crisis centres separate from NHS. b. Signposting in pharmacies and visible helpline services. c. Provide more community recovery spaces (e.g., cafes with resources and support). **4. Stigma Reduction Measures** a. Train employers and statutory services in stigma and trauma-informed care. b. Normalise conversations about harm, grief, and addiction. c. Introduce Naloxone in all public spaces and shops (especially in cities like Glasgow). **5. Use of Lived Experience** a. Involve peers in service delivery and policy consultation. b. Empower peer workers and reduce barriers to their employment. **6. Policy and Legislative Change** a. Make addiction a protected characteristic. b. Legislate trauma-informed care across all public health services. c. Move toward **transformative justice**—focus on recovery, not punishment. **7. Structural Overhaul** a. Decriminalise drug use and shift perspective from criminal issue to health issue. b. End poverty and address class-based inequality in access to services. c. Rethink statutory services to be person-led and culturally competent.

	8. Cultural and Institutional Change a. Require **compassion and sensitivity training** in all public roles. b. Ensure public service access without judgement or assumptions. c. Create **community-led advisory boards** to shape government and service priorities. **9. Long-Term Investment** a. Double funding for mental health and substance use services. b. Develop more housing and long-term recovery environments post-incarceration. c. Integrate national organisations (e.g., SDF, SFAD) with local community voices.

Discussion 3: Shaping our own national programme that addresses stigma

Framing Addiction as a Health Issue	• Present addiction as a health condition, not a crime. • Emphasise addiction as a symptom, not a cause. • Acknowledge trauma, grief, and complex reasons behind substance use. • Promote open, honest, non-blaming conversations about harm and addiction.
Messaging Approach	• Use empathetic, human-first, hopeful language. • Avoid negative, stigmatising terms like "junkie" or "alchy". • Focus on facts, personal stories, and real people from all walks of life. • Messages should be relatable, emotional, and thought-provoking (e.g., statistics + a reflective question). • Celebrate recovery – be honest about relapse and success.
Media and Campaign Strategies	• Use diverse platforms: TV, internet pop-ups, posters, QR codes, community-led media. • Highlight recovery stories and lived experience in mainstream media. • Campaigns should come from communities, not just government – feel authentic and grassroots. • Use bold visuals and messages but avoid harmful stereotypes or fear tactics. • Involve relatable figures, including celebrities and people in power, sharing real stories.
Education and Awareness	• Provide education to all age groups – not just youth. • National training campaigns on naloxone and addiction awareness. • Promote understanding of what addiction looks like – break the stereotype. • Improve public understanding of support options and recovery pathways.
Stigma Reduction in Everyday Life	• Challenge stigma in workplaces, pharmacies, healthcare settings, and schools. • Encourage conversations around addiction in communities and families. • Highlight that addiction can affect anyone – "addiction doesn't discriminate." • Normalise conversations and portray people who use drugs as whole, valuable individuals.
Successful Examples & Inspirations	• Campaigns like Bodyform using real blood, NHS rights messages, HIV campaigns (Terrence Higgins Trust), TV dramas addressing social issues, and celebrities speaking out (e.g., Matthew Perry). • Emphasis on local stories with national reach – balance community voice with wide visibility.

Discussion 4: Prioritising our national programme ideas that address stigma

All 3 groups ideas were mixed up and have been prioritised by star vote from the design team below:

Idea 1 – 8 star votes ★★★★★★★★

Target audience:	**General public**
Core message:	**"Addiction doesn't discriminate. Do you discriminate?"**
Secondary messages:	"Which one of these people are an addict? They all are." (tackling the stigma of what does an addict look like)
Data/visuals/representation:	Photo of a line-up of people as in a crime line-up including a judge, nurse, police officer etc. Second visual option 3 people that are the same.
Formats and methods:	Usual suspects poster. Short video clip looking at each person. Ad campaign.

Idea 2 – 5 star votes ★★★★★

Target audience:	**Families**
Core message:	**Recovery is possible. It's never too late.**
Secondary messages:	Living proof of recovery before and after. Photos.
Data/visuals/representation:	Examples of short story and how they recovered.
Formats and methods:	SFAD group e.g., in the know. Support groups. Facebook and X. WhatsApp groups. Pop-up sign. Literature. Pamphlets. Support workers.

Idea 3 – 4 star votes ★★★★

Target audience:	**Prisoners and prison officers**
Core message:	**"Fines, Freedom and Recovery"**
Secondary messages:	"Inject some cash into your canteen."
Data/visuals/representation:	Recovery groups in prisons supporting prisoners. Recovery coaching.

Formats and methods:	Training on overdose. No one should leave prison without naloxone training. Paid for naloxone training – financial incentive.

Idea 4 – 3 star votes ★★★

Target audience:	**Everyone**
Core message:	**"Show stigma the door"** **"We are recovery"** **"Kettle on. Stigma out"** **"Come on in and leave stigma at the door"**
Secondary messages:	Open up the conversation, preventative naloxone's, join the community, come on in and meet us, resetting the harmful stereotypes.
Data/visuals/representation:	Community of people – created and led by us. Not government branding heavy. Start a fresh on knowledge. True stories. Less on stats.
Formats and methods:	Posters, TV indents, welcome pack, brand identity like See Me, programmes for schools, peer to peer pupil MVP, pledge.

Idea 5 – 2 star votes ★★

Target audience:	**Healthcare services**
Core message:	**"Connection is key"**
Secondary messages:	"If you can't help me, find someone who can"
Data/visuals/representation:	Stats on the work ADP's do.
Formats and methods:	Recovery events with ADP's coming in – mandatory. Third sector coming in having conversations.

Idea 6 – 2 star votes ★★

Target audience:	**NHS Staff**
Core message:	**"See the person"**
Secondary messages:	They might only be seeing someone at their worst when they are unwell. Remember it's a health issue.

Data/visuals/representation:	Personal stories. Someone reflecting on when they were dealing with addiction. Seeing the person at their best and showing an image of them during addiction. How the family see the person.
Formats and methods:	Video for staff. Part of online learning, blog – regular perspectives from different people.

Idea 7 – 2 star votes ★★

Target audience:	**Parents dealing with addiction**
Core message:	**"Self-reflection – am I affected by addiction and am I affecting my children?"**
Secondary messages:	"1 in 3 children worry about a grown-up using alcohol. Is your child worried?" and how to access help
Data/visuals/representation:	Local and targeted – services in your local areas (removes postcode lottery). No photos just logos of orgs who can help. Bright contrast colours, colourful.
Formats and methods:	To the point posters, social media, public places, community centres, pub, toilets, bus stops. Whole family approach, QR codes.

Idea 8 – 1 star votes ★

Target audience:	**Public sector**
Core message:	**"Who cares if they die…We do"** **"Stamp out stigma"** **"Stigma stinks" / "Stigma is bad news" "F**k stigma"** (connect to F**K cancer campaign)
Secondary messages:	People continue to be stigmatised. Substance use is a health condition and therefore needs to be treated as one. Stigma stops people accessing lifesaving healthcare. Stamp out stigma.
Data/visuals/representation:	Graphs of deaths, inequalities gap and how stigma can lead to inequalities gap widening. If use stories – no fluffy stories. How stigma really is – getting support for health condition.
Formats and methods:	All of the above. Social media etc.

Idea 9 – 1 star votes ★

Target audience:	**Public services**
Core message:	**"Addiction friendly"** (like people get pride lanyards/badges/first aid notices – must be voluntary)

Secondary messages:	Organisational champions – sharing learning, highlighting needs, ensuring respect and dignity, bringing colleagues on board, being a safe space.
Data/visuals/representation:	A visual identifier (like the sunflower lanyards). Peer led.
Formats and methods:	Included in social media & training. Posters to share opportunity.

Idea 10 – 1 star votes ★

Target audience:	**Rural areas (Link/connect to Addiction doesn't discriminate programme)**
Core message:	**"It might happen to you. How far would you go for drugs?"**
Secondary messages:	Where do you go for help? Rural areas get forgotten about because rural. Tackling the stigma of rural areas which are put aside/less deserving.
Data/visuals/representation:	Fisherman, farmer, offshore worker etc money, recreation.
Formats and methods:	Posters, social media through societies.

Idea 11 – 1 star votes ★

Target audience:	**Young people/teenagers**
Core message:	**"Know the truth"**
Secondary messages:	The cause and effect of drugs and alcohol – the good and the bad
Data/visuals/representation:	Real people's stories in person – young people talking.
Formats and methods:	Education in schools with young people with lived experience.

Idea 12 – 0 star votes

Target audience:	**People in Scotland**
Core message:	**"No more stigma surrounding addicts…" (positive message not justice)**
Secondary messages:	"Troops continue to die this is someone's son or daughter. Yet they are still being called junkies or Alkies." "There is life at the end of the tunnel. After addiction". Sponsored by Mind.

Data/visuals/representation:	Poster with before/after and someone's journey through recovery. Clean visuals.
Formats and methods:	In Sheffield ex addicts were given the opportunity to go into schools they go paid £40 to tell the story around addiction. Posters done by the people for the people. Scottish Government in small writing.

Idea 13 – 0 star votes

Target audience:	**People in the midst of addiction**
Core message:	**"There is hope and there is help"**
Secondary messages:	"You might not be ready just now, but when you are…" "You're not alone" "how bad is bad enough?" (planting the seed for change.)
Data/visuals/representation:	Positive recovery stories, local help, quotes from people about what triggered change and seeking help. Images of substances.
Formats and methods:	Posters in public spaces. Videos with people who've been through recovery. Sharp and in your face.

Outputs - Workshop 3 Summary Report

Discussion 1: Refining our Campaigns

The following ideas are from thinking about the research focus groups feedback and if the groups would change any of their initial ideas.

This discussion focussed on reframing addiction as a **shared human experience**, not limited to substances but inclusive of behaviours like shopping, sex, food, and tech use. The campaign should emphasise that **"we are all addicts"** in some form—normalising the concept to reduce judgement and tackle stigma. There's a strong call to move beyond stereotypes of what an "addict" looks like, using messaging that shows **real people with diverse experiences**. The campaign should emphasise that **addiction is a universal human experience**, suggesting that everyone has coping mechanisms that could be viewed as forms of addiction—whether it's alcohol, food, shopping, or technology. It promotes **normalising addiction** to challenge harmful stereotypes and reduce stigma, encouraging people

to reflect on their own behaviours and perceptions. There are some that are seen as acceptable and some that aren't seen as acceptable.

The approach should be **layered and progressive -** starting softly, building empathy, and becoming more direct and impactful. Tools like **memes for young people**, **QR codes linking to resources**, and **TV or social media ads** featuring honest, relatable recovery stories are recommended. **Peer research**, **human storytelling**, and **representations from all walks of life** are key.

Campaigns must **challenge public assumptions**—for example, confronting acceptable vs. unacceptable addictions, showing how trauma underpins many behaviours, and connecting addiction to deeper pain rather than moral failure. There's recognition that **stigma is a coping mechanism of the general public** and **"the opposite of addiction is connection."**

Messaging should invite **critical thinking** and **self-reflection**:

- What's your addiction?
- Is your behaviour accepting of others?
- Addiction doesn't discriminate—why do we?
- We're all human

The idea of **"ripples" or a butterfly effect** underlines the belief that even small, community-level actions can spread broader change. Recovery is framed not just as sobriety but as **restoring identity, connection, and dignity**, and the importance of **conversations over slogans** is strongly emphasised.

The campaign should **humanise addiction, spark dialogue**, and **shift societal thinking**—with community involvement, peer voices, and intersectional perspectives at its heart.

Key strategies include:

- Fostering open conversations
- Highlighting the **costs and consequences** of addiction

- Emphasising **recovery and hope**
- Addressing **intersectionality and identity**
- Promoting **empathy, not judgement** "we're all human" and that trauma/pain is the main cause of addiction.
- Encouraging **critical thinking and activism** and asking "is your behaviour accepting of others?" / "what do you use as a coping mechanism?"

New campaign proposal (normalising addiction to build empathy and understanding with general public on alcohol and drug use):

Target audience:	**General public**
Core message:	**"How do you cope?"**
Secondary messages:	"What do you do when your stressed?" Underneath: "so who's go the addiction?"
Data/visuals/representation:	Lots of different people in a cafe, on a bus, on a train. Underneath/above each person a word: "sex, phone, shopping, alcohol, coffee, drugs, gambling"
Formats and methods:	Poster Short ad – bubble comes up with what this person is addicted to.

Measuring impact and change

To measure impact and ensure that **anti-stigma efforts are sustainable, systemic, and people-led,** key indicators of success include:

- reductions in drug and alcohol-related deaths
- increased compassion in services like pharmacies
- a healthier, supported frontline workforce capable of engaging in difficult conversations without burnout

Peer networks are seen as essential drivers for change, creating relatable voices and influencing cultural shifts. **Key touchpoints**—such as GPs, pharmacies, ADRs, and job centres—are identified as critical spaces for intervention, training, and compassion. There's a call for an **ambassador or training programme** (similar to "See Me" for suicide prevention) to spread awareness and tackle stigma on the ground.

Other ideas include:

- Tracking **before-and-after baselines** to assess change.
- Using **stories of change** to inspire and educate.
- Providing **guidelines for media** to avoid harmful stereotypes.
- Understanding and improving the **"feelings and vibes"** experienced in interactions, drawing parallels to how free period products shifted perceptions of dignity and access.

The tone emphasises **kindness, satisfaction, and practical change** as key ingredients to long-term impact.

Discussion: Developing our solutions and actions for change (building on solutions from workshop 2)

Specific Actions	How is it measurable?	Achievable?
Increasing assertive outreach ADP's - proactive ADP workers. Review and retrain ADP workers Hire more on a needs' basis	Third sector reviews ADP workers/people they work with through rating them	Professional development – quick win Hiring is a high cost
Create a more informed society Campaign strategy – using the bus/coping strategy	Number of reach's/ number of people who have clicked QR code	Yes Recovery walk Costly
Addiction becomes a protected characteristic		Can't change legislation but can change the policy For example, specific exclusions - housing
Create legislation for healthcare to lead in a trauma-informed way Annual standardised training. Connecting of real-stories and apologise for shortcomings.	Number of healthcare staff who have completed trauma-informed training and understand MAT standards Ensure medical information is known by supporting third sector orgs to free up capacity. Highlight best practice – what is working.	Professional development – quick win Pilot scheme Within 3 months – put honesty and transparency first.

Integration of third sector and statutory services must happen first		
One-stop shop/conversation cafe for holistic problems (more hubs)	One-stop hub/recovery cafe in every local authority area Conversation cafes in every area with GPs, ADPs and health care.	How to utilise existing spaces? Better local advertising. Expand existing model of conversation cafes.
National helpline that is available 24/7		Yes, but expensive – Samaritans advertised more
Equity accessing acute services – A&E / mental health support	Having various support people options. NHS helpline advertised for alcohol and drugs. More navigators in hospitals More access to community-based rehab	Expensive (MHAS Mental Health Assessment Service). MHAS is a 24-hour, nurse led service for people in acute mental health crisis. Available through NHS 24. They cannot commence or review medication.
Self-stigma booklet that includes: What recovery means to me? Take away stigma about yourself. Identify your own coping strategy to identify why stigma. Why do we feel alcohol and drugs are worse? Focus on yourself and ask where your judgement comes from? Is it fact? Have I checked my own thinking?	Drop-out throughout Scotland – self-stigma booklet with multiple methods e.g., letterboxes.	Expensive and would have to be through multiple methods.
People in recovery providing workshops on healthy coping mechanisms.		
Provide opportunities for people to be kind		
Safe boundaries/ Educating people on front-line knowing the reason behind/ How we care for people who are dying.		

Notes: It's human nature to be judgemental to keep ourselves safe. We don't talk about it but we want to open up the conversation. Why do we feel the need to judge others? How would I like to be treated? Fear of being kind/ don't want to make it worse.		
Reinvigorate the community by creating local events where people can hear stories. Be part of the community council – events/speakers.	Inviting/allowing people into garden/event days	
Do more to speed up the rights-based approach. Encourage compassion and sensitivity across society.		
Commitment from SG to come back and present what they have done		6 month review
Justice, housing and health policy including mental health are priority.	-SMART recovery – making it in prison and health -Tackling stigma in criminal justice training -Sort out renters rights – right to own a home	
Tax big corporations – more money into services		
Groups which put the person first and respond to their needs		
Talk more about the cost of addiction – win people over	Publish cost of addiction to society. Highlight benefits.	

Outputs - Workshop 4 Summary Report

Discussion 1: Defining Success for a National Pledge that Addresses Stigma

The following ideas are from thinking about developing our national pledge that addresses stigma of drug and alcohol use. The group got into discussions about what success would look like of the national pledge. Some examples might include the following: The National Pledge for Mental Health – countries like Canada and Australia have implemented pledged focusing on mental health awareness and reducing stigma related to mental illnesses, encouraging communities to prioritise mental health support.
The National Pledge for Climate Action; Pledge to End Homelessness; Pledge for Gender Equality; Pledge Against Racism and Discrimination; Pledge for Public Health during Covid-19 pandemic.

- **Raising Awareness.** Does it raise awareness of the issue, mobilise public interest and encourage discussions around the topic that might otherwise be overlooked?
- **Genuine commitment.** Does it allow individuals, organisations and/or governments to signal their commitment to a cause which can inspire action and accountability? How easy is it to commit to? What are the steps a (service/organisation) would need to take?
- **Community Engagement.** Some pledges can bring people or organisations together fostering community and shared purpose. How could this work for this pledge? How can community organisations and leaders play a role in promoting a national pledge against stigma?
- **Guiding policy and action.** National pledges can influence policy changes and resource allocation, guiding governments and organisations to prioritise issues. We will break this up in the next discussion on housing, mental health, health and education. However what are some overarching policy actions?
- **Measurable goals and effective language.** Successful pledges often include clear, measurable goals and specific actions. This allows for tracking progress and holding parties accountable for their commitments. We will break this up in the next discussion on housing, mental health, health and education. What could be some overarching goals that are very simple to follow?
- **Building partnerships.** How could the pledge encourage collaboration between organisations, stakeholders, governments and businesses leading to better outcomes for change? Who are the key stakeholders that should be involved in the development and promotion of this national pledge and how can we engage them effectively?

The group were split into pairs at tables to discuss in themes:

Raising Awareness & Genuine commitment

Prompt questions

- ***Raising Awareness.*** *How does the pledge raise awareness of the issue, mobilise public interest and encourage discussions around the topic that might otherwise be overlooked?*
- ***Genuine commitment.*** *Does it allow individuals, organisations and/or governments to signal their commitment to a cause which can inspire action and accountability? How easy is it to commit to? What are the steps a (service/organisation) would need to take? What would the commitment look like? What's in it for them? If they do not adhere to the goals what would the accountability mechanism look like?*

- Existing campaign boosts – naloxone
- Living Wage? Why are businesses celebrated for doing the bare minimum? It shouldn't be a toast – like being stigma free
- If they don't adhere it could lead to loss of funding etc.
- People thinking – planting seeds.
- Check all policies and destigmatise language.
- Raise more awareness in third sector models.
- Minimum thresholds – people able to access addiction services same as any other place. No locked doors. Pharmacists not having separate doors/queues.
- Minimum thresholds – organisations appointing a stigma champion (duty bearer).
- Raising awareness through national collaborative call for evidence and report what people are experiencing.
- Changing the narrative of stigma & using it to our advantage rather than trying to get rid of it.
- Prove that you are actually living by the pledge and show process on how you're doing it – has to be read and signed by all members of organisation and quiz at end.
- Having proactive conversations, being proactive and challenging them.
- Talking to friends and family, chain effect can then be created.
- Acknowledging how our own history shapes/creates our outlooks of the world and how we view stigma.
- Approach and language.
- National and education, public, GPs, schools
- Needs to avoid feeling/looking government sanitised.
- If committed to pledge, updates needed. What have you done to achieve it?
- Creating roles for people with lived experience, by the power of example. Shifting the narrative.

Partnerships and Community Engagement:

Prompt questions

- ***Community Engagement.*** *Some pledges can bring people or organisations together fostering community and shared purpose. How could this work for this pledge? How can community organisations and leaders play a role in promoting a national pledge against stigma?*
- ***Building partnerships.*** *How could the pledge encourage collaboration between organisations, stakeholders, governments, and businesses leading to better outcomes for change? Who are the key stakeholders that should be involved in the development and promotion of this national pledge and how can we engage them effectively?*

- Partnerships with COSLA, SOLACE, chief housing officers or YSCP, chief officer of NHS Scotland boards, community planning partnerships, Duty bearer panel of national collaborative.
- Improve collaboration with the third sector services.
- Engage key seldom heard groups, pledges should be specific to their work (young people, LGBTQ+, BAME groups etc)
- Promotion of pledge through community and business leaders- launch event.
- Making it clear why the pledge is important – prevalence of the topic in society.
- Increasing amount and length of people accessing services
- Where's the line between consequences/taking accountability and stigma i.e., in hospitals/GPs.
- Representation of every area SDF report? Not representing Inverclyde.
- ADRS Voluntary Sector, Statutory service, housing, chemist, recovery groups
- Utilising and engaging with existing resources – third sector etc.
- Have partnerships within the 3rd sector be more involved in policy change.
- Inspection leads to quality assured processes.
- Partnerships, comms, engagement – stat services, recovery communities, prescribers/chemists, third sector, housing, emergency services, Mental health CCPNs, crisis services, rape crisis, sexual health
- Stakeholders including government, third sectors, businesses, services, this group etc.
- Streamlining several policies into one strong tool.
- Schools, libraries, prisons, GP offices and have public figures dedicates to raising awareness.

Guiding policy action and measurable goals

Prompt questions

- ***Guiding policy and action.*** *National pledges can influence policy changes and resource allocation, guiding governments, and organisations to prioritise issues. We will break this up in the next discussion on housing, mental health, health, and education. However what are some overarching policy actions that would support a national pledge to tackle stigma?*
- ***Measurable goals and effective language.*** *Successful pledges often include clear, measurable goals and specific actions. This allows for tracking progress and holding parties accountable for their commitments. We will break this up in the next discussion on housing, mental health, health and education. What could be some overarching goals that are very simple to follow? How will we measure success over time?*

- SFAD – policy is not to use stigmatising language. It's in the meeting outline at the beginning of the meeting. If stigmatising language is used the facilitator will raise the issue with the individual in order to change language behaviour. Booklet available to teach us alternative language.
- No public funding if you won't allow access to people who use alcohol and drugs.
- Measurable learning and development modules as part of your job which is compulsory.
- We pledge that we will treat every service user with dignity and respect.
- We pledge that our staff members and colleagues will use destigmatising language at all times.
- Inspection of services like care inspectorate.
- Assessment attitudes by secret shoppers in services.
- Public bodies to sign up to a set of standards that can be evidenced. Measured by sign-up rate and monitored on an annual basis.
- Each public body will have measurable actions they can evidence change of actions.
- All public bodies have standards in accordance whistleblowing standards protecting staff/people from detrimental behaviours.
- First contact in service will show a caring attitude.
- Regulate inspection statutory service drug. Not legal but with existing powers public reform – health improvement Scotland have powers.
- Professional hierarchies preventing collaboration.
- Commit to doing something specific to tackle stigma.
- Mult-directional pledge – responsibility of government to work with others (orgs are already working together).

Discussion 2: Pledge for Change: Housing, Education, Mental Health, and Health Services

The team were split into groups of 3-4 and to each get a topic to develop: Housing, Education, Mental Health, or Health Services. They answered a series of questions to develop specific goals for services to commit to a national pledge around tackling stigma. The team considered how each of these services could be improved with clear measurable goals to tackle stigma and discrimination and goals or tasks they could undertake as individual sectors.

Housing

Prompt questions

- ***Overarching clear goals.*** *What clear measurable goals could Housing services undertake to reduce stigma for individuals with a history of drug and alcohol use? E.g., 5-8 achievable clear goals for housing services to undertake.*
- ***Inclusive practices.*** *How can we ensure that our pledge goals promote inclusive practices that welcome individuals with a history of drug and alcohol use without bias?*
- ***Training****. What kind of training should be implemented for housing staff to better understand, and address stigma related to substance use?*
- ***Collaborative working.*** *How can housing services collaborate with local organisations to create a more supportive environment for individuals who use substances?*
- ***Support from housing services****. What support systems/resources could housing services pledge to provide residents with to facilitate their recovery and reintegration?*
- ***Public awareness campaign.*** *Should housing services include commitments to launch public awareness campaigns aimed at changing perceptions of individuals who use drug and alcohol? What key messages/strategies should be included in their pledge?*
- ***Feedback mechanism.*** *How could housing services implement feedback mechanisms that allow residents to share their experiences and suggestions for improving stigma reduction efforts in housing services?*
- ***Sustainability and measuring success****. How will we measure success? How can we ensure that housing specific pledge goals are sustainable and not just a temporary initiative?*

Pledge goals:

1. **Training informed and delivered by lived experience to promote the development of staff perspective**. Induction and ongoing appointments of staff are long term with clear backgrounds/experience (LLE) and provided opportunities to develop. The right people in the right jobs. Regular top-up/refresher made mandatory. It encourages conversations and challenges misconceptions and old attitudes. Use secret shoppers to evaluate its success.
2. **Existing support network integration**. Meetings and open communication between service providers/clients and their networks in housing advocacy and compassion. Client centred.

3. **Anonymous pathways for feedback. Named person**. Professional responsibility of named person identifying and actioning gaps based on feedback. It gives space for feedback without retribution. They will need protected time (salary).
4. **Welfare reforms and sanctions**. How housing benefit is paid by DWP for people with NDA and prison leavers and those on remand. Sanitation review/removal – chaotic lifestyle.

Key discussion points:

- **Training.** Training informed and delivered by lived experience to promote staff personal development in. perspective. Understanding stigma for all staff especially front facing staff. Leave personal opinions at home. Encourage learning conversations for development. Conscious and unconscious bias and boundaries training. Review.
- **Collaborative.** Integrating existing support networks in advocacy for those at all stages, keeping them informed with regular communication and engagement. Person centred support network included in the advocacy of person (using/in recovery). Review regularly. Communication between service providers.
- **Feedback mechanism.** Creating anonymous pathways for feedback, overseen by a named staff member ideally with lived experience who is responsible for implementation of feedback resolution. Provide anonymous pathways for feedback. A named person with lived experience who takes responsibility for collating and actioning gaps in service delivery. Secret shoppers.
- **Preventing the impact of welfare reductions** which disadvantage individuals with substance use including sanctions.
- **Get it right first time**. Consequences for not getting it right.

Education

Prompt questions

- ***Overarching clear goals.*** *What clear measurable goals could Education services undertake to tackle stigma for drug and alcohol use? E.g., 5-8 achievable clear goals for education institutions/services to undertake.*
- ***Curriculum.*** *What topics should be included in the education curriculum to effectively address and reduce stigma surrounding drug and alcohol use?*
- ***Training for educators.*** *What specific training programmes should be implemented for educators to help them understand and address stigma related to substance use in the classroom?*
- ***Student and youth engagement.*** *How can we actively involve students and young people in the development of pledge goals to ensure their perspectives and experiences are considered in tackling stigma?*
- ***Peer support programmes.*** *What role could peer support programmes play in fostering a supportive environment for students and young people affected by substance use and how could this be integrated into our pledge goals?*

- ***Collaborative working.*** *How can educational institutions/schools etc collaborate with local organisations, healthcare providers and advocacy groups to promote awareness and understanding of substance use?*
- ***Family and guardian involvement.*** *What strategies could we implement to engage families, parents, and guardians in discussions about drug and alcohol use to help reduce stigma within families and communities?*
- ***Promoting open dialogue.*** *How can the education pledge goals create safe spaces within educational settings that encourage open dialogue about drug and alcohol use without fear of judgement or stigma?*
- ***Public awareness campaign.*** *Should education institutions/schools include commitments to launch public awareness campaigns about the realities of substance use and the importance of compassion, kindness and understanding? What key messages/strategies should be included in their pledge?*
- ***Sustainability and measuring success****. How will education institutions/schools measure success? How can we ensure that education specific pledge goals are sustainable and not just a temporary initiative?*

Pledge goals:

1. **Directors of education are aware of current policies**. Training courses, online strategy, direct education and cascading down. Written word has to be clear and specific. If followed correctly it will create change and destigmatise. Fully monitored to ensure success measures identified.
2. **Educating head teachers and teachers in the effects of addiction – break down to relevant level**. Communities, individuals, families, NHS & other agencies, crime. Integrate substance use into teacher training as mandatory. Background reading needed. GIRFEC SHANARI. Measurable number of schools/teachers monitored pass rate of online courses and course attendance.
3. **Pupils/prefects share ideas and thoughts**. Who it affects when it really hits home. Families/friends, individuals, loved ones, pupils, peer groups, socially. Health, finance, relationship breakups, mental health. Implementing training based on an agreed strategy – get it right and this will create change in the longer term. ADP sessions within schools. Named person – expand guidance/pastoral to include substance use and make this full-time.
4. **Family & friends lets talk about this**. Addressing stigma education from top down. Assessments feedback. Real success stories. Continual improvement and roll out. Based on stats and figures. Sign-posting.
5. **Peer groups/ social activities**. What is right/wrong. Who or what are consequences.
6. **Teacher training compulsory from the start**. Experienced people do training fellowship encourages attendance in meetings and real cases. Recovery cafes
7. **Make sure it is real and not a made-up story**. It is reality. It is happening.

Key discussion points:

- Need clear statistics to understand impact on children and young people and families.

Mental Health

Prompt questions

- ***Overarching clear goals.*** *What clear measurable goals could mental health services undertake to tackle stigma for drug and alcohol use? E.g., 5-8 achievable clear goals for e mental health/health services to undertake.*
- ***Holistic understanding.*** *How could our pledge goals for mental health address the relationship between mental health and substance use disorders, promoting a holistic understanding of these issues?*
- ***Training.*** *What specific training programmes should be implemented for mental health professionals to help them better understand and combat stigma surrounding drug and alcohol use?*
- ***Access to integrated services.*** *How can we develop pledge goals that promote integrated services for individuals facing both mental health and substance use challenges?*
- ***Public awareness campaign.*** *What types of public awareness campaigns can mental health services implement to educate the community about the realities of substance use and reduce stigma?*
- ***Patient-centred approached.*** *How will our pledge goals prioritise patient-centred approaches that respect the dignity and autonomy of individuals with substance use?*
- ***Peer support and recovery programmes.*** *What role could peer support and recovery programmes play in reducing stigma and how could we incorporate this into our pledge goals?*
- ***Collaborative working.*** *How can mental health services collaborate with local organisations, healthcare providers to foster a more supportive environment for individuals with substance use?*
- ***Feedback from clients.*** *What mechanisms could we put in place to gather feedback from clients regarding their experiences with stigma in mental health services and how can this inform our pledge goals?*
- ***Sustainability and measuring success****. How will we/mental health services measure success? How can we ensure that mental health specific pledge goals are sustainable and not just a temporary initiative?*

Pledge goals:

1. **Stop treating mental health and addiction as separate issues**. When people stop using drugs that we used to address trauma we then have to deal with that trauma and no support. “chicken or egg” what came first the addiction or the mental health issues. More trauma informed training for staff as substance use is often the result of trauma. Treat people holistically using person centred approach. Incorporate more therapies not just CBT, find out what works for each individual.
2. **Trauma informed mental health services**. We know trauma is the foundation of MH issues and also substance issues.
3. **Patient centred-approach.** Treat the issue as its presented. If MH is suffering treat it as part of the substance use. Need a higher level of tolerance for how people present. Dig deeper into why they are presenting as aggressive/depressed/hyper/sad. Need parameter for unacceptable behaviour to protect staff and people who use services. Give people an option to present at a

different time if they are not in the right place to be seen/heard. Set people up for success – give support even if they are presenting as intoxicated.

4. **Peer support advocacy within MH services**. People who have accessed services have a better understanding of how to support someone. They don't have to be "lived/living experience".
5. **Feedback for MH services through an anonymous system**. iPad check-in. Services would see how people feel about the service they are receiving. Services would be able to implement change based on feedback. Feedback should be published publicly. Services responsible for implementing change based on feedback. People who use services invited to participate in implementing change conversations. Students involved in conversations around change they have awareness on issues. If services fall below a specific rate they are held accountable and investigated.
6. **Trained nurses/staff practitioners should be able to support people with MH issues if they present at addiction services as they are capable and have capacity. Upskill people.** People would get holistic support, staff would get more training and be able to co-treat multiple issues i.e. addiction, MH, wounds, etc. Would close the gap between services.

Health Services including GPs, hospitals & pharmacies.

Prompt questions

- ***Overarching clear goals.*** *What clear measurable goals could health services undertake to tackle stigma for drug and alcohol use? E.g., 5-8 achievable clear goals for health services to undertake.*
- ***Access to services.*** *How can we ensure that pledge goals promote equitable access to healthcare services for individuals with drug and alcohol use?*
- ***Training****. What specific training should be provided to GPs, hospitals and pharmacy staff to help them address stigma and support individuals with substance use issues effectively?*
- ***Integrating Mental Health & Substance Use Care****. How can we develop pledge goals that encourage the integration of mental health care with substance use treatment within the NHS?*
- ***Creating Supportive Environments****. What actions can be taken to create a stigma-free environment in healthcare settings that encourage individuals to seek help for drug and alcohol-related issues?*
- ***Public awareness campaigns.*** *What types of public awareness campaigns can health services implement to educate the community about the importance of compassionate care and kindness for individuals with substance use?*
- ***Patient Confidentiality and Trust.*** *How can we ensure that our pledge goals prioritise patient confidentiality and build trust between healthcare providers and individuals seeking help for substance use issues?*
- ***Collaborative working.*** *How can NHS services collaborate with local orgs and support groups to create a network of care for individuals with substance use disorders?*

- ***Feedback.*** *What mechanisms could we establish to gather feedback from patients regarding their experiences with stigma in healthcare settings and how can this inform our pledge goals?*
- ***Sustainability and measuring success****. How will we/national health services measure success? How can we ensure that national health service specific pledge goals are sustainable and not just a temporary initiative?*

Pledge goals:

1. **Staff understand legal duties around patient rights and responsibilities.** Patient rights 2012 and 2022, human rights and MAT standards. Mandatory training that's accredited. Measure access and complaints. Staff are responsible for informing people of advocacy support and how to complain if they are unhappy.
2. **Humanising healthcare through compulsory training.** Compulsory training within curriculum for trainee medical professionals to attend peer support groups and fellowships to create connections and understanding. 2 or more sessions per year for every medical study year. Building on connections through networks. Conversation cafes are taking place in Glasgow and Dundee. Need more of this.
3. **Mandatory training for all in health staff in GP practices including admin staff around stigma/discrimination/language and access**. Include in GP contracts as mandatory requirements. Training in Harm Reduction (prescribed Valium rather than street Valium). Peer staff in GP practices.
4. **No wrong door policy.** It doesn't matter whether initially mental health or an addiction issue – will receive. Help and not be passed from pillar to post. Direct access to advocacy. Identify roles/responsibilities – who is responsible? What resources are made available?
5. **Buildings and services are all psychologically trauma informed as mandatory.** Integrate community service teams. Increase number of addiction services in primary care settings. Reduction in number of community service settings.

Key points:

- **Mandatory training** for all staff working in GP practices including receptionists so they are aware of stigma practices. Charter of rights training.
- **Educate stigmatising practices** that can prevent people accessing GP services for example people accessing GP services with opiate replacement therapy are being denies access to GP services.
- **Lack of awareness** of workforce to patient rights, patients' justice 2012 & 2022 and human rights.
- **Staff know legal duties** around patient's rights and responsibilities measured through mandatory training. Measure indicators/outcomes improving.
- **Supportive environment.** Have equity in terms of supportive environments compared to other health policy areas.
- **Create connections between services** in health care and those that access them.
- Lack of supportive environments for people affects by substance use.

- Exploits a small window of opportunity when people are in a position where they are willing to accept help.
- **Embed conversation café** within the 5 medical schools in Scotland, then rolled out to existing staff.
- Quicker action when someone presents in A&E with an overdose – who's responsibility is it?

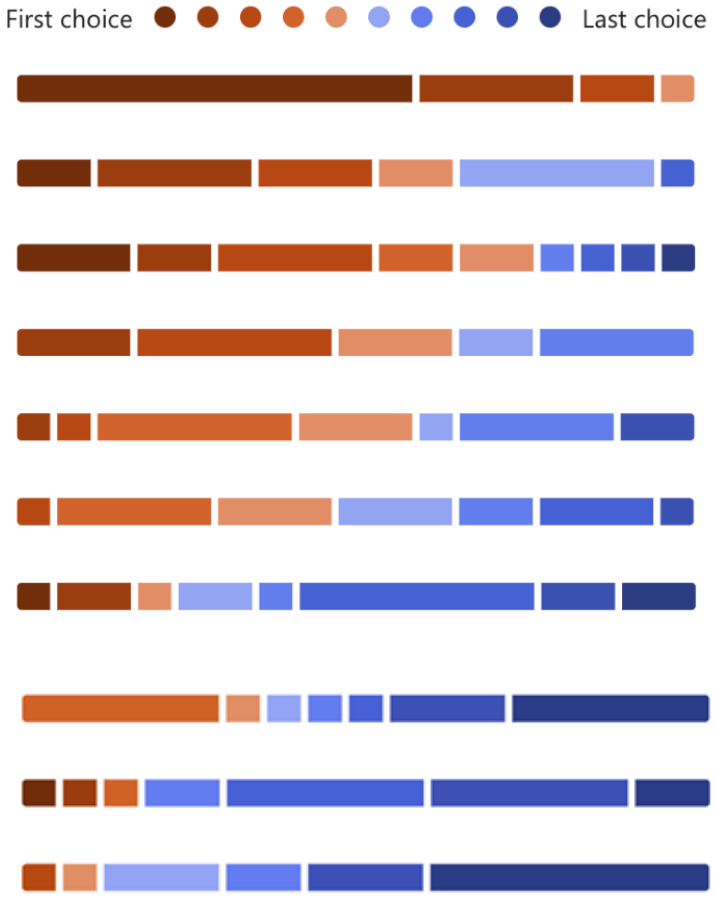
Discussion 3: National Campaign Messaging Survey Responses

The design team have been working on National campaign ideas and messaging in the first 3 workshops. The design team made the decision to ignore the feedback from the research focus groups on the messaging as they felt it was too small a sample and that a public campaign needs to be more radical. The group were asked to review the survey responses they had voted on for their ideas for the national campaign messaging and have an open discussion on the results. Some of the team felt the format of the survey could create bias and so we had a plenary vote through a show of hands to decide whether to undertake the survey again in a different format to see if the results would be different or the same. The consensus (10 people to keep as is/4 people to undertake survey again). Therefore, the survey results below will to go to a communications strategist for further development. The design team's final survey vote on the messaging also aligns with the star voting exercise they did in workshop 2 and 3 and so there has not been too much variation on what they want to see tested since the beginning of the process.

2. Rank your favourite messages in order of preference

17 Responses

Rank	Options
1	ORIGINAL/8 star votes. Core message: **"*Addiction does n't discriminate?" "Do you discriminate"*** "Which one o...
2	ORIGINAL/5 star votes. Core message: "***Recovery is possi ble. It's never too late.***" Living proof of recovery before ...
3	NEW IDEA. Core message: *"**How do you cope?" "What d o you do when you're stressed?"*** Underneath: "so who'...
4	ORIGINAL/3 star votes. Core message: **"Show stigma the door/we are recovery"** Open up the conversation, prev...
5	ORIGINAL/2 star vote. Core message: ***"See the person"*** Y ou might only be seeing someone at their worst when th...
6	ORGINAL/2 star votes. Core message: ***"Connection is ke y"*** "If you can't help me, find someone who can" Stats on...
7	ORIGINAL/2 star votes. Core message: ***"Am I affected by addition and am I affecting my children?" "*** 1 in 3 chil...
8	ORIGINAL/4 star votes. Core message: ***"Fines, Freedom a nd Recovery"*** "Inject some cash into your canteen." Rec...
9	ORIGINAL/1 star vote. Core message: *"**Who cares if they die... we do" / Stamp out Stigma / F**k stigma"*** Peopl...
10	ORIGINAL/1 star vote. Core message *"**Addiction friendl y"*** Organisational champions – sharing learning, highlig...



Discussion 4: Pledge for Change: Social Care, Private Sectors e.g. workplace, Police & Prisons.

The team were split into groups of 3-4 and to each get a topic to develop: Social Care, Private Sector e.g. businesses and workplace, Police or Prisons. They answered a series of questions to develop specific goals for services to commit to a national pledge around tackling stigma. The team considered how each of these services could be improved with clear measurable goals to tackle stigma and discrimination and goals or tasks they could undertake as individual sectors. This was the last discussion of the day and these pledge for change for all service areas will be continued in workshop 5.

Social Care

Prompt questions

- ***Overarching clear goals.*** *What clear measurable goals could Social Care Services undertake to tackle stigma for drug and alcohol use? E.g., 5-8 achievable clear goals for Social Care Services to undertake.*
- ***Understanding community needs.*** *How can social care services implement client-centred approaches that respect the autonomy and dignity of individuals with substance use?*
- ***Training & Education.*** *What types of training programmes should be implemented for social care staff to enhance their understanding and compassion of substance use disorders and reduce stigma in their interactions with clients? How can we develop pledge goals that emphasise the importance of empathy and compassion in service delivery?*
- ***Collaborative approach.*** *What strategies can be employed to ensure that individuals with substance issues have equitable access to social care resources, support services and healthcare services? What could the pledge look like?*
- ***Peer support programmes.*** *What role could peer support initiatives play in social care services and how can we incorporate these into our pledge goals to reduce stigma?*
- ***Support for families.*** *What social care programmes can be developed to provide support and education for families of individuals with substance use to help reduce stigma and promote understanding?*
- ***Awareness campaigns****. What types of awareness campaigns can be developed within the social care system to educate communities and social care staff about substance use and promote a culture of understanding and support?*
- ***Sustainability and measuring success****. How will we/social care services measure success? How can we ensure that social care service specific pledge goals are sustainable and not just a temporary initiative?*

Pledge goals:

1. **Education**. Learn more about client needs, social situations. Check standards are met. Mandatory training at induction and ongoing.

2. **Charter.** How to treat people and updated approach to people with addictions/disabilities/health issues – same treatment for everyone.
3. **Boundaries**. Understanding the needs and personal boundaries with help from advocate. Help people distance themselves.
4. **Clear sign-posting for services** – named person. Wherever you get your information from i.e. app, word of mouth, cafes, specific.
5. **All agencies working together.** One place at same time. Help should be available within realistic timescales.
6. **Governing body**. Anonymous feedback for those employed in social care services to keep standards.
7. **Support for families.** Include families and their views in the care of person with disabilities, health issues and addictions for better outcomes. Set goals and expectations – clear signposts for families.
8. **Awareness campaign**. Educate, listen to lived experience.
9. **Sustainability and measuring success** – identify service users, set goals from beginning and monitor through. named person.

Key discussion points:

- Peer support groups – have local groups and drop-in centres with available support, mentors, advocates specific to social groups.

Private Sectors e.g., workplace & businesses

Prompt questions

- ***Overarching clear goals.*** *What clear measurable goals could businesses undertake to tackle stigma for drug and alcohol use? E.g., 5-8 achievable clear goals for businesses to undertake. What steps could business leaders take to visibly commit to reducing stigma related to substance use within their organisations setting an example for employees?*
- ***Workplace policies.*** *What specific workplace policies should businesses implement to support employees with substance use issues while promoting a stigma-free environment?*
- ***Training.*** *How can organisations provide training to employees and management on understanding substance use and addressing stigma in the workplace?*
- ***Workplace awareness campaigns.*** *What types of awareness campaigns can businesses implement to educate employees about substance use and reduce stigma in the workplace?*
- ***Inclusive hiring practices.*** *How can companies revise their hiring practices to be more inclusive of individuals with a history of substance use, ensuring they are given fair opportunities?*

- ***Employee Assistance Programmes.*** *What resources can businesses provide through employee assistance programmes to support employees struggling with substance use and how can these be communicated effectively?*
- ***Customer Awareness.*** *How could supermarkets and businesses raise awareness among their customers about the importance of understanding substance use disorders and supporting affected individuals?*

Pledge goals:

1. **Pressure to disclose or how to disclose – employees more confident on support available.**
2. **Random drug tests abolished where not legally needed.** Reduced costs. Reduced fear and more people in work.
3. **In supermarkets, near alcohol sales. Placing information and leaflets on addiction issues**. Increased customer awareness and addiction champions.
4. **Increased opportunities for mentoring/employment with financial stability**. Increased diversity and skilled set of staff.
5. **Induction and continual training developed by LLE**. Staff are educated and confident.
6. **Create a stigma friendly network of staff champions working with local/regional services and communities**. Stigma friendly logo and shared best practice.
7. **Posters and information in toilets in workplaces**.

Policing

Prompt questions

- ***Overarching clear goals.*** *What clear measurable goals could Police Scotland undertake to tackle stigma for drug and alcohol use? E.g., 5-8 achievable clear goals for Police Scotland to undertake.*
- ***Training & Education.*** *What specific training programmes should be implemented for police officers to enhance their understanding of substance use issues and reduce stigma in their interactions with affected individuals?*
- ***Community engagement.*** *How could police foster stronger relationships with communities to promote understanding and support for individuals with drug and alcohol issues? What would this look like in a pledge?*
- ***Crisis intervention protocols.*** *What protocols could be established to ensure officers respond to incidents involving substance use with compassion, kindness and understanding rather than punitive measures?*
- ***Collaboration with treatment services.*** *How can police Scotland collaborate with local treatment and recovery services to provide support and resources for individuals?*
- ***Sustainability and measuring success****. How will we/Police Scotland measure success? How can we ensure that Police Scotland specific pledge goals are sustainable and not just a temporary initiative?*

Pledge goals:

1. **Custody based recovery/peer workers**. More awareness of substance use withdrawals to support people. Encourage engagement with addiction/recovery services. Educating police on issues with release e.g. not releasing people when they can't access medication and support. Acceptance that not everyone who uses substances engages in criminal activity. Not withholding medication as a tactic.
2. **Carrying Naloxone/Nyxoid is mandatory as is Harm Reduction Training**. Carrying Naloxone should be as mandatory as a baton. Training undertaken regularly. Awareness of where to access Harm Reduction supplies i.e. IEP, fails, to advise people how to access.

Key discussion points:

- Work harder on developing community liaison
- Carrying naloxone is mandatory alongside harm reduction training.
- Custody based recovery/peer workers. More awareness of substance use withdrawals to support people.
- Peer support working along with Police for e.g. overdose calls.
- Recruit people with lived and living experience

Prisons

Prompt questions

- ***Overarching clear goals.*** *What clear measurable goals could Prisons in Scotland undertake to tackle stigma for drug and alcohol use? E.g., 5-8 achievable clear goals for Prisons in Scotland to undertake.*
- ***Substance Use Treatment Programmes.*** *What types of substance use treatment programmes should be implemented within prisons to support inmates struggling with addiction? What would this look like in a pledge?*
- ***Training.*** *What specific training should be provided to prison staff to help them understand and address the stigma associated with substance use among inmates?*
- ***Partnerships & Mental health support.*** *How can we ensure mental health services are integrated with substance use treatment within the prison system to address co-occurring issues? What would this look like in a pledge?*
- ***Peer support initiatives.*** *What role can peer support programmes play in providing encouragement and understanding to inmates dealing with substance use and how can these be incorporated into our pledge goals?*
- ***Rehabilitation focus.*** *How can we shift the focus of prison policies from punishment to rehabilitation for inmates with substance use issues to reduce stigma and promote recovery? What could this look like in our pledge?*
- ***Family engagement and post-release support strategies.*** *What strategies can be developed to involve families and support systems for inmates upon release to facilitate their reintegration and reduce stigma they may face in the community?*

- ***Awareness campaigns***. *What types of awareness campaigns can be developed within the prison system to educate inmates and staff about substance use and promote a culture of understanding and support?*
- ***Sustainability and measuring success***. *How will we/Prisons in Scotland measure success? How can we ensure that Prison specific pledge goals are sustainable and not just a temporary initiative?*

Pledge goals:

1. **More aid and help.** More mental health practitioners. More mutual aid recovery. More direct access to rehab. More vocational training. More family involvement to repair/improve relationships prior to liberty. SDF training?
2. **Additional medical support.** More SISCO like support. Alternative treatment such as Buvidal rather than constant methadone script. Better access to medication.
3. **Better training and understanding**. Prison officer mental health and stigma training.

Key discussion points:

- More mental health practitioners SMART mutual aid. More about drug rehab. SDF training – trainee addiction programme. More like SISCO
- Treatment – buvidal into prisons rather than constant meth script.
- Better access to mental health support such as medications.
- Qualification training – vocational training.

Outputs - Workshop 5 Summary Report

Discussion 1: Introduction to charter of rights & how the charter of rights could work alongside the Tackling Stigma recommendations.

There is a strong need for **people to be clearly informed of their rights** when accessing drug and alcohol services—because if people don't know their rights, they effectively don't have them. This includes **issuing a Charter of Rights at the start of service delivery** and having **staff read these out** to ensure understanding. **Advocacy is essential**, offering a voice to those who are often unheard, especially in complex or vulnerable situations. **Independent advocacy** should be widely available, with services engaging people with lived experience to understand what real change looks like. Services should be **inclusive**—no one should be excluded—and support should be **clear, accessible, and simple**, avoiding information overload. Instead of "signposting," services must actively **connect people with help**.

To ensure change is meaningful and trackable:

- All public bodies should have **measurable actions** tied to the Charter.
- These measures should be **relevant to each organisation**, and **used by inspector bodies** during evaluations.
- Suggestions include linking the Charter to existing frameworks like the **Investors in People award**.

There must be **accountability**, with **identified individuals (e.g. human rights officers or chief executives)** responsible for upholding rights. A **simpler and clearer complaints system** is also needed.

Concerns were raised about **resource gaps**, such as a lack of housing or services, and **inequitable funding**, which undermine rights in practice. **Panels of service users** could help **review how money is spent**, ensuring funding goes to where it's most needed.

Ideas from EU models like **community commissions**—where local people, including drug user unions, influence how resources are allocated—were seen as promising approaches to create **community-controlled funding models**.

The overall aim is to shift from reactive systems to **proactive, rights-based, person-centred services**, backed by transparency, funding reform, and meaningful community involvement.

Discussion 2: Workforce & Private Sector Refining Pledge Goals

Inclusive hiring

- Call out the Scottish Government on their own hiring practices
- They should lead by example. They have to as this is fundamental to tackling stigma
- Scottish Government should lead a review of hiring practice and vetting. Using LLE to do this.
- Encourage employers to hire local people.

Customer/client awareness

- Posters and information provided to customers and staff signposting to support

- Pop-ups when buying alcohol online – target Scottish customers.

Training

- Stigma information as part of induction.
- Increased apps for upskilling with financial incentives around addiction and stigma (instead of goal number 4)
- Someone's come out of prison and done a recovery programme – evidence of change. Proven tracked record of changed behaviours. Gaps in CV

EAP's

- Assistance of same form is provided to all employees, and they are aware of this so that people are supported as early as possible.
- A safe and supported culture where people are asking for help and met with compassion.
- Access to information e.g. Samaritans.
- Changing the first pledge: Ensure employees are enabled and comfortable to disclose.

Awareness campaigns

- Champion organisations that are inclusive through a list. Celebrating encourages good practice.
- List of sympathetic employers e.g. local authorities, contractors/where contracts are involved – won't hold convictions against you.

Policies

- Make information available about what people can expect at work.
- Remove reducing costs from goal number 2 – not needed.
- Scrap goal number 2.
- Goal number 6 – drop 'stigma friendly' - visible show of support of the pledge for challenging stigma.
- Encourage employees to disclose substance use and why. Provide grounds for support if disclose a drug or alcohol addiction.
- Implement mental health first aiders for all organisations.
- Creating a culture of support to be open and honest.
- Company sends employees to rehab/medical insurance.

Discussion 3: Health & Mental Health Refining Pledge Goals

The discussion focused on improving the integration of health and mental health services, strengthening patients' rights, and enhancing support for both individuals and staff. Key suggestions included:

- **Rights & Advocacy:** Ensure all patients know their rights, including receiving the Charter of Rights in all mental health services. Advocacy should be readily available when needed. Staff and patients alike must understand these rights.
- **Service Improvement:** GPs should be aware of local resources like social prescribers, crisis cafes, and community assets. Training should include patient pathways and a more trauma-informed, humanised approach to care.
- **Feedback & Accountability:** Pledge 5 should focus on better use of Care Opinion for feedback. Inspectorates and health boards should learn from best practices and include people with lived experience in the process. Employment pledges should apply across all sectors.
- **Access & Inclusion:** Recognise limitations of "no wrong door" policies, particularly for smaller organisations. Improve access to medication and information through campaigns and apps like the Dundee Recovery App or Let's Get Connected. Use appointment cards to encourage behavioural change.
- **Language & Culture Change:** Shift language from "peer worker" to "harm reduction worker" if needed. Encourage culture shifts through role modelling, using first names, and supporting families in advocacy.
- **Workforce Wellbeing:** Acknowledge second-hand trauma and the mental health needs of healthcare staff. Consider time constraints for training and support suicide prevention education.

Process Learning and Recommendations

Area of learning	Challenges	Recommendations
Open channels of communication	At times during the process, Deciding Matters was unable to reach the main point of contact. This could have been for multiple reasons, including illness or capacity issues. However, it resulted in	We ask that the commissioning team assign additional points of contact to a project should the lead be unavailable or unresponsive for any reason. There should also be a clear process to follow

	limited feedback at critical points in the co-design process which had been requested by participants.	should the delivery organisation have concerns to raise.
Ministerial and senior representation	This process was fortunate to have the late Christina McKelvie in attendance at the first Tackling Stigma workshop in her role as Minister for Drugs and Alcohol Policy. Staff and participants alike were saddened to hear of her passing in March 2025. Lack of availability of senior representatives for the remainder of the process resulted in delayed workshops due to the need for Scottish Government input and feedback at key stages. Lack of Ministerial attendance at the final workshop and presentation of recommendations resulted in several participants deciding not to attend as they did not feel their contribution was being appropriately valued and considered.	Processes such as these which recruit a co-design panel of experts by experience committing to a time-intensive project should secure Ministerial and senior representation in advance. While it may be impossible to plan exact dates, there should be a commitment from appropriate representatives to attend relevant sessions where possible. We ask that Scottish Government engages multiple representatives so that even if one cannot attend, someone is likely to be available to engage and take note of the participants' hard work. An appropriate number of identified people who have responsibility
Setting clear and realistic expectations	This project was initiated with the expectation that budget was available to deliver a campaign shaped by the participants' recommendations. The co-design panel was made aware in Workshop 3 in September 2024 that this budget was no longer available and that follow up work based on the outputs of this process could not be guaranteed. Participants shared that this felt disheartening and frustrating and minimised their confidence in the process as a whole.	We ask that Scottish Government formally commit to any guarantees they make to participants as part of deliberative processes. Where this commitment cannot be made, the offer should not be verbalised as it sets unreasonable expectations resulting in broken trust. Deciding Matters understands that budgets may shift and adapt to meet evolving Government needs, but where a commitment has been made, there should be every attempt made to uphold that commitment. Where that is no longer possible, clear communication should come directly from Scottish Government detailing changes and reasoning.

		Transparency and honesty
Timely feedback and guidance from Scottish Government	Full feedback was not provided on all draft reports which left and no additional expertise even after requests for campaign specialists Draft reports were shared with Scottish Government between workshops, often with specific questions from participants highlighted (such as queries around devolved powers). Limited feedback was shared with the Deciding Matters team and co-design panel, which impacted the refining process for recommendations.	Iterative processes benefit from regular feedback and input to help with the design and shaping of consequential workshops. Deciding Matters asks that Scottish Government project leads ringfence time to review and comment on draft outputs throughout the process. If capacity changes and this is unable to be done (in a rapidly shifting political environment), a written response should be sent to participants explaining why feedback cannot be provided at that time, and what alternative actions will be taken to ensure participants are adequately supported.
Access to additional expertise	Participants requested additional expertise to support design of recommendations (specifically those with campaign experience and behaviour change expertise). These experts were unable to be sourced, which impacted the co-design panel's ability to draft specific and relevant recommendations.	Deciding Matters asks that a directory of approved experts/organisations be made available to delivery teams to support engagement with additional information at the request of participants.
Broken trust & maintaining positive relationships with participants	The other challenges mentioned resulted in participants feeding back that they felt their input was not valued, and that their final outputs would not meet their full potential. Limited engagement from Scottish Government staff and representatives, workshop delays, lack of communication and no confirmed next steps has severely eroded participants' trust in the process and in Scottish Government's commitment to co-design. Participants have given up a significant portion of their time, sharing their expertise and insights, and deliberating challenging and emotive	Deciding Matters asks that Scottish Government teams commissioning co-design work engage with the Open Government team for ongoing support and guidance to embed the principles of co-design and to ensure participants' engagement is meaningful and valued.

	topics, and many feel that their contribution has not been valued by Scottish Government. This broken trust in the process has had the direct consequence of some participants leaving the process altogether.	
Flexi-time	Rushed workshops, not enough time to think or get to know each other	Add workshops or reprioritise what is being worked on Space to vent or talk about something not related to the workshop content Micro-groups

Resources

The following resources are tools and relevant examples highlighted by the co-design panel during workshops, many of which are not specific to drugs and alcohol but are successful programmes which could be used as a model. Inclusion in this list is not an endorsement.

Useful Resources:

- Public Health Skills and Knowledge Framework
- Anti-Stigma Language Guide, Anti-Stigma Network
- Medication Assisted Treatment (MAT) Standards
- Charter of Rights for People Affected by Substance Use
- Scottish Drugs Forum

Support programmes:

- Recovery Coaching Scotland
- Scottish Families Affected by Alcohol and Drugs
- SMART Recovery
- MHAS & Vocal

Campaigns:

- Humanising Healthcare
- Stop the Deaths
- Naloxone Campaign
- SeeMe

Training:

- REACH Advocacy
- The National Trauma Training Programme (NTTP), NHS
- MAV Academy

Workplace programmes:

- Workplace Anti-Stigma Champions, SeeMe

Appendices

Appendix 1: Campaign Timeline

Implement immediately → long-term goal

SG needs to commit to transparency; sharing exactly what they are going to do, who is responsible, when it will be done, all as a follow-up to this process. This needs to be shared in a timely manner.

Services should have a person-centred approach. Service users' rights should be openly embedded and emphasised at the first point of contact as well as what services are available and what the individual is entitled to. Services should function with kindness and provide a welcoming, comfortable, non-judgemental environment. If a service does not deliver a person-centred approach this should be acknowledged and corrected. This should be monitored and evaluated on an ongoing basis based on service-user feedback.

Review and retrain ADRS workers with ongoing reviews on their understanding of stigma, and differences between the different drugs people might take, and issues regarding class and classism

All public service staff should be trained in trauma-informed practice (including GP receptionists, hospital porters, police etc.). Training should be included as part of induction processes with regular reviews and ongoing training opportunities.

Not prioritising service users who may receive a prescription over those who would need other forms of support

There should be clarity for services users as to which services work collaboratively and share information. There should be clarity over where information is shared voluntarily versus mandatory reporting and the reasoning for this.

Experts from experience should have access to opportunities to share their stories when and if they want to as part of relevant processes (e.g. service reviews, staff team training). These opportunities should not be forced or tokenistic and should be appropriately compensated.

Having holistic and informal support available equally across the country, in the form of drop-ins and cafes open during out of office hours, with support for access (such as travel passes, childcare, etc.). These services should be appropriately resourced with well paid and trained staff. There should be an audit of services currently available to be able to target support and funding.

Service directorates (justice, housing, health, education) need to hold their own reviews of stigma and develop internal processes to strengthen the supports available. These processes need to be led by experts from experience.

SG should adopt a policy (working towards legislation) that addiction is a protected characteristic: people are not refused access to any services on the basis of addiction (includes employment, housing, education, health (physical and mental), benefits, policing etc.). Rights should be presented at point of access.

Minimum unit pricing profits should be used to fund substance resources instead of profit for suppliers.

Ensure engaging with ADRS results in support rather than punitive actions taken against the service user, e.g. currently have driving licence removed, using OST (oolate substitute treatment) as carrot and stick with treatment being stopped if engagement isn't deemed enough. Where actions do have to be taken for safety, clearly explain the decision and the process.

e-learning module trauma-informed training should include real-life stories and examples.

SG should publish the true costs of not prioritising recovery in society – financial impacts and societal impacts including hospital appointments, prison services, treatment centres and loss of life.

Recovery groups should emphasise peer support, including experts from experience delivering workshops and shaping programmes, from creative opportunities to structured projects and coaching.

Educational programmes for young people, both those in school and those in alternative programmes (e.g. college, employability funds). This education will focus on stigma across a range of topics including gender, ethnicity, sexuality, disabilities, drugs and alcohol and how they interconnect.

NHS24 should have substance use options as well as mental health options.

Ensuring ADRS spaces are safe to access without police and security presence which is off-putting to service users, understanding of relation between legal system/prison system and impact on health support access. "Safe" defined by services users not workers.

It shouldn't matter where you live or what your local health agency is, you should have the same access to high quality care. SG and NHS needs to reduce variation in provision across different localities. All first points of contact (such as GP surgeries, A&E) should have a "navigator" to signpost service users to appropriate resources.

There should be easy ways for service users to provide feedback on services and interactions with staff

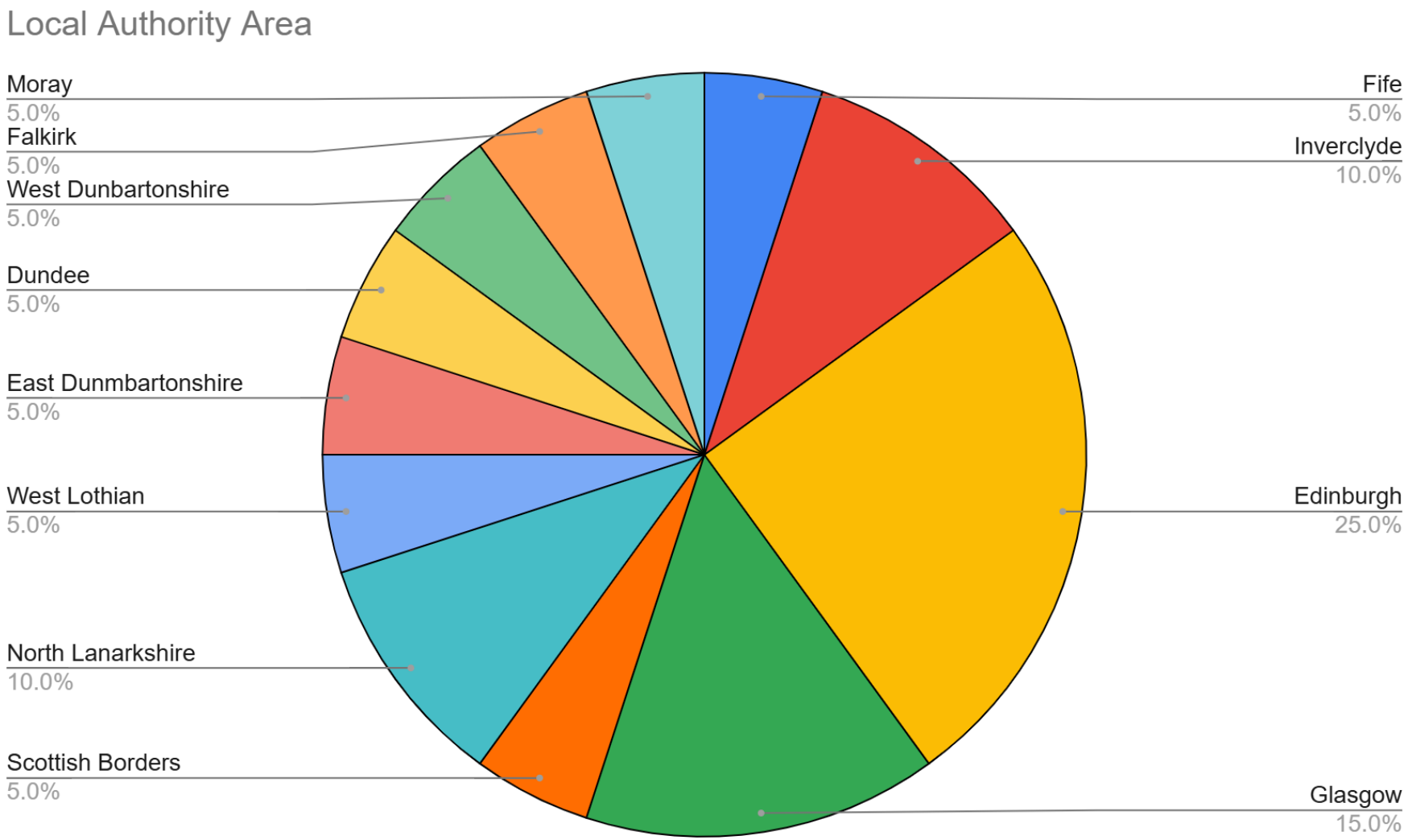
There should be a 24 hour helpline available to signpost to different substance use resources in different areas. This helpline would be delivered by and informed by experts from experience.

in-person trauma informed training designed and delivered by people with lived experience

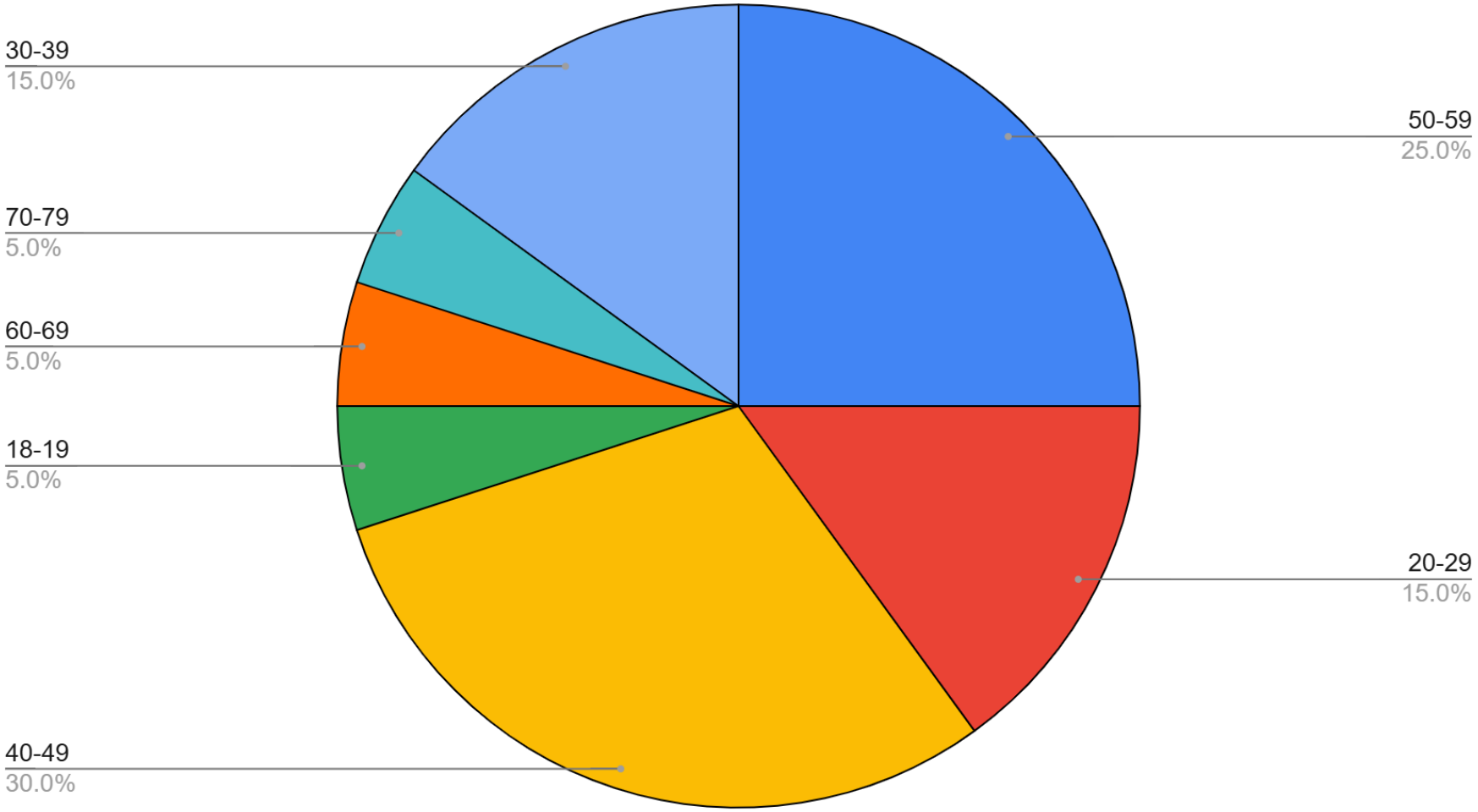
There should be an online platform for people to submit anonymous questions and receive honest answers. The platform should ask users to specify their age before entering (e.g. are you over 18) to provide age appropriate responses/signposting.

naloxone training

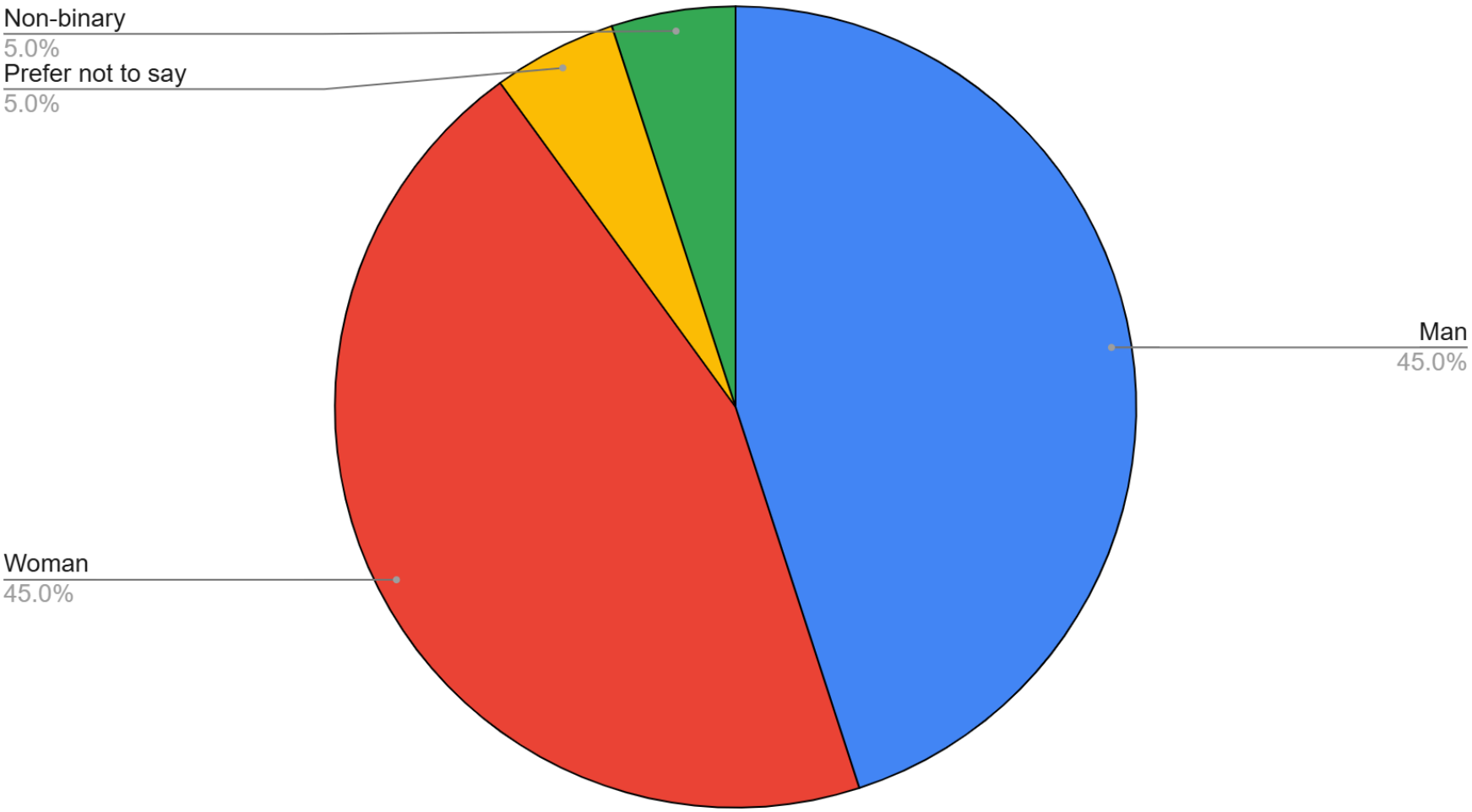
Appendix 2: Participant Demographics



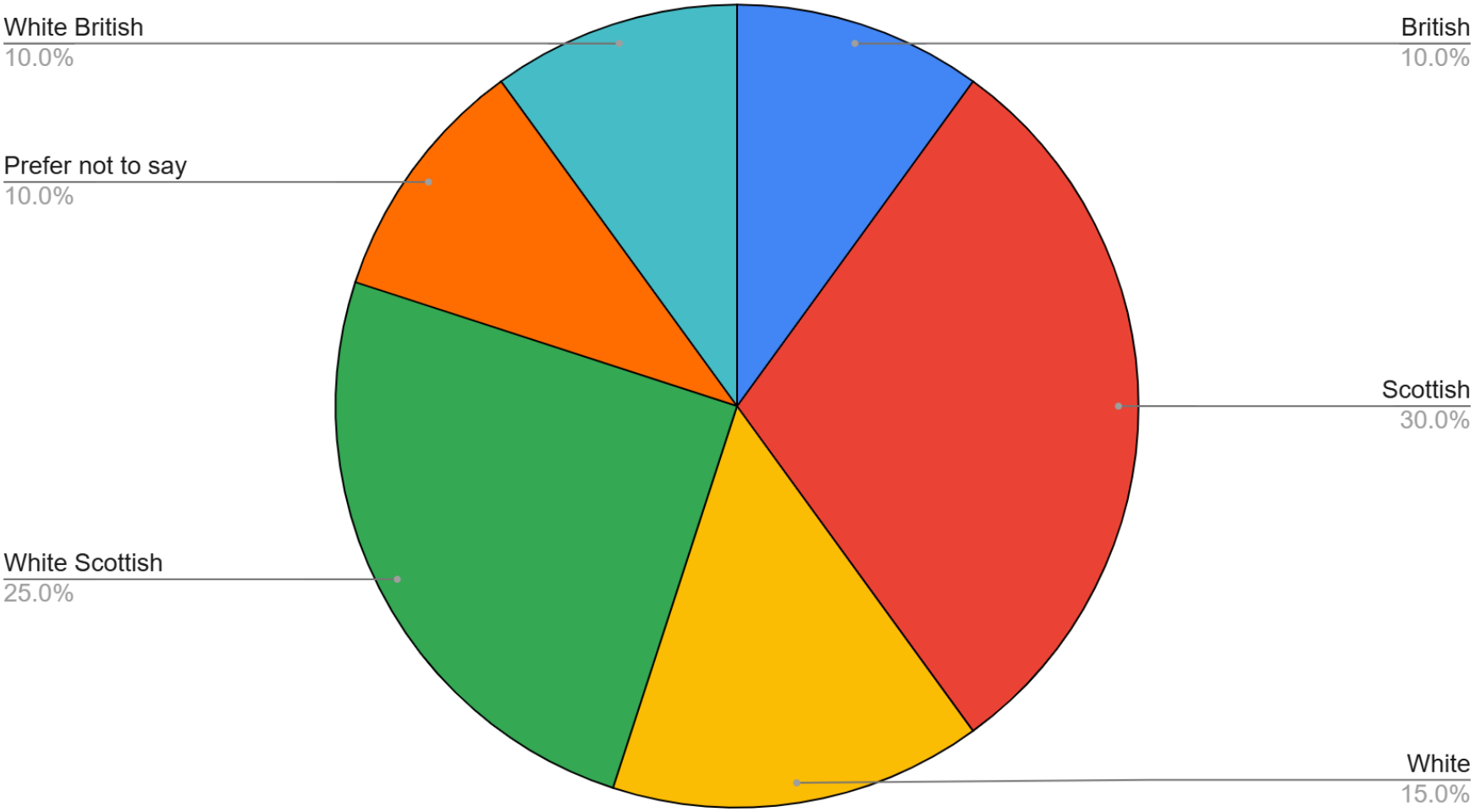
Age Bracket



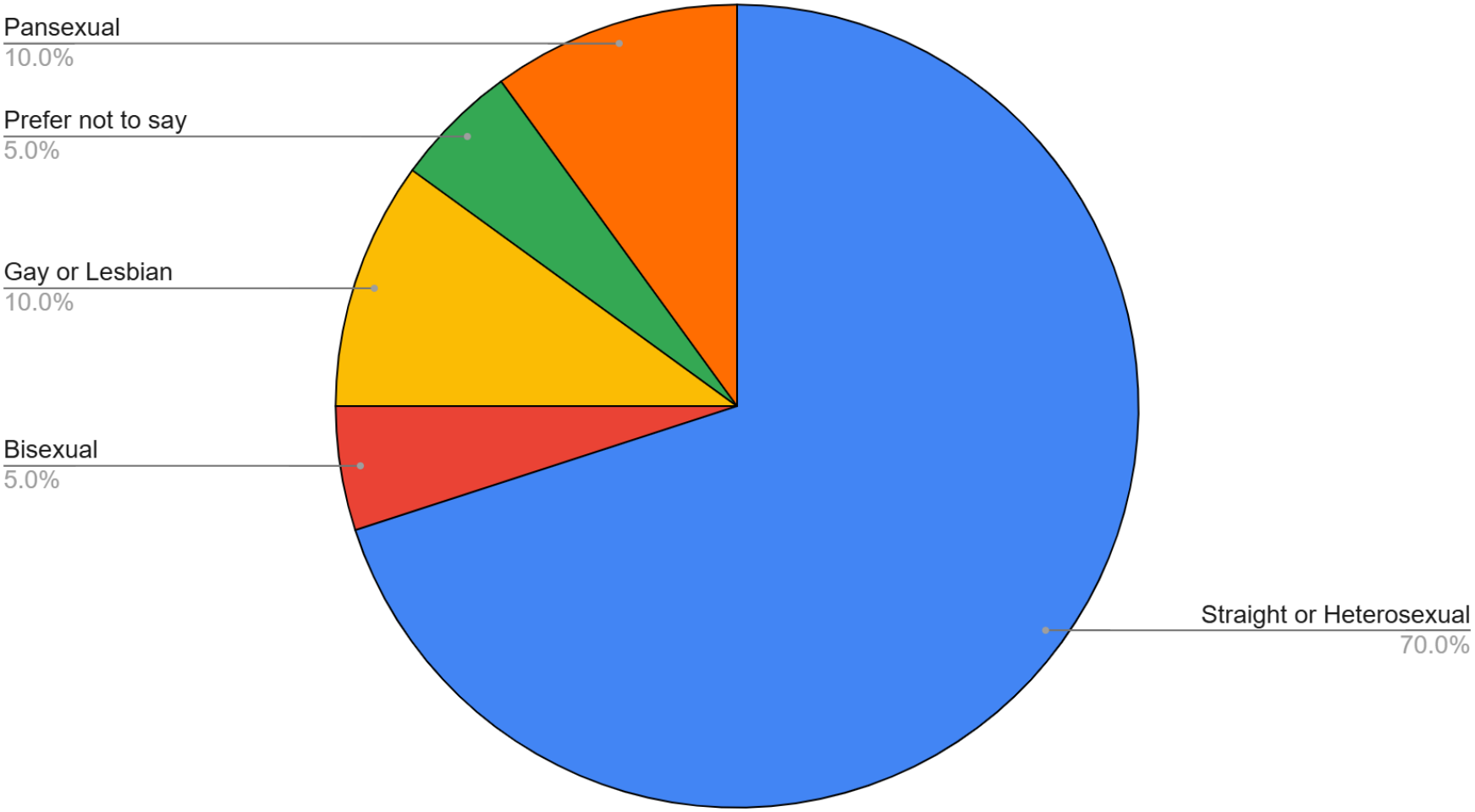
Gender



Ethnicity


White British
10.0%
British
10.0%
Prefer not to say
10.0%
Scottish
30.0%
White Scottish
25.0%
White
15.0%

Sexual Orientation



Do you consider yourself to have a disability or health condition? (physical or mental)