The Destigmatisation of People With Lived Experience of Methamphetamine Use in Aotearoa-New Zealand

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Abstract

Whilst only 1.1% of the total population use methamphetamine (or meth), a recent Aotearoa-New Zealand (ANZ) drug harm ranking study placed methamphetamine second only to alcohol, with estimated societal (personal plus community) harm costs of $865 million (Crossin et al., 2023; Mercier, 2024). Significant stigma surrounds meth and people who use meth (PWUM) (Yasbek et al., 2022). Such stigma is multifaceted involving structural, public, associative and self-stigma. Through exploring the perceptions about meth and PWUM, of both the public and subject matter experts, this research project seeks to clarify approaches to destigmatise PWUM in ANZ, ultimately aiming to improve outcomes for those experiencing methamphetamine use disorder (MUD).

Accordingly, thirty public and expert participants took part in focus groups and semi-structured interviews, with Reflexive Thematic Analysis being used to analyse the transcripts produced. The inclusion of public and expert participants allowed for a comparison of the views of these two groups, highlighting obvious misinformation and potential campaign pitfalls. Seven key themes were produced, namely: the deleterious effects of meth use; the perceived 'moral failing' of substance use; the legal versus illegal divide; the portrayal of meth as a 'bottom-rung' drug; the courage of recovery; the generation gap and, finally, the systemic shortcomings in treatment.

The research subsequently draws upon academic literature, interview analysis and international models of destigmatisation, applied to ANZ's unique sociopolitical landscape, to suggest pathways for destigmatisation, the aim being to reframe meth use as a health rather than a criminal justice issue. Through policy change, media reform and education, destigmatisation can shift public perception, reduce harm and create recovery pathways not dependent on punitive measures. As will be argued, when the largest driver of stigma, structural stigma, is dismantled through policy reform, public, associative and self-stigma follow. By confronting the biases that fuel stigma, ANZ can move toward a more humane, effective and evidence-based approach to drug use and addiction.

Tirohia te tangata, kaua ko te waranga.

See the person, not the addiction.

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Special thanks must go to Sarah Helm and the team at the New Zealand Drug Foundation who I approached. I hope this thesis will contribute to the body of knowledge in this area and contribute in some small way to destigmatising those who are currently experiencing problematic use. Profound thanks go to the participants; both the public who gave so generously of their time, and the subject matter experts who shared their knowledge and expertise – such a gift.

This project would not have been completed without the assistance of my ‘personal librarian’, James Duncan, who overnight would email requested articles I could not access as they sat behind paywalls, and without whom no overseas student would survive. Thanks James.

Thanks to my friends and whānau in New Zealand for their support, including my mentor and friend, Kim Hatton. Special thanks to my mother, Bev, who taught me to believe that ‘girls can do anything’, and at any age!

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Tuku mihi ki a koutou katoa.

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List of Abbreviations

ACEs	Adverse Childhood Experiences
ADHD	Attention-Deficit/Hyperactivity Disorder
ANZ	Aotearoa New Zealand
AOD	Alcohol and Drugs
AODTC	Alcohol and Other Drug Treatment Court
BDMA	Brain Disease Model of Addiction
CDT	Commission for the Dissuasion of Drug Addiction
FINIS	Framework Integrating Normative Influences on Stigma
HSDF	Health Stigma and Discrimination Framework
MoDA	Misuse of Drugs Act
MUD	Methamphetamine Use Disorder
NIDA	National Institute on Drug Abuse
NZDF	New Zealand Drug Foundation
PLWHA	People Living With HIV/AIDS
PWC	Pou Whānau Connectors
PWUD	People Who Use Drugs
PWUM	People Who Use Methamphetamine
RTA	Reflexive Thematic Analysis
SSI	Semi-Structured Interview
SC	Social Constructionism
SDOH	Social Determinants of Health
SUD	Substance Use Disorder

CHAPTER ONE: OVERVIEW

1.1 Introduction

The stigma surrounding methamphetamine (or meth) use in Aotearoa - New Zealand (ANZ) exists not merely in the realm of public opinion; it permeates policy, healthcare and the very fabric of society. This thesis explores the mechanisms of stigma and proposes a framework for dismantling it. As will become clear, methamphetamine has been framed as a 'bottom-rung' drug, evoking images of criminality, moral failure and dangerous unpredictability. Media portrayals amplify the perception that meth users are irredeemable. However, whilst drug use is often framed as a personal failing, the systemic conditions leading to meth use – poverty, trauma, social isolation – are rarely examined with the same scrutiny.

The stigma of meth use is not just about negative perceptions; it is a layered process involving structural, public, associative and self-stigma. Structural stigma manifests in drug laws criminalising use rather than treating it as a health issue. Public stigma is perpetuated through media narratives depicting users as violent and beyond help. Associative stigma extends to family members and even healthcare providers, whilst self-stigma, the internalized shame meth users carry, becomes a significant barrier to treatment-seeking. By breaking down these stigma layers, this thesis aims to reframe meth use as a health, rather than a criminal justice issue.

The research draws upon academic literature, interviews with public participants and addiction experts, and international models of destigmatisation, applying them to ANZ's unique sociopolitical landscape. Through policy-change, media reform and education, destigmatisation can shift public perception, reduce harm and create recovery pathways not dependent on punitive measures. Portugal's decriminalization efforts and the Te Ara Oranga programme both demonstrate that treating meth use as a health issue leads to better outcomes without increasing drug use. As will be argued, when the largest driver of stigma, structural stigma, is dismantled through policy reform, public, associative and self-stigma follow. The aim of this research is clear: to separate the drug from the person, to replace condemnation with compassion, and to develop a roadmap toward a society where those struggling with problematic use are met not with scorn, but support. By confronting the biases that fuel stigma, ANZ can move toward a more humane, effective and evidence-based approach to drug use and addiction.

This chapter introduces the historical context for this research, including Portugal's approach to decriminalization. An overview of the drug market both worldwide and in ANZ follows,

along with the impact of the media, the rationale for this study and its emphasis on methamphetamine, and the research objective of destigmatising users of meth in ANZ.

1.2 Historical Perspective

Humans have cultivated and consumed drugs since ancient times. Equally, many governments have attempted to prohibit or control drug use for numerous political and religious reasons. Even tea and coffee have been prohibited in various cultures in earlier times. In the mid-17th century coffeehouses were banned in both the Ottoman Empire and England because of their association with seditious political discourse (Allen S., 2003). Worldwide drugs were mostly unregulated until the early 20th century. Despite religious and moral opposition, the opium trade flourished until the signing of the International Opium Convention by 13 countries in 1912 and subsequently registered with the League of Nations in 1922 (League of Nations, 1927).

Around this time, temperance movements in the US and Scandinavia were lobbying for the prohibition of alcohol, based on the moral outrage they felt due to the alcoholism and domestic violence they were witnessing in their societies. Ultimately this proved unpopular with the public, however, prohibition, or the legal prevention of the manufacture, sale and transport of alcoholic beverages, was enacted in the USA under the Eighteenth Amendment (McGirr, 2015) and remained in place from 1920 until repealed in 1933 by the Twenty-first Amendment (Gitlin, 2010). Counter to its intentions, this brought about the rise of the illegal production and sale of alcohol known as bootlegging and secretive, illegal bars (speakeasies), and this underground market was capitalized on by organised crime (McGirr, 2015). By the 1930s the policy was widely viewed as having failed, in that alcohol consumption had not decreased, much needed tax revenue had been foregone, and organized crime had flourished with the black market for alcohol (McGirr, 2015). The criminalization of alcohol was thus proven to be completely ineffective. Whilst ANZ never introduced prohibition per se, the parallels to the illicit drug market will become apparent with the global “War on Drugs” from the 1970s to the present-day.

Early 20th century Western countries legally permitted many substances now classified as "Class A" drugs. Cocaine remained in Coca Cola until 1903 for example (Pendergrast, 2013). During World War II amphetamines were widely available to soldiers to combat fatigue and boost morale, and sold as diet pills to the ANZ public (Collins, 2023). However, this was to change.

In the following decades, US-driven international pressure to establish a coordinated response to the global prohibition of drugs grew. This culminated in the 1961 UN Single Convention on Narcotic Drugs, which prohibited the possession and recreational use of cannabis, opiates and cocaine, and to which ANZ was a signatory (European Union Drugs Agency, 1961). This was followed by the Convention on Psychotropic Substances of 1971 which added prescription, hallucinogenic and synthetic drugs to the list (United Nations., 1971). The third of the three UN treaties which together comprise the legal framework for global drug control was the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988, which tackled international drug trafficking and criminalized the entire market chain (United Nations, 1988).

In 1971, President Nixon declared “a War on Drugs”, citing drug abuse as “public enemy number one” (Richard Nixon Foundation., 2016, April 29). This historic intervention sought to stamp out drug trafficking and drug use, emphasising punitive law enforcement over public health and treatment. Over successive decades, governments around the world have sought to ward off drug use with the threat of excessive punishment and incarceration, as well as waging war on drug traffickers. The War on Drugs has proven costly and ineffective in both reducing drug use and halting drug trafficking, as overall worldwide drug consumption has increased and organized crime has profited (International Drug Policy Consortium, 2018; Kreit, 2010). In ANZ alone, the official estimate of crime proceeds is $1.76 billion per annum, and authorities were able to seize a mere 3.3% of these criminal proceeds from 2010-2014 (Pol, 2018).

Since the early 2000s, worldwide voices of dissent have grown. In the US, African Americans face incarceration rates 13.4 times higher than whites despite similar usage rates (Boyd, 2001; Alexander, 2012). Indeed, in 1994 John Erlichman, a Nixon aide, admitted to journalist Dan Baum that the ‘war on drugs’’ deliberately targeted anti-war activists and Black communities, by linking hippies with cannabis and blacks with heroin and then criminalising both to disrupt their communities (Baum, 1996, April). Erlichman stated: “Did we know we were lying about the drugs? Of course we did” (Baum, 1996, April). A parallel may be seen in ANZ, given that Māori constitute 51% of methamphetamine convictions despite representing only 16% of the population, a clear case of systemic racism (Ministry of Justice, 2024). It seems the war on drugs really is a ‘war on drug users’ (Buchanan & Young, 2000).

By 2011 the Global Commission on Drug Policy proclaimed the war on drugs’ a failure (Global Commission on Drug Policy, 2011). UK strategists found no evidence that threatening punishment would reduce demand, and “no clear relationship between the stringency of drug

laws and drug use prevalence” (Holland et al., 2023, p.218). In 2023, the UN High Commissioner for Human Rights argued that “decades of punitive, ‘war on drugs’ strategies had failed to prevent an increasing range and quantity of substances from being produced and consumed” (Office of the United Nations High Commissioner for Human Rights, 2023, August 15, p.6). As we shall see in the next section, when Portugal rejected the War on Drugs and decriminalized all personal drug use it “broke with a global paradigm” (Domoslawski & Siemaszko, 2011, p.4).

1.2.1 The Portugal Example

In the 1990s Portugal faced rising heroin use, drug related deaths and an HIV crisis (Slade, 2021). Additionally, more than 75% of prisoners were jailed for drug-related offences (International Drug Policy Consortium, 2018). Furthermore, whilst heroin use began amongst marginalized communities, it had spread to the middle and upper classes (Hari, 2015, p 237). Dr João Goulão, creator of Portugal’s decriminalisation policy, highlighted that at that time, it was not possible to find “one Portuguese family that had no problems inside the family or in the close neighbourhood” (Hari, 2015 p. 237). These circumstances provided a high level of social cohesion towards the view that something needed to change (Félix et al., 2017).

In 2001 Portugal introduced a comprehensive form of decriminalisation, Law 30/2000, which eliminated criminal convictions for drug possession and consumption. Instead of arrests, individuals found with small amounts (up to 10 days' supply) are referred to the "Commission for the Dissuasion of Drug Addiction" (CDT), a multidisciplinary health ministry panel that may recommend voluntary treatment, fines, or community service (International Drug Policy Consortium, 2018; Domoslawski & Siemaszko, 2011; Moury & Escada, 2023).

The CDT panel determines if and to what extent an individual may be addicted to drugs, and may orientate them towards a voluntary treatment programme, a fine or community service (Moury & Escada, 2023). Whilst drug possession and use no longer result in criminal convictions, they remain illegal and the drugs are confiscated (A. Mastro, 2021). Drug trafficking and dealing remain illegal and are still prosecuted through the court system (Domoslawski & Siemaszko, 2011; Laqueur, 2015). Crucially, the law reform also encompassed funding for the scaling up of drug treatment programmes, needle exchange programmes, and social reintegration (Moury & Escada, 2023; Rêgo et al., 2021).

Portugal’s innovative policy has sparked intense interest and hot debate as to its efficacy (Domoslawski & Siemaszko, 2011; Félix et al., 2017; Hawkes, 2011; Hughes & Stevens, 2010; Laqueur, 2015; Moury & Escada, 2023; Rêgo et al., 2021). In 2009 the United Nations

Office on Drugs and Crime highlighted that Portugal's strategy had not led to an increase in drug tourism, and that numerous other drug-related problems had also decreased (United Nations Office on Drugs and Crime, 2009). Two leading independent researchers, Hughes and Stevens (2010), concurred. Two studies followed proffering widely differing accounts, one citing "a resounding success" and the other "a disastrous failure". (Coelho, 2010; Greenwald, 2009). This prompted Hughes and Stevens (2012) to analyse the interpretation of certain data in each study. In their 2016 article, they outlined a comprehensive and nuanced analysis of the Portuguese Decriminalisation Act and drew several significant conclusions (Stevens et al., 2016):

- Reduction in Drug Consumption: General population declared drug use has reduced to levels lower than in 2001.
- Cannabis Consumption Increased Among Adolescents: Cannabis use among adolescents has increased, though is on par with other European countries.
- Decrease in Problematic Drug Use: The number of individuals experiencing problematic drug use has declined.
- Reduction in Drug-Related Offences in the Criminal Justice System: In 2000, 43% of prisoners in Portugal were imprisoned for drug-related crimes, but by 2013, this had dropped to 20%.
- Increase in Engagement with Treatment Programs: In 2000, 29,204 individuals received some form of drug treatment. In 2008 this jumped to 38,532 (A. Mastro, 2021). This is indicative of a shift towards managing addiction as a health rather than a criminal issue. Significantly such treatment was voluntary.
- Reduction in Infectious Diseases and Drug-Related Deaths: Newly diagnosed HIV cases have decreased from 1,287 in 2001 to 16 in 2019 (Ashley Mastro, 2021). Drug-related deaths have dramatically decreased, with a drug-related mortality rate of just three deaths per million people, compared to Europe's average of 17.2 deaths per million (Stevens et al., 2016).
- Increase in Drug Seizures: While drug use has remained fairly static, decriminalisation has allowed police to shift resources from minor users towards trafficking/organized crime. From 1995-1999 to 2000-2004, drug seizures rose dramatically by 499%, particularly for ecstasy (1,526%) and heroin (219%) (Stevens et al., 2016).

Finally, not only has the health and well-being of the population increased, but another recent study has shown how from 2000-2010 the government has seen average social costs reduce by 18% (Gonçalves et al., 2015). This resulted not only from a reduction in indirect health costs, but also legal system costs for drug violations and indirect costs associated with lost income/productivity of individuals incarcerated for drug-related offences (Gonçalves et al., 2015).

The biggest fear of policymakers worldwide in relation to decriminalisation was that drug use would increase, but there is now broad consensus that this fear has not been realized (Domoslawski & Siemaszko, 2011; Stevens et al., 2016). Whilst no causal relationship can be claimed, the comprehensive approach, combining decriminalisation along with expanded prevention and treatment measures, harm reduction and reintegration, has helped improve social solidarity and lessened public health risk (Stevens et al., 2016). This opinion was supported by Portugal's legislative architect, Dr. João Goulão, who noted its greatest achievement was "to allow the stigma of drug addiction to fall", enabling people to "pursue professional help without fear." (Hawkes, 2011, p.1).

Since then, multiple countries such as Belgium, Germany, Chile, Peru, Italy, the Netherlands, Switzerland and Poland, have implemented their own versions of decriminalisation, focusing either on all substances or just marijuana, with the IDPC most recently noting that 26 countries have now adopted a model of decriminalization (Eastwood et al., 2016; International Drug Policy Consortium, 2018). As we shall see in the next section, when Portugal rejected the War on Drugs and decriminalized all personal drug use it "broke with a global paradigm" (Domoslawski & Siemaszko, 2011, p.4).

1.2.2 The Misuse of Drugs Act 1975

Turning to ANZ, following the two international conventions on drug control, the United Kingdom passed its Misuse of Drugs Act 197 in 1971. At that time ANZ still looked to England for guidance on such matters and so in 1975, ANZ followed suit, adopting this framework (Misuse of Drugs Act 1975 No.116, 1975). The Misuse of Drugs Act 1975 (MoDA) is still the key piece of legislation governing drug use in ANZ and has not been comprehensively updated since 1975, despite significant evolution in our understanding of the issues surrounding substance use over the last 50 years. The Law Commission's 2011 review concluded that the MoDA was inconsistent with harm reduction principles and recommended evidence-based amendments, however this legislation has yet to receive comprehensive reform (Mayo, 2021; New Zealand Law Commission, 2011).

1.3 Overview of the World Drug Market

Globally cannabis remains the most utilised drug, with approximately 228 million users, constituting 4.4 % of the global adult population (United Nations Office on Drugs and Crime, 2024). Estimates suggest that in 2022, 30 million people had used amphetamines, 23 million had used cocaine, with another 20 million using ecstasy-type substances (United Nations Office on Drugs and Crime, 2024). Treatment needs vary regionally: opioids dominate treatment admissions in Europe and most of Asia; cannabis in parts of Africa; cocaine in Latin America; and methamphetamine in East/South-East Asia (United Nations Office on Drugs and Crime, 2023). In New Zealand and Australia, the primary substances used by people in drug treatment are cannabis, followed by methamphetamine, then opioids. Different drugs impose varying burdens on health and health-care systems. Globally opioids cause the most severe drug-related harm, inclusive of fatal overdoses (United Nations Office on Drugs and Crime, 2023).

1.4 Overview of Drug Use in NZ

In terms of the global data sketched above, the situation in New Zealand is different, in that methamphetamine rather than opioids contributes most significantly to drug-related harm (Crossin et al., 2023). This section unpacks the rationale for selecting methamphetamine as a focus for this research project, which, in brief, is that it causes the greatest harm and carries the most stigma amongst illicit substances in ANZ (McFadden, 2016; McFadden et al., 2022).

1.4.1 Legal Drugs

Alcohol, though legally available, is by far the most harmful drug. In 2020/21, 78.5% of New Zealanders consumed alcohol, with 25.4% of drinkers (approximately 825,000) doing so hazardously[1] (Mercier & Jarrett, 2022). The total cost to society of alcohol harms in 2023 is approximately $9.1 billion based on disability adjusted life years (DALYs) (New Zealand Institute of Economic Research., 2024). In 2020/21 tobacco, also legally available, was smoked by only 9.4% of New Zealanders daily, with those living in deprived areas seven times more likely to smoke than those in the wealthiest neighbourhoods (Mercier & Jarrett, 2022; Wilkinson & Marmot, 2006).

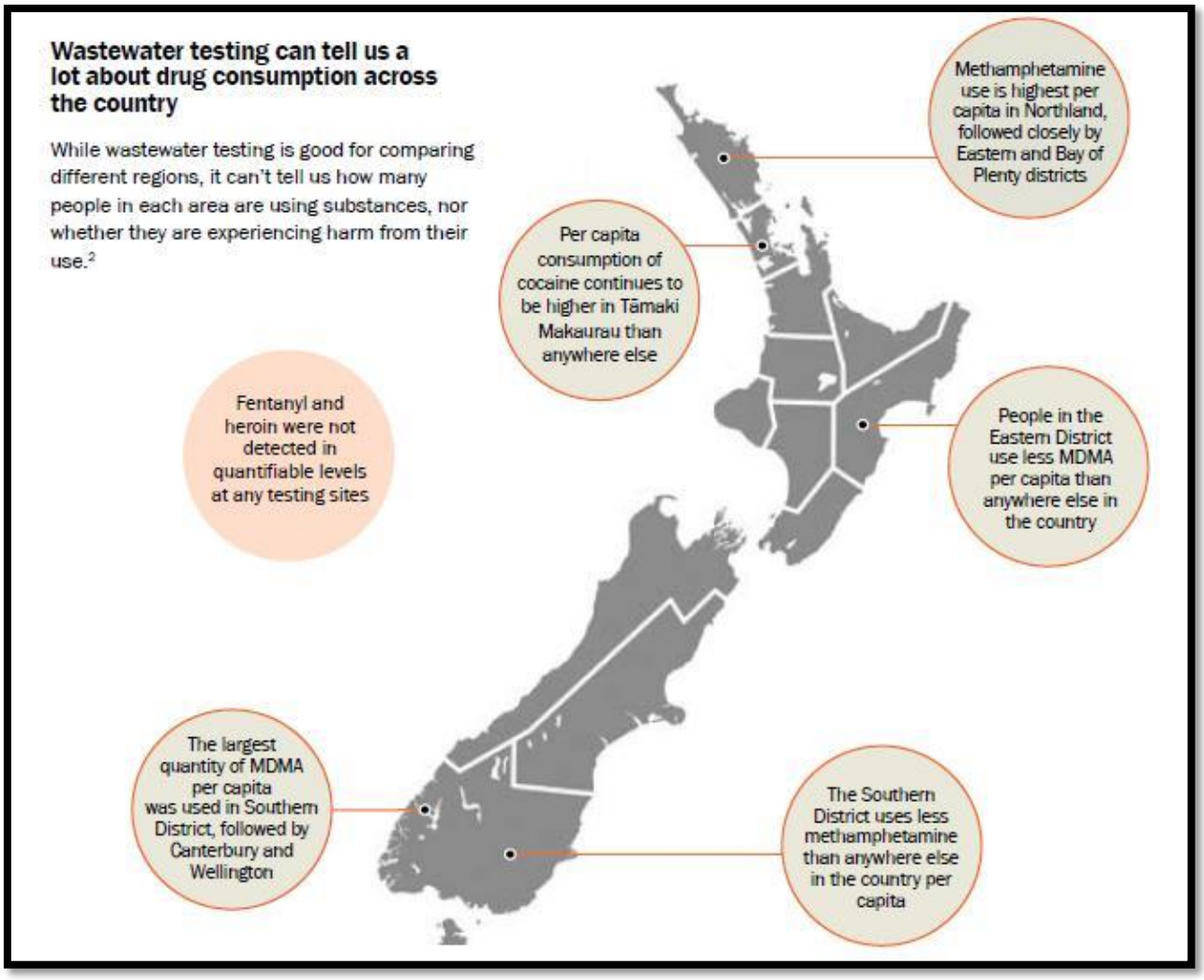
[1] Hazardous drinkers are those who obtain an Alcohol Use Disorders Identification Test (AUDIT) score of 8 or more, representing an established pattern of drinking that carries a high risk of future damage to physical or mental health.

1.4.2 Illegal Drugs

Cannabis is the most commonly consumed illegal drug in ANZ, with 14.2% of adults (597,000 people) partaking of cannabis in 2022/23 (Mercier, 2024). This is followed by amphetamines/methamphetamine, with approximately 47,000 people, or 1.1% of adults aged 16 and above consuming amphetamines (including methamphetamine) in the past year (Mercier, 2024). Approximately 11% of methamphetamine users are impacted by dependence during their lifetime (Yasbek et al., 2022). Substance use exists on a continuum from occasional use to severe use disorders, and evidence suggests that stigma most affects those with moderate to severe disorders, evaluated to be up to 150,000 people in ANZ (Te Pou., 2022). Usage of different drug types varies widely around the country (refer Figure 1).

Figure 1

Variations in Drug Consumption Across ANZ



Note. (Mercier & Jarrett, 2022)

1.4.3 Methamphetamine Use in NZ

Methamphetamine, (also called meth or, colloquially P or, Ice) is a Class A drug used by a range of groups within New Zealand society. Polydrug use is common amongst methamphetamine users (Yasbek et al., 2022). Disabled people are five times more likely than non-disabled people to use amphetamines (Mercier, 2024). Others take methamphetamine for socializing, or for better sex and increased libido amongst sex workers or men engaging in sex with other men under the influence of psychoactive drugs (termed chemsex). Lastly, some individuals self-medicate with methamphetamine to address unmet health issues, such as Attention-Deficit/Hyperactivity Disorder (ADHD), and some use methamphetamine to increase cognitive performance or wakefulness (Yasbek et al., 2022).

Prolonged high dose use can cause significant physiological harm, including weight loss, tachycardia, hypertension, and long-term cardiovascular damage (Darke et al., 2008). Psychological consequences of both acute and chronic use may include depression, psychosis, anxiety, suicidality, and violent behaviours (Darke et al., 2008; McKetin et al., 2014; Zarrabi et al., 2016) Emerging evidence also indicates potential neurotoxicity, with impairments observed in attention, memory, and executive functioning (Barr et al., 2006; Rawson, 2013). Methamphetamine's potent activation of the brain's reward circuitry contributes to its high potential for dependence, particularly when administered via smoking or injection, which may accelerate addiction due to rapid onset of effects (Rawson, 2013).

Methamphetamine use varies greatly across the country. (Refer Figure 1.) The 2022/23 wastewater testing data indicates that methamphetamine use rates were highest in Waikato (average 843mg/day/1000 people), followed by Northland (average 698mg/day/1000 people), and lowest in Dunedin/Southland (average 164mg/day/1000 people) (Mercier, 2024). Statistics show that usage correlates strongly with socioeconomic status; those living in deprived areas are over seven times more likely to use amphetamines (including methamphetamine) than those in wealthy neighbourhoods (Yasbek et al., 2022). Wastewater testing data shows national consumption increased to 32.4 kilograms weekly in Q3 2024, more than double the previous year's average (Barber & Ika, 2025).

A New Zealand drug harm ranking study placed methamphetamine second only to alcohol, with estimated societal (personal plus community) harm costs of $865 million (Crossin et al., 2023; National Drug Intelligence Bureau., 2024). A panel of experts assessed the scale of potential harm to self as well as the community for every drug type including alcohol, which

was ranked as the most harmful (Crossin et al., 2023). In ANZ, methamphetamine was deemed the second most harmful substance overall, which differed from the EU and UK rankings, but was consistent with Australia (United Nations Office on Drugs and Crime, 2023). Similar to Australia, ANZ has a relatively high methamphetamine use when compared internationally, with that use being overrepresented amongst males, Māori and areas of socio-economic deprivation (Bax, 2021; Price et al., 2021).

The ANZ expert panel also assessed each drug's harm incorporating two additional criteria: intergenerational harm and non-physical/spiritual harm, to reflect a Te Ao Māori perspective (Crossin et al., 2023). Methamphetamine ranked second only to alcohol, with intergenerational harm among its most significant contributing factors. Māori are disproportionately affected by drug-related harm, with higher rates of methamphetamine and cannabis use (Marie et al., 2008) and greater alcohol-related harm (Winter et al., 2019) reflecting systemic inequities rooted in colonisation, institutional discrimination, and intergenerational trauma (Waitangi Tribunal, 2023). Methamphetamine's high-ranking stems from its severe physical and psychological health impacts, high dependence potential, cognitive impairment, links to crime, community harm, and stigma (Barr et al., 2006; Boden et al., 2023; Darke et al., 2008; Deen et al., 2021; Foulds et al., 2020; McKetin et al., 2020) These factors underscore its significance as a pressing social issue in ANZ.

1.5 The Media and the Legal / Illegal Divide

The media wield a power often underestimated by society. In ANZ the Samurai Sword wielding Antoine Dixon is often cited for his horrifying, 11-hour meth-fueled rampage (Collins, 2023). This story is genuinely shocking, but given it occurred over 20 years ago it serves to demonstrate how the media and thence the public continue to link methamphetamine to the risk of unpredictable violence (Collins, 2023). This persistent narrative demonstrates the media's power in constructing drug discourse and shaping public perception.

Multiple studies demonstrate the large role played by print media in constructing and disseminating particular images of illegal drugs and their users to both policymakers and the general public (Elliott & Chapman, 2000; Hart et al., 2012; Jenkins, 1997, 1999; Weidner, 2009). For instance, Jenkins cites US media descriptions of crystal methamphetamine as an 'epidemic' or 'plague' (Jenkins, 1997). As for ANZ examples, Collins (2023), cites a selection of NZ newspaper headlines over the last few years: "How NZ fell prey to the demon P", "Scourge and legacy of evil drug tearing at our society", and "NZ's meth crisis – fighting the demon", highlighting the use of Old Testament language (Collins, 2023).

This demonisation obscures methamphetamine's history as a legally available diet pill, for example. However, as soon as a substance becomes illegal it is subjected to a completely different construction in meaning. Constructions offered are binary, a drug is either legal, such as alcohol, and as such, socially acceptable, or it is illegal, and as such is criminal and 'othered' (Teo, 2000). Thus, a simplistic representation of good versus bad, right versus wrong, is constructed. Society is thus divided into two groups: the law abiding and the criminally deviant (Garland, 2001). The media perpetuation of the perception of people with methamphetamine use disorder (MUD) as antisocial criminals, contributes strongly to the stigma they endure. The media are thus complicit in the construction of methamphetamine as a "moral panic", defined as a condition perceived to provide a moral threat to social order (Cohen, 2011; Forrest-Lawrence, 2016).

1.6 Rationale For This Study

As I embark on training to become a clinical psychologist, I have a particular interest in addiction and the stigma it attracts. With over two decades of experience in branding and international marketing, I was also motivated to undertake research with real-world impact and potential to support social change. In exploring possible Master's thesis topics, I approached the New Zealand Drug Foundation (NZDF) for guidance on areas they wished to see researched. They generously offered several suggestions and endorsed the project I ultimately selected (refer Appendix A). While I initially considered a broader focus on all illicit drugs, I refined the topic to specifically examine the destigmatisation of methamphetamine users. This was in part to ensure it was a manageable thesis topic, but more importantly methamphetamine was prioritized because of its ranking as the drug causing the most harm after alcohol (Crossin et al., 2023).

1.7 Research Aim

This research project seeks to investigate approaches to destigmatize drug users in ANZ, to improve outcomes for those experiencing substance use disorders (SUDs). This study focuses particularly on methamphetamine, as it is currently the illegal drug identified as causing the most societal harm and is associated with the most stigma for both individuals and communities (Crossin et al., 2023).

Chapter Two considers the core concept of stigma as it relates to drug use, including considering various models for assessing stigma. Chapter Three details my methodological approach. Chapter Four outlines my findings, namely the identified themes and their stigmatizing implications. The ability to draw on two sets of discourse, namely that of the

public and expert participants, to highlight the contrasts in their perceptions, provides a richness to this thesis. In Chapter Five I discuss a few strategically selected previous campaigns which seek to destigmatise people with problematic substance use and analyse their critical success factors. Lastly, in Chapter Six I discuss the implications of my research and look at pathways for destigmatizing people with methamphetamine use disorder (MUD), including a destigmatisation campaign and decriminalisation of personal possession/use. Improving our understanding of the stigma experienced by individuals who use methamphetamine, may assist in decriminalising personal use, decreasing stigmatisation and reframing methamphetamine use as a health rather than criminal justice issue to both reduce harm and improve health outcomes.

CHAPTER TWO: STIGMA

Stigma represents a core concept of this thesis. Broadly, stigma is a mark of disgrace associated with particular persons, qualities or circumstances - an “attribute that is deeply discrediting”, which reduces the bearer “from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p.3). Methamphetamine use attracts significant stigma, and this chapter examines both why this occurs and its consequences.

In this chapter the stigmatisation process is examined in detail, as well as the types of stigmata, namely structural (institutional and governmental), public (public perceptions and behaviours), associative (familial) stigma and self-stigma (internalized stigma). Stigma is accompanied by feelings of shame, fear, isolation and rejection for those stigmatised, negatively impacting health and wellbeing, and can act as a barrier to treatment seeking in the case of problematic MUD. Understanding these mechanisms is crucial for developing interventions that can reduce stigmatisation and improve access to evidence-based treatments.

This chapter reviews current literature on stigma to establish the theoretical framework for my research. I begin by investigating stigma’s origins and history and conceptual evolution. The various types of stigmata will be explained, along with difficulties the field has encountered in defining drug use stigma, arriving at a stigma definition for this research project. The social construction of drug-related stigma is explored, followed by an analysis of methamphetamine-specific stigma and its consequences. Thereafter the chapter will explore the potential for a comprehensive stigma model or framework, or a destigmatisation model.

2.1 Defining Stigma

The practice of stigmatisation dates back to ancient Greece, where stigmata were physical signs, cut or branded on the body, indicating moral disgrace (Jones & Corrigan, 2014). Such marks of failure or shame indicated that the bearer, a slave, traitor or criminal, was immoral and should be avoided.

In his seminal work, sociologist Erving Goffman (1963) offered a classical social interactionist theory in which he identified three types of stigma: “abominations of the body” (i.e. physical deformities such as amputations or hunchbacks), “blemishes of individual character” (such as addictions, homosexuality or mental disorders) and lastly “tribal stigma” (social labels associated with ostracized groups, such as religious or ethnic groups) (Goffman, 1963, p3). These resulted in a “spoiled social identity” (Goffman, 1963). Goffman further distinguished

between *discredited* individuals (i.e. whose stigmata are visible), and *discreditable* ones (i.e. whose stigmatized statuses may be concealed) (Pachankis et al., 2018).

As Goffman's distinctions indicate, in today's world the concept of stigma has expanded, no longer the mere physical mark of ancient Greece but rather an attribute that results in widespread public disapproval. Today a person experiencing stigma is often a member of a group devalued by the social mainstream. A myriad of attributes may be deemed flaws by society and thence classified as stigmas. This includes physical illnesses or impairments such as leprosy, obesity and HIV/AIDS (Barta & Kiropoulos, 2023; Livneh et al., 2014; Puhl & Heuer, 2009). Mental illnesses such as bipolar or hoarding disorder may be considered by some a blemish on one's character (Chasson et al., 2018; Goffman, 1963; Richard-Lepouriel et al., 2022). Behaviours which transgress societal norms, such as addiction or prostitution, as well as characteristics such as religion, gender or ethnicity may also attract stigma (Herek, 2015). Addiction stigma is even more acute than that of mental illness (Krendl & Perry, 2023). The degree of 'blemish' is not inevitable but rather, is socially constructed and varies over time, place and culture (Phelan et al., 2008).

Since Goffman's classic treatise academics have attempted to further define stigma, acknowledging the challenges in applying a single stigma definition to such a wide range of conditions. Given the wide range of physical and mental illnesses which can become stigmatised, as well as the range of social situations seen by a community as abnormal or deviant, it follows that the kind of stigma experienced by someone with obesity or schizophrenia will differ from that experienced by a sex worker or someone who is transgendered. Many disciplines have conceptualised stigma in different ways since Goffman's text emerged in the early 1960s (Corrigan, 2014). Three main conceptual approaches demonstrate how the field has developed.

First, cognitive and psychological models examine stigma's impact on social processes. Jones et al. (1984) sought to characterize the processes by which social stigmatisation operates. They identified six dimensions along which stigma differs, namely: concealability, course, aesthetic qualities, disruptiveness, origin and peril, all of which they regarded as having implications for how stigma might impact social interaction (Jones et al., 1984). *Concealability* deals with the extent to which a stigmatizing condition can be concealed from others. The *course* is the manner in which the condition changes over time and its final outcome. *Disruptiveness* refers to how much social interactions are disrupted. *Aesthetic qualities* refer to how much the attribute makes the afflicted person ugly or repellent to others. The *origin* refers to how the stigmatizing condition was acquired and who is regarded as responsible, and lastly *peril* speaks to the degree and kind of danger posed to others

(Jones et al., 1984). These dimensions are still identified in the literature as highly relevant to today's research, (e.g., Krendl & Perry, 2023).

Crocker et al. (1998) were influential in defining stigma as an attribute conveying a "devalued social identity in a particular context" (Crocker et al., 1998, p506). They posit that for those who stigmatise, stigma is about maintaining the belief that we are fair, deserving, and that our worldview is justified. For the stigmatised, stigma is a threat to their self-esteem and sense of having a safe and valued identity. Coping strategies such as ingroup social comparisons and disengagement assist in maintaining a sense of worth in the wake of devaluation (Crocker & Major, 1989; Crocker et al., 1998). Major and O'Brien (2005) posited a model of stigma-induced identity threat, in which they argue that possession of a public stigma, or a consensually devalued social identity, would increase one's exposure to stressful, or identity-threatening situations. Identity threat results when stigma-relevant stressors are appraised as potentially damaging to one's social identity and beyond one's coping skills (Major & O'Brien, 2005).

Second, evolutionary and biological perspectives frame stigma as a survival mechanism. Kurzban and Leary (2001) argue that social exclusion might offer an evolutionary benefit akin to natural selection, with stigma operating in three main ways. The first is the avoidance of low social capital partners and the second is coalitional exploitation, whereby group members exclude others from the benefits of group membership and instead exploit such individuals (Kurzban & Leary, 2001). The third adaptation is the avoidance of pathogens or communicable diseases. In this way they argue that stigmatization provides evolutionary benefits in terms of survival of the fittest. Similarly, Fetterhof (2023), explains the stigmatizing of groups and individuals as a biological predisposition to delineate "us from them" for protective purposes. The amygdala is activated for precognitive reactions of fear, aggression and anxiety to enhance our safety and trigger fear reactions (Fetterhoff, 2023). Stangor and Crandall (2000) also propose that stigma originates from the motivation to avoid danger (Stangor & Crandall, 2000). The difficulty with such evolutionary and biological explanations, however, is that they remove such practices from their contemporary context and function, so that such practices become decontextualized and depoliticized.

Third, structural and power-based theories view stigma as a tool for social control. Link and Phelan (2001) made a strong sociological contribution when they conceptualized how people construct categories and link these to stereotypical beliefs, building on the work of Jones et al. (1984) and adding discrimination to the mix. They define stigma as the co-occurrence of five key components, namely: labeling, stereotyping, separation, status loss and discrimination (Link & Phelan, 2001). Whilst many human differences are ignored (e.g. green

eyes), some differences come to be negatively socially constructed, resulting in a ‘label’, (e.g. drug addicts) which is metaphorically affixed to a person. The label functions to link an individual to a group of undesirable characteristics that form a negative stereotype. The label further functions to constitute the person as a member of an outgroup such as ’them’ from ‘us’. For example, in health-related discourse an individual *has* cancer or the flu, whereas rather than *having* problematic substance use, a person *is* a ‘drug addict’. In this way drug use behaviour becomes conflated with the person himself/herself, constituting a dominant, or ‘master’ identity (Lloyd, 2010, p.37). The fourth component demonstrates how a person, once labeled, is set apart and linked to certain undesirable characteristics, which leads them to experience status loss. This new, lower status then becomes the basis of discrimination. Lastly, Link and Phelan (2001) also added the dependence on power differences to their definition, as without this, discrimination would not be effective. Thus, stigma occurs when the five components occur together in a power situation which enables them. This has become a dominant stigma model, garnering nearly 15,000 citations according to Google Scholar.

Also within this third grouping, Phelan et al. (2008) undertook to assess whether prejudice could be fully equated with stigma, to that end examining eighteen models of prejudice and stigma for commonalities and differences, including hearkening back to classic works on prejudice by Allport and social identity theory by Tajfel and Turner (Allport, 1954; Hodgetts et al., 2020; Tajfel & Turner, 1979; Tajfel & Turner, 1986). They concluded that prejudice and stigma have much in common, with differences a matter of emphasis. A distinction is found in the human characteristics that are the core focus of prejudice models (e.g., race) and stigma (e.g. deviant behaviour, disease and disabilities) (Phelan et al., 2008). Phelan et al.(2008) determined a conceptually concise classification of three outcomes of prejudice and stigma, namely domination and exploitation (keeping people *Down*), the reinforcement of norms (keeping people *In*) and pathogen avoidance (keeping people *Away*) (Phelan et al., 2008). What is made explicit across these theories is that stigma is not just about individual bias, but is also embedded in social institutions, policies and cultural norms. In the same manner, Hatzenbuehler and Link (2014) linked stigma to the social determinants of health, showing how structural stigma limits access to healthcare and employment. Thornicroft et al. (2007) framed stigma as problems of “knowledge (i.e., ignorance), attitudes (i.e., prejudice), and behaviour (i.e., discrimination)” (Thornicroft et al., 2007, p. 92). In the literature there is an increasing focus on discrimination, seen as the behavioural consequences of stigma which marginalize those who are stigmatized (Thornicroft et al., 2007).

In sum, while social theories explain how stigma’s creation and assignment, psychological

models explore its personal impact, evolutionary perspectives suggest biological origins, and structural theories reveal its institutional reinforcement. As Chapters Four and Five will demonstrate, structural stigma plays a significant role, and measuring discriminatory practices will provide an important mechanism in assessing destigmatizing strategies.

2.2 Types of Stigma

In 2011 Pryor and Reeder proposed a conceptual model for stigma in relation to HIV/AIDs, which sought to offer further conceptual clarity amid a diverse stigma literature. Their model proposed four distinct, interrelated components: public stigma, self-stigma, stigma by association and structural stigma (Pryor & Reeder, 2011). Where possible I have given examples linked to substance use in general.

2.2.1 Public Stigma

At the core of their model is public or social stigma, a form of prejudice in the general population defined as a “category-based negative evaluative tendency” (Pryor & Reeder, 2011, p.4). Within a social psychological framework of attitudes, public stigma comprises cognitive, affective and behavioural components (Pryor & Reeder, 2011). For substance use, common cognitive elements of stigma are the public’s stereotypes or beliefs about the potential dangerousness or unpredictability of someone who is ‘high’ (Sattler et al., 2017; Yang et al., 2017). People with problematic substance use often blamed if their condition is perceived as a moral failing rather than a disease (MacCoun, 2013; Rundle et al., 2021; Volkow, 2020). Emotional or affective responses often derive from cognitive processes, such as anger towards someone considered responsible for their problematic use, or fear regarding drug induced psychotic episodes (Perry et al., 2020; Volkow, 2005; Zarrabi et al., 2016).

2.2.2 Self-Stigma

Self-stigma occurs when individuals internalize and assign public stigma attitudes and negative stereotypes to themselves (Albertín et al., 2011; Corrigan, Watson, & Barr, 2006). Self-stigma engenders feelings of shame, fear and guilt, leading to social withdrawal, and reduced treatment-seeking (Luoma et al., 2013). Overall self-stigma can diminish self-esteem and quality of life (Davis et al., 2020b; Luoma et al., 2007).

2.2.2.1 ‘Felt’, ‘enacted’ and ‘internalized’ stigma

Stigma studies often distinguish amongst felt, enacted and internalized stigma (Sayles et al., 2008). *Felt* stigma is the fear of experiencing acts of discrimination, real or imagined, and results from the person’s identification with a stigma-attracting attribute like problematic drug use (Lancaster et al., 2018). *Enacted* stigma occurs when prejudice results in real discrimination, such as job loss or the removal of a child from a parent’s care (Brown et al., 2003; Corrigan & Watson, 2007). *Internalised* stigma develops when an individual internalizes cultural norms identifying him/her as belonging to a deviant group, reducing self-worth and agency (Fernández et al., 2022; Pryor & Reeder, 2011; Ventura et al., 2022).

2.2.2.2 ‘Perceived’, anticipated’, ‘received’ and ‘enacted’ stigma

Pescosolido and Martin (2015) identify still more forms of stigma, namely: *perceived, anticipated, received* and *enacted* stigma. *Perceived* stigma signals agreement that prejudice or discrimination exists towards a labeled group (Pescosolido & Martin, 2015). *Anticipated stigma* relates to expectations of discrimination. *Received stigma* overlaps with *felt* stigma in that it relates to personal experiences of prejudice and discrimination. Lastly, *enacted stigma* is the same as that above, namely actively discriminatory behaviour. Various fine-grained distinctions have thus emerged in the exploration of self-stigma.

2.2.3 Stigma by Association

Originally termed ‘courtesy stigma’ by Goffman (1963), stigma by association affects the family and friends of a ‘discredited person’, such as someone with problematic drug use (Biegel et al., 2007; Mak & Cheung, 2008; Marshall, 2013; Pryor & Reeder, 2011). Family members may experience helplessness, guilt, shame and reduced self-esteem if their connection to the stigmatized individual is known, bringing shame on the family and providing the layering of not only self-stigma but also public stigma (Corrigan & Miller, 2004; Corrigan, Watson, & Barr, 2006; Mak & Cheung, 2008). ‘Affiliate stigma’ connotes the internalization of associative stigma by family members, distinguishing it from the construct of self-stigma, or individuals internalizing a primary stigma (Corrigan, Watson, & Miller, 2006; Mak & Cheung, 2008; Marshall, 2013). With these conceptualisations we see attempts to capture relational and process nuances.

Stigma by association has been found to be more pronounced for drug dependence than other health conditions. Given their social proximity, family members’ status becomes devalued, and they may be blamed and ostracised for both the onset and relapses of a

relative's disorder (Corrigan, Watson, & Miller, 2006; Dyregrov & Selseng, 2022; Pescosolido & Martin, 2015). Furthermore, Shin et al. (2016) found that group-oriented cultures are more likely to stigmatise non-normative groups than individual-oriented cultures (Shin et al., 2016). Thus, we might expect to see Māori and Pacific Peoples communities experience stigma-by-association more keenly than Pākehā, given their communal, group-oriented culture (Te Pou., 2022).

Provider-based stigma is another key form of stigma by association. Studies from around the world, predominantly the US and Australia, have found that healthcare workers often hold some of the most stigmatizing attitudes towards people with SUDs (Mora-Ríos et al., 2017; Muncan et al., 2020; Pescosolido & Martin, 2015; Ricciutti, 2023; Santos et al., 2021). Consequently, people with SUDs may be deprioritized, undertreated or denied healthcare access (Livingston, 2021). For example, an Australian study describes how health workers often implicitly assume that people who take drugs are an extra health resource burden rather than legitimate citizens deserving of care (Farrugia et al., 2021). Similarly, people with SUD are sometimes denied assistance in the Emergency Department of a hospital, due to perceptions they are merely "drug seeking" (Ginther & McNally, 2024). Without additional training, healthcare workers may well share public stigma assumptions, like viewing substance use as a moral failing (Ricciutti, 2023). When practitioners engage in stigmatising practices, they are not merely agents of the health-care system, but also agents of structural stigma (Jowett et al., 2021; Lee et al., 2006; Livingston, 2020). Research indicates that this commonly manifests in sub-standard clinical practices, including diagnostic and treatment overshadowing, (i.e., ascribing a problem to drug use when another medical condition may in fact be comorbid), task-oriented, depersonalized methods, withholding of information and excluding individuals from receiving services (Livingston, 2020). Here we also see the overlap of concepts, when publicly generated associative stigma in turn shapes structural stigma, to which we now turn.

2.2.4 Structural Stigma

Structural stigma involves the manner in which institutional legislation, policies, and cultural norms perpetuate stigma and restrict opportunities for those stigmatised (Bos et al., 2013; Hatzenbuehler & Link, 2014). This extends the stigma construct beyond the individual and interpersonal levels to macro-levels (Hatzenbuehler, 2016). A recent meta-analysis of 42 articles explored structural and health worker stigma at health facilities for substance use issues, mental illness and HIV, recommending policy changes and a focus on reducing health worker stigma by reducing fear, negative attitudes, and treatment uncertainty (Atkins

et al., 2020; Barry et al., 2014; Nyblade et al., 2019). Here structural discrimination against stigmatized groups plays out through government policies and legislation (Thornicroft et al., 2007). Within structural stigma the term ‘discrimination’ is gaining traction over ‘stigma’, in that opportunities accessed or denied via institutional access, not mere sentiment, are the increasingly preferred target for social change (Pescosolido & Martin, 2015).

Ethnicity, gender and socioeconomic status may also influence structural stigma. In the US, a mental illness stigma study found structural stigma to be worse amongst Asian, Black and Latino groups than White comparison groups (Misra et al., 2021). In ANZ, Jowett et al. (2021) found that Māori, youth, women and people with comorbid mental health issues were particularly vulnerable. Another ANZ study indicated that Asian populations also had lower access levels to addiction services, potentially due to a desire to avoid family shame (Te Pou., 2022).

Intersectionality, a concept from legal scholar Crenshaw (1991), occurs when multiple stigmas combine to multiply marginalize or create greater oppression than their simple summation (Do et al., 2021; Simien, 2007). For instance, in their research into HIV related stigma in Vietnam, Do et al. (2021) specified an intersection between HIV stigma, drug-use stigma and potential criminal justice system involvement, all leading to an avoidance of treatment (Do et al., 2021). Individuals may experience stigma at multiple levels or from multiple sources (Logie et al., 2011; Stangl et al., 2019). They may also find that one stigma depends on another, for example, people living with HIV/AIDS (PLWHA) may be less likely to admit their HIV status than PLWHA who do not inject drugs (Earnshaw & Kalichman, 2013). In a study of the intersection of SUD stigma and gender, women who were in recovery reported that others stereotyped them as having engaged in sex work (Earnshaw & Kalichman, 2013).

Notably, the addiction treatment system in the US has been largely separated from ‘mainstream’ healthcare, a reality ironically both stemming from and contributing to stigma (Adams & Volkow, 2020; Atkins et al., 2020). This is a comment I also encountered frequently when interviewing ANZ experts, suggesting that it is also prevalent in ANZ, and will be taken up in Chapter Four.

2.3 Difficulties with Defining Drug Use Stigma

My review of the ten most recent meta-analyses reveals that difficulties in defining stigma in relation to individuals who use drugs, appear to rest on six key points. First, the conceptual clarity of stigma lags behind research into its effects, with Manzo arguing that stigma is

consistently “underdefined and overused” (Livingston & Boyd, 2010; Manzo, 2004, p.404). This lack of coherence and consistency impedes the effective integration of findings across areas where stigma occurs, thereby limiting potential progress. I have summarised the key theoretical constructs to elucidate comparison and understanding (refer Figure 2).

Figure 2

Comparison of Stigma Constructs

<table>
<tr><th>GOFFMAN 1963</th><th>Link & Phelan 2001</th><th>Kurzban & Leary 2001</th><th>SAYLES ET AL 2008</th><th>PHELAN & LINK 2008</th><th>PRYOR & REEDER 2011</th></tr>
<tr><td>Abomination of the body</td><td rowspan="2">Labeling
Stereotyping
Separation</td><td>Avoid poor partners
Avoid communicable diseases</td><td>Felt Stigma</td><td>Keeping people AWAY</td><td rowspan="2">Public Stigma</td></tr>
<tr><td>Blemish of Individual Character</td><td></td><td>Enacted Stigma</td><td></td></tr>
<tr><td>Tribal Stigma</td><td>Status loss
Discrimination
Power differential</td><td>Coalitional exploitation</td><td></td><td>Keeping people DOWN</td><td>Structural Stigma</td></tr>
<tr><td></td><td></td><td></td><td>Internalised Stigma</td><td></td><td>Self Stigma</td></tr>
<tr><td>Courtesy Stigma</td><td></td><td></td><td></td><td></td><td>Stigma by Association</td></tr>
<tr><td></td><td></td><td></td><td></td><td>Keeping people IN
(Reinforcement of norms)</td><td></td></tr>
</table>

Note: The use of shades of green denotes similar concepts across publications.

The second difficulty is the multidisciplinary nature of stigma research, given contributions are garnered from psychologists, sociologists, political scientists and anthropologists alike (Link & Phelan, 2001). While multiple disciplines offer valuable diverse perspectives, this creates challenges for unified understanding.

The third difficulty is that, until recently, stigma research has been decidedly individual focused, concerned with intra-psychic perceptions and micro-interactions (Corrigan et al., 2017). This approach sidesteps structural issues and reduces a social phenomenon to individual psychology. Additionally, such small scale, individual level research aligns with the gold star clinical trial model but does not allow successive researchers to “stand on the shoulders of giants” and build collective knowledge exponentially (Newton, 1675; Pescosolido & Martin, 2015).

The fourth issue is the extremely wide array of applications, though concentrated in fields of leprosy, mental illness, AIDs, obesity, race and sexuality (Manzo, 2004). Indeed, in 2018,

Pachankis et al. identified 93 highly specific expressions of stigma (Pachankis et al., 2018). Most studies examine only one stigmatized circumstance and assess only one condition-specific outcome or intervention (Link & Phelan 2006, as cited in Kulesza et al., 2013). Livingston et al. (2011) highlight the extensive work done in addressing self-stigma, but again in the limited context of a single stigmatizing factor and a single outcome, for example, self-esteem at the individual level. This appears to be a function of measurement challenges and the academic system, with funding allocated in silos for ever more compartmentalized fields. One US study readily demonstrates this disturbing trend, finding 444 measures of stigma used between 2004-2014 (Fox et al., 2018). It found 304 measures (68%) had been created for single studies and not necessarily psychometrically validated. Only 24 scales had been cited at least 10 times, a clear example of the highly fragmented nature of stigma research (Earnshaw, 2020). What is needed (once a stigma construct is more fully agreed), is the synthesis of these studies along broader categories or continua, such as health-related stigma, or all mental illnesses, or all stigmatized issues which are currently illegal, and considering multiple factors simultaneously (Hatzenbuehler & Link, 2014; Hatzenbuehler et al., 2013; Link & Hatzenbuehler, 2016).

Recently, broader, bigger picture issues such as structural stigma have received more attention. Given humans exist on multiple, intersecting axes of difference (e.g., gender, disability, ethnicity and sexuality), the intersectionality paradigm could assist (Hancock, 2007; Hankivsky & Cormier, 2009; Livingston et al., 2011). However, no consistent theoretical framework exists to empirically measure stigma at a structural level, and this will be discussed later in this chapter. Measurement is an important aspect because it allows for stigma to be assessed against population health issues and for policy changes to be assessed for efficacy.

The fifth difficulty is the relatively little research dedicated to addictive behaviours, forcing reliance in part on studies in mental illness (which may in part be concomitant) (Crisp et al., 2000). Among mental illnesses, psychotic disorders face more stigma than mood or anxiety disorders, (Anderson et al., 2015; Corrigan & Kosyluk, 2014; Krendl & Perry, 2023, p.97; Robinson et al., 2019; Sorsdahl & Stein, 2010). Substance dependence typically emerges as the *most* stigmatized condition of all (Kulesza et al., 2013). Numerous studies indicate that SUD stigma is generally worse than other psychiatric disorders such as schizophrenia, with individuals blamed for their own condition (Lloyd, 2013; Schomerus et al., 2011; Yang et al., 2017).

The magnitude of SUD stigma varies by drug type and legality (Janulis et al., 2013; McGinty et al., 2015). Social psychological researchers have identified the key beliefs driving stigma

as including perceptions of: dangerousness, socially undesirability, controllability, changeability and/or visibility (Jones et al., 1984; Krendl & Perry, 2023). However, more work is required on the convergence and divergence of these drivers between mental illness and SUD research, and this will be considered more closely in Chapter Four (Corrigan et al.,

2017). Whilst SUD research has previously been underfunded in many countries, the increasing prevalence of opioid addiction in mainstream US populations, means government attention and studies in this area are increasing (Corrigan & Nieweglowski, 2018; Kelly et al., 2024; Krendl & Perry, 2023; McCradden et al., 2019).

Lastly, the sixth issue is the dearth of longitudinal studies (Kulesza et al., 2013; Livingston et al., 2011; Yang et al., 2017). Whilst cross-sectional data provides helpful information, it lacks the richness of longitudinal studies regarding the relationship between stigma and substance use over time. Longitudinal studies could illuminate the causes and effects of drug use, and identify the stages at which attitudes become stigmatizing (Kulesza et al., 2013; Yang et al., 2017).

2.4 Stigma Definition

Having reviewed the stigma literature, I will utilise the following definitions for this research project, drawing primarily from Link and Phelan (2001), Pescosolido and Martin (2015) and Pryor and Reeder (2011). Stigma represents the mark, condition or status which devalues a person within society. As Link and Phelan (2001) elucidate, the process of stigmatisation first requires the *labeling* of differences, terms encoded by the establishment, such as ‘criminal’ by the justice system, or informally by the public, (e.g., ’fat’). These differences become imbued with negative attitudes or *stereotypes*, resulting in separation between *‘us’ from ‘them’,* leading to *status loss* and *discrimination.* These four components can only be realized when they occur in a *power imbalance* which enables them, enacted through social relations. Lastly, stigmas are produced and reproduced through cultural configurations arising through time and place (Pescosolido & Martin, 2015).

The second part of my stigma definition draws from the work of Pryor and Reeder (2011). Their model identifies four distinct, yet interrelated types of stigma, namely public stigma, self-stigma, stigma by association and structural stigma (Pryor & Reeder, 2011). As I argue in Chapters Four and Six, addressing structural stigma by way of decriminalization could profoundly affect all other types of stigma, interlinked and mutually reinforcing as they are.

2.5 The Social Construction of Drug Use Stigma

Social constructionism posits that our social reality is constructed through shared meanings, practices and beliefs that originate and are reinforced through social interaction (Burr, 2015). If we look at drug use stigma, social constructionism suggests that the discourse about people experiencing problematic drug use do not rest on objective reality but result from social processes and language that both produce and reinforce such negative stereotypes (Augoustinos & Walker, 1998; Gergen, 1985; Gergen, 2009; Gergen, 2022).

Within the realm of social constructionism, the social acceptability of certain substances is determined by the norms, beliefs and values of any given society or culture. These social norms are shaped by a myriad of factors, such as historical, cultural, political and economic forces. For instance, alcohol and nicotine are widely accepted and legally available substances in multiple societies, despite their addictive qualities and negative health consequences. This is likely due to their cultural and historical significance, their ubiquity and substantial economic impact (Gilroy, 2023).

In contrast, substances such as cannabis, methamphetamine and opioids are frequently stigmatised and criminalised, even though they may have medicinal properties or be used recreationally by a wide range of people. This is probably due to a variety of influences, including the historical and cultural construction of these drugs as dangerous and deviant, and association with marginalized groups or subcultures (Crocker et al., 1998; Pescosolido & Martin, 2015). Such cultural beliefs have then been bolstered by media portrayals of people with problematic use as erratic and dangerous, and the justice system's criminalisation of drug possession and use (Collins, 2023).

In this way social constructionism helps us understand that drug acceptability is not governed solely by inherent properties, but results from social processes shaped by broader cultural, social and political forces. Society is thus divided into two groups: the law abiding and the criminally deviant (Garland, 2001). The choice is binary: good versus bad, legal versus illegal, socially sanctioned or heavily stigmatized. "Stigmas reflect the fault lines in a society at any one point and are as artificial and subject to change as national boundaries on a world map" (Pescosolido & Martin, 2015, p 6).

Importantly, social constructionism reminds us that these 'fault lines' are not only arbitrary but change over time. For many years, methamphetamine was used by armies and athletes to boost their performance, and in ANZ it was legally available as a diet pill (Collins, 2023). Its status changed the minute it became an illegal substance – thereafter demonized by society

and the media alike (Collins, 2023). It is probable that every generation will have its own form of “most stigmatized substance”, and as per the 1936 anti-marijuana propaganda film “Reefer Madness”, this position is currently occupied in ANZ society by methamphetamine (Hall & Yeates, 2021). Simultaneously we see ANZ society’s attitudes to marijuana shifting, with marijuana becoming less stigmatised and more acceptable. Although already available for medicinal uses, once decriminalised or even legalised, it will likely attain far greater social acceptability (Manthey et al., 2024; Statistics Canada., 2023). A parallel example can be seen in the decriminalization of homosexuality in ANZ in 1986, with more positive, less stigmatized attitudes to homosexuality these days (Betts, 2020; Herek, 2015; Loftus, 2001). A further example was the attitude shift after the Prostitution Reform Act 2003 legalised sex work, with the positive outcome of a reduction in harm for sex workers (Prostitution Reform Act 2003, 2003, June 27; Wahab & Abel, 2016).

We see such shifts not only in ANZ, but globally, with public attitudes to a raft of issues changing over time. In a similar vein, Hansen et al.(2014) writing in the US, tracks the changing status of poverty stigma, with the stigmatized labels having shifted from being a symptom of “racial weakness”, to the “culture of poverty”, and now to “permanent medical pathology”, namely the increasing need for a mental illness or chronic pain diagnosis to qualify for a disability benefit following the dismantling of the welfare system (Hansen et al., 2014). On a more positive note, Germany has experienced improved perceptions of people treated for alcohol problems, indicating an increased acceptability of professional treatment (Schomerus, Matschinger, & Angermeyer, 2014; Schomerus, Matschinger, Lucht, et al., 2014).

Social constructionism posits that drug user stigmatisation is not a natural nor inevitable outcome of drug use itself but rather results from processes that produce and underpin negative attitudes towards drug users. Link and Phelan (2001) remind us that power differences are critical in stigma reproduction. Foucault was writing at a similar time to Goffman, and whilst Goffman typically defined the social production of difference as deviance, Foucault linked this to language and power, with the abnormal being necessary for the definition of normality (Foucault, 2000; Foucault, 2020). Thus, Foucault highlights the cultural production of difference in aid of power (Parker & Aggleton, 2007). Combining Foucault and Goffman’s conceptualisations provides a powerful argument for the role of culturally constructed stigmatisation as critical to the founding and maintenance of the social order. In putting culture, power and difference centre-stage with respect to stigma, structural stigma comes to the fore. Instead of seeing stigma merely as something individuals impose on one another, we understand the broader cultural, political and economic forces at play

and we clearly see stigma and discrimination as social processes linked to the production and reproduction of structural inequalities (Parker & Aggleton, 2007). Thus, the stigmatisation of drug users may be linked to broader issues of socioeconomic status, ethnicity and gender, with some groups disproportionately affected by drug use stigma (Gilroy, 2023). In the next section I will focus specifically on methamphetamine use.

2.6 The Stigma of Methamphetamine Use and its Consequences

As previously noted, Goffman (1963) distinguished three types of stigma, and each of these can be mapped onto methamphetamine use. As noted earlier the first is labelled "abominations of the body" (p.4). People with MUD sometimes develop outward signs from long-term use. A 2010 meta-analysis identified physical symptoms as decayed teeth (meth-mouth) and skin infections associated with MUD (Hamamoto & Rhodus, 2009; Hart et al., 2012; Marshall & Werb, 2010).

Goffman's second stigma type is "blemishes of individual character" (Goffman, 1963, p.4). People with MUD may be perceived as dangerous and potentially violent, especially if experiencing a meth-induced psychosis (Gilchrist et al., 2019). The most common psychotic symptoms associated with MUD have been found to be auditory hallucinations and persecutory delusions (Zarrabi et al., 2016). People with MUD may be met with public stigma responses ranging from expressions of disgust and repugnance and the maintenance of social distance (Pescosolido & Martin, 2015). More broadly, people with MUD may experience numerous negative effects, including isolation, harm and sometimes even death (Bos et al., 2013; Gage & Sumnall, 2019). Fear of disclosing drug use to a healthcare professional may prevent appropriate care, increasing the risk of infections or overdose (Kiriazova et al., 2017).

Goffman's third stigma is "tribal stigma", nowadays known as structural stigma, whereby a person of lower socioeconomic status or a particular minority may experience systemic discrimination (Goffman, 1963, p.4). Stigmatisation can lead to social isolation, as people may fear that disclosure might lead to consequences such as exclusion from family, police involvement or having a child removed from their care (Bos et al., 2013; Te Pou., 2022). An example of structural stigma in ANZ was the overreaction generated by the meth testing industry and Housing New Zealand. Guidelines developed for meth labs were inappropriately applied to homes where meth had merely been smoked (Bardsley, 2022). The subsequent Chief Science Advisor's report found no evidence that smoking residues on household surfaces would negatively impact health (Bardsley et al., 2018). Housing NZ was

subsequently obliged to compensate the over 800 evicted tenants and their families (Cooke, 2018). Notwithstanding this scathing report, some PWUM now inject rather than smoke meth, as this cannot be detected, although this method carries with it a higher risk of overdose (Know Your Stuff, n.d.).

Family members may also be imbued with public stigma and experience stigma by association (Corrigan, Watson, & Miller, 2006). Lastly, people with problematic use themselves are not immune to societal norms – they are likely to have internalized this public stigma and experience feelings of shame, guilt, blame and low self-esteem (Bax, 2021, 2024). This leads to a reluctance to seek treatment, as they fear the judgment, prejudice and discrimination that may await them. Indeed, if they remain in an environment of drug takers, avoiding non-drug users, they may, in their minds, ‘pass’ as normal, and need only confront this internalized stigma if they do indeed reach out for assistance or medical care (Lloyd, 2010, p.38).

2.7 Stigma Models and Frameworks

When embarking on this research, I expected to find models of stigmatisation and indeed destigmatisation in the literature. However, much of the current research literature is caught in the trap of ‘one disease, one stigma, one intervention’, hindering comparison and knowledge accumulation. The evolution of stigma frameworks reflects a fundamental challenge in the field: how to effectively measure stigma's multiple dimensions. Measurement is important because government investment in a destigmatisation campaign, for example, requires accountability through suitable metrics. While various models have emerged, many struggle with the inherent difficulty of measuring attitudes and beliefs, as opposed to concrete behaviors and outcomes.

Early attempts at framework development, such as Earnshaw and Chaudoir's HIV Stigma Framework, focused primarily on individual-level impacts (Earnshaw & Chaudoir, 2009). While valuable for understanding how stigma affects both HIV-infected and uninfected individuals, its narrow focus on individual outcomes limits its utility for understanding broader structural impacts or developing comprehensive interventions.

A significant advancement came through Jones et al.'s (1984) dimensional approach, which identified six key aspects of stigma: concealability, course, aesthetic qualities, disruptiveness, origin, and peril (see Section 2.1). This framework gained renewed relevance when Pachankis et al. (2018) applied it to classify 93 distinct stigmas, creating a taxonomy linking these dimensions to health outcomes. Every possible condition associated with

stigma was considered, from autism to blindness, to drug dependence, to homelessness, to being a teen parent (Pachankis et al., 2018). This categorization represented an important step toward a more unified understanding of stigma's effects across different conditions.

The field further evolved with van Brakel et al's (2019) adaptation of Weiss's leprosy model, which advocated for a more integrated 'health-related stigma concept' (Van Brakel et al., 2019; Weiss, 2008). This framework's strength lies in its practical application, recommending specific measurement scales and interventions that have proven effective across various health conditions. However, like many frameworks, it still relied heavily on attitudinal measures rather than behavioral outcomes.

Watson and Corrigan's (2005) contribution focused on intervention strategies, through three key mechanisms: *protest, education, and contact*. They outline how organized protests about stigmatizing behaviour, education to replace myths with facts, and interpersonal contact with people who are members of a stigmatized group can all help to ameliorate stigma. This model provides practical guidance for intervention design and has been widely taken up in the literature (Lloyd, 2010). However, it highlights the persistent challenge of measuring attitude-change effectiveness versus concrete behavioral changes.

More sophisticated approaches emerged with Pescosolido et al.'s Framework Integrating Normative Influences on Stigma (FINIS) Model and Stangl et al.'s (2019) Health Stigma and Discrimination Framework (HSDF) (Pescosolido & Martin, 2015; Pescosolido et al., 2008; Stangl et al., 2019). FINIS integrates insights from micro, meso and macro level research and utilizes labelling theory, the limited capacity model of media influence, social network theory, the social psychology of prejudice and discrimination, as well as theories related to the welfare state, all of which contribute to the 'stigma complex' (Pescosolido & Martin, 2015; Pescosolido et al., 2008). HSDF evinces its application to various health conditions, namely: leprosy, cancer, mental illness, epilepsy, obesity and HIV (Stangl et al., 2019). It incorporates intersectionality and considers how stigma relates to gender, class, race, sexuality and occupation intersect with health-related stigmas (Hancock, 2007; Stangl et al., 2019). Both models represent significant progress in understanding stigma's complexity, though the HSDF particularly stands out for addressing measurement challenges by incorporating both attitudinal and behavioral components.

A crucial limitation of many frameworks is their reliance on attitudinal surveys and self-reported data, which often fail to capture actual discriminatory behaviours or structural barriers. As Thornicroft et al. (2007) highlight, stigma comprises problems of "knowledge

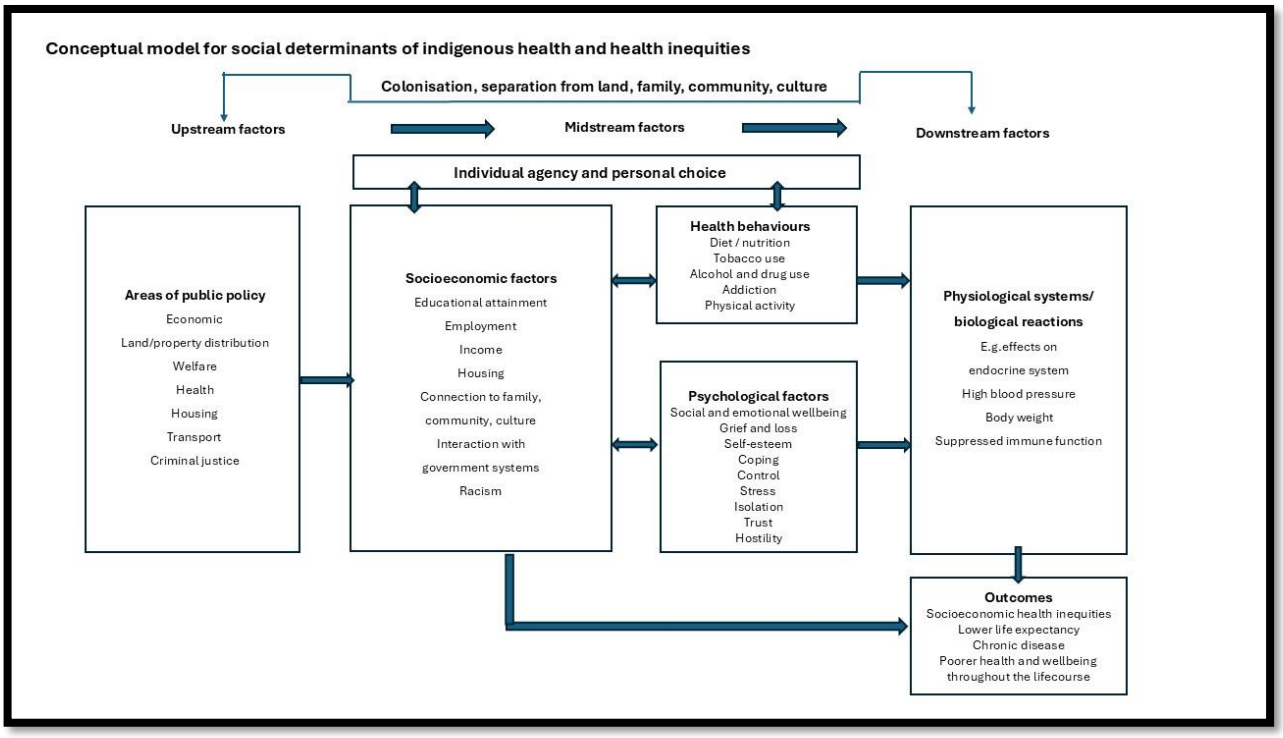
(ignorance), attitudes (prejudice), and behaviour (discrimination)" (Thornicroft et al., 2007, p.92). The literature increasingly focuses on discrimination, seen as stigma's behavioural consequence. To date the literature has concentrated on things such as attitude surveys rather than establishing an evidence base of effective interventions. While ignorance and prejudice are difficult to measure reliably, discriminatory behaviours offer concrete, measurable outcomes. For example, while individual chauvinist attitudes are difficult to measure, we can track the gender-pay-gap or the number of women in board positions as per the Women-on-Board index, to steer companies towards gender equity in managerial positions. Focusing on discriminatory practices rather than knowledge or attitudes could more effectively measure progress in decreasing stigma.

Hatzenbuehler et al.'s (2013) proposal to incorporate stigma into the Social Determinants of Health (SDOH) model is particularly compelling. By focusing on measurable discriminatory practices and health outcomes rather than attitudes, this approach offers more robust evaluation possibilities. If stigma causes stress and social disadvantage, then one could expect it to have a substantial, negative impact on population health, morbidity and mortality rates, similar to other social determinants (Link & Hatzenbuehler, 2016; Richman & Hatzenbuehler, 2014). Their study on the health impacts of same-sex marriage laws demonstrated concrete, measurable outcomes: a 15% reduction in healthcare costs, including specific reductions in depression (14%) and hypertension (18%) (Hatzenbuehler, 2016; Hatzenbuehler et al., 2012). Such health outcomes provide stronger evidence than attitudinal surveys alone.

The SDOH model is well established and widely utilized by health ministries globally, with a strong evidential base (Australian Institute of Health and Welfare, 2020; Braveman et al., 2011; Ministry of Health, 2021; Wilkinson & Marmot, 2006). Drug use already features within the model as an individual health behaviour with bidirectional causality - social deprivation may lead to drug use, causing further social marginalization (Wilkinson & Marmot, 2003). Adding stigma as a root cause, similar to socioeconomic status or education level, could generate novel insights into population health inequalities and provide clearer measurement through behavioural and health outcomes (refer Figure 3).

Figure 3

Social Determinants of Indigenous Health and Health Inequities



Note: (Australian Institute of Health and Welfare, 2020, p.110). Adapted from original diagram.

As we see in Figure 3, incorporating stigma into the box titled ‘socio-economic factors’ might enable its measurement within a well-supported model. Self-stigma could also be considered under ‘psychological factors’. Though beyond this project’s scope, this direction could prove fruitful and is worthy of further consideration.

Overall, this evolution of frameworks suggests that future models would be most effective when combining robust theoretical understanding with concrete, measurable, behavioural outcomes. By emphasizing discrimination over attitudes alone, researchers and policy makers can better track progress and demonstrate the effectiveness of anti-stigma interventions. The field requires a framework that not only captures the complexity of stigma processes but also provides clear guidance for measuring behavioral change and health outcomes. Such a framework could help dismantle the current siloed approach to stigma research, allowing for more efficient knowledge accumulation and more effective program development across different stigmatized conditions. Finally, the clear policy implication is that as well as addressing the stigma limiting treatment seeking behaviour for those with

SUD, we must also address such root causes as social deprivation (Wilkinson & Pickett, 2009).

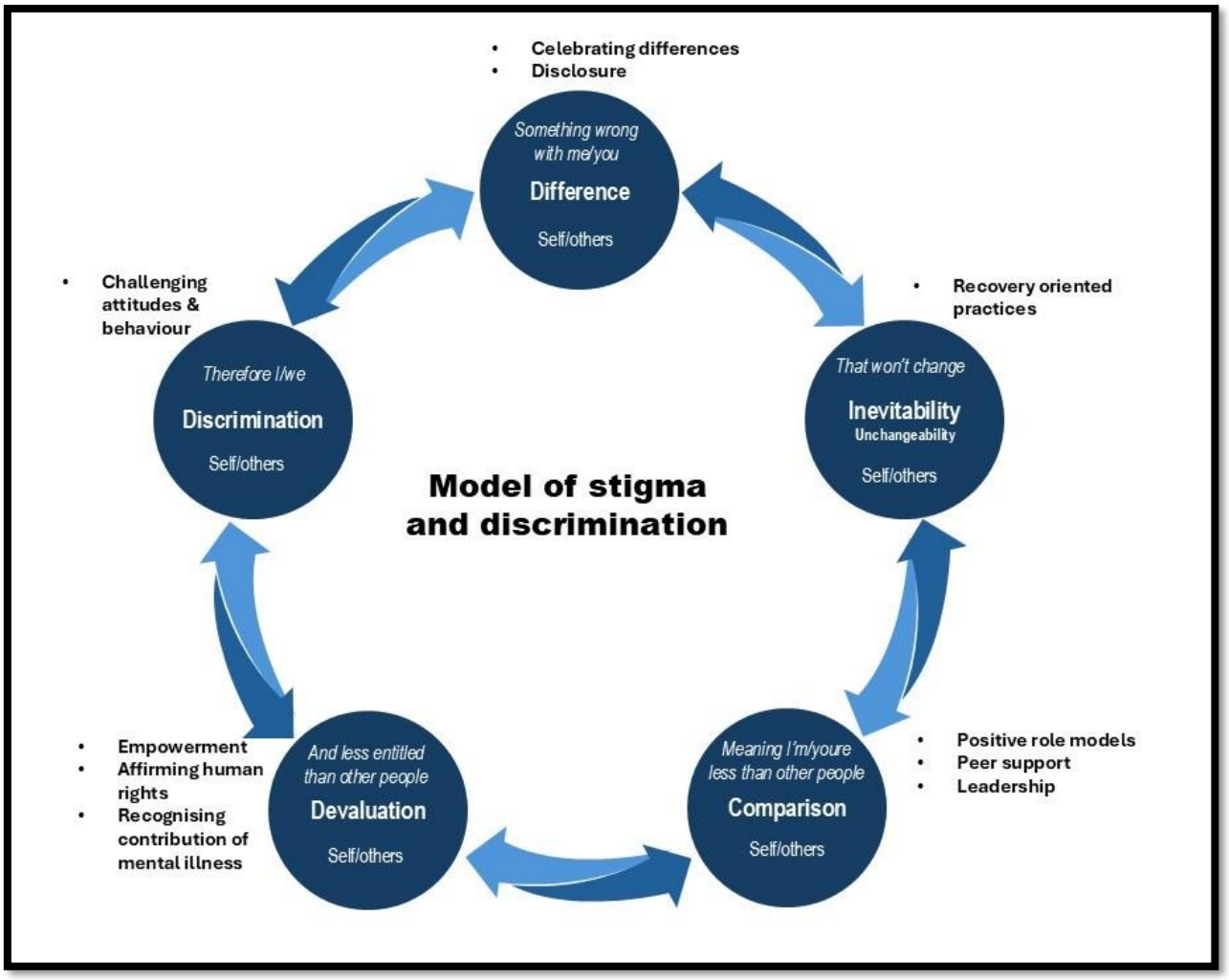
2.8 Destigmatisation: Definitions, Models and Interventions

I also explored the literature for suitable destigmatisation models, but despite Kunze's (2024) meta-analysis of 79 articles, virtually none were forthcoming (Kunze, 2024). Kunze (2024) did provide two explicit *definitions* of destigmatisation, however. The first is that destigmatisation is "the process by which low status groups gain recognition and worth in society" (Lamont, 2018, p.420). The second identifies it as the 'normalisation and acceptance of previously stigmatized groups by lessening or neutralizing the negative stereotypes related to the Other, and by decreasing the separation between Us and Them" (Lundahl, 2020, p.244). Whilst both represent adequate definitions, the second one clearly references the core components of stigmatisation outlined by Link and Phelan (2001) and as such is preferable for this research.

Although Kunze's meta-analysis (focused only on media articles) identified no destigmatisation models, I located a single ANZ model identifying 'circuit breakers' to break the stigmatisation cycle (Peterson et al., 2008). This model emerged from research for the Like Minds, Like Mine programme aimed at countering mental illness stigma. It addresses self-stigma specifically and shows techniques for challenging stigma at each stage. For instance, under 'Difference', a circuit breaker would be 'celebrating and accepting difference' (Peterson et al., 2008). For example, if society were able to celebrate and accept difference, people experiencing mental illness would feel less marginalized. Similarly, under 'Inevitability or unchangeability', circuit breakers of 'recovery-oriented practices' would assist. If healthcare services instilled hope and people experiencing mental illness felt they could recover, then self-stigma would be reduced (Peterson et al., 2008) (refer Figure 4).

Figure 4

Model of Stigma and Discrimination



Note: (Peterson et al., 2008) Adapted from original diagram.

If we turn now to possible interventions, as mentioned in Section 2.7, the most cited approaches to promote destigmatisation are: *Protest, Educate, Contact* (Corrigan et al., 2017; Livingston et al., 2011; Watson & Corrigan, 2005). Under *Protest*, organised demonstrations or celebrity involvement are potential strategies. However, under *Educate,* evidence suggests that focusing solely on knowledge improvement has limited value (Heijnders & Van Der Meij, 2006; Pescosolido et al., 2010). This appears to be particularly the case with the idea that emphasizing genetic causation would reduce stigma (Pescosolido & Martin, 2015). Consequently, profiling recovered users under C*ontact* may merit more consideration, along with social inclusion as a more viable approach (Carter et al., 2013).

In summary, whilst the core definition of stigma and the various types of stigma are in fact relatively well established, the field remains stuck in the quagmire of 'one disease, one stigma, one intervention' (Link & Phelan, 2001; Pryor & Reeder, 2011). The importance of

structural stigma is emerging but is as yet not easily measured. More work is needed to develop rigorous frameworks for the stigmatization process, followed by strategies to dismantle it, accompanied by robust metrics to assess the efficacy of these strategies. In the next Chapter I discuss research methodology, before turning to the results of the analysis in Chapters Four and Five.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Research Design

This research explores the stigma associated with people with lived experience of methamphetamine use in ANZ and aims to identify ways in which this population may be destigmatised. This chapter provides a description and justification of my research procedures. First, I examine the ontological and epistemological orientation of my study. Then, I explain my recruitment process and describe the study participants. Thereafter I explain the interview guide development and the interview process. Next, I introduce reflexive thematic analysis and my rationale for selecting this approach, followed by an outline of my iterative data analysis process and theme development. Finally, I attend to ethical considerations including cultural responsiveness, trustworthiness, my positionality in the research and my own reflexive process.

3.2 Ontological and Epistemological Assumptions

3.2.1 Critical Realism

Ontology is the philosophy of being and existence; it considers the nature of this reality, whereas epistemology concerns itself with knowledge; what can be known, how we can know it and the nature of truth (Burr, 2015; Fox et al., 2009). This study is grounded in the ontological position of critical realism, which espouses a middle ground between ontological realism and epistemological constructivism (Willis, 2023). Ontological realism acknowledges a real world which exists ‘independent of any perceptions, theories or constructions” (Willis, 2023, p.6). It describes a reality which exists outside of human minds or social activity and is made up of real structures which persist and operate independently of our own knowledge and experience. Epistemological constructivism then suggests that any understanding of this world is a construction from a particular perspective (Willig & Stainton Rogers, 2017; Willis, 2023). We do not have direct access to the underlying real world but are reliant on drawing on a range of methods to give us an understanding of this reality. One approach would be to attend to how language is used to construct the difficulties we encounter in society and what the implications (consequences) are of these different constructions. Social constructionism (SC) then provides a suitable framework for such an investigation.

3.2.2 Social Constructionism

Epistemologically, Gergen’s (1985) social constructionism asserts that psychological experiences emerge from sociocultural contexts, not from ‘what there is’ (Gergen, 2009, p.5)

as in the positivist sciences, but from the 'outcomes of relationship' (Gergen, 2009, p.6), or how we describe, construct and make meaning of our world. Gergen asserts we construct meaning from our history, culture, language and social context. Thus, against the ontological backdrop of critical realism, SC is an epistemology which places knowledge origin in social process; the ways in which we describe/explain the world are the outcomes of relationship, a construction which is *co-created* with others (Ravenek & Rudman, 2013). These interchanges amongst people are both culturally and historically situated (Burr, 2015; Gergen, 1985; Gergen, 2009; Gergen, 2022). SC seeks no absolute 'truth', but rather accommodates multiple truth constructions, co-created between individuals/society, and maintained by their social and political utility.

Constructions, as articulated through language, also change over time. Thus, for example, the concept of "stigma", a core notion in this project, is time-and-culture bound, reflecting the shared values/co-constructed realities of our current period. In SC, language, or discourse, does not merely describe reality but constructs accounts of reality. This highlights the role of power since different constructions offer different positions, roles, responsibilities and rights to different persons/groups. Wetherell and Potter (1992) in their study of racist discourse in ANZ, demonstrate how patterns of discourse, such as stereotypes, prejudice and stigma, can create unequal power dynamics between Māori and Pākehā. Thus, how we talk about (construct) something, or someone has implications for how we respond to that something or someone. Dominant groups typically have a vested interest in maintaining the status quo and are reinforced at a systemic level through their policies and institutions (Burr & Dick, 2017). Power relations are historically/socially constituted and reproduced through language, a device of power (Foucault, 1990; Mortari, 2015). Equally, as language has consequences, it is a form of social action, so changing language can help to destigmatize a particular behaviour. This project, for example, examines how language is deployed by the public to construct prejudice and stigma towards methamphetamine users, and how experts deploy the language of compassion. Words can either enable or challenge societal norms (Foucault, 2002). As individuals are meaning-making agents embedded in sociopolitical contexts, this study highlights human action and agency (Fox et al., 2009). In subscribing to critical realism my aim is to generate knowledge that has emancipatory relevance.

3.3 Data Collection

3.3.1 Recruitment

During the initial project conceptualization I identified three groups of interest, namely: the public, people with lived experience and subject matter experts. However, following

discussions with my supervisor, noting the ethical clearance challenges that would emerge in working with people with lived experience, and for practical reasons given the extensive number of semi-structured interviews (SSIs) was already well beyond the normal scope of a Masters, it was decided to focus on members of the public and subject matter experts in drug use/treatment. This approach was also logical for gathering information for a destigmatisation campaign. With the public participants, I sought to understand their current perception of meth users, as a starting point for any destigmatising interventions. With the subject matter experts, I hoped to uncover any gaps in understanding between the public participants and the experts. As it transpired, several of the peer support staff interviewed did offer a lived experience perspective, which was also very helpful.

3.3.1.1 Public Participants

Recruitment began in May 2024 and public participants were recruited using convenience sampling. Public participants were required to live in Aotearoa and not have direct personal or familial experience of problematic methamphetamine use, ensuring their views would be comparable to most members of the public. Participants were recruited through two avenues. The first was an invitation posted to two Massey University psychology student Facebook pages, (yielding two participants), and the other utilised my own personal network, posting the invitation to my own Facebook page and approaching people directly (refer Appendix B).

After potential participants expressed their initial interest, I emailed them an Information Sheet and Letter of Endorsement from the NZDF (refer Appendices C and D). For those with continued interest, I then requested demographic information (age, ethnicity, location) and preferred interview timings/locations. If they fitted within the diversity grid and confirmed their willingness to participate, I sent a meeting invitation, followed by time and place confirmation.

For the public participants I utilised a diversity grid (refer Table 1). I entered willing participants into a spreadsheet, regularly reviewing it to achieve as diverse a range of participants as possible across genders, age, ethnicity and socio-economic, ensuring a wide spectrum of views amongst people aged 18-60.

Table 1

Public Participant Recruitment Diversity Grid

Pseudonyms	Age Range	Gender	Ethnicity	Socio-Economic Background	Location
Focus Group 1 - South Auckland					
Angela	55-59	Female	Māori	Medium	Auckland
Linda	55-59	Female	Pacific Peoples	Low	Auckland
Fiona	55-59	Female	European	Low	Auckland
Kevin	55-59	Male	European	Low	Lake Karapiro
Diana	55-59	Female	European	Low	Auckland
Focus Group 2 - Auckland Central					
Sarah	50-55	Female	European	Medium	Auckland
Nick	55-59	Male	European	High	Auckland
Individual Interviews - Auckland					
Katie	30-35	Female	European	Low	Northland
Amanda	30-35	Female	European	Medium	Auckland
Margot	40-45	Female	European	Low	Auckland
Hannah	50-55	Female	European	Medium	Auckland
Max	35-40	Male	European	Medium	Auckland
Dave	20-25	Male	Korean	Medium	Auckland
William	20-25	Male	Chinese	High	Auckland
Billie	20-25	Male	European	High	Auckland
Individual Interviews - Wellington					
Germaine	20-25	Male	European	Medium	Wellington

3.3.1.2 Subject Matter Expert Participants

Subject matter experts in drugs and addiction were approached utilising purposive recruitment. I compiled a list of NZDF stakeholders quoted in previous NZDF reports and consulted with their CEO to augment and confirm the list. The NZDF provided an endorsement letter to accompany my interview requests (see Appendix A), yielding very positive results with 14 of the 18 experts agreeing to participate (refer Table 2). This was well above the number expected to agree to an interview but, rather than waitlisting some experts, it was decided to proceed with all these interviews (O'Reilly & Parker, 2013). This was a rare opportunity to engage with knowledgeable persons from a range of different organisations, which would capture an even broader range of relevant perspectives and insights. It, of course, resulted in a large number of transcripts, a dilemma that had to be addressed at the data analysis stage.

Table 2

Subject Matter Expert Interviewees

Name	**Title**	**Organisation**	**City**
Sarah Helm	CEO	NZ Drug Foundation	Wellington
Wendy Allison	Chair of Board of Trustees	Know Your Stuff	Wellington
Emma Schwarcz	Clinical Director, CADS Tāmaki Makaurau	CADS Tāmaki Makaurau, Waitemata DHB	Auckland
Deb Fraser	Co-Chair	National Committee for Addiction Treatment	Dunedin
Shawnee Brausch	Research & Communications Analyst	Whare Tukutuku, Te Rau Ora	Wellington
Lynette Hutson	Director	Salvation Army Social Services	Wellington
Sam McBride	Lead Clinician	Capital & Coast Health Opioid Treatment Services	Wellington
Rhonda Robertson	Long Time Lived Experience Champion		Christchurch
Trish Dribnenki - Pennock	National Harm Reduction and Hep C Lead	NZ Needle Exchange Programme	Auckland
Carl Greenwood	General Manager	Drugs Project	Wellington
Brendan Short	General Manager, Health Services	Auckland City Mission	Auckland
Sheridan Pooley	CADS Regional Consumer Advisor	Waitemata DHB	Auckland
Media Contacts			
Guyon Espiner	Journalist	Radio New Zealand	Auckland
Benedict Collins	Journalist	TVNZ	Wellington

Once a potential participant confirmed their interest in being interviewed, I emailed them an Informed Consent Form, offering to answer any questions at any time including immediately before the interview (refer Appendix E).

3.3.2 Participants

3.3.2.1 Public Participants

The demographic information obtained guided recruitment to ensure as wide a range of interviewees as possible across age, gender, ethnicity, socio-economic status and age. For practical reasons I chose to focus on young and working aged people (Generations X, Y, Z). This meant I did not recruit anyone over 60 (Baby Boomers). Whilst very mindful of the various ethnicities and trying to ensure Māori/Pacific Peoples were sufficiently represented, I was only able to recruit one Māori and one Pacific Peoples participant as members of the public.

3.3.2.2 Subject Matter Experts

The subject matter experts included professionals in alcohol and drug (AOD) addiction, comprising doctors, AOD peer workers, and experts from charities and NGOs, plus two knowledgeable journalists. Three Māori participants and one Māori organization were represented.

Sample size and participant selection are important considerations in any study. Whilst quantitative research requires the statistical calculation of an appropriate sample size, in qualitative research the sample size is not necessarily predetermined, and is dependent on the number of participants required to fully elucidate the aims of the study (Sargeant, 2012).The concept of data saturation originated in grounded theory (Guest et al., 2006) and indicates the point at which no new information or themes are elicited from additional interviews (Mason, 2010; O'Reilly & Parker, 2013).

Malterud et al (2016) propose an alternative to saturation, namely “information power”, or the “information richness” of the data set (Braun & Clarke, 2022, p.16). This criterion comprises five dimensions along which to assess the suitability of the sample size, namely study aim, sample specificity, the use of established theory, quality of dialogue and analysis strategy (Malterud et al., 2016). The research aim was particular in focusing on stigma in relation to persons who use meth. In terms of sample specificity this varied with a range of participants for the public interviews, and a dense specificity for the expert interviews. Given the rich

theorisation of the core concept of stigma, the number of interviews (23 plus two focus groups), and the richness of dialogue that emerged across the interviews, it is argued that significant information power was achieved. I adapted the questioning emphasis in each new interview considering discussions in previous interviews so that rich and nuanced discussions were held about all relevant topics. For example, in late-stage interviews with the younger interviewees, I particularly probed their generation's views on drugs compared with older generations.

3.3.3 Interview Guide Development

I utilised semi-structured interviews (SSI) to explore participants' perspectives regarding people with problematic meth use (Bearman, 2019; DeJonckheere & Vaughn, 2019) (refer Appendices F and G). The public questionnaire began with the word cloud exercise, then probed general views on substance use. Thereafter I explored perceptions surrounding the stigma of meth use, as well as stigma in relation to a recovered user. In expert interviews I asked about the consequences of stigma experienced by a person experiencing or recovered from MUD. I probed what strategies might be effective to aid in destigmatisation, including any effective campaigns experts were aware of from around the world. Lastly, I asked for their view of current government policy and what if anything they would recommend.

Two initial focus groups (see Focus Group section below) tested the *public SSI* to refine it and ensure that stigma responses could be clearly identified. For example, a question regarding whether stigma might attach to a close family member was usually too close for comfort, ("My son wouldn't do drugs"), resulting in denial, so I changed this to scenarios like:

- How would you feel if your daughter's boyfriend had problematic use?
- How would you feel if your son's girlfriend had problematic use?
- How would you feel if a new neighbour moved in next door and had problematic use?

These scenarios elicited more personal expressions of stigma than abstract explanations.

3.3.4 Interview Process

The interviews were conducted over June/July 2024. The location of the interviews was determined by the participant and held – wherever they and I felt most comfortable. Kanohi ki te kanohi (face-to-face) interviews were preferred as then manaakitanga could be offered and stronger rapport built. All but three public and two expert interviews were possible face-

to-face, with the remaining five conducted via Zoom. Despite being Auckland-based, I travelled to Wellington to conduct eight face-to-face interviews.

Before commencing each interview, I spent time on whanaungatanga, re-explained the project goals and answered any questions before the Informed Consent form (refer Appendix E) was signed. Manaakitanga was offered in all cases (Smith, 2012). Whilst participation was voluntary, at the end of each interview I explained the next steps and provided a $40 New World voucher as a koha to thank participants for their time and generosity.

3.3.4.1 Focus Groups

For the public participants, I first conducted two focus groups to gain an overview of the key perceptions of methamphetamine users and refine the proposed public SSI guide, one with five South Auckland participants and another with two Central Auckland participants (after one cancellation). Focus groups allow for a plurality of perspectives in the discussion of complex and opposing views (Runswick-Cole, 2011). The focus groups primarily helped to test out the SSI format and questions and identify any potential gaps (Smithson, 2000). I was also interested to see if there was any form of group conformity or fear of social judgment relating to the concept of stigma that limited or influenced expression compared to an individual SSI, but this did not appear to be the case.

3.3.4.2 Public Interviews

Following the focus groups, I conducted nine SSIs with public participants, bringing the total to 16 public participants (Clarke & Braun, 2013; O'Reilly & Parker, 2013). While using the SSI topics as a guide, I remained flexible in probing areas of expertise or depth of feeling, such as exploring workplace responses with an HR manager.

At the start of each public interview, participants wrote down (unprompted) words describing a person with problematic meth use, and another for a person who had recovered from use. I provided paper and pens for this activity. (At the data analysis stage these words were fed into a word cloud app, Free Word Cloud Generator.) Once these SSIs were well underway and I had a good sense of the range of public perceptions, I initiated the SSIs with subject matter experts.

3.3.4.3 Subject Matter Expert Interviews

I conducted fourteen SSIs with subject matter experts associated with the NZ Drug Foundation, all health professionals with expert knowledge of drugs, addiction and treatment

programmes. I aimed to contrast these SSIs with the assumedly less well-informed perceptions of members of the public, to identify knowledge gaps that could inform future destigmatization campaigns. I also sought the experts' professional opinions on potential destigmatization strategies.

As the interviews progressed, I explored different aspects of the subject more deeply, building on previous learnings and tailoring according to the particular expertise of the health professional being interviewed. The interviews became a two-way dialogue exploring key themes. I also added questions, such as whether it is possible to be a “functioning addict”, a phrase akin to the public’s stigmatizing use of “functioning alcoholic” and probed whether recovery could be understood as a linear process. Several of the subject matter experts had lived experience of drug use and whilst I did not ask about this, they volunteered to share this with me freely, so this provided a first-hand indication of the self-stigma that people with problematic substance use experience. By positioning myself as a humble learner eager to soak up their expertise, I quickly built rapport with these experts.

3.4 Data Analysis

3.4.1 Reflexive Thematic Analysis

For this study I adopted the methodological framework of Reflexive Thematic Analysis (RTA), as originally espoused by Braun and Clarke (2006) but developed considerably since (Braun & Clarke, 2013; Braun & Clarke, 2019, 2021; Braun et al., 2022). Thematic analysis is a method for recognizing, analysing and reporting themes or patterns within a data set. A theme comprises some level of patterned response within the data and says something important relative to the research question (Braun & Clarke, 2019). Additionally, RTA encourages the ongoing reflexivity of a researcher about their assumptions, beliefs and interactions with the data during theme construction (Braun & Clarke, 2019).

RTA as a methodology is congruent with social constructionism’s epistemological paradigm (Braun & Clarke, 2021; Taylor & Ussher, 2001). As Gergen (2022) asserts, our explanations of the world derive from relationships rather than being required by ‘what there is’, gaining their importance from their social utility (Gergen, 2022). As the philosopher Caputo argues: Knowing is always a matter of situated interpretation, in which ‘there are no pure facts’ (Caputo, 2018, p. 4). This does not imply that all interpretations are equal (i.e., relativism), that everything is ‘just’ an interpretation. Rather ‘some interpretations are better than others’ (Caputo, 2018, p. 5) by being ‘well tested’ and there being ‘good reasons’ for stating that something is the case. However, such statements never attain the status of Absolute Truth

and remain matters of interpretation. The discourse constituting the interviews and transcripts is co-constructed through the shared perceptions of interviewees and the researcher.

3.4.2 Stage 1: Transcription and Data Familiarisation

All the interviews were recorded using two devices (dictaphone and mobile phone or Zoom with a mobile phone back-up). The initial transcription was conducted using Otter.ai, followed by thorough editing to ensure accuracy and to correct Kiwi accent misinterpretations. For public interviews, pseudonyms were applied or selected if a participant had elected not to choose one themselves. I also recorded key points in my research journal and highlighted potential themes as I identified them.

I listened to each audio recording repeatedly, reliving the interviews and continuing to construct, interpret and make meaning by noting key points in my research journal (Riessman, 2001). Nonetheless, transcription is by its nature a reductionist process, and so I admit that unavoidably some of the contextual richness was lost.

I completed 23 interviews and two focus groups, generating 480 pages of transcripts. I compared the transcripts to the original audio recordings, editing for accuracy, and worked hard to ensure I produced orthographic transcripts which were a verbatim record of the dialogue, but was less stringent about rapport seeking utterances from myself, as they did not add to the overall meaning for insights or theme construction (Poland, 2002). Although I had originally intended to, because of the large amount of data I did not automatically send each interviewee their transcript, but rather offered a copy to each interviewee, which only four experts took up. None requested any changes to their transcript.

3.4.3 Stage 2: Generating Initial Codes

I began Stage Two by creating a master coding spreadsheet with multiple tabs. Firstly, I entered the proto themes identified during interviews, noted in my journal and articulated to my supervisor in reflexive sessions. On the next tab I coded the public interview transcripts using an inductive, bottom up, data driven approach without forcing data into preconceived themes. Only after completing this process did I revisit the original eight proto themes for comparison. Having said that, I did not code in an “epistemological vacuum” (Braun & Clarke, 2006, p12; Braun & Clarke, 2013) as my attitudes and beliefs necessarily influenced the process. I then repeated this coding process for the expert interviews on another worksheet, adding another tab for expert recommendations (refer Appendix H).

Rather than be beholden to “methodolatry” (Braun & Clarke, 2021; Chamberlain, 2000; Willig & Stainton Rogers, 2017), I augmented the RTA method by trialing a few other techniques, such as Word Clouds and MindMaps to enhance analytical rigour and consider meaning from different vantage points. For the Word Clouds I asked public interviewees to jot down words they associated with people with MUD and those who had recovered. These were fed into a word cloud app, Free Word Cloud Generator, producing aggregate visualisations included in Chapter Four. These provide stark visual representations of the stigma associated with meth’s physical effects and perceived behaviours, along with a hopeful cloud for recovered users, and will constitute a useful input for any future destigmatisation campaign brief.

3.4.4 Stage 3: Constructing Themes

Despite having extensive data (480 pages of transcripts), rich in detail and nuance, I was keen to consider strategies to ensure academic rigour (Geertz, 2008). After discussing with my supervisor, I decided to use a MindMap app to generate a destigmatization strategy summary, which he considered a worthwhile experiment. I emphasize that I used no AI for researching, planning, or writing my thesis, but employed this technology creatively to potentially aid the NZDF (Perkins, Furze, et al., 2024; Perkins, Roe, et al., 2024; Roe et al., 2023).

After coding all data and identifying major themes, I used Mapify (a MindMap program) as a cross-check. First, I anonymized transcripts by removing expert names and public pseudonyms and replacing my name with "interviewer." I then used ChatGPT to remove interviewer questions and comments from each transcript before transferring this output into Mapify's long text option to produce various mindmaps from both public and expert perspectives. Finally, I cross-checked these outputs against my ground-up themes.

This use of AI was helpful, as in no way did it replace the original longhand coding, but provided a useful cross-check to improve credibility, or internal validity, akin to a member check (Perkins, Roe, et al., 2024). I was pleased to see how well the Mindmaps aligned with the themes already produced, and I made very few changes to the Mindmap in total, as it represented a comprehensive summary of all the interviews. Furthermore, a full destigmatisation strategy encompassing all areas is beyond the scope of my analysis, but utilizing this tool allows me to provide an option to the NZDF, creating additional value from the research data (refer Appendix I).

3.4.5 Stage 4: Reviewing the Themes

In Stage Four I reviewed the themes further to determine whether any of these could be collapsed or combined. I wrestled with having too many themes, and considered whether any were purely semantic, descriptive notions rather than latent themes. It was important to ensure the analysis had moved from simple description to nuanced interpretation, so that the underlying ideas and assumptions were conceptualized against the constructionist paradigm (Braun et al., 2022). After verifying that the themes had sufficient supporting data, and re-examining the entire dataset, I justified collapsing certain purportedly independent themes into subsets of others, reducing the total to a more compelling, coherent result (Braun & Clarke, 2021).

3.4.6 Stage 5: Defining and Naming the Themes

Themes represent the end result of data coding and iterative development. I identified pithy names to accurately describe each theme and concisely convey its meaning, and typically these were co-constructed, drawn as they were from transcript quotations. Theme development continued throughout the writing up process, as I reflected more deeply on content and considered relevant literature (Braun & Clarke, 2013). In this way analysis was understood as a process, beginning with the first participant encounter right through until the final write-up.

3.4.7 Ensuring Trustworthiness

Validity and reliability are traditionally associated with positivism and quantitative research (Crotty, 1998). However, qualitative studies increasingly seek sufficient academic rigour in data collection and analysis to ensure confidence in the conclusions reached (Coleman, 2022). Given the differing assumptions underlying social constructionism and positivism make comparisons complex, Guba (1981) addressed the positivist paradigm by proposing alternative language for equivalent qualitative concepts to ensure trustworthiness. He proposed four criteria as follows: 1) credibility (vs internal validity); 2) transferability (vs external validity or generalizability); 3) dependability (vs reliability) and 4) confirmability (vs objectivity) (Guba, 1981). I followed these principles as outlined by Shenton (2004) to ensure this study's findings demonstrate high quality and academic rigour.

Credibility criteria included: adopting a well-recognized research method, recruiting to a diversity grid to ensure diverse demographics, triangulating with focus groups and interviews with both public and expert participants, obtaining consent, and holding frequent supervisor debriefing sessions. I employed reflexive evaluation and offered transcripts to interviewees

for member checking. Rich descriptions of the data have been provided, and the findings were compared with existing literature (Shenton, 2004).

Transferability refers to the extent to which we can generalize findings to other settings (Jhangiani et al., 2019). I provided rich descriptions to engender reader trustworthiness and allow consideration of the applicability of findings to other settings (Finlay, 2006).

Dependability was attended to by providing a detailed description of the method, data and reflexive decisions made which future researchers can scrutinise (Finlay, 2006). Ethical considerations have been discussed, and details provided about interview numbers, lengths, and data collection timeframes.

Confirmability seeks to render decision-making and reflexive considerations transparent. This has been considered through the admission of researcher assumptions and beliefs and recognition of methodological limitations. For example, I would have preferred more ethnic diversity amongst the public participants, but this was not achieved. My supervisor and I discussed the analysis in supervision to identify assumptions. Reflexivity is an ongoing process, documented in my research journal throughout interviews and theme analysis (Shenton, 2004).

3.5 Ethical Considerations

3.5.1 Ethical Approval

In consultation with my supervisor, we determined a Low-Risk Application with Massey University Northern Committee would be appropriate as I would not be interviewing people with lived experience of MUD. To ensure comprehensive ethical consideration, I completed the entire High-Risk application form (without submission), giving particular attention to Te Tiriti and data confidentiality. Human Ethics Notification 4000028449 was approved on 5th May 2024.

3.5.2 Informed Consent, Harm Minimisation and Confidentiality

All potential participants received the Project Information Sheet, and NZDF endorsement letter to ensure they were well informed about the research purpose. When confirming interview participation, either by email or phone I reviewed these documents with them to address any questions. As outlined in Section 3.3.1.1, I then emailed the Participant Consent Form, which was signed prior to recording each interview. I had prepared a printed list of

mental health resources in case of participant distress. Had anyone become distressed I would have stopped the interview, if necessary, advised my supervisor and followed up in the coming days to check on their wellbeing (refer Appendix J). One expert participant became briefly upset, but indicated they were managing well, and wished to continue the interview. I advised my supervisor and followed up the next day to confirm their wellbeing.

The Participant Consent Forms were kept confidential, accessible only to me. The transcripts and electronic data will be kept for five years, and interview recordings have been disposed of as no longer required. The recordings and transcripts were held on password protected encrypted devices. Due to the volume of interviews, I offered transcripts on request rather than automatically providing them; four participants requested copies. Public participants were assigned pseudonyms to preserve their anonymity, however the subject matter experts, having agreed to be on the record, were identified by their real names.

3.5.3 Cultural Responsiveness

Associate Professor Matt Shepherd agreed to act as cultural advisor for this project, and I discussed the full High Risk and Low Risk application responses, as well as the questionnaires with him in detail.

The research was undertaken with the aim of upholding the Te Tiriti o Waitangi principles of Partnership, Participation and Protection (Barnes et al., 2014; Hudson et al., 2010; Hudson & Russell, 2009). As a tauiwi, having grown up in Mangere and studied Te Reo for two years so far at Te Wānanga o Aotearoa, I felt comfortable with Māori protocols, and offered these to participants as required (Sue et al., 2009).

Professor Shepherd recommended I share the questionnaires with the NZDF Cultural Advisor. Their CEO, Sarah Helm, (Ngāi Tahu) subsequently reviewed them with me, both as an expert and particularly through a Māori cultural lens. I outlined to both consultants that I would have a karakia available if anyone desired one and offered this when I interviewed Māori participants (Sonn et al., 2019). Whanaungatanga preceded every interview and manaakitanga was offered in all in-person interviews. A $40 New World voucher was provided as a koha to all participants, an important gesture and mark of respect. In return, the participants gifted me with the koha of their personal stories and experiences, engendering reciprocity and goodwill.

3.5.4 Reflexivity and Positionality

As discussed in Section 3.4.7, while the positivist paradigm requires researchers to be personally detached and unbiased, removing all ‘contaminating variables’ (Burr, 2015), SC acknowledges that researchers necessarily bring their social/cultural contexts and power into any research projects. A challenge is thus maintaining critical awareness of what researchers bring to the studied environment and its influence on participants (Pillow, 2003). Thus, reflexivity involves ongoing self-reflection and contributes to qualitative research rigour by utilizing self-supervision to ensure trustworthiness, credibility and non-exploitative research (Alvesson et al., 2022; Berger, 2015; Darawsheh, 2014).

In assessing any preconceptions or biases I brought with me I acknowledged my liberal views and remained mindful when speaking with participants espousing more conservative views to avoid influencing them. Given my business experience and liberal stance, I found I responded well to the pragmatic approach of experts with lived experience versus psychiatrists/health practitioners who were sometimes more cautious. My research journal helped me critically assess how my beliefs, personality and history might influence the research outcomes, enhancing research rigour through honesty, transparency and accountability (Darawsheh, 2014; Willig & Stainton Rogers, 2017).

SC allows for the fluid movement along the Participant-Observation-Continuum (Runswick-Cole, 2011) and the changing nature of power/identity to be brought into the research process, especially if it is acknowledged and discussed transparently. A researcher’s perspective depends upon her experience level within the community being studied (Suzuki et al., 2007). I adopted different positions along the spectrum at different times, reflecting whether I was at that moment an insider or outsider (Runswick-Cole, 2011).

Positionally, I began as an outsider, coming to this project with no lived experience of drug use (Hayfield & Huxley, 2015). My initial knowledge level resembled that of public interviewees, making me an insider in that respect. I worked hard to recognize my own beliefs and standpoint in fortnightly meetings with my supervisor and kept a research journal to note observations as they surfaced. I was conscious of my membership in the dominant ethnic group (tauiwi), and sought to remain neutral with public participants, though I answered some of their questions post interviews based on my reading. I listened non-judgmentally, clarifying answers by restating and confirming intended meanings. My own views were deprivileged as I became increasingly aware of my participants’, or “reciprocators”’ perspectives, so termed in acknowledgment of the relational nature of a constructionist approach (Griffin & Bengry-Howell, 2017).

With the subject matter experts, I acknowledged my lack of lived experience and positioned myself not only as an outsider but a humble learner, asking many questions. The NZDF's endorsement fast-tracked me to a "partial or trusted insider", since interviewees perceived the project would benefit their sector (Finefter-Rosenbluh, 2017). Thus, my position was dependent on context and process and changed depending on who I was interviewing. Additionally, notwithstanding my consistent lack of lived experience, my position shifted over time from outsider to insider as my knowledge increased. Throughout, I aimed to *co-create* knowledge with participants or 'reciprocators' on equal terms (Griffin & Bengry-Howell, 2017).

CHAPTER FOUR: ANALYSIS AND DISCUSSION

4.1 Chapter Overview

This chapter presents seven themes derived from my analysis of interviews with public participants and subject matter experts. The purpose of these interviews and focus groups was to understand public participants' perceptions of PWUM, contrasted with the more detailed understandings of the expert participants, to identify effective destigmatisation pathways for PWUM.

I conducted nine interviews and two focus groups with members of the public, as well as fourteen interviews with subject matter experts. The first six themes I abstracted based on my analysis of the public participants' views, contextualized by expert insights. The final theme emerged exclusively from expert interviews, drawing on their specialized knowledge of the health system, treatment options, and healthcare worker attitudes. In addition to reflexive thematic analysis, I utilised word clouds to visualize conceptualizations of methamphetamine users and those in recovery, and mindmaps to synthesize stigma-related findings across all interviews. These techniques will be discussed further throughout this chapter (refer Table 3).

Table 3:

Summary of Themes and Subthemes

Themes	Subthemes
Effects of Meth Use	**"Unpredictability and violence are scary"**
	"Anything for a fix"
"It's a Moral Failing"	
The Legal / Illegal Divide	**Consequences of Illegality**
	"It's illegal and gangs are involved"
	"They need help, not prison"
	"War on Drugs"
"It's All Bottom-Rung"	**Meth – the "bottom-of-the-barrel" drug**
	Social Determinants of Health and Intersectionality
"The Courage of Recovery"	
Generation Gap – Use vs Misuse	
Systemic Shortcomings in Treatment	**More resources**
	"Abstinence is not the only goal"
	Associative stigma from healthcare workers

4.2 Theme 1: Effects of Meth Use

Almost all public participants expressed the view that meth was perceived to be highly addictive. Many, such as Sarah below, expressed concern about meth, portraying it as profoundly addictive, with a single exposure taking complete possession of the user.

> *"It's okay with some drugs, maybe. But like with meth, as far as I know, like, it's so devastating. You only have to take it once and you completely go down this spiral. That's how I feel about it, you know, and so it's horrifically powerful, and it kind of takes over you almost immediately." (Sarah)*

> *"I've never taken drugs like that though, because to me, it's like you just have one bit and then you're going to hell in a handcart." (Sarah)*

Against this backdrop of a catastrophically addictive drug, we have two images emerging of the meth user: that of the violent unpredictable high user and the person who will do anything to get their next fix.

4.2.1 Theme 1.1 "Unpredictability and violence are scary"

Many participants spoke of meth users, specifically when high or in withdrawal, as unpredictable and dangerous.

> *"Unpredictable, agitated, violent, totally disconnected from reality" (Margot)*

> *"People get scared of a physical confrontation." (Germaine)*

> "*Because I see people on the streets that I think are on drugs, and they're talking to themselves, and I don't know what drug it is. But they just look crazy to me…. And it's very, and you're just like go away... I cross the road; they freak me out." (Louise)*

Theme 1.1 captures the public participants' perceptions of the behaviour of someone with MUD when high or undergoing withdrawal. Some participants' accounts imply that these are based on actual observations. Louise's comment about a person she witnessed in Otara "talking to themselves" could be indicative of psychosis or eccentricity or old age, rather than addiction per se. The literature confirms that a meth-induced psychosis may manifest in erratic, unpredictable behaviour and violence (Gilchrist et al., 2019; Zarrabi et al., 2016). This first theme is very much linked to the symptoms displayed by people with long term methamphetamine use. It exemplifies Goffman's "blemishes of individual character" and public stigma (Bos et al., 2013; Goffman, 1963). It also links directly to the original study by

Jones et al. (1984), which highlights one of the six stigma dimensions as “peril”, or the type and degree of danger posed to others (Crocker et al., 1998; Jones et al., 1984). This then drives the public’s fear and a desire for social distance (Marie & Miles, 2008).

> *“But like I wouldn't walk down Queen Street on my own at night because I feel there’s unpredictable people down there who are taking illegal substances.” (Hannah)*

Hannah’s comment above also locates meth use in time and place, namely in a public space in the inner city, at night, and foregrounds meth’s illegal status as we shall later witness. Public participants also shared descriptions of the behaviours and appearance of meth users.

> *“They look homeless, they look dirty, and they look gaunt, their teeth are missing, their skin is awful, yellow…” (Louise)*

> *“I always think that if they're on P, they're the ones that look closest to death to me. The ones that you're least likely to be able to help.” (Sarah)*

A secondary component of the stigma related to long term meth use and its physiological effects is the potential for “abominations of the body”, or visible signs of discreditation such as skin infections or decayed or missing teeth (Goffman, 1963; Marshall & Werb, 2010). Jones et al (1984) and Crocker et al (1998) espouse the notion of “aesthetic qualities”, or the extent to which such attributes make a person repellent, ugly or upsetting to others, and this plays into the sense of abnormality, distaste and desire for social distance (Crocker et al., 1998; Jones et al., 1984). The public participants are thus portraying the meth user as a violent, unpredictable, dangerous, dirty, sick, downtown street dweller. Some of these accord with the research (violent, unpredictable, dangerous), but this corresponds with the long-time addicted user and is extrapolated by public participants to represent *all* users. It is this guiding stereotype used by these public participants that facilitates the stigmatization of *all* PWUM.

4.2.2 Theme 1.2: “Anything For A Fix”

This sub-theme links to the consequences described by the public participants of addiction or having a MUD. The public participants typically presented a scenario where once addiction took over and controlled a person’s life, they would become a slave to that addiction. Most interviewees assumed a person with MUD might lie or beg for money from their friends/whānau or alternatively engage in stealing or sex work to finance their next fix.

“I feel like they're constantly looking for something to pay for the next fix.” (Sarah)

“… and I wonder where they get the money to be able to afford them.” (Hannah)

“They might steal your jewels. Put your jewels away…. You don't want them in your house, because they'll take something.” (Diana)

“Yeah, the funding for it. And as long as they get their fix, they’re happy. And they don't care how they do it. And it's not just the girls, it’s also young guys prostituting themselves, just to get that extra fix. Yeah. And this is so sad. So young. A lot of them are young. You just see them on the streets. You see the homeless ones; that's the way to keep themselves warm.” (Angela)

For some participants those looking for a fix were untrustworthy and, as for Angela, typified by a sense of indestructibility and entitlement, in stigma terms another “blemish of character” (Goffman, 1963).

“And I think they think they are invincible. Nothing's gonna harm them. They're not scared. Yeah. They just think that life owes them. And that's why they’ll go and just take whatever they can.” (Angela)

Angela alludes to a lack of morality here, the idea that the social contract no longer matters. Being high has been associated with increased confidence, or a feeling of “mastery and power” (Sommers et al., 2006, p.1473). Some studies indicate that meth use could lead to altered perceptions of risk and reward, making risk taking more likely (Bax, 2024). This will be addressed in more detail in Theme 2. Here I would highlight two points. The first is that public perceptions do (at times) align with research findings about the behaviour of PWUM. The second is the image fostered with this discourse and what it means for stigma. The public participants offered the construction of all PWUM as addicted and driven by this addiction to override any moral sense in pursuit of their next fix. Yet again we see the construction of long-term problematic use being applied to all PWUM, when in fact only 11% in ANZ will have a dependence over their lifetime (Yasbek et al., 2022).

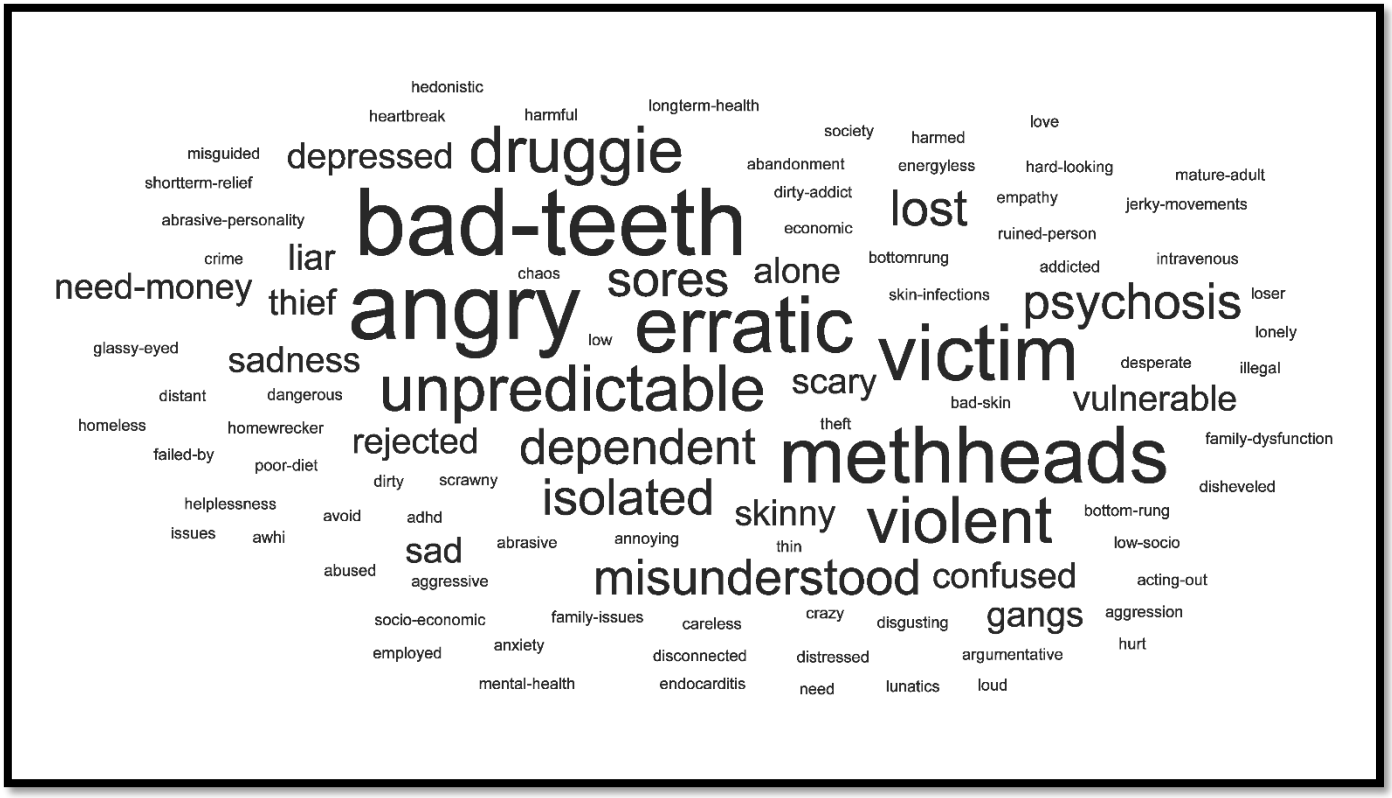
4.2.3 Word Cloud

At the beginning of each public interview, participants were asked to write down, unaided, the first words that came to mind when thinking about a person who uses methamphetamine problematically. These responses were compiled using the Free Word Cloud Generator to create a visual summary.

Although originally intended as a briefing aid for an advertising agency, the word cloud unexpectedly served as a vivid encapsulation of Theme 1, surfacing core public perceptions with striking immediacy. The language that emerged aligns closely with Goffman's (1963) stigma typology, particularly "abominations of the body." Physical descriptors (bad teeth, sores, skinny, dirty), reflect a preoccupation with physical decay, reinforcing the notion of visible deviance. Simultaneously, behavioural terms (crazy, dangerous, erratic, violent) match Theme 1.1´s behavioural deviance. The moral framing of meth use as criminal or exploitative (thief, liar, crime), further supports Theme 1.2, "Anything for a fix." Pejorative labels (druggie, meth-head, loser) illustrate the reduction of individuals to stigmatized identities, while more affective terms (isolated, distressed, vulnerable) gesture toward stigma´s social consequences. These emotional and social descriptors begin to bridge the transition to Theme 4, which explores the role of systemic and socio-economic conditions. References to family dysfunction, abandonment, homelessness, and ´bottom rung´ indicate that participants, whether consciously or not, locate meth use within broader structures of marginality. Thus, while the word cloud was not initially intended as a thematic device, it reveals an embedded hierarchy of stigma: physical, behavioral, moral, and structural, mirroring the very architecture of the analytic themes (refer Figure 5).

Figure 5:

Public Perceptions of People with MUD



In summary, with Theme One the public participants articulated a view of the meth user as someone who could be erratic, unpredictable and potentially violent when high, and would be willing to do anything to get their next fix.

4.3 Theme 2: "It's a Moral Failing"

Definitions of addiction and views on appropriate responses have differed considerably over time and remain multiple and contested. Among some public participants, a common depiction was that substance use represented a 'moral failing' stemming from poor choices.

> *"I guess the majority of the population think it's a weakness, it's that people could just choose not to, and then the fact that they choose to do it, they're to blame. And that they should be responsible for their own actions, and therefore they should be punished." (Max)*

> *"So, I think a lot of people probably do think that it's a choice, and that, you know, if they wanted to get high, maybe they should have thought of the consequences, you know… Yeah, no one lit the pipe for them." (Germaine)*

Importantly in both the above extracts, the interviewees present this as how they think others (not themselves) see such a problem - it's their perception of public perception. Since only 1.1% of the population use meth and most members of the public have no direct experience, it is likely that these predominant constructions have been framed largely by media discourse (Yasbek et al., 2022).

Another public participant, Fiona, countered the position proffered by many public participants that MUD could be a result of abuse or low socioeconomic status, (which will be discussed under Theme Five, Section 4.5.2), citing her husband´s experience to emphasise individual choice and character.

> *"Because I mean, you hear of these people that say they don't know any different, because that was the lifestyle they were brought up in. And I say to them, that's bullshit. If that's the case, my husband should be beating me up every day. Because that's what he lived through because his father did it, his brother did it…. but he decided he didn't want that for me and our children... so, he broke the cycle. Yeah, and very strong. I am thankful that he lived through that. "(Fiona)*

Compassionately, Kevin explains that addiction is likely not a life goal, but perhaps a result of a particular set of choices or circumstances:

> "Nobody leaves school with this as their life plan, to become a drug addict." (Kevin)

One novel stance was articulated by Nick, who portrayed any drug use as inevitably compromised morally (being a high-quality person) and performatively, understanding use as an enjoyable activity that always comes at a cost.

> *"I have never been impressed by someone who's a drug addict. You know what I mean? You don't meet someone who's a dope smoker, and go wow, they're a high-quality person…. So, it's like, there's a high-quality person who smokes a bit of dope, but it doesn't improve them at all. It's sort of like to me it slows them down or degrades whatever they've got, even though they enjoy it." (Nick)*

As indicated above, many public participants constructed such drug use as a failure of personal responsibility – not merely a series of bad choices, but evidence of moral failure, of a character deficiency. This positions such behaviour as an individual failing rather than indicative of larger social processes. Their faulty character was exposed, and they had 'only themselves to blame'. There are perhaps three components to this type of stigma. Firstly, the "just-world hypothesis" suggests that people wish to believe the world is fair (Lerner, 1980). Blaming individuals for their struggles reinforces the illusion that bad outcomes are a result of bad choices, not random misfortune. Secondly, blaming PWUM helps individuals distance themselves from similar vulnerability. Thirdly, stigma serves as a form of social control, maintaining the status quo, as the *person* is faulty, not the system.

Such notions are embedded in Western society, tracing back to Judeo-Christian traditions and Protestant work ethic, where success is a sign of salvation, a direct result of hard work and sacrifice (Lerner, 1980). We will encounter this notion again when we consider the concept of recovery (Theme 5). Drug use behaviour thus becomes conflated with the individual (Link & Phelan, 2001). This moral attribution counters alternative interpretations, like biopsychosocial responses to stress, deprivation, trauma and other adverse childhood experiences (ACEs) (Hashemi et al., 2021; Walsh et al., 2019).

Notions of 'moral failing' are also borne out in the literature, where the idea that addiction is entrenched in repeated bad choices is seen as persuasive (Lancaster et al., 2018; Lloyd, 2010; Room, 2005). For instance, in summarizing six studies from the US, UK and Australia, Olsen et al. (2003) found participants felt that illegal drug/alcohol users and tobacco smokers

should receive reduced priority in health care (Olsen et al., 2003). The notion of moral failure is also closely linked to the assertion that willpower alone should suffice in overcoming an addiction. This attitude is redolent of the “Just Say No” anti-drug campaigns promulgated by Nancy Reagan in the USA in the 1980s, and aligns with conservative political agendas, with more than a whiff of righteousness at the transgression of these social norms (Vinson, 2020).

Several expert interviewees emphasized that beyond a certain point in MUD, an individual has literally ‘lost control’ and personal choice is no longer relevant:

> *“Well, and that's the whole problem we have is that people do not understand that there's a loss of control with drug use, that you lose the power about whether you can take it or not, it becomes driven by the need to have it. And so it's really hard for people to get their heads around, that actually, personal responsibility doesn't count – there’s a point that gets past that - that person no longer has personal control…They’ve absolutely lost control over what's happening.” (Deb Fraser, Co-Chair, National Committee for Addiction Treatment)*

Some public participants also articulated addiction as a disease model:

> *“It’s a mental health issue. It’s an illness.” (Diana)*

> *“And then we're not as a society, we're not looking after these people, because like you were saying, if meth changes, like the chemical imbalance… and alcohol does the same thing. Yeah. Why are we so much more lenient on alcoholics?” (Louise)*

Whilst some public participants viewed addiction as a disease, this was a common opinion across all expert interviews. The experts highlighted that drug use generally was more stigmatized than other physical illnesses in the extracts below:

> *“If you are identified as having issues around any substances, meth particularly, you are seen to have caused it yourself and are therefore less deserving of, of support or empathy. Often people are described in ways that are seen as lesser, you don't talk about people who use methamphetamine in the same way that you're talking about people that have heart disease or other physical health issues, for example.” (Brendan Short, General Manager, Health Services, Auckland City Mission)*

> *“So, for example, if I went for a job interview, and you looked at my CV and you said, Brendan, what's this two-year gap in your CV, and I said, that's where I was recovering from a stroke, that would sound very different to me saying I was*

struggling around my dependence at that time." (Brendan Short, General Manager, Health Services, Auckland City Mission)

The constructions of addiction as either a moral failing or an illness do not appear to be mutually exclusive; several public participants subscribed to both views within the interview, and research suggests the utilisation of these contradictory discourses appears quite common in society (Room, 2005). Gergen highlights this tension, citing that free will concepts may be traced back to Christianity and linked to moral failure accounts, whereas cause-effect reasoning, critical to scientific arguments, is more akin to disease notions of addiction (Gergen, 2022).

The National Institute on Drug Abuse (NIDA) in the US promotes addiction as a chronically relapsing 'brain disease' rather than a moral failing (Volkow, 2005; Volkow & Li, 2005). This model highlights how drug use alters brain circuitry concerned with self-regulation, reward processing, mood and stress. Once someone has a significant SUD, taking drugs is no longer pleasurable nor a matter of will, but is largely a means of reducing excruciating distress and satisfying powerful cravings. Over time, NIDA has moved away from simple bio-reductivism and evolved toward a biopsychosocial framework that acknowledges genetic predisposition, traumatic life experiences or adverse social environmental vulnerabilities (Adams & Volkow, 2020; Volkow, 2020; Volkow et al., 2016). Indeed, some researchers have claimed alcohol dependence to have a genetic heritability of 50-60% and cocaine dependence at 70% (Ray & Grodin, 2021). Volkow positions the Brain Disease Model of Addiction (BDMA) as the single, binary counter to the 'moral failure' argument, absolving addicted individuals of personal responsibility and offering a less stigmatizing way of positioning addiction. The 'medical model' discourse has, however, also ensured close ties to pharmaceutical companies and research funding, although a literature search did not indicate any new treatments emerging. Reducing social issues to biology risks reinforcing the societal status quo and aligning with profit motives (Krimsky, 2004).

Other luminary neuroscientists have countered the notion that the dopamine theory of reward and addiction conclusively proves addiction is a disease (Hart, 2013; Heather, 2017; Marc, 2017). Rather they offer a scientific explanation of addiction that *rejects* disease *without* simultaneously blaming or punishing addicts (Heather, 2017). They suggest that despite dopamine's central role in stimulant addiction, a unified theory remains elusive as different substances involve different neurotransmitter systems (Nutt et al., 2015).

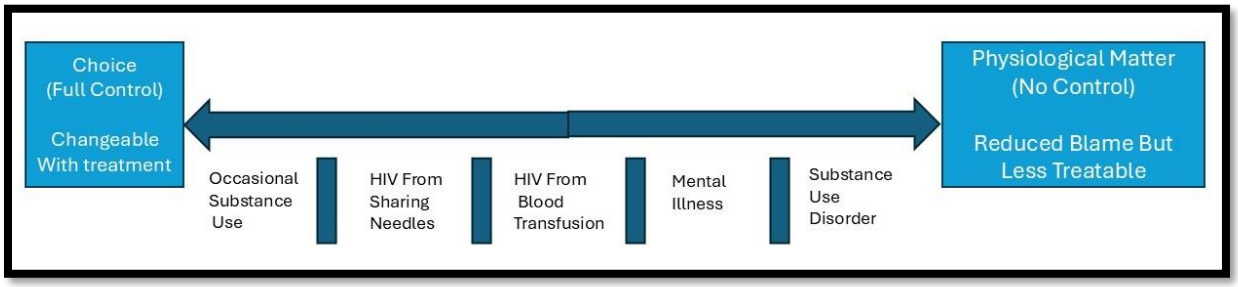
Whilst Volkow's BDMA attempts to replace a more severe stigma (criminalization) with a less harsh one (pathologization), it risks reducing blame whilst increasing pessimism about

recovery (Kelly et al., 2021; Kvaale et al., 2013; Pennington, 2023; Rundle et al., 2021). Attributions of threat, controllability and disruptiveness (as found in public participant interviews) have been shown to predict greater stigma and have been more closely linked to SUD than mental illness, which may explain why SUD is the more stigmatized condition (Feldman & Crandall, 2007; Krendl & Perry, 2023). Emphasising *changeability* (the potential for improvement through treatment), may offset negative beliefs about *controllability* (the belief that individuals are responsible for their condition onset) (Krendl & Perry, 2023). In support of the former, a recent USA study indicated total recovery rates across all substance types as 75% (Jones et al., 2020).

Perhaps a more pragmatic way to view substance use risk is along a continuum of control, from an issue of choice in the early, pleasure-seeking stages at one end, to a physiological matter at the other, when choice or control is subsumed by addiction (Haslam & Kvaale, 2015; Henderson & Dressler, 2020). This continuum could map various physical and mental conditions, based on the degree of control, with SUDs appearing across multiple points depending on the severity of dependence (refer Figure 6).

Figure 6

Control Continuum



The field of addiction neuroscience remains contested. Some evidence suggests that whilst prolonged substance use can damage the brain, dopamine nerve cells may recover after periods of abstinence (Volkow et al., 2001). Additionally, whilst research has focused on uncoupling drug cues and responses, new insights into memory and learning processes recommend that building new, therapeutic memories might prove more beneficial (Ray & Grodin, 2021). Rather than a 'winner takes all' approach, a more integrative approach allowing multiple insights to co-exist may prove the most productive (Corrigan & Watson, 2004).

Whilst the pursuit of neurological clarity and potential pharmacological treatments is a worthy goal, I recognise the immediate needs of practitioners working with clients. Expert

participants all agreed on the importance of meeting a client 'where they're at'. Brendon Short (City Mission) explained that some clients subscribe to the 12 Steps philosophy, which frames addiction as a disease over which one is powerless, whilst others subscribe to a CBT philosophy, which frames addiction as unhealthy ways of thinking, feeling and behaving, and which an individual *can* change. Short explained he will work with whatever approach will get a person to a better space.

In summary, Theme Two exemplifies the dichotomy of public participants' views: whether addiction represents a moral failing (bad choices leading to self-blame), or a 'brain disease' (relieving responsibility but potentially undermining recovery beliefs).

4.4 Theme 3: The Legal / Illegal Divide

As we saw in Chapter One, the demarcation of social acceptability is often seen in the divide between that which is legal versus illegal, licit versus illicit. In ANZ, tobacco and alcohol are both legally available, despite alcohol causing far greater societal harm than illicit substances (Crossin et al., 2023). Conversely, marijuana (apart from medicinal use), methamphetamine, cocaine and heroin remain largely illegal and hence stigmatized and criminalized, despite medicinal properties or recreational use patterns (Brain & Coward, 1989; Rychert et al., 2020; Sawynok, 1986). Legislation constructs the dividing line between upright, law-abiding citizens and criminals. The stigmatisation of individuals with problematic drug use stems from its historical and cultural construction as deviant, immoral and criminal (Crocker et al., 1998). Whilst virtually every public interviewee mentioned methamphetamine's illegality, a few offered the view that they felt this was outdated:

> *"So I'm sort of, ah, illegal drugs, to me is the biggest problem we've got in society really, in terms of them being illegal, because that creates all the problems with the health issues not being treated, the quality of the drugs not being able to be regulated and that sort of stuff. And there's always going to be people using illegal drugs, whether that be legal or not." (Nick)*

> *"So, I think that for the young brain, drugs are really bad. But that doesn't mean that well, that they should be illegal. Just because they're bad, doesn't mean they should be." (Nick)*

One of the most telling comments to my mind was the pithy summation by Kevin:

"The thing is they're on the wrong side of the law." (Kevin)

Kevin gets to the crux of the matter very succinctly. Matters would be very different for people with problematic meth use if their usage were not illegal. The notion of this dividing line between licit and illicit drugs and what is acceptable/unacceptable within society was unpacked further by numerous expert participants, with one example here:

> *"And so, if you look at the harm that is caused by methamphetamine, when you compare it to other things, such as alcohol, which is the obvious legal one, the harm by alcohol is significantly greater." (Guyon Espiner, Journalist, Radio New Zealand (RNZ))*

Similarly, the media plays a significant role in developing and maintaining dominant discourses, which legitimize alcohol/tobacco consumption and demonise not only illegal substances, but those who partake of them. Nick argued methamphetamine's illegality justifies media's demonisation of this substance, and the long-lasting impact of such media portrayals is apparent in this extract below:

> *"Well yes. The media generate our first impressions that come here, often from that guy with the machete or whatever it was, remember the samurai sword. Remember that back in the day? There was some guy who chopped someone's arms off or something because they were running a P-lab? And he was out of it on P? And that's what gets left in the memory." (Nick)*

In at least half my interviews with public participants, they mentioned the incident involving New Zealander Antoine Dixon where he injured two women with a Samurai sword and later murdered a man using a machine gun, during an incident lasting 11 hours where he repeatedly used meth (Collins, 2023). Given this genuinely shocking story occurred over 20 years ago (i.e., 21 January 2003), it serves to demonstrate how the media, and thence the public, continue to link methamphetamine to the risk of unthinkable violence (Collins, 2023). Dixon and his sword represent a primary, orientating image which, via its representation in the media, provides the public with a basic sense of meth use. As Foucault (Foucault, 2013, p.116) argued, "language becomes the primary instrument through which ideology is transmitted, enacted and reproduced". Such visceral media representations serve to justify, entrench and defend dominant positions in relation to meth use, whilst marginalizing alternative accounts, blaming and excluding alternative ideologies (Augoustinos & Every, 2007; Teo, 2000). Notably, the implications of Dixon's repeated abuse as a child were not

remembered/mentioned by the public participants ("Dixon sexually abused by mother, friends, court told," 2008, 14 July).

In summary, Theme Three deals with the consequences of methamphetamine‘s illegal status and what happens when PWUM transgress this boundary.

4.4.1 Consequences of Illegality

As a Class A substance under the MoDA 1975, methamphetamine possession/use are deemed illegal in ANZ, however, the ramifications extend far beyond a fine or prison term. Expert participants unanimously identified meth’s illegal status as a treatment barrier, beginning with the secrecy this engenders:

> *“Secrets make you sick…. And because it's illegal, of course, it's hard to own up to this stuff, because you're not sure what will happen at that point, are you?” (Guyon Espiner, Journalist, Radio New Zealand (RNZ))*

> *“So if people don't know, yeah, that the person is using methamphetamine, the consequences include having to become secretive, having to hide it, and all the psychological damage that goes with that sort of dishonest approach to life.” (Wendy Allison, Chair of Board of Trustees, Know Your Stuff)*

Secondly, as we see from the expert extract below, as methamphetamine is illegal, a person with MUD has a secret that cannot be divulged for fear of negative consequences, such as a loss of employment, reduced access to housing, and even the loss of children if one is deemed by authorities as unfit to parent.

> *“And then, of course, if people know you use methamphetamine, which is illegal, the consequences are: Lose your kids, lose your house, lose your job, lose your social standing, often lose people from your family who see the stigma of methamphetamine and just don't want to know…. You may generally lose respect within your community as well. I mean, you can lose everything just by people knowing you use it, whether you use it problematically or not.” (Wendy Allison, Chair of Board of Trustees, Know Your Stuff)*

Literature also bears this out. In Portugal, the most substantial barrier to treating the addict population was the “addicts’ fear of government officials as a result of criminalization” (Greenwald, 2009, p.7).

"So that alone, that prevents people from being able to access services like health care. So being able to have an honest conversation with your general practitioner…and them not just flagging you on the system as a drug seeker…Let alone getting good advice around the drug use and health checks that are relevant to that drug." (Sarah Helm, CEO, New Zealand Drug Foundation)

"Some absolutely awful stuff happens in our sector, in relation to people who are known or considered to have a drug habit or addiction. And yes, they are refused treatment. They're not given treatments or health options that normal people would be given, not given pain relief. For procedures that need to have pain relief, there's just story after story of, I guess, ethical and medical questionable practice in relation to people with substance use issues including meth. I just know so many. It's just not funny." (Deb Fraser, Co-Chair, National Committee for Addiction Treatment)

Thirdly, as highlighted by several expert participants above, the stigma of illegality creates significant help-seeking barriers. The literature demonstrates that people with MUD are highly likely to experience stigma in their encounters with healthcare workers (Earnshaw, 2020; Eaton et al., 2015; Farrugia et al., 2021; Fetterhoff, 2023; Paquette et al., 2018). Rhonda Robertson, a longtime lived experience champion, highlighted that people with MUD experience self-stigma, public stigma and even structural stigma:

"People are stigmatized at multiple levels." (Rhonda Robertson, Long Time Lived Experience Champion)

As with Rhonda's extract, several expert interviewees highlighted that such individuals are stigmatized at multiple levels, and the literature also suggests self-stigma plays a large role in hindering help-seeking (Albertín et al., 2011; Davis et al., 2020; Luoma et al., 2013; Pavarin, 2016; Ventura et al., 2022). Self-stigma is associated with feelings of shame, unworthiness and self-loathing, and anticipated stigma makes requesting treatment more difficult.

Fourthly, expert interviewees highlighted that keeping a MUD secret leads to isolation and problems can mount up. As Johan Hari wrote: "Connection is the opposite of addiction" (Hari, 2015, p.299). The expert below uses the same phrase:

"And if you've read Chasing the Scream, you know that connection is the opposite of addiction. So the more you isolate yourself, if you can imagine you're isolating yourself on a substance, so that if you isolate yourself, you're probably going to use more, which also makes you feel even more paranoid, removed, just from the nature

of the substance, you're using it day in and day out and on binges, suddenly you've completely extricated yourself from any kind of comfort now." (Trish Dribnenki-Pennock, National Harm Reduction and Hep C Lead, NZ Needle Exchange Programme)

Lastly, several expert interviewees mentioned the potential for stigma to occur by association, known as courtesy or associative stigma.

"And often in a Māori environment, we, you know, we've got nannies, we've got aunties, uncles, mums, dads, kids, that are getting majorly impacted." (Shawnee Brausch, Research & Communications Analyst, Whare Tukutuku, Te Rau Ora)

Family members/whānau may experience associative stigma through their relationship to the PWUD (Corrigan et al., 2006; Marshall, 2013). They may lack experience or resources to help and feel helpless as a result. Whānau may experience feelings of shame, guilt, inferiority and helplessness and lowered self-esteem (Angermeyer et al., 2003; Mak & Cheung, 2008).

In summary, the consequences of illegality may be severe. Experts highlighted that PWUD fears contact with government authorities, as they risk criminal conviction, imprisonment, employment loss, housing instability and child custody issues. The treatment-seeking barrier is very high, as they cannot afford to be flagged as a 'drug-seeker' under any circumstances.

4.4.2 "It's illegal and gangs are involved"

Public and expert participants shared different perspectives on gang involvement with methamphetamine, with the experts having a more nuanced understanding. I shall firstly explore the public participants' views. Many public participants linked gangs with the manufacture/ distribution of meth. As with prohibition of any kind, whenever a substance is illicit, a profit margin automatically emerges for those willing to traffic in the substance.

"…and your supply is through a whole bunch of criminals that are criminals because there's the profit margin there. And the reason there's such big gang problems, is because there's such big profits and so there's a whole bunch of societal issues around those drugs being illegal, and the effects of those drugs are made worse because of that." (Nick)

"I don't know…I'm just thinking about the economics of it all… you know the industry is supporting 20,000 gang members… I don't know how many gang members there

are. But it's supporting a lot of workers and billions of dollars of income's going through that." (Nick)

"With methamphetamine, a much stronger association with criminality, gangs particularly, much stronger association with a far more addicted individual with far worse health outcomes for them…" (Max)

As seen above, many public participants linked drug illegality to gangs, which were in turn perceived to be linked to criminality, organized crime, guns and violence, making them fearful as law-abiding citizens. Whilst no doubt not the only form of distribution, gang involvement has been much reported in the media, although recent statistics suggest there are only approximately 8,357 gang members in ANZ, not the 20,000 Nick suggested (Maher, 2022, Nov 22). The Te Ara Oranga evaluation suggests that Northland was likely targeted as a testing ground by organised crime to establish a methamphetamine market (Walton & Martin, 2021). Criminal networks manage drug supply in ANZ, though police report only approximately 20% of methamphetamine is locally produced, with 80% imported from Myanmar, Mexico and Afghanistan (Collins, 2023).

One public participant discussed gangs' territorial control over communities, including blocking other potential market entrants:

"I think it's just their revenue. So, they protect their patch.... they don't want to let another gang in there… and then it's a sort of pyramid selling scheme. So, the more people you can control that are selling for you, then the better off you are and the gang I think." (Nick)

Public participants could speak compassionately about PWUD, expressing sympathy for their plight. This shifted, however, when I asked how they would feel if a new neighbour moved in next door with a drug dependency. This prompted a more visceral, more stigmatized reaction, of fear and discomfort, something of a "Not In My Back Yard" reaction. Thus, proximity seems to heighten the sense of danger.

"I'd be nervous. I think currently, the access to said substances, falls deeply in the hands of gangs. And as we talked about price point, if a person were in a financial situation where they needed the money. I think that that desperation would make someone do things they wouldn't otherwise do. And I would be concerned living next to someone who had a current blaring dependency issue…. And the fact that the drugs are held in the hands of gangs, then having that relationship would put

surrounding people in, not imminent danger, but in a higher likelihood of having to deal with people that don't care so much". (K*atie)*

Expert participants acknowledged the perception that some gangs are involved meth distribution in ANZ, but with a more nuanced understanding:

"There is criminality around supply, and it's often gang linked." (Rhonda Robertson, Long Time Lived Experience Champion)

"Look, regulations could fix that. We really gave gangs drugs to sell when we created the Misuse of Drugs Act" (Sarah Helm, CEO, New Zealand Drug Foundation)

"But so many of the stories that are out within the public realm associated with methamphetamine are about the association with criminal activity…. The association of methamphetamine with the gangs? Yes. Okay. But it's not only the gangs who manufacture and distribute drugs. But the focus goes on one particular group of people…" (Sheridan Pooley, CADS Regional Consumer Advisor, Waitemata DHB)

"We were approached by a Chapter within the Mongrel Mob. They wanted help because of methamphetamine… when it came on the scene. And they looked and thought, ooh this is a good way to make money. But as they described to us, the problem was they sampled the product on the way through, and very soon experienced terrible results. And for the sake of their children, and the grandchildren and families, they had come to the point like, this is a recovery story as a group. And they came to us and wanted help…. Anyway, it ended up we had an 11-year journey. In that time, we now see because it finished in 2018. And the funding went to a kaupapa Māori provider, which was always the thought. But we're still seeing those long-term results. Like if you get one degree of change, it may not look much, but if that trajectory continues, it becomes five, ten, fifteen, twenty degrees of change." (Lynette Hutson, Director, Salvation Army Social Services)

These expert participant perspectives reveal greater complexity. Sheridan Pooley highlights that gang-dealer conflation creates another 'othered' group. Lynette Hutson's example provides a counter narrative to the public participants' perspectives; it complexifies the reality and the positions held by gang members, who are not only possibly dealing, but then concurrently suffering the negative impacts within their own families and wanting to help themselves out of the situation. The Te Ara Oranga evaluation also suggests that in line with the multi-level marketing scheme promoted by gangs in Northland, "meth users are usually

also meth sellers" (Walton & Martin, 2021, p.24). Lynette's extract highlights what a socially complex issue this is, and what a "thin line there is between being an 'offender' and a 'victim'"(Walton & Martin, 2021, p.10).

Several public participants noted that illegality also causes concerns over supply quality. They noted the risk of harmful added contaminants, ranging from concrete powder to fentanyl and the lack of consumer protection or redress.

In summary, this subtheme highlights that ANZ's methamphetamine market is largely (though not exclusively) controlled by gangs. The underground nature of drugs and gang involvement heightens concerns about violence, quality control and criminal activity.

4.4.3 "They need help, not prison"

Some public participants advocated viewing meth use as a health issue or a consequence of social or psychological issues (e.g., abuse) and contradicted the earlier view of drug use as a moral failure, expressing a measure of sympathy.

> *"I wish society would flip the script. And instead of isolating these people welcome them in and get to the bottom of why they use substances and what hole they're filling in their life with these substances." (Katie)*

> *"It's about the rehabilitation process. And recognising that maybe it's more, you know, recognising it as a health problem, not a criminal activity problem." (Billie)*

> *"There's a lot of stigma with it - that might need to be tackled from a public perception point of view. Because not every drug addict is a murderer or a thief necessarily…. But it's not like you can go to the police station and say, I'm a druggie – help me." (Kevin)*

> *"This meth, there could be abuses happened when they were younger, all sorts - people don't know that. You know, and it's getting right to the bottom of that - they're using it to escape what they've been through." (Angela)*

Public participants showed limited awareness regarding the extent of prison sentences for drug possession. Ministry of Justice statistics to June 2024 show 2,053 methamphetamine-related convictions, with three quarters for possession/use, including of utensils (Ministry of Justice, 2024, June). In contrast, expert interviewees uniformly advocated for reframing meth use as a health rather than a criminal justice issue:

“Look one win that we have had as a sector, …has been to reframe it from a justice issue to a health issue, you can't arrest your way out of addiction.” (Lynette Hutson, Director, Salvation Army Social Services)

“I think there has been a huge societal change, as far as that this needs to be a health issue, not a criminal justice issue. I think people are really hearing that, and that has resonated with society, which I think is a good thing.“(Carl Greenwood, General Manager, Drugs Project)

“This idea that we can police our way out of the problem, it's frustrating, it just so clearly doesn't work.” (Guyon Espiner, Journalist, RNZ)

The 2019 amendments to the Misuse of Drugs Act 1975 granted police greater discretion to avoid arrests for minor possession unless deemed in the public interest (Misuse of Drug Amendment Act 2019, 2019, August 12). Brendan Short of Auckland City Mission noted the expense and ineffectiveness of incarceration, adding that the Department of Corrections is currently the biggest funder of drug treatment.

“I think much of addiction is a sort of a “consequence of societal failures…I think, even Bill English said, “prisons are a moral and fiscal failure.” (Dr Sam McBride, Lead Clinician, Capital & Coast Health Opioid Treatment Services)

Indeed, English did, in a speech in May 2011, later expressing hope that a proposed South Auckland prison would be the government’s last, citing costs of $250,000 a bed [in capital costs] and $90,000 [per prisoner] to run it, and when we're tight for money, it would be good if we could have ... less young people coming into the ... pipeline where they start with a minor offence and end up with a 10-year sentence" (Otago Daily Times, 2011, May 24).

Incarceration fails to address substance use issues while providing an education in criminality, reducing life chances through criminal records, and imposing significant taxpayer costs (Otago Daily Times, 2011, May 24; Yasbek et al., 2022). As we saw in Chapter One, Portugal’s decriminalisation resulted in 18% reduction in average social costs through reduced health, legal and indirect expenses (Gonçalves et al., 2015).

A 2009 Law Commission review revealed that District Court judges identified alcohol and drug problems in 80% of all crime in ANZ (New Zealand Law Commission, 2009). Corroborating this, a Corrections Department study found nearly 90% of offenders were affected by substances when committing offences (Department of Corrections, 2009). In 2012 the Alcohol and Other Drug Treatment Court (AODTC) was established (initially as a

pilot, now with three permanent courts), to address addiction-driven offending through evidence-based, best practice treatments including monitoring, case management, drug testing and mentoring, with positive outcomes in reducing incarceration (Ministry of Justice, 2019, June). The expert participants praised AODTC's work. Sheridan Pooley, Waitemata DHB, noted increased justice referrals as courts prioritise addiction treatment and observed that meaningful change often occurred when PWUM recognized their impact on their families.

The expert participants almost unanimously supported decriminalisation.

> *"I mean, I think decriminalization makes a lot of sense." (Dr. Sam McBride, Lead Clinician, Capital & Coast Health Opioid Treatment Services)*

> *"So I think that actually, while drug use is illegal, then we stop conversations, we stop people actually owning up to it and being honest. I think that there's a lot more risk around bad drug supply. I think I really am an advocate that we move away from prohibition. It hasn't worked, and we need to look at alternatives, because actually what we've currently got isn't working, and it's not going to stop. I think there's a real naivety, if you think that prohibition will just end drug taking, it's not going to happen." (Carl Greenwood, General Manager, Drugs Project)*

Guyon Espiner's documentary "Wasted" investigates the 'war on drugs' in ANZ, and in it, as well as in our interview, he highlighted the success of the Te Ara Oranga programme (RNZ, 2023).

> *"The biggest impacts have been from Te Ara Oranga, or programmes like that, that are making a real difference. If you look at the evaluations of that they were very impressive and successful." (Guyon Espiner, Journalist, RNZ)*

4.4.3.1 Te Ara Oranga Programme

Te Ara Oranga, The Path to Wellbeing, is ANZ's response to meth abuse, operational since October 2017. This Northland initiative partners government agencies (Police and Health), with NGOs (e.g., Salvation Army, Odyssey House, Ngāti Hine Health Trust) and other service suppliers (Mahitahi Hauora, Salvation Army Bridge), in a client-centric approach addressing meth use harms. The programme offers a 16-week therapeutic treatment, modelled on the Matrix Model (Rawson et al., 2004). The programme has been augmented to ensure a kaupapa Māori approach, given the large population of Māori in Northland (33% vs national

average of 15.1%) and has enjoyed strong community and iwi support (Walton & Martin, 2021).

The programme possesses several unique strengths. Firstly, police offer treatment rather than arrest to known users, recognizing that “Police could not arrest their way out of it, Health cannot treat their way out of it.” (Walton & Martin, 2021, p. 47). Secondly, treatment is offered regardless of addiction severity and as early as possible in a person’s readiness. The service is usually offered within 48 hours, and repeatedly to those who withdraw or cycle in/out of dependence. Thirdly, Te Ara Oranga’s model is evidence based and employs the DiFranza framework, viewing dependency as neurological remodeling rather than maintaining drug levels to avoid withdrawal (DiFranza, 2020). This model recognises that even low-level methamphetamine exposure creates physiological-led struggles between use and abstinence, contrasting with traditional addiction models requiring continued exposure past a ‘critical set point’ (DiFranza, 2020). Fourthly, the Health partnership has aided a shift in police mindset from enforcement to prevention, with officers trained in Motivational Interviewing (Miller & Rollnick, 2012; Walton & Martin, 2021). Lastly, Pou Whānau Connectors (PWC) are another innovation within the Te Ara Oranga blueprint. PWC provide support to service users, connecting them to treatment services and supporting marae-based meth education with tikanga, adapting the peer support worker model specifically for Northland.

Te Ara Oranga demonstrates the effectiveness of a Portugal-style, health-based approach in ANZ. Analysis shows methamphetamine users typically commit *low harm acquisitive crimes*, like shoplifting and theft (Goldsmid & Willis, 2016; McKetin et al., 2020; Walton & Martin, 2021). The programme has helped over 3,000 individuals and achieved a 34% reduction in post-referral crime harm using the NZ Crime Harm Index (Curtis-Ham & Walton, 2017). The cost-benefit analysis suggests returns of between $3 - $7 per dollar invested. The NZDF estimates nationwide implementation would cost approximately $40-$45 million, but would yield returns of $100 - $150 million (New Zealand Drug Foundation, 2022, May 12). A second pilot is underway in Murupara (Little A., 2022).

In summary, this Theme Three sub-theme examines whether methamphetamine use should be viewed as a criminal justice or a health issue, with public participants predominantly supporting a health-oriented approach.

4.4.4 Historical Context: War on Drugs

Only a few of the public interviewees, especially Nick, referred to the ‘war on drugs’. They highlighted how any form of prohibition will enable criminal profiteering and disputed that illegality would deter use:

> *“Every time we have some form of control over a substance, the profit margins go up, and the bad people get involved. So yeah, I think there are different issues about being illegal versus being bad for you…. And I think those questions are just starting to come up in the media now which is quite interesting, which they haven't before, which is quite nice…the last year it seems to be a lot more. We're not winning the war. We can't, you know, we've been trying for 30 years. Something's got to change, otherwise, the result won't change.” (Nick)*

> *“But what I mean is, though, I just don't think it makes any difference at all, that it's illegal. Oh, I won't take it then. You know, people, if their lives are, if people are taking it because their lives are in a mess. I don't think they care if they're breaking the law or not... Nor do I think there would be more meth users if it was legal.” (Nick)*

In contrast, and unsurprisingly, all experts were well aware of this issue, with clear opinions on the subject:

> *“I mean, the war on drugs has been a complete failure, hasn't it?” (Dr. Sam McBride, Lead Clinician, Capital & Coast Health Opioid Treatment Services)*

> *“Honestly, I don't think it is actually a war on drugs. I think that's just a fancy way of saying a war on class, and a war on race.” (Trish Dribnenki-Pennock, National Harm Reduction and Hep C Lead, NZ Needle Exchange Programme)*

> *“I mean, the idea that you that you can just suppress and black-market this thing out of existence just isn't going to work. And we've realised this with just about every other social dilemma we face, whether it's prostitution, gambling, or alcohol, or whatever, ...we know that that prohibition and just beating people up, locking people up and getting tougher on it hasn't worked. So why do we think it's going to work now? So, your question was what frustrates me – it’s that we, you know, by the very definition of madness, seem to be trying the same thing again and again and expecting a different result.” (Guyon Espiner, Journalist, RNZ)*

As discussed in Chapter One, the Global Commission on Drug Policy has stated “the war on drugs has failed” (Global Commission on Drug Policy, 2011, p.17). Despite enormous global expenditures on criminalisation and repressive measures targeting manufacturers, traffickers and consumers, supply and consumption continue unabated (Global Commission on Drug Policy, 2011). Any victories in trafficking elimination are quickly replaced by new traffickers. The repressive criminalization efforts aimed at consumers obstruct public health efforts to decrease overdose fatalities, HIV/AIDS and other harmful consequences of drug use. Government spending is wasted on ineffective supply reduction and incarceration, diverting resources from evidence-based demand and harm reduction interventions (Global Commission on Drug Policy, 2011). Research consistently shows “no evidence to support assertions that criminalization reduces use or that decriminalization increases use”(Global Commission on Drug Policy, 2011, p.10). Similarly, a critique of the UK’s 10 Year Drug Strategy (2023) also found “no clear relationship between the stringency of drug laws and drug use prevalence” (Holland et al., 2023, p. 218).

The ‘war on drugs’ metaphor itself reinforces combative approaches. The discourse is combative – the argument may be won or lost – it may destroy or be shot down. As Gergen notes, such framing constructs a ‘world of enemies’, undermining constructive dialogue (Gergen, 2022, p.43).

> *“It needs to be a wider and a deeper conversation about how you manage drug use and accepting the reality that the judge who has a gin and tonic isn't that much different from the guy who has an edible before a concert or whatever it is. And it needs a more mature discussion…. New Zealand has a pretty juvenile conversation about this, where alcohol is fine, and every other drug is for criminals.” (Guyon Espiner, Journalist, RNZ)*

The ‘war on drugs’ discourse is also effectively one of propaganda, with recurring drug tropes or ‘alternative facts’ that simply target different substances over time. Carl Hart, discussing this with Johann Hari (2015), observes that while today's public would reject claims that marijuana use leads to homicidal behavior (claims once made by first Federal Bureau of Narcotics Commissioner Harry Anslinger), they readily accept similar claims about methamphetamine or crack cocaine (Hall & Yeates, 2021; Hari, 2015, p.287). Same trope, different era, insert relevant drug. Hart’s point is that until we debunk such a “mythical view of drugs” we will never escape the ‘war on drugs’ rhetoric (Hari, 2015, p.288). In this instance we see that the construct of drugs as evil and dangerous persists across eras, merely reattaching to whatever are deemed the most dangerous drugs of that particular time.

Decriminalisation

As with the 'war on drugs', few public interviewees were familiar with decriminalisation concepts or Portugal's efforts, however the expert participants were aware of this and almost without exception supported decriminalisation (if not legalisation):

> *"I'm part of the Harm Reduction Coalition, and we advocate for the legalization, and we have reasons for that, but I think politically, the New Zealand population would be more on board with decriminalization at this point." (Wendy Allison, Chair of Board of Trustees, Know Your Stuff)*

Many expert participants argued that decriminalization would help to solve several problems: improved treatment access, health system access to methamphetamine prescriptions reducing gang/criminal network revenues, decreased incarceration costs and improved employment and housing opportunities without criminal convictions. Portugal's experience demonstrates that comprehensive support systems can create net taxpayer savings despite increased health expenditures (Gonçalves et al., 2015).

In summary, the *War on Drugs* sub-theme reveals a failed strategy acknowledged by some public participants and unanimously confirmed by all expert participants. Notwithstanding the worldwide effort by governments to curtail both drug production and consumption, this approach has proven costly and ineffective, with worldwide drug consumption increasing whilst organized crime has profited (International Drug Policy Consortium, 2018; Kreit, 2010). Beyond its failure to achieve its stated aims, the 'war on drugs' has further exacerbated structural inequities in society, perpetuating cycles of stigma and social inequality.

4.5 Theme 4: "It's all bottom rung"

With the first sub-theme, public participants articulated the idea of a brand hierarchy for drugs with meth as a bottom-rung drug, and with the second sub-theme public participants associated meth use with lower socio-economic strata and areas. In short, both meth and its users were perceived to be "bottom-rung".

4.5.1 Meth – the "bottom-of-the-barrel" drug

Public participants shared a clear 'brand hierarchy' in their interviews. At the premium end were heroin and cocaine (though heroin use remains limited in ANZ currently). Cannabis was still portrayed as a 'gateway' drug, something with which you might experiment before trying others. Following cannabis came a cluster of recreational drugs including MDMA, LSD,

ketamine and psychedelics. Methamphetamine, however, was consistently positioned on the lowest rung of the brand ladder:

> *“P is bottom rung.” (Sarah)*

> *“Meth is the home brand of drugs.” (Nick)*

> *“I don't know people brag that they're taking meth. I think they brag they've got coke. But it’s not a braggy kind of drug, is it? Maybe because I have such a negative connotation here…I think as a drug to me P seems more sordid than coke.” (Sarah)*

As can be seen in the extracts below, the typical narrative is that poorer people would be buying methamphetamine because cocaine and heroin would be too expensive, and that they might progress downwards to methamphetamine as addiction intensifies and finances deteriorate:

> *“Yeah. With coke I presume the price is more expensive, I don't know, but I presume once you've fallen, gone down that path, then you have to do something like a P, which is at the bottom-of-the-barrel. So that's where you fall into.” (Nick)*

Most public participants linked cocaine to affluent, white-collar highflyers, who they portrayed as less prone to addiction, and better resourced for recovery, if needed.

> *“Cocaine and heroin are more elitist drugs, like they're a lot more expensive. But it's the upper level – actually, the ‘white-collar’ drug is the word I'm looking for.” (Diana)*

> *“I think that's the big difference between cocaine and methamphetamine - is your actual socioeconomic status. And so, the cocaine users, in the UK, the cocaine users were the affluents, the businessman, businesswoman, lawyers that sort of thing. Whereas the methamphetamine was the lower socioeconomic class.” (Max)*

The public conflates the perception of methamphetamine with those who use it, and the negative connotations mount up. They converge in an overarching narrative that could be summarized as follows:

> Methamphetamine is an illegal, addictive, dirty drug which has deleterious health consequences, is distributed by gangs, is often used by marginalized people and is associated with the unpredictable violence of the likes of Antoine Dixon and the Samurai Sword.

Expert participants' understanding of methamphetamine's position in the brand hierarchy largely aligned with public participants:

> *"Yes, I would say that meth is probably one of the most stigmatized in the hierarchy. Yes. And probably for a number of reasons. A, it's not commonly found in a pure form. So it's automatically known as a dirty drug. It's made in people's kitchens with different solvents or has been made and can be made…. Which would create a hierarchy, I'm assuming, given that kind of perspective on even how it's made." (Trish Dribnenki-Pennock, National Harm Reduction and Hep C Lead, NZ Needle Exchange Programme)*

> **"**Yeah, so in terms of that hierarchy, it depends on your level of privilege, yes, depends on what drugs you have access to, and it depends on why you're taking them. Yes." *(Wendy Allison, Chair of Board of Trustees, Know Your Stuff)*

In summary, this sub-theme captures public participants' articulation of meth as positioned on the lowest rung of the brand ladder, as the "bottom-of-the-barrel" drug.

4.5.2 Social Determinants of Health and Intersectionality

In keeping with the idea of a brand hierarchy for drugs and their positioning of meth as a bottom-rung drug, public participants associated meth use with lower socio-economic strata and areas.

> *"I usually associate meth with a lower income person - has been hard done by." (Billie)*

> *"I don't think it is the drug, I really do believe it's a socioeconomic issue." (Sarah)*

> *"But, you know, when you hear about Northland towns and that sort of stuff, it sounds like poverty. It just gets in there. And, you know, the gangs are there." (Nick)*

Most of the expert participants agreed that people from lower socioeconomic areas were more likely to experience stigma from meth use.

> *"Meth users are hugely stigmatised. It's also probably a class thing to some degree…. or almost sort of prejudice in a way. Meth is seen as a drug of the hard out working class, criminal element, who've got nothing going for them…. Yeah, if you were doing cocaine or MDMA, that would be seen as kind of almost acceptable for the children of rich lawyers and property developers. But the answer to the question, are they*

stigmatised? Absolutely they are, and that seems to be based largely on prejudice." (Guyon Espiner, Journalist, RNZ)

The Social Determinants of Health (SDOH) describe the conditions in which individuals are born, grow, work, live, and age, and the broader economic/political systems shaping daily life conditions (Bonner, 2018; Wilkinson & Marmot, 2006; Wilkinson & Pickett, 2006; World Health Organisation, n.d.). Here we see how neoliberal policies reinforce systemic inequity, discrimination and structural stigma in health access (Barnett & Bagshaw, 2020). As Brady (2009, p.6) notes, "Where poverty is low, equality has been institutionalised. Where poverty is widespread, as most visibly demonstrated in the US, there has been a failure to institutionalise equality". There is also clear evidence that individuals who experience several Adverse-Childhood-Experiences (ACEs) may suffer relatively worse health in later life (Hashemi et al., 2021; Maté, 2018; Walsh et al., 2019). One recent analysis linked the incidence of four or more ACEs to increased meth use likelihood across the life-course in ANZ (Bax, 2021).

Health, illness and even life expectancy follow a social gradient, with lower socioeconomic status correlating with shorter life expectancy (Marmot et al., 2020). Tobacco usage patterns demonstrate this principle, with higher education and income inversely related to smoking rates across economically advanced societies (Feldman & Bayer, 2004). Whilst research shows that individuals with higher socioeconomic status have a higher likelihood of initiating drug use, those from lower socioeconomic groups are more likely to develop drug use disorders (United Nations Office on Drugs and Crime., 2020). Marginalised groups facing disadvantages like poverty or limited education are especially vulnerable to mental health issues and drug use disorders (United Nations Office on Drugs and Crime., 2020). This implies that the burden of public health measures designed to reduce tobacco consumption are borne by those at the lower end of the social ladder, something to be borne in mind when considering how to lessen the structural stigma experienced by methamphetamine users (Bayer, 2008; Rohleder, 2012; Wilkinson & Pickett, 2007; Wilkinson & Pickett, 2009) Such socioeconomic disadvantages may further limit their access to healthcare and treatment (Hodgetts & Stolte, 2017).

I was surprised by how quickly several public participants drew a link between meth users and the homeless, with references to Queen St and Rotorua motel communities, as they are a very visible group of people, some of whom may use meth.

“You know, like, because I work on Queen Street, I do come across a lot, a lot of P takers. I always think, if I think that they're on P, they're the ones that look closest to death to me. The ones that you're least likely to be able to help.” (Sarah)

“Because I think of COVID and Rotorua hotels took in a lot of homeless people during COVID. And then there's been reports of lots of violence. And people feeling unsafe on the streets of Rotorua because of people, homeless people, who I'm assuming homeless people aren't necessarily dangerous, but they must be on something. And I'm assuming that they'd be on meth.” (Hannah)

Expert participants challenged such characterisations:

“I think that the homeless, so not all homeless people use drugs, and not all people, or very few people who use drugs, are homeless.” (Sarah Helm, CEO, New Zealand Drug Foundation)

Such linkages in the public participants’ discourse possibly stem from the shared marginalisation of the homeless and PWUM, both perceived as ‘bottom-rung’. A recent ANZ study indicated that homeless people have a life expectancy 15-30 years shorter than housed counterparts (Charvin-Fabre et al., 2020). Similarly, residents of ANZ’s most deprived areas live approximately ten years less than those in affluent areas (Ministry of Health., 2024). Homelessness, poverty, unemployment and welfare reliance are inescapably linked to poorer health outcomes (Wilkinson & Marmot, 2006).

A few of the public participants linked gangs and meth, and saw gang membership as being dominated by people of Māori or Pacific Peoples ethnicity:

“And then gangs being in my head, predominantly Māori and Pacific Islanders and then again, I'm living on the Shore in a white neighborhood where there's plenty of, probably plenty of methamphetamine use but it’s kind of more hidden from or less noticeable to me.” (Hannah)

Almost all expert interviewees spoke to the impacts of colonisation and systemic racism in ANZ:

“The other positive shift sort of, has been the amendments to the Misuse of Drugs Act to encourage police discretion. It’s designed to reduce the number of people who are being prosecuted for use across the spectrum of different drugs. Less so for methamphetamine use. Less so if you're Māori - in fact, Māori now outnumber non-

Māori for convictions for personal use." (Sarah Helm, CEO, New Zealand Drug Foundation)

"But also being Pākehā, when you look at the intersections, and intersectionality, and how that impacts each one of us in our variety of spaces that we fit. Being Pākehā, male, middle aged, wealthy, all these things are going to make it easier for you and your family to navigate than it would for somebody who might be living in poverty, a person of colour, etc… Like I hang out with a relatively affluent group of individuals. They're quite financially stable, good looking, et cetera, have their own businesses. And so, it was interesting, because not too long ago, one of them was ingesting cocaine and being like, well, I've never been criminalized. I'm like, literally cops could come in here right now. Look at your flash house and you. And all you'd have to do is turn on some charm and they would leave you alone. Guarantee they would not arrest you. But if we were all in South Auckland, yep. At a council flat or a government flat using meth for sure the tables would be significantly different. It's really interesting. Yeah, so like the self-shame, the self-stigma and family stigma exist differently based on the hierarchy and the intersectionality of the substances used. And privilege." (Trish Dribnenki-Pennock, National Harm Reduction and Hep C Lead, NZ Needle Exchange Programme)

Colonisation has impacted Māori through the "dispossession of lands…culture…language … knowledge" (Pihama, 2019, p.193). The migration away from tribal whenua and the systemic alienation of Māori from their resources has led to intergenerational trauma, or "spiritual homelessness" (Memmott et al., as cited in Groot et al., 2011, p.378), and intergenerational poverty. Additionally, it has broken apart the relational support systems enjoyed by Māori in communal living (Sonn et al., 2019). Racism is increasingly recognized as an important determinant of health (Ministry of Health., 2024). Guy Standing coined the neologism "precariat" (Standing, 2011), an emerging class affected by employment, income and rights insecurity (Standing, 2014).The NZ precariat has been estimated at 606,000 and in this Māori are over-represented, constituting 29% of the precariat versus 16% of total population, a clear indicator of systemic discrimination (Cochrane et al., 2017; Rua et al., 2023; Rua et al., 2019). 38% of those using meth regularly are Māori (Yasbek et al., 2022). Finally, several expert interviewees also highlighted intersectionality (Crenshaw, 1991) or the manner in which some disadvantaged groups within society may be multiply marginalized:

"Well, I think that our drug legislation is really, pro law enforcement, pro prohibition and pro abstinence, which leads to treating people with intersections and ultimately perpetuates harm on the most marginalized, which are usually people in poverty, people of colour, LGBT, particularly trans, women. Again, it just kind of perpetuates the colonial and the patriarchal structure." (Trish Dribnenki-Pennock, National Harm Reduction and Hep C Lead, NZ Needle Exchange Programme)

One UK study argued for stigmatizing drugs rather than PWUD, though acknowledging the strong interconnections, as the image of a drug reflects on the user of that drug and vice versa (Lloyd, 2010). Nevertheless, the harsh stigmatization of PWUM implies potential to reduce user stigma without rendering dangerous substances more appealing (Lloyd, 2010).

In summary, with Theme Four sub-theme two, both public and expert participants articulate the SDOH (lack of education, poverty, colonialism and intersectionality), as underlying factors in meth use and its associated stigma.

4.6 Theme 5: "The Courage of Recovery"

Public participants, despite expressing highly stigmatized views of active methamphetamine users, displayed remarkable positivity toward recovered users and expressed willingness to support them with employment/other life chances. The contrast was stark. Having portrayed people with problematic meth use as 'nearly dead', Sarah's attitude towards recovered individuals was *effusive* in comparison:

"I can only speak for myself, but I would absolutely go out my way to try and employ someone like that. Because it just shows enormous strength of character and fortitude, and most people have fuck all, right? You know, so, anyone that's been asked to fight an incredible addiction and come out the other side... I mean, hats off to them. And ...that was a huge honesty for them to tell you that. And integrity. So, I'd be like, to me, definitely. And not everybody would think the same way as me. But I'd like to think, you know, smaller companies, private sector, you know, where you had that flexibility to think of it differently. And they should definitely be given opportunities." (Sarah)

"I think someone who's recovered is, I guess that's one of the most impressive feats you can do, just recovering from any sort of addiction, meth being one of the ones that are viewed as strongly addictive. So, these people are viewed in a really positive light. People are really strong willed. They kind of have the ability to recover. And you

sense that these people want to go in the right direction. So, I think there's a lot of respect for them, actually, and goodwill. Yeah, goodwill." (William)

Public participants characterized recovered individuals as embodying courage, strength, honesty, integrity, willpower and determination, all highly admirable qualities. Their ability to overcome addiction and find a will to live was framed positively, with public participants unanimously supporting second chances:

"Second chances, I think, are very important." (Germaine)

"You gotta give huge respect to somebody that's recovered. Yeah. Like an alcoholic." (Fiona)

"Because I think coming away from such an intense substance takes strength and determination, and, and a passion and a will to live." (Katie)

"I think recovered addicts definitely deserve a second chance." (Margot)

There are three parts to these positive portrayals. Firstly, participants earnestly stated that recovered users had *earned* the right to second chances, suggesting New Zealanders would generally subscribe to this generosity of spirit. Secondly, beneath the public participants' praise of the courage shown, there lies an unspoken undercurrent of moral righteousness - the person has redeemed him/herself by returning to the law-abiding side of a binary social construction. Users are absolved from their past 'sins'. The concept of redemption is redolent of religiosity, featuring as it does in Christianity, Judaism and Islam. Redemption refers both to deliverance from sin and to freeing from captivity, with the Latin word *redemptio* meaning "buying back" (Demarest & Feinberg, 2006). Thirdly, the stigma lingers, albeit ameliorated, with public interviewees suggesting recovery must be sustained over time before trust is fully regained, lending caution to the upfront goodwill:

"I think if you if you were free for anything more than five years, I think people would take it seriously. If someone was like, Oh, they're off it for like, five minutes…yeah, it's just until the next hit… even a year, there's still that lingering danger. …I think, once you've had those five or six years, people would start changing their perception around you. And it'd be more of this, they survived something that a lot of people don't." (Billie)

Expert participants were also positive about recovery:

> *“Everyone loves a good redemption story. “(Carl Greenwood, General Manager, Drugs Project)*

> *“You know, there's quite a lot of mana associated with having…. recovered from addiction.” (Dr. Sam McBride, Lead Clinician, Capital & Coast Health Opioid Treatment Services)*

However, expert participants who shared this positive view of recovery also expressed more nuanced perspectives. They described recovery as nonlinear, often involving relapses and persistent stigma. Some expert participants pointed out the problematic binary framing of current versus recovered users, depictions which mutually reinforced each other whilst entrenching status quo power structures:

> *“So, it won't be the case that you either are a meth user, so you're an utter loser and homeless or you're a recovered hero. You know, there'll be all sorts of gradients in between and I think this is where the stigmatisation comes back to that - once you say meth, you just write someone off - that's just not a credible position. “(Deb Fraser, Co-Chair, National Committee for Addiction Treatment)*

> *“So, the bottom line is, yeah, it's becoming more and more acceptable to acknowledge that you used to use drugs, but, oh, I'm clean now, which by implication, suggests you used to be dirty when you used drugs.” (Wendy Allison, Chair of Board of Trustees, Know Your Stuff)*

> *“But see, we do it with other stigmatized communities, too, if you look at the unhoused, as soon as they get housed, we’re like, great work…. someone’s mentally unwell…but as soon as they take their medication, and suddenly they're complying with the status quo, oh, they're amazing. Look how they've progressed. Even though they may look completely miserable. They don't have any like, passion for the art that they used to do because now they're so over-medicated, they don't have any kind of drive.” (Trish Dribnenki-Pennock, National Harm Reduction and Hep C Lead, NZ Needle Exchange Programme)*

From a social constructionist perspective, these comments illustrate how conformity is socially produced through binary ‘clean vs dirty’ constructions. When a PWUM returns ‘inside the box’, society breathes a sigh of relief, though this may not be the preferred outcome for recovering individuals. This parallels Stephen Fry’s documentary on bipolar disorder, where

diagnosed actors preferred creative potential over stability despite difficulties managing without medication (BBC, 2006). Consider the traditional recovery story: “Susan overcame addiction through willpower and determination”, in comparison with one of systemic recovery: “Susan’s recovery became sustainable when policy changes allowed her to access healthcare, stable housing and employment opportunities”. The second approach highlights how personal recovery intersects with structural support, creating a more complete and actionable understanding of what successful recovery requires. Without this approach, Susan may face a “stigma cascade” – where personal, professional, and institutional discrimination compound and amplify each other. She might face skepticism from healthcare providers, discrimination from employers, financial instability and exclusion from housing opportunities – each barrier reinforcing the others in a devastating feedback loop and threatening recovery. Even in recovery, structural stigma looms.

Once recovered, a person is deemed to have ‘lived experience’. Expert participants emphasized the importance of peer advocates with lived experience in harm reduction contexts, enabling authentic connection with current users:

> *“In the harm reduction space, we actually need the advice of people who have living experience, not just those who have been through treatment and been absolved, somehow, because they no longer do that behavior.” (Sarah Helm, CEO, New Zealand Drug Foundation)*

> *“We have lived experience persons running our drug checking clinics, because otherwise, how the hell are they going to have a useful conversation with anyone about 2CB, which is a current substance that's doing the rounds. So, you need to have some connection with our community to be able to help them and they’re out there doing that work.” (Sarah Helm, CEO, New Zealand Drug Foundation)*

Expert participants also spoke of the risks in highlighting recovery achievements. Firstly, this approach might further marginalise current users. Secondly, recovered individuals might perpetuate stigma through evangelical beliefs about their own recovery journey, implying judgment through statements like: ‘I’ve done it, why can’t you?’ (Eaton et al., 2015; Santos et al., 2021)

> *“So, it's difficult, when there is a hierarchy within the recovery communities about who's the most recovered. And that people don't realize that that in itself is stigmatizing of others.” (Sheridan Pooley, CADS Regional Consumer Advisor, Waitemata DHB)*

Best and colleagues' concept of 'recovery capital' provides a useful lens through which to interpret the recovery process (Best et al., 2016; Best & Colman, 2019a, 2019b; Bunaciu et al., 2024). Recovery capital refers to all external and internal resources accessed to support a recovery process (Best & Ivers, 2022; Best & Laudet, 2010). This involves "resources and capacities that enable growth and human flourishing" (Best & Hennessy, 2022, p.2). Best reports that the average "addiction career" spans approximately 27 years from initiation to stable recovery (defined as five years sober), after which relapse likelihood drops to 14 percent (Best & Lubman, 2012).

Recovery is not only possible, but probable. One meta-analysis of epidemiologic studies found that on average, 58% of individuals with chronic substance dependence had achieved sustained recovery (Sheedy & Whitter, 2009). Many expert participants expressed similar opinions:

> *"There is life after significant methamphetamine addiction…People do get well, and actually people get better than well, because often, they get the opportunity to address the issues that were driving their addiction." (Deb Fraser, Co-Chair, National Committee for Addiction Treatment)*

> *"It's not recovery, but discovery…. Yeah, we don't return to what was but rather we become better than was and discover new aspects of self and other community etc. - connections that actually take us to a different and better place, and studies do demonstrate that actually - that those people in sustained recovery actually have a better quality of life than those people who've never actually gone through recovery. So, if you've never had a dependence as such, then you're worse off than someone who's had a dependence and recovered. But I don't think that's general knowledge." (Emma Schwarcz, Clinical Director, CADS Tāmaki Makaurau, Waitemata DHB)*

4.6.1 Word Cloud

As with the word cloud in 4.2.3, public participants wrote down unprompted words they associated with people who had *recovered* from problematic meth use. These were compiled into a visual summary that was notably more optimistic than the one for people with current problematic use.

Although originally intended as a resource for advertising agencies, this visualization vividly encapsulates Theme Five, with 'hope' surfacing as a core public aspiration. Public participants' admiration for recovered users appears in descriptors like 'courage',

'perseverance' and 'determination'. The notion that recovery is earned and worthy of second chances appears in phrases like 'rebuilding-relationships', employed-now', improved health' and 'new-outlook'. Even the notion of recovered users being 'better than before' emerges in phrases like 'more-discerning' and 'self-aware'. The redemptive framing is evident in words such as 'saved', 'freed', 'happier', 'relief', and 'thankful'. Lastly, cautionary perspectives emerge through descriptors like 'constant-work', precarious', trust-until', 'vigilance', 'cautious' and 'slipping-back'. Thus, while not initially intended as a thematic device, this visualization reveals the issues portrayed in Theme Five very accurately (refer Figure 7).

Figure 7

Public Perceptions of People Recovered from MUD

In summary, Theme Five reveals a marked contrast between public perceptions of active meth users and those in recovery. Public participants consistently expressed respect for individuals who demonstrated courage and determination in overcoming addiction and were willing to offer second chances like employment. As Chapter Six will explore, while negative campaigning approaches have proven ineffective according to research literature, the compassionate attitudes expressed by public participants toward recovered users suggest that recovery narratives could be effective campaign elements. Personal recovery vignettes appear to generate both public optimism about rehabilitation possibilities and a generosity of spirit toward second chances (Anderson, 2010; Anderson & Elsea, 2015).

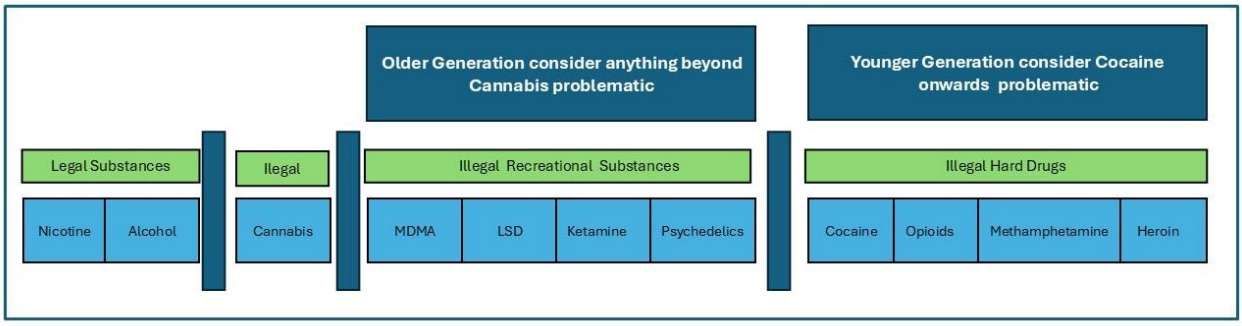
4.7 Theme 6: The Generation Gap

I was able to interview four young men aged twenty-five or younger. While they came from different cultural backgrounds and expressed varying degrees of liberal and conservative views, they showed remarkable consistency in their conceptualization of the drug spectrum. All younger generation participants clearly distinguished between recreational drugs and harder drugs.

Cannabis occupied its own distinct category across the population. Though technically illegal, it was seen as 'almost legal' and categorically separate from all other illegal substances. The under-25 public participants positioned MDMA, LSD, ketamine and psychedelics as recreational, 'party drugs', that they described as not highly addictive. However, they all drew a clear boundary with what they termed 'harder drugs', (cocaine, opioids, meth and heroin). Based on public participant comments, Figure 8 shows the older and younger generations' attitudes to the drug spectrum.

Figure 8

Older vs Younger Generations' Attitudes to the Drug Spectrum



Several of the public participants aged 25 and under acknowledged experimenting with cannabis, MDMA, LSD, ketamine and psychedelics, often preferring MDMA to alcohol at a rave. The advantages cited were dosage certainty, lack of hangover, and lack of weight gain.

> *"Off the top of my head, I can't name a single person that hasn't tried them (recreational drugs). If I'm honest, at least in my close circle. So, I guess people are more inclined to try it because it is normalized these days. But because they think it's something that's so normal, they might feel the need to try some just to fit in." (William)*

The participants shared less stigmatized views about drug use than older generation public participants.

> *“It is definitely divided. I think, generally, younger audiences don't have the same sort of negative feelings towards it, I think. I feel like the younger generation has a lot more empathy.” (Billie)*

> *“I think drugs, including meth have actually become more normalized these days, and I do hear about more and more people using it. So, I guess the stigma is already getting better. But that is only the younger generation.” (William)*

Recreational drug use was positioned as relatively acceptable, as it was occasional and (in their opinion) unlikely to be habit forming. This attitude did not extend to ‘harder drugs’ like meth:

> *“Yes, there is stigma more towards the harder drugs. Yeah, I wouldn’t say for the recreational ones. Yeah. Meth, I guess, is outside of the recreational… it's kind of the one that and me personally, one that I would never touch. One that I guess there's a stigma against it. It's, if you use this, once, your life is kind of over, you're going to be addicted to this for the rest of your life. That's just how it was portrayed to me growing up.” (William)*

> *“I have no personal experience of meth, but I think there's a reason why they started in the first place, and I think that was to chase something more than what the current recreational drugs can give you.” (William)*

> *“Yeah, I guess we'll find something that you believe you can't get hooked on. So, you do that frequently. Whereas meth, I think it's well known that it's very addictive.” (William)*

In my interview with Sarah Helm, CEO, NZDF, she explained that older generations like Gen X typically had experience limited to alcohol and cannabis. However, recent media reports have begun covering MDMA use amongst middle-aged couples and cocaine use amongst mothers (Brown, 2024, June 25; Gannon, 2024, July 1). With the title “The wines and lines mums” it’s clear that cocaine has gone mainstream when it’s being reported non-judgmentally in the Australian Women’s Weekly.

In summary, Theme Six demonstrates how, in line with social constructionism, attitudes towards drugs evolve over time, with distinct generational perspectives evident between

Generation X and Z participants. Whereas older public participants often articulated negative views about drug use overall, younger participants spoke more acceptingly of recreational drugs in particular.

4.8 Theme 7: Systemic Shortcomings in Treatment

Theme Seven addresses systemic issues identified by expert participants regarding the current health system: insufficient resources, limited treatment options for SUDs and healthcare worker stigma towards SUD patients.

4.8.1 More Resources

Public participants rarely identified available treatment options for MUD, likely because they were specifically recruited without personal or familial experience. One participant who had attempted to help a colleague noted the challenges:

> *"There's actually not much support in New Zealand for help. Unless you've got money. I've actually personally been through it trying to get a colleague into rehab. And unless you've got money, there's actually not much support." (Diana)*

This theme was overwhelmingly informed by expert participants, who indicated that the AOD sector is perceived as a subset of mental health which is a subset of health, which, in turn, is regarded as the poor cousin of the rest of government.

> *"And I guess addictions is, what do they say? That it's always been the poor cousin of mental health." (Shawnee Brausch, Research & Communications Analyst, Whare Tukutuku, Te Rau Ora)*

> *"Health is always the poor cousin of what's happening elsewhere in government. And then mental health is the poor cousin of physical health, and then addictions is a poor cousin of mental health." (Brendan Short, General Manager, Health Services, Auckland City Mission)*

Similar to observations made by Dr Volkow (Chapter Two) regarding the US addiction treatment system being separate from 'mainstream' health care, the position of the ANZ AOD sector suggests structural stigma in both perception and funding (Adams & Volkow, 2020; Atkins et al., 2020). Some expert participants recommended creating a separate department for addiction services to bring the sector 'into the light' as a first step toward destigmatisation.

In summary, this sub-theme speaks to the lack of resources and systemic stigma facing the addiction services sector.

4.8.2. “Abstinence is not the only goal”

Along with 100% abstinence-based, 12-step programmes, other treatment approaches exist for MUD. These include contingency management and agonist-based treatments, though both have limitations and are under-researched (Farrugia et al., 2021; Yasbek et al., 2022). Kaupapa Māori services often utilise Durie’s (1997) ‘Te Whare Tapa Wha’ model, addressing physical, spiritual, family and mental/emotional health through marae based, cultural activities involving whānau. Whilst under-researched there is growing evidence that Kaupapa Māori approaches can offer an effective role in reducing meth use (Rolleston et al., 2020).

Recent studies suggest that individuals who describe themselves as ‘recovered’ (as with therapeutic community therapies) rather than ‘in recovery’ (12 Step programmes) report better psychological health, lower identification with addicts and stronger support networks (Best et al., 2017, p. 2; De Leon, 2000). This aligns with the ‘CHIME’ mental health recovery model which asserts that Connections is one of five core recovery support components, as well as Hope, Identity, Meaning and Empowerment (Leamy et al., 2011).

Expert participants acknowledged the value of existing abstinence-based programmes in ANZ, noting that they offer an effective approach for certain clients. However, they advocated more diverse treatment options, especially in the harm reduction space, as not every person might be ready to commit to an abstinence-based programme.

> *“But I also think we have one path in New Zealand around substance use, which is funded, which is abstinence, and whilst that might be the thing that works for some people, it's not the thing that works for everybody. And we don't have, for example, ongoing care and support in the community that is funded for people that are still actively using - the impact that has on their life - in the same way that we might, for example, around mental health. So, if you have severe and enduring mental health issues, you may be assessed and you may get some support to sit alongside you. We don't have that in the addictions space. So, your options really are to go to a group at CADS and then maybe go to detox. And so, I think we need to have some more interventions that support people where they are at and a lot of that is around harm reduction. Right? It's around recognising that what I may choose for somebody is not what they are choosing for themselves. And so how do we keep them as well as*

possible in that time?" (Brendan Short, General Manager, Health Services, Auckland City Mission)

"Because harm reduction, for me, is also very much linked to the drug use movement, which is about respect for people, drug users who continue to use drugs, not abstinence." (Rhonda Robertson, Long Time Lived Experience Champion)

Several expert participants highlighted that a person with problematic use might not wish to/be able to commit to 100% abstinence for the rest of their lives, and worried about potential judgment if abstinence could not be maintained. And if a person who had recovered from MUD, then elected to drink the odd beer or smoke cannabis every weekend to relax, could that not be seen as a win in recovery terms? This is an example of discourse which positions recovery as a binary mindset of right/wrong, either/or, weak/strong, clean/dirty, legal/illegal, law-abiding/moral failure. Trish Dribnenki-Pennock explained how she'd once spoken to a group of people working in the abstinence space:

"Yeah, I said to them, isn't it great that no one policed how and when you used your coffee today. Like I was, like, fuck you, you tell everyone how they can use and how they can't use and you judge them and punish and coerce and oppress them if they slip, which is also part of recovery." (Trish Dribnenki-Pennock, National Harm Reduction and Hep C Lead, NZ Needle Exchange Programme)

Here Trish refers to the fact that tea and coffee are also drugs, though not illegal, and that if abstinence were exclusively pursued these attendees might also have 'failed' this particular binary.

Several experts noted that most methamphetamine use (89%) is non-problematic (Yasbek et al., 2022), suggesting more harm reduction approaches might prevent progression to problematic use.

"So, with non-problematic use, I think as long as we're able to have safe drug supply, good advice around quantity, and for a person to have somebody in their lives that they can talk to about it. Because people who have problematic use probably didn't start with problematic use. That's the thing I don't think we pay enough attention to." (Sarah Helm, CEO, New Zealand Drug Foundation)

Additionally, several experts interviewed identified a significant population using methamphetamine to self-medicate ADHD. A 2024 study suggests that whilst the estimate of

ADHD prevalence in the ANZ population is 2.6%, only 0.6% are receiving dispensed medication, indicating a treatment gap (Beaglehole et al., 2024). NZDF's ANZ analysis of 2006 data estimated the lifetime prevalence of SUD across the neurodiverse population at 12.3% (New Zealand Drug Foundation., 2024). As of December 2024, Pharmac has begun funding lisdexamfetamine, a slow-release stimulant for ADHD patients (Davison, 2024, 30 September).

> "I think the goal can't just be to eradicate meth. I think that's quite unrealistic. So, if the goal, however, is to reduce use and reduce problematic use, we've identified a population with ADHD, where an alternate treatment for ADHD, you know, diagnosis and treatment would very likely reduce, if not shift them off methamphetamine, then, to me, it's a no brainer. Well, it's one of the few things I've seen in my time that I think is a relatively sizable part of our drug-using population. I mean, it's almost half of people that use illicit stimulants." *(Sarah Helm, CEO, New Zealand Drug Foundation)*

In summary, with this sub-theme, expert participants are highlighting that drug-use harms exist on a continuum, based on the extent of use. As a result, no single approach can address the resultant problems and thus a range of strategies/treatment options is needed.

4.8.3. Associative stigma from healthcare workers

As discussed in Chapter Two, healthcare workers have been found to hold some of the most stigmatizing attitudes towards people with SUDs (Haug et al., 2016; Kiriazova et al., 2017; Pescosolido & Martin, 2015). Numerous expert participants raised this:

> *"But folks that work in mental health and substance use actually tend to have the highest rates of stigma, or stigmatizing ideation towards PWUD than any other profession." (Trish Dribnenki-Pennock, National Harm Reduction and Hep C Lead, NZ Needle Exchange Programme)*

This is turn explains the operation of self-stigma in the face of such structural stigma:

> *"So, whether or not someone chooses to take on shame associated with a certain behavior is difficult if they're being greeted with discriminating behavior at an organizational and a societal level that helps confirm the messaging." (Emma Schwarcz, Clinical Director, CADS Tāmaki Makaurau, Waitemata DHB)*

Previous negative experiences may cause healthcare workers to view PWUD as aggressive or manipulative, resulting in deprioritized or denied healthcare (Livingston, 2021; Lloyd, 2010,

p.8). It is logical that without *effective* training, healthcare workers would exhibit the same prejudicial attitudes seen in the public arena with public stigma, as they too are influenced by societal values and culture (Farrugia et al., 2021).

> *"Meth is identified by the public scrutiny as the worst of the worst. It translates into healthcare service provision as 'therapeutic nihilism' – a sense of helplessness and powerlessness. So, it's much more palatable, to think that it must be your problem if I can't help you." (Emma Schwarcz, Clinical Director, CADS Tāmaki Makaurau, Waitemata DHB)*

> *There's a big push for equity now. Equity of access, equity of experience, equity of treatment and equity of outcome. And I think stigma could certainly affect all of those predominantly, and most importantly, the equity of access. (Emma Schwarcz, Clinical Director, CADS Tāmaki Makaurau, Waitemata DHB)*

Clearly this is an important area to address, as equity of access is a critical structural barrier to treatment seeking. Healthcare organizations could implement assessment tools to benchmark progress in reducing internal stigma through awareness-raising and staff training.

In summary, Theme Seven highlights some key areas for improvement within the AOD sector: increasing resources, diversifying treatment options, and addressing stigma among healthcare workers.

This chapter presented the findings from all interviews and focus groups with both public and expert participants. Next, Chapter Five analyses some best practice campaigns from around the world, to identify core principles to guide any future destigmatisation campaign for meth users.

CHAPTER FIVE: CAMPAIGN ANALYSES

5.1 Best Practice Campaigns: Insights into a Methamphetamine User Campaign

As part of the dissemination of this project I have offered to write a destigmatisation campaign brief for meth users for NZDF. To inform this work, I examined other destigmatisation campaigns from around the world to identify effective approaches and lessons learned. My investigation included a review of general campaign literature (e.g., Kunze, 2024; Lloyd, 2010; Walsh & Foster, 2021; Watson & Corrigan, 2005). I also questioned expert participants about effective campaigns, although they identified very few. I subsequently identified campaigns that were relevant to meth use or drug stigma. While I identified various exemplary campaigns, closer assessment was sometimes hampered by the lack of efficacy analyses. If little evaluation was available, I further selected, drawing on my 30 years of experience as a professional marketer, campaigns that demonstrated useful aspects. For example, the merits of effective straplines, the pitfalls of negative campaigning, the effectiveness of political lobbying, an effective training programme, the benefits of annual campaigns, or the best practice example of ANZ's comprehensive Like Minds, Like Mine campaign (see Section 5.2 below).

5.1.1 The Destigmatization Process and Campaign Phases

The destigmatization of methamphetamine users requires a multi-phase approach that considers public attitudes, institutional policies, and the lived experiences of PWUD (Kotler, 2003; Kotler et al., 2016). The process typically unfolds through the following phases:

1. **Raising Awareness** – Addressing misconceptions/biases through mass media and educational initiatives.
2. **Building Empathy** – Humanizing PWUD by sharing personal stories and shifting focus from criminalization to public health.
3. **Structural Change** – Advocating for policy reforms and inclusive service provision.
4. **Sustained Engagement** – Ensuring long-term attitudinal/behavioural shifts through continuous reinforcement in media, education, and policy.

Structural change, particularly decriminalization, represents the most pivotal aspect of destigmatization. However, such reforms require both public and political will, built through community-engagement, awareness-raising, and empathy-building, to influence the public and thence policymakers. Without these foundational steps, structural change faces

significant resistance. Campaigns may target any phase, depending on their objectives. An early-stage campaign might focus on challenging stereotypes, whereas later campaigns might advocate policy changes such as decriminalization or improved treatment access.

5.1.2 Essential Elements of a Destigmatization Campaign

Campaign success depends on alignment with the targeted destigmatization phase (Binet & Field, 2007, 2009; Rossiter & Bellman, 2005) Key elements include:

- **Targeted Messaging:** Using "person-first" language like "a person with a substance use disorder" rather than "addict" avoids stereotyping.
- **Community Involvement:** Engaging PWUD in campaign development to ensure authenticity/relevance.
- **Multi-Platform Approach:** Leveraging social media, print, radio, television, and community-based initiatives.
- **Strategic Partnerships:** Collaborating with health organizations, advocacy groups, and policymakers.
- **Evaluation Metrics:** Setting clear success indicators, such as shifts in public perception and increased treatment-seeking behaviour.

5.2 Analysis of Best Practice Campaigns

Below is an analysis of selected campaigns as outlined under 5.1 and their relevance to methamphetamine user destigmatisation (refer Table 4). For each campaign the phase it addresses and its contribution/relevance to this overview is outlined in the summary boxes that follow.

Table 4

Selected Destigmatisation Campaigns by Country

Destigmatisation Campaign	Country
Montana Meth Project	USA
Meth. We're on it.	USA
Nice People Use Drugs	UK
Just Say Know	USA
Stop The Stigma	Ireland
50 Years of the Misuse of Drugs Act	UK
Annual Recovery Month	USA
Like minds, Like Mine	ANZ

5.2.1 Negative Campaigning: Montana Meth Project – USA

	Montana Meth Project (USA) Negative Campaigning
Phase:	Raising Awareness
Strengths:	High visibility, strong funding, and widespread exposure
Weaknesses:	Overly stigmatizing portrayals, limited behavioural impact, and failure to resonate with PWUD.
Relevance:	Highlights the risks of negative campaigns that may reinforce stigma rather than reduce use.

The Montana Meth Project (MMP) was founded in 2005 by billionaire, Thomas Siebel, to reduce methamphetamine use, especially amongst teenagers. The campaign employed graphic public service announcements across television, print, radio and internet, depicting the deleterious consequences of methamphetamine use. Messaging included the deterioration of health, living conditions, moral compromise, regret and danger. One innovative tactic was a ‘Paint the State” public art competition, using the campaign tagline: ’Meth. Not even once.’

Well-funded and high profile, with teenagers exposed to ads three-five times per week, the campaign initially claimed significant success, acquired state funding and was rolled out to seven other states. Proponents reported a 45% reduction in teen meth (2005 to 2007), whilst national rates remained constant (Siebel & Mange, 2009). However, subsequent independent analyses revealed some results had been selectively reported and others ignored (Erceg-Hurn, 2008). Utilising data from the Youth Risk Behaviour Surveys and after accounting for a pre-existing downward trend in meth use, Anderson (2010) found the campaign’s effect on meth use was “statistically indistinguishable from zero” (Anderson, 2010, p.1). A later study reconfirmed this, though noting possible decreases amongst white, high-school students (Anderson et al., 2015).

The question remains whether stigmatization might prevent or escalate drug use. While negative campaigning has proven effective for behaviours like seatbelt use or stopping smoking (Bayer, 2008), and Satel (2007) argues stigma can motivate treatment-seeking, the literature generally cautions against this approach for SUDs (Lloyd, 2010). UK research demonstrates that anti-drug campaigns have often "added to isolation and marginalisation" (Buchanan & Young, 2000, p.8). Critically, a study of PWUD in Montana found they did not recognize themselves in the campaign's portrayal, believing they had ‘more control’ than depicted and consequently saw no reason to change their behaviour (Marsh et al., 2017). This suggests that overtly stigmatizing user portrayals may act as a barrier to desistence (Marsh et al., 2017).

5.2.2 Effective Campaign Straplines

5.2.2.1 Meth. We're On It.

	Meth. We're On It. (USA)
Phase:	Raising Awareness
Strengths:	Generated significant public attention.
Weaknesses:	Confusing messaging that led to ridicule rather than engagement.
Relevance:	Illustrates the need for clear and unambiguous messaging.

In November 2019, the state of South Dakota's Department of Social Services reported the number of 12–17-year-olds admitting meth use in the previous year was twice the national average (South Dakota Department of Social Services, n.d.). To tackle this issue, South Dakota launched a $1.4 million campaign, utilizing television, billboards, radio and social media, featuring the strapline "Meth. I'm on it." over images of citizens on a football field, in a cafe or wearing cowboy hats. Unfortunately, its double entendre headline was widely mocked on television news reports and social media (Keelson, 2019, November 19). Notwithstanding it generated awareness, the confusing strapline definitely missed the mark and appears to have been quietly changed to "Meth can affect anyone, so it's time to help everyone."

5.2.2.2 Nice People Use Drugs

	Nice People Use Drugs (UK)
Phase:	Building Empathy
Strengths:	Provocative, encouraged public debate, challenged stereotypes.
Weaknesses:	Faced censorship and resistance from regulatory bodies.
Relevance:	Demonstrates the power of reframing drug use through non-judgmental narratives.

Release, a UK NGO with UN Economic and Social Council Special Consultative Status, launched the "Nice People Take Drugs" campaign in 2009. This provocative headline aimed to challenge public perceptions of drug users and stimulate drug reform debate (Rubin, 2009). Despite initial positive global reception, bus advertisements were subsequently removed by the company who booked the ads, after the Committee of Advertising Practice suggested adding the word 'too' (Crisp, 2009, June 16). Release decried the unnecessary censorship. This campaign is included because its tagline still lives on, certainly stimulates debate, and merchandise is sold internationally to this day, available on multiple websites including Amazon.com. (I obtained one at the Needle Exchange on Karangahape Rd.)

5.2.2.3 Just Say Know

	Just Say Know (USA)
Phase:	Building Empathy
Strengths:	Peer-led approach, education-focused, engaging youth.
Weaknesses:	Limited large-scale evaluation data.
Relevance:	A useful model for harm reduction education and peer involvement.

'Just Say Know' represents a strategic initiative by Students for Sensible Drug Policies, a student-led organization promoting harm reduction (Vensel, 2025, January 7). This programme certifies young people as peer educators to deliver drug education workshops in schools and universities. The slogan's subversive play on Nancy Reagan's original 'Just Say No' campaign offers potential applications for drug checking services at music festivals and universities (Lilienfeld & Arkowitz, 2014, Jan 1). Currently implemented in both the USA and Nigeria, this approach, whilst still under evaluation, exemplifies youth engagement in educational campaigns (International Drug Policy Consortium, 2018, p.46).

5.2.3 National Recovery Month

	Recovery Month (USA)
Phase:	Sustained Engagement
Strengths:	Long-term visibility, policy and community support, evolving messaging.
Weaknesses:	Primarily focuses on ex-users, less engagement with current users.
Relevance:	Offers a model for long-term cultural change around drug use and recovery.

The annual Recovery Month initiative, supported by SAMHSA since 1989, occurs every September across the USA. This program champions evidence-based treatments, celebrates the recovery community, and recognizes service providers and communities supporting diverse recovery paths (Lavack, 2007). Community outreach is facilitated through dedicated toolkits, while purple branding enhances awareness and recognition. This strategic approach creates a recurring platform for introducing new messaging annually, highlighting the comparative ease of destigmatizing former substance users versus current users (Lloyd, 2010).

5.2.4 Stop The Stigma Campaign

	Stop The Stigma Campaign (Ireland)
Phase:	Structural Change
Strengths:	Multi-faceted approach addressing language, service delivery, and policy.
Weaknesses:	Lacks comprehensive impact assessment.
Relevance:	Provides a framework for addressing systemic discrimination against PWUD.

Citywide Drugs Crisis Campaign launched the Stop The Stigma campaign in Ireland (February 2018) to address drug-related stigma and its impact on PWUD (Citywide., 2018, February). It concentrated on five key messages:

- Changing stigmatizing language
- Challenging stigma in service delivery
- Strengthening community drug programs
- Promoting understanding of addiction complexity
- Ending the criminalization of PWUD

Whilst comprehensive campaign impact assessments appear unavailable, the initiative developed a training programme for staff in relevant public service departments (Barron et al., 2019). Importantly it involved people with lived experience of drug use in its co-design, with plans for their involvement in eventual implementation. The initial pilot evaluations have been positive and may provide learnings for other organisations (Comiskey et al., 2021).

5.2.5 50 Years of the Misuse of Drugs Act (UK)

	50 Years of the Misuse of Drugs Act (UK) #50YearsOfFailure #50Voices
Phase:	Structural Change
Strengths:	Highlights that the Act has not reduced use, nor harm, nor has it made communities safer.
Weaknesses:	Political support is difficult to achieve as drug use is considered a minority issue.
Relevance:	Lobbies politicians, engenders cross-party support and raises awareness with the public. Coincided with the 50th anniversary of The Misuse of Drugs Act.

The UK launched a '50 Voices' campaign in 2021 marking the 50th anniversary of its MoDA (Transform Drug Policy Foundation., 2021, May 24). The initiative first secured public commitments from 50 MPs and Peers who signed up to a statement acknowledging the Act is unfit for purpose, has not reduced consumption, has increased harm, and worsened social inequalities. Currently, 65 politicians are featured on the campaign website, with citizens encouraged to lobby their local MPs. The campaign also produced 50 video testimonials from diverse stakeholders, including affected families, activists, politicians and police officers, presenting 50 reasons for UK drug law reform (Transform Drug Policy Foundation., Retrieved 6 February 2025). With limited budgets, Transform's CEO, Jane Slater, advised they relied

on PR/social media, and cited the sign-up of more than 50 politicians as a critical success factor.

5.2.6 Like Minds, Like Mine – ANZ

	Like Minds, Like Mine (ANZ)
Phase:	Comprehensive Approach (Awareness to Engagement)
Strengths:	Community-driven, culturally tailored, sustained over decades.
Weaknesses:	High resource investment required.
Relevance:	Demonstrates the effectiveness of sustained, evolving campaigns that include lived-experience voices.

This campaign addressed stigma and discrimination against people with mental illness, stemming from the Mason Inquiry findings, with funding assigned in 1997 (Mason et al., 1996). Launched in 2000, it employed television, radio, and cinema for awareness, supported by PR and community education (Vaughan & Hansen, 2004). Specialized print and radio campaigns targeted Māori and Pacific Peoples audiences, and the campaign also utilised celebrities with lived experience like ex-All Black John Kirwan (Cunningham et al., 2017).

The campaign has completed five phases with exemplary results, establishing itself as a gold standard for anti-stigma initiatives. Telephone surveys and in-depth studies demonstrate increased positive attitudes/acceptance and reduced negative perceptions (Wyllie & Lauder, 2012). From 2000 to 2012, discomfort with talking to someone with mental illness decreased (61% to 78% disagreement), shame about personal mental illness declined (30% to 44% disagreement), and willingness to support those experiencing mental illness increased (32% to 49%) (Thornicroft et al., 2014; Wyllie & Lauder, 2012). A 2010 cost-benefit analysis commissioned by the Ministry of Health revealed that the $52 million investment had generated $720 million in economic benefits (Vaithianathan & Pram, 2010).

Key success factors included prioritizing people with lived experience in design and delivery and ensuring cultural appropriateness for Māori and Pacific Peoples (Crocket et al., 2020). The campaign collaborated with media to improve mental illness reporting through resources like a Media Handbook and the video ‘*Working with Mental Health Stories’* (Cunningham et al., 2017). The campaign's longevity has allowed messaging to evolve, effectively addressing different aspects of stigma in each phase.

- Phases One and Two: ”Are you prepared to judge? You can make a difference.” Featured celebrities like John Kirwan to build awareness and challenge perceptions.

- Phase Three: “Know me before you judge me” – highlighted ordinary people with conditions like bipolar and schizophrenia, emphasising “They can live great lives. With understanding they can do even more.”
- Phase Four: “Discrimination is still the biggest barrier to recovery for people with mental illness: What you do makes a difference”. This shifted the focus to discrimination. Advertisements focused on an individual with lived experience, his wife, friends and employer.
- Phase Five: “Be there. Stay involved.” Prominently featured Māori and Pacific Peoples’ stories while encouraged extended family/friends to provide support networks (Cunningham et al., 2017).

After 25 years as “Like Minds, Like Mine” the campaign has evolved into “Nōku te Ao Like Minds”, embedding kaupapa Māori principles into its latest phase (Nōku te Ao Like Minds., 2021).

5.3 Recommended Campaign Elements

In an ANZ study, sharing recovery stories from MUD was rated the most appealing campaign approach, with 74% of respondents considering it most effective (Ministry of Health et al., 2009). My research suggests effective concepts include: the opposite of addiction is connection, and the opposite of stigma is autonomy, mana and lack of judgment. Another promising concept: Recovery. No one does it on their own.

Celebrity involvement can be highly effective (Lloyd, 2010; Lundahl, 2020). Stephen Fry’s documentaries have raised bipolar disorder awareness while Princess Diana transformed HIV perceptions overnight by shaking hands with patients (BBC, 2006; Cope, 2024, June 4). Recently, ex-Warrior Matthew Ridge spoke of his methamphetamine experiences (New Zealand Herald., 2024, November 3). Of course, this strategy faces challenges in contexts where drug use is criminalized.

Based on evaluative research, key components for an effective multimedia destigmatisation campaign addressing methamphetamine use should include:

- Fully integrated multi-media campaign
    - Television / print / radio / cross-platform social media / PR / dedicated website
- Messaging:
    - Provide engaging, effective strapline
    - Share optimistic recovery narratives

    - Address misinformation (myth-busting)
- Targets a particular week or month annually
    - Allows for the messaging to evolve annually
    - Allows for tracking of public sentiment post campaign each year
- Recognisable logo and colour scheme to build awareness/recognition year on year
- Strategic celebrity involvement
- Community outreach toolkits to extend the campaign/ensure maximum inclusion
- Media strategy to improve meth reporting practices through:
    - Media Handbook with best practice language guidelines
    - Media awards for best destigmatizing journalism
    - Video resources specifically for media
- Arts events and community radio shows
- Strategic partnerships with policymakers, NGOs, health organisations
- Clear evaluation metrics tracking perception shifts, increased treatment-seeking behaviour and policy changes.

In the next chapter, the key findings from Chapters Four and Five are summarised, followed by strategic recommendations as to how we might destigmatise PWUM. This study's limitations are considered alongside recommendations for future studies.

CHAPTER SIX: DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS

When embarking on this project I anticipated focusing on how a destigmatisation campaign might reduce stigma towards meth users in ANZ. However, with my research, interviews and analysis, I became sensitised to the criminal justice system ‘s profound role in establishing, maintaining and intensifying stigma and its societal consequences. Reframing meth use as a health issue rather than a criminal justice matter is critical. Decriminalising personal possession/use would significantly reduce structural stigma, with cascading effects on public, associative and self-stigma. I propose a strategy which includes *both* a destigmatisation campaign and the concurrent decriminalisation of meth use to effectively reframe this issue.

This chapter begins with a brief summary of the findings. The key ideas which have emerged are then considered in relation to literature and stigma theories. My strategic recommendations for how we might destigmatize methamphetamine users then follow. Lastly, the limitations of this study are considered alongside recommendations for future studies.

6.1 Summary of Findings

This research project reveals several core issues underlying the stigmatisation of problematic methamphetamine users. Themes One-Four represent the public participants’ perceptions that would need to be addressed in any destigmatisation strategy. Theme One articulated public participants’ fear, disgust and desire for social distance when encountering people with problematic meth use. Theme Two highlights the dichotomy in public participants’ views as to whether addiction represents a moral failing (where individuals made poor choices and bear full responsibility), versus addiction as a brain disease (which removes responsibility but questions recovery potential). As Chapter Four argues, this is better conceptualized as a continuum, from choice in early stages to a physiological condition where addiction eventually subsumes control (Haslam & Kvaale, 2015; Henderson & Dressler, 2020).

Theme Three addresses issues related to methamphetamine’s illegality. Firstly, the *consequences of illegality* are myriad and severe. Expert participants highlighted that PWUD fears contact with authorities due to potential criminal convictions, imprisonment and subsequent loss of employment, housing and custody of children. The barrier to seeking treatment is thus very high, as they cannot afford to be flagged as a ‘drug-seeker’ under any circumstances. Secondly, the methamphetamine market in ANZ is largely (though not exclusively) *controlled by gangs,* with users often becoming sellers (Walton & Martin, 2021). The underground nature of the market heightens fears of violence and lack of quality

assurance. The third sub-theme highlighted that public participants largely spoke of methamphetamine use as a health rather than a criminal justice issue. Finally, some public participants raised the sub-theme of the *War on Drugs* as a failed strategy, a view strongly endorsed by all experts. Despite massive worldwide governmental efforts targeting manufacturers, traffickers and consumers, drug production and consumption continue unabated (Global Commission on Drug Policy, 2011; International Drug Policy Consortium, 2018).

These four sub-themes are very much intertwined. As expert interviewees explained, prohibition of meth has allowed criminal organisations to flourish through black market operations. Lack of regulation precludes quality control, and illegality increases the risk of violence. The 'war on drugs' has served to exacerbate structural inequities, perpetuating stigma and inequality cycles. Treating meth use as a criminal rather than a health issue dramatically reduces life chances for marginalized individuals, who are then more likely to receive a criminal conviction than medical treatment. With Theme Four both public and expert participants position meth as the lowest in the drug brand hierarchy and identify perceived causes of use, including social determinants like educational deficits, poverty, colonialism and their intersectionality.

Theme Five addresses matters linked to recovery, offering optimism for any future destigmatisation campaign. Research highlights that negative campaigning is ineffective, while public participants demonstrated compassion toward recovered users. Recovery vignettes engendered both optimism about recovery possibilities and support for second chances (Anderson, 2010; Anderson & Elsea, 2015). Theme Six highlights how, consistent with social constructionism, attitudes towards drugs evolve over time, with generational differences between the public participants representing Generations Z and X. Whereas older public participants expressed more negative views about drug use overall, younger public participants spoke more acceptingly about drug use generally and recreational drugs specifically. Finally, Theme Seven identified areas for improvement within the AOD sector including an increase in resources and treatment offerings and the reduction in treatment-seeking barriers by addressing potential associative stigma from healthcare workers.

6.1.1 Media and the Fear of Drugs

One key question appears to be why our society, as represented by public participants, fears drugs disproportionately to their potential harm. Here the media plays a significant role. The process the media engages in applies not just to drugs but to issues like immigration, murder and pedophilia to name a few. The formula is clear – media identify perceived personal

danger to readers alongside ‘foreign’ others or ‘foreign’ substances, creating a classic: “danger and stranger” narrative (Lloyd, 2010, p.52). PWUD are portrayed as outsiders, separated from society by their need for drugs. They are considered a danger to loved ones, not only through acquisitive crime, but also perhaps, because of the potential for one’s child to become “lost to addiction, to become one of ‘them’ “ (Lloyd, 2010, p.52). In a sensationalist media such framings of drug users as dangerous, obscure and marginalize a fuller appreciation of PWUD.

In at least half the interviews I conducted with the public, participants mentioned Antoine Dixon’s “meth-fueled rampage” (Collins, 2023, p.46). Though this occurred over 20 years ago its continued reference demonstrates how media and thence public discourse continue to link methamphetamine to unthinkable violence (Collins, 2023). ANZ media headlines have included: ”Meth plague at record levels”, “Bishop calls for action over evil drug” and “P-addict jailed for violent attack” to name a few (Carton, 2016; Collins, 2023). The concept that news media influences public opinion is termed ‘agenda setting’ (Lippmann, 1922). Agenda -setting theory was later formalized by McCombs and Shaw (1972) in their analysis of 1968 presidential election coverage (McCombs & Shaw, 1972). Agenda-setting theory holds that media coverage volume heavily influences public perceptions of an issue’s importance (Wanta & Alkazemi, 2017). Furthermore, media can influence not just *what* the public thinks about, but also *how* they think about it (Wanta & Alkazemi, 2017). The public participants interviewed had no personal experience of drug use, making media a significant factor in shaping their views. The headlines cited above vilifying drug users demonstrate the way in which the media can influence public discourse and set agendas.

Such media language intertwines with judgmental morality regarding drug use and the failed War on Drugs. Indications are that if methamphetamine use were decriminalised, this rhetoric would abate, as has occurred with numerous other examples throughout the past century (Collins, 2023).

6.1.2 Language

The language used to label PWUD exerts significant influence on people experiencing problematic use and shapes perceptions among the public, policymakers and healthcare workers. As Link and Phelan (2001) established, labelling’ constitutes the first step in the stigmatization process. Numerous studies demonstrate how stigmatizing language facilitates discrimination among healthcare workers/the public (Kelly et al., 2021, 2024; Kelly & Westerhoff, 2010; White & Kelly, 2011). Language can be used either to promote or lessen stigma (Zwick et al., 2020).

Words matter. Language does not merely describe reality, it constructs it, a core notion of social constructionism. Replacing terminology that implies choice and control with more medicalized terms is thought to lessen stigma (Kelly et al., 2016). Consequently, terms like ‘abuse’ and ‘abuser’ are replaced by ‘misuse’, whilst ‘dirty and clean’ toxicology results become ‘positive and negative’. Kelly et al (2016) argue for consensus on an “addiction-ary” (Kelly et al., 2016, p.122). Yet over time further language changes will emerge as society reproduces language to reflect the latest views (Botticelli & Koh, 2016; Forrest-Lawrence, 2016; Nairn et al., 2006).

6.1.3 The Blame Game

Public participants often portrayed PWUD as experiencing a failure of willpower and personal responsibility – individuals who made bad choices. This construction locates responsibility entirely with the individual, erasing social context and determinants. Blame is assigned to preserve a sense of justice, to distance oneself from experiencing a similar situation and to preserve the current social order. Since drug use was their ‘own fault’ it follows they have ‘only themselves to blame’, thus conflating drug use behaviour with the individual’s identity (Link & Phelan, 2001).

Lloyd (2010) identifies blame as a ‘unifying factor’ in the stigmatization occurring in the media and in interactions between problematic drug users and both healthcare professionals/the public (Lloyd, 2010, p.55). This notion of blame comprises two components. First, PWUD initially chose illegal drugs, leading to their predicament. Secondly, the public perceives PWUD as engaging in ongoing voluntary behaviours to *continue* taking drugs – obtaining money, buying drugs and taking them (Lloyd, 2010). Constructing drug use as a moral issue serves the public by perpetuating the normative preferences of dominant societal members and their ‘moral purity’ (Stevens & Zampini, 2018). This respect for authority coincides neatly with existing power structures, reinforcing the status quo by explaining why ‘they’ are in this state and ‘we’ are not, and sustaining continued belief in a ‘just world’ where people ‘get what they deserve’ (Lloyd, 2010, p.56). This is a key issue to be addressed within any destigmatisation campaign.

6.1.4 The Medical Frame

In recent decades, arguments have been advanced that addiction should be framed as a brain disease requiring treatment rather than as a moral failing deserving punishment through the criminal justice system (Volkow, 2005; Volkow & Li, 2005). Whilst this attempts to replace a more severe stigmatization (criminalization) with a less severe one

(pathologization), it overlooks how many illnesses have been stigmatized historically, even when etiology precludes personal responsibility. Hansen disease (leprosy), for example, has been so stigmatized that ‘leper’ became synonymous with “outcast”. Moreover, as my findings and the literature indicate, the public is capable of entertaining both moral and medical views simultaneously (Room, 2005; Wetherell & Potter, 1992). Nevertheless, the medical model likely remains preferable to a criminal paradigm, as greater criminalization of a behaviour corresponds with increased stigmatization (Lloyd, 2010). Criminalization amplifies stigma. When substance use is framed as a legal violation rather than a health issue, it casts individuals as criminals deserving of punishment rather than healthcare.

6.1.5 Social Inequity

Whilst PWUD span the full societal spectrum, public participants typically portrayed PWUD as hailing from lower socioeconomic and marginalized groups. Whilst cocaine may be perceived as glamourous and enjoyed by white-collar professionals, methamphetamine is seen as a ‘lower-class’ substance – ‘bottom-rung’ as public participants described it. This drug hierarchy transfers to users; public participants characterized meth users in moralistic and classist terms as likely socially deprived.

The UNODC (2020) reports that whilst people in higher socioeconomic groups have a greater likelihood of initiating drug use than those in lower socioeconomic groups, those in lower socioeconomic groups more frequently progress from drug use to drug use disorders (United Nations Office on Drugs and Crime., 2020). Populations facing socioeconomic disadvantages (poverty, educational deficits, limited employment opportunities), are particularly vulnerable to drug use disorders and mental health issues (United Nations Office on Drugs and Crime., 2020). Intersectionality compounds disadvantages for already marginalised groups regarding healthcare access (Crenshaw, 1991). The Te Ara Oranga evaluation reveals that poorer rural communities like Northland, with proportionately higher Māori populations, experience both economic deprivation and above-average methamphetamine use (Walton & Martin, 2021). Such examples demonstrate how power asymmetries and unequal access to wealth and support reproduce structural disadvantage through policies reflecting the material interests and normative beliefs of the socially advantaged (Stevens & Zampini, 2018).

6.1.6 The Criminal Frame

Criminalization amplifies stigma. Framing substance use as a legal violation rather than a health issue portrays individuals as criminals deserving punishment rather than care.

Criminalisation represents the predominant issue causing the stigmatization of methamphetamine users. All expert participants emphasized it as the "most substantial barrier to treatment for users, as they fear any contact with government officials as a result of criminalization" (Greenwald, 2009, p.9). This prevents them from accessing treatment. Furthermore, young people receiving criminal convictions for methamphetamine possession or personal use face severely limited life chances and may struggle to find employment thereafter. As the former UN Secretary General, Kofi Annan, put it: "A criminal record for a young person for a minor drug offence can be a far greater threat to their well-being than occasional drug use" (International Drug Policy Consortium, 2018, p.49). The burdens of criminalization (arrests, fines, prison terms, criminal records) disproportionately affect young people or disadvantaged minorities (Stevens, 2010).

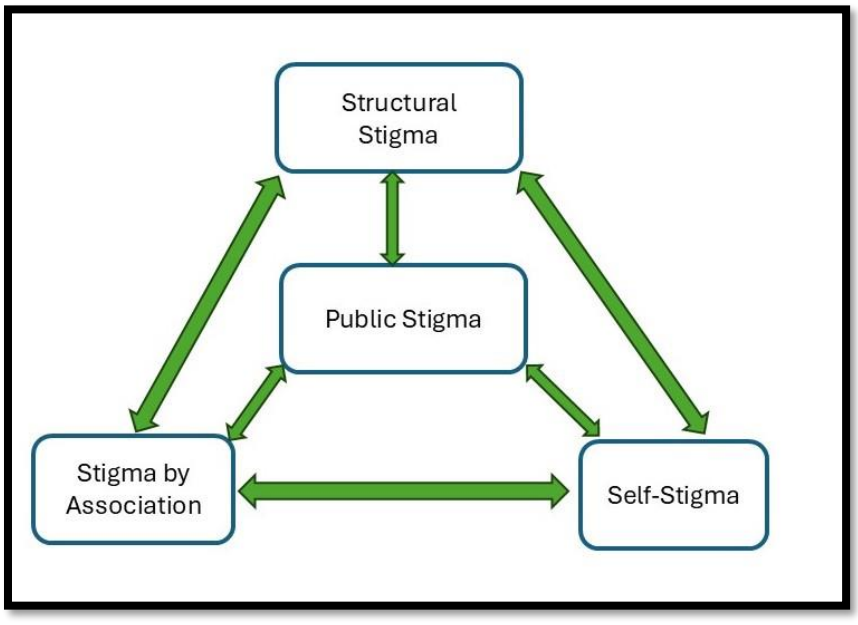
We must eliminate the criminalization and structural stigmatization of PWUD but who do no harm to others. Te Ara Oranga represents one effective avenue. In Northland the community, iwi and local government agencies recognized they could neither arrest, nor treat, their way out of methamphetamine-related harm and developed a Kaupapa Māori solution. My description of 'decriminalisation by stealth' may seem flippant, but represents one solid avenue to removing criminalization, the most significant structural stigma by far.

6.2 The Influence of Structural Stigma on Public, Associative and Self-Stigma

Pryor and Reeder's (2011) conceptual model places public stigma at the centre, suggesting that public stigma is foundational to all other types of stigmas (refer Figure 9).

Figure 9

Pryor and Reeder (2011) Model.



Note: (Pryor & Reeder, 2011). Adapted from original diagram.

Following my analysis of the various transcripts, it became clear that structural stigma is the type of stigma which has the biggest impact on PWUM. As the expert interviewees made clear, criminal convictions from meth use materially impact life chances, limiting employment, housing options and travel. The structural stigma arising from this punitive legislative framework produces effects far greater than public disapproval. I propose modifying Pryor and Reeder's (2011) model to position structural stigma, rather than public stigma, at the diagram's centre.

Methamphetamine's illegal status and the resulting negative effects of criminalization constitute the largest barrier to treatment for users. The impact of the Misuse of Drugs Act 1975 in criminalizing methamphetamine users, with consequent effects across government agencies, creates significant stigma. This punitive regulatory environment influences public opinion, generating observable public stigma. This, in turn, affects family/whānau, imbuing them with many of the same views as the public, since they are themselves public members. This is known as associative or courtesy stigma (Goffman, 1963). Lastly, flowing from structural to public to associative stigmas, we reach the internalized stigma experienced by people with MUD. As society members, they are not exempt from the other pervasive stigmas. They internalize these 'constructions,' applying these discourses to themselves, resulting in self-stigma. While personal, associative, public, and structural stigma reinforce and amplify each other, I argue that dismantling efforts are most effective when following this order (refer Figure 10):

Figure 10

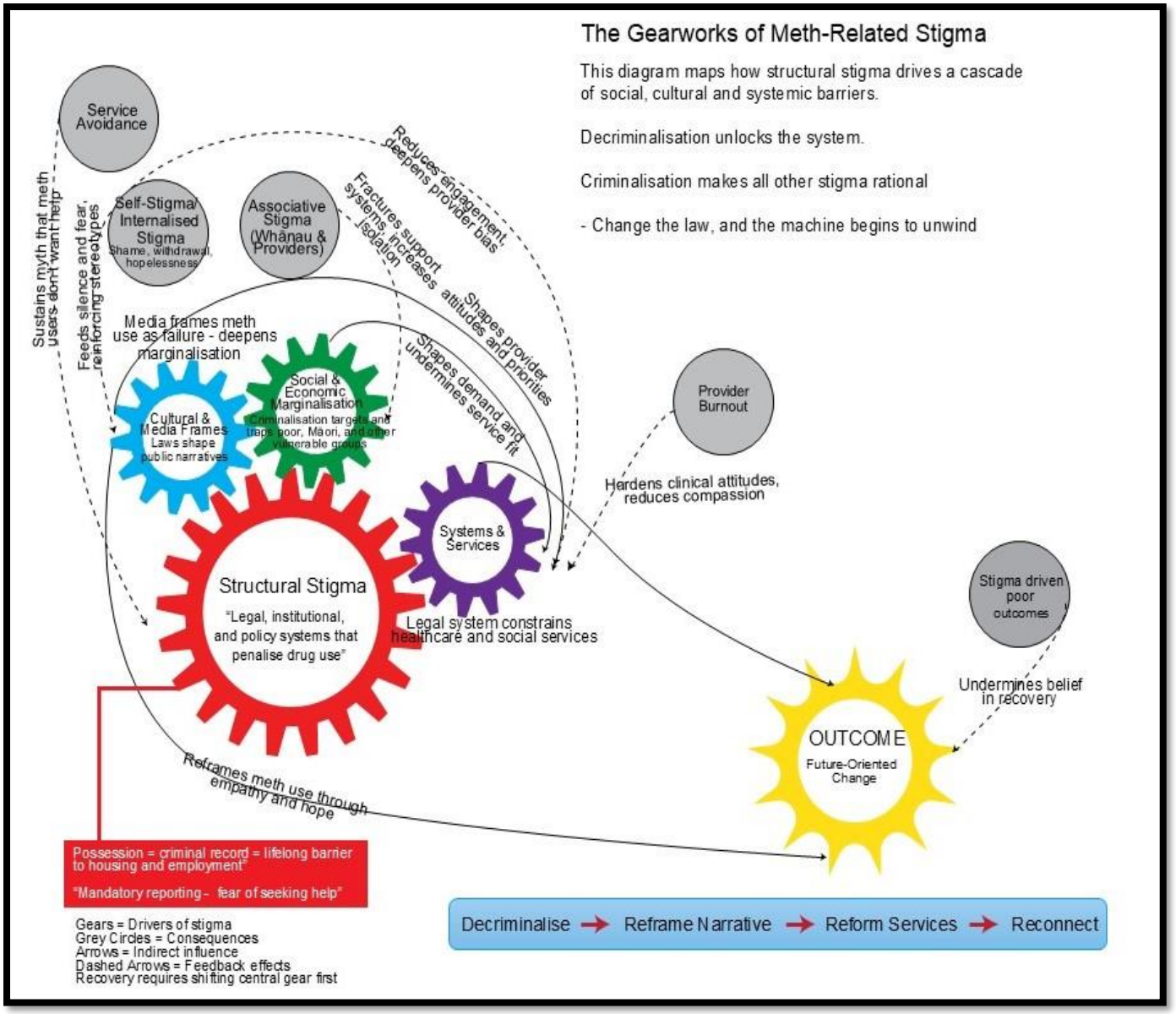
Pathway For Dismantling Stigma

Another way of viewing the significant role structural stigma plays is with the following 'gearworks diagram'. This diagram maps how structural stigma drives a cascade of social,

cultural and systemic barriers. Decriminalisation unlocks the system. Criminalisation makes all other stigmas rational, so if we change the law, the machine begins to unwind (refer Figure 11):

Figure 11

The Gearworks of Meth-Related Stigma



6.3 The Way Forward: Recent Successes in Aotearoa New Zealand

ANZ has already demonstrated several successful harm reduction initiatives. The Te Ara Oranga pilot, which successfully trialed in Northland, is now being tested in Murupara (Walton & Martin, 2021). Since 1987, the Needle Exchange Programmes have operated with

government funding, making ANZ the first country worldwide to provide a government funded needle exchange programme. This has no doubt contributed to ANZ's low rates of HIV/AIDs and Hepatitis C infections (Yasbek et al., 2022). These peer workers provide factual, non-judgmental advice. More recently, in 2020-2021, ANZ passed Drug Checking legislation, becoming the first country in the world to offer free, legal and confidential drug checking services nationwide and at music festivals, another important innovation in the country's harm reduction strategy (Hutton, 2022).

It should be noted that there are many other worthwhile community-level initiatives already in place (like Speed Freaks, a community-led 'running for recovery' programme) and these have not been addressed here (Gherkin Media, n.d.). The recommendations in this research project are limited to major initiatives likely to have the greatest impact on destigmatisating methamphetamine users. The Mindmap (refer Appendix I) indicates a comprehensive strategy addressing all areas, but would need comparison against existing initiatives across government, NGOs and communities to identify gaps and establish measurement systems for each initiative.

6.4 The Strategic Pathway For Destigmatisation of Methamphetamine Users

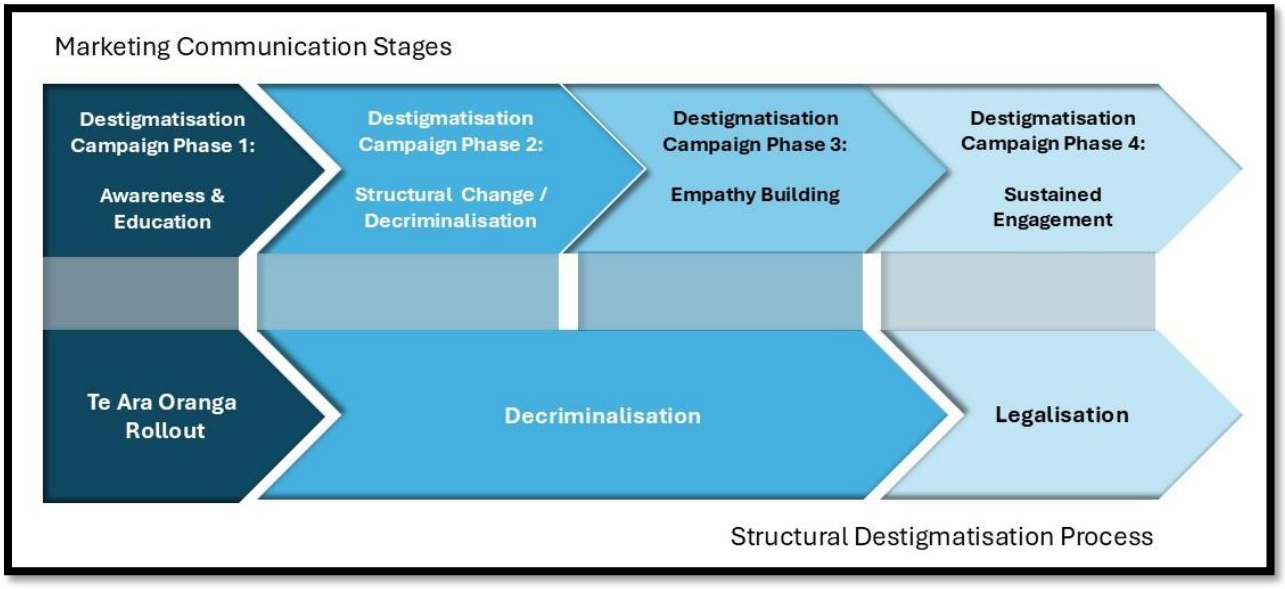
Below is a diagram outlining a strategic pathway for the destigmatisation of methamphetamine users. To achieve this, we must recognise that every policy decision, from healthcare to housing regulations, either reinforces or assists in dismantling stigma. The challenge is therefore not just to change attitudes, but to redesign systems to support rather than impede recovery. I am reminded of Nelson Mandela's famous statement that poverty is man-made and can be removed through human action (Mandela, 1994). Similarly, if stigma is a societal construct, it too can be dismantled through intentional effort, demanding a collective response. Alone the opportunity cost of the lost potential of PWUD highlights that breaking the stigma chain is not merely a moral imperative; it is an investment in our shared future.

My recommendations revolve around three key elements: a Destigmatisation Campaign, the nationwide rollout of Te Ara Oranga nationwide, and the Decriminalisation of personal drug possession/use. While the legalization of all drugs could be considered as a future step, potentially regaining lucrative tax revenue and removing income streams from criminal organisations, this does not form part of my current recommendations (Sense Partners, 2018)., ANZ would not likely be ready for such a step until these other strategic elements had been successfully implemented. Nonetheless this is the policy direction advocated by global organisations such as the UN and WHO, particularly for marijuana (International Drug Policy

Consortium, 2018; Office of the United Nations High Commissioner for Human Rights, 2023) (refer Figure 12).

Figure 12

Strategic Pathway for Destigmatisation of Methamphetamine Users



6.4.1 Step One: Destigmatisation Campaign

The first step is to implement a multi-media destigmatisation campaign, a form of protest as propounded by Watson and Corrigan (2005) to challenge public stigma.

6.4.1.1 Phase One: Awareness and Education

- The first phase revolves around generating awareness of the failed ‘war on drugs’, the outdated nature of the MoDA, and the rationale for decriminalisation, along with the groundbreaking case study from Portugal, and successes from the concurrent roll-out of Te Ara Oranga. Education to dispel myths/misinformation surrounding meth use can also be deployed. Emphasising the medical and psychological nature of SUDs can shift attitudes from blame to compassion. Media guidelines should be shared with the media as part of reframing the discourse around meth use. Shifting to person-first language such as “person with a substance use disorder” instead of “addict” helps to humanise individuals and challenge stereotypes.
- Positive polling of New Zealanders in relation to decriminalisation should be shared at this stage. Widespread support must be built up in advance, so that ’progressive’ or even ‘radical’ starts to look like ‘common sense’. The decriminalization reform should achieve

cross-party support or at least become so widely accepted that opposing parties maintain it once in office.

6.4.1.2 Phase Two: Structural Change/Decriminalisation

- Phase Two focuses on clarifying the distinction between decriminalisation and legalisation, to address public concerns. Ending the 'war on drugs' need not be a binary choice between prohibition and legalisation. Under this approach, trafficking in meth *will still* be subject to criminal prosecution whilst personal use will not.
- Decriminalisation aims to end the marginalization of PWUD without harming others, reframing the issue from criminal justice to public health. Cost savings to taxpayers is a crucial benefit to be highlighted.

6.4.1.3 Phase Three: Empathy Building

- Phase Three messaging centres on recovery stories of PWUM, fostering hope and optimism that rehabilitation is possible. Educational messages addressing common myths about methamphetamine use will be incorporated, though avoiding negative messaging which research shows is ineffective and potentially restigmatising for existing users (Marsh et al., 2017).
- Video vignettes featuring diverse recovered individuals provide a form of contact for the public to aid understanding. Positive and nuanced media portrayals of recovery help challenge stigma and inspire empathy, implementing Watson and Corrigan's (2005) three key strategies: *protest, educate* and *contact* (Watson & Corrigan, 2005).
- NZDF and other interviewed experts could help identify candidates for these profiles, including a middle-aged, high-flying businesswoman, a sporting celebrity, someone self-medicating for ADHD, an ex-gang member from Northland who experienced Te Ara Oranga, a sex worker and a gay person who has recovered from both meth addiction and HIV/AIDS.

6.4.1.4 Phase Four: Sustained Engagement

- The campaign should ideally occur annually, potentially as Recovery Week, allowing for additional messaging as public awareness and empathy increase.
- Should drug regulation or legalization become a future objective, this process could be adapted with legalisation replacing the decriminalization component.

6.4.1.5 Campaign Elements

The destigmatisation campaign should comprise the following elements:

- Fully integrated multi-media campaign including television / print / radio / cross-platform social media / PR / dedicated website
- Messaging:
    - Optimistic, recovery-based messaging
    - Addressing misinformation
- Targets a particular week or month annually
    - Allows for messaging to evolve annually
    - Allows for public sentiment tracking post campaign annually
- Adopts a colour and logo of optimism to build recognition/awareness each year
- Utilises celebrity endorsements where appropriate
- Strong, engaging strapline, such as 50 Voices (50 years on from the Misuse of Drugs Act 1975)
- Voluntary media guidelines for media; destigmatising language

It should be noted that until personal possession is decriminalized, public stigma can never be fully ameliorated, due to the dominant role of structural stigma through criminalization. The role of any potential destigmatisation campaign is to prepare the public by fostering awareness and empathy, ensuring receptivity when decriminalisation occurs. This preparatory work is an important precursor to Step Three: Decriminalisation. As with all social change campaigns, the complexity involved should not be underestimated. The campaign should continue in tandem with structural reforms, guiding the public through the progressive dismantling of stigma from structural to public domains and beyond.

6.4.2 Step Two: Te Ara Oranga Rollout

Te Ara Oranga represents another key plank in the proactive dismantling of structural stigma. In a recent budget submission document, the NZDF indicated that government spending on drug law enforcement typically exceeds spending on drug treatment/harm reduction strategies by a factor of four (New Zealand Drug Foundation, 2022, May 12). CEO Sarah Helm noted: “At present, we wait until someone ends up needing hospital-level care or in prison before we offer them help. This is both inhumane and a poor use of government money.” (New Zealand Drug Foundation, 2022, May 12).

As discussed in Chapter Four, Te Ara Oranga demonstrates the effectiveness of a Portuguese-style, health-based approach to methamphetamine use in ANZ. Evaluation shows a 34% reduction in post-referral crime harm using the NZ Crime Harm Index (Curtis-Ham & Walton, 2017). The cost-benefit analysis indicates returns of $3 - $7 for every dollar invested (Walton & Martin, 2021). A nationwide roll-out makes sense, or at least to all regions experiencing high levels of harm. Nationwide implementation, estimated at $40-$45 million, could deliver returns of $100 - $150 million (New Zealand Drug Foundation, 2022, May 12).

6.4.3 Step Three: Decriminalisation of Personal Possession and Use

The criminalization of personal possession with its attendant penalties (arrests, fines, prison terms, criminal records) constitutes the most significant structural stigma facing PWUD. While Te Ara Oranga offers alternatives to incarceration, methamphetamine's illegal status perpetuates stigma. Below I outline proposed legislative changes and three justifications, namely: criminalisation fails to reduce substance use, exacerbates drug harms, and intensifies societal inequities.

6.4.3.1 Replace the Misuse of Drugs Act 1975

The Law Commission’s 2011 review deemed the MoDA 1975 no longer fit for purpose and inconsistent with harm reduction principles (Misuse of Drugs Act 1975 No.116, 1975). It recommended treating illegal drug use as a health rather than a criminal-justice issue and introducing a police caution scheme with referrals to brief interventions (New Zealand Law Commission, 2011). (This has similarities to the Te Ara Oranga programme, where treatment is offered on a voluntary basis.) The Law Commission also recommended repealing Section 13, which criminalises possession of drug utensils, as counterproductive to harm reduction (New Zealand Law Commission, 2009, p.13). I support these recommendations and advocate for removing criminal penalties for personal possession by repealing Section 7. Expert participants interviewed largely endorsed this approach, similar to Portugal’s successful policy (Cabral, 2017; Gonçalves et al., 2015; Stevens et al., 2016). Under this system, drug trafficking remains illegal with existing penalties, while personal possession/use is treated as a health issue, proven most effective for reducing substance use and related harms (Greenwald, 2009).

6.4.3.2 Criminalisation of Drugs is Ineffective

The rationale for criminalizing substance use is to reduce production and consumption, thus limiting exposure to drug-related harm. Evidence demonstrates criminalization has failed to

reduce supply or demand (New Zealand Law Commission, 2011). The UN High Commissioner for Human Rights, Volker Türk, recently stated: “The evidence is clear. The so-called War on Drugs has failed, completely and utterly,” (Tuerk, 2024, December 5). Drug offenders comprise twenty percent of the global prison population, with 61% incarcerated for personal possession (Office of the United Nations High Commissioner for Human Rights, 2023). In ANZ 2023/2024, 50% (3,554) of finalised charges for methamphetamine offences were for possession/use, and of those convicted of meth-related offences, 74% (1,727) were convicted of possession/use (Ministry of Justice, 2024, June). In Portugal, following decriminalization, drug-related imprisonments decreased from 43% in 2000 to 20% by 2013 (Stevens et al., 2016). Decriminalisation there allowed police to redirect resources from targeting users toward combating trafficking and organized crime. Portugal’s approach has succeeded for over twenty years, with problematic drug use below European averages (Eastwood et al., 2016). In short, there is currently no evidence that decriminalization increases problematic drug use (Cabral, 2017).

6.4.3.3 Criminalisation Increases Drug Harms

The prosecution of PWUD causes avoidable harms. Prison time correlates with poorer health outcomes (New Zealand Law Commission, 2011). Post-prison stigma and social exclusion negatively impact health (Mayo, 2021). Fear of criminal prosecution remains the most significant barrier to treatment-seeking, a view unanimously supported by interviewed experts (Greenwald, 2009). Following decriminalization in Portugal, voluntary treatment participation increased from 29,204 in 2000 to 38,532 in 2008 (Mastro, 2021). Whilst ANZ already has low levels of Hep C and HIV/AIDS, these would likely further decrease, similar to Portugal’s experience (Mastro, 2021).

6.4.3.4 Criminalisation Increases Societal Inequities

As per earlier chapters, problematic drug use disproportionately affects Māori, males and those in socioeconomically deprived areas (New Zealand Ministry of Health., 2024). Young people and Pacific Peoples face similarly high risks (New Zealand Law Commission, 2011). Criminalisation disproportionately impacts these groups, perpetuating inequities (Mayo, 2021). Despite a 2019 amendment to the MoDA, granting police more discretion in minor possession cases (unless in the ‘public interest’), Māori continue to face disproportionate prosecution (Hutton, 2021, March 21). Despite comprising only 16% of total ANZ population, Māori comprised 50% of those convicted for meth-related offences (Ministry of Justice, 2024, June) Decriminalising personal possession/use would address discrimination against disadvantaged minorities and improve social equity.

Approximately half the methamphetamine-caused societal harm comes from the criminal justice system. NZDF estimates enforcement expenditure by the Ministries of Police, Justice, Department of Corrections and Customs costs between $365-$410 million per annum, compared with $93 million on drug addiction services (not including alcohol) (Mercier & Jarrett, 2022). Whilst currently difficult to quantify, I argue decriminalising methamphetamine possession would have the biggest impact in dismantling structural stigma.

6.4.3.5 Benefits of Decriminalisation

In 2020 in ANZ a referendum to not just decriminalize but to fully legalise marijuana was narrowly defeated (Hutton, 2021, March 21). Having said that, a 2022 NZDF-commissioned poll indicated 68% support for replacing the 1975 MoDA with a health-based approach, and 61% support for removing penalties for drug use while enhancing education and treatment resources (The Navigators, 2022, June). Although not top of mind compared with issues like the cost of living or housing affordability, there is strong support for drug law reform (The Navigators, 2022, June). While a destigmatisation campaign addresses public stigma, by rehumanizing perceptions and countering myths, decriminalization solves a much larger portion of the structural stigma facing PWUD. Structural stigma drives public stigma, which generates associative and in turn self-stigma, so is critical to reducing total stigma overall. Decriminalisation would eliminate arrests, fines, imprisonment and criminal records for personal use, improving access to housing and employment. Media language would shift, reducing public vilification. The failed ‘war on drugs’ rhetoric should reduce. However, most tellingly, PWUD would access treatment more readily, experience less stigma from health workers and improved self-esteem and family relationships.

Furthermore, decriminalisation delivers fiscal benefits, *saving taxpayer money.* As Bill English noted, “Prisons are a moral and fiscal failure” (Otago Daily Times, 2011, May 24). Portugal experienced an 18% reduction in average social costs between 2000-2010, including decreased legal system costs and lost productivity from incarceration (Gonçalves et al., 2015). A 2018 NZDF-commissioned analysis estimated decriminalization would benefit ANZ society by $34m-$83m annually, primarily through reduced criminal justice costs of $27m-$46m yearly (Sense Partners, 2018).

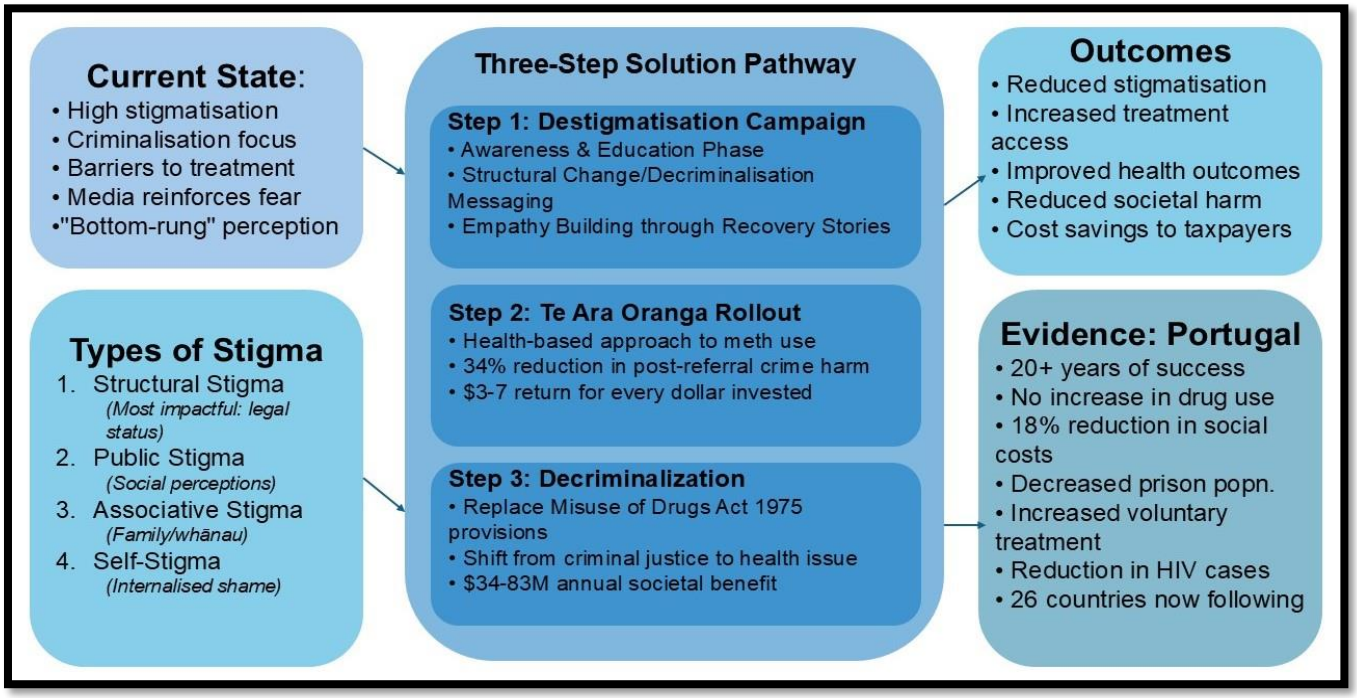
The global shift toward health-based approaches is accelerating as evidence demonstrates the failure of punitive approaches to reduce drug production or consumption (Office of the United Nations High Commissioner for Human Rights, 2023). As at 2018, twenty-six countries so far have implemented some form of decriminalisation model, whether legally formalized or in practice (International Drug Policy Consortium, 2018). A few have addressed

possession/use of all drugs, although a majority have dealt with cannabis alone, with several states in the US moving to legalize marijuana. In numerous countries medicinal use of cannabis-based products has been legalized as well, including ANZ (United Nations Office on Drugs and Crime, 2023).

This strategy could be summarized with the following figure (refer Figure 13).

Figure 13

Strategy Summary Chart



6.5 Limitations and Future Research

Because of the rightfully high bar in terms of seeking Ethics Committee approval, interviewing people with problematic drug use was impractical within this project's timeframe, limiting the richness of data regarding self-stigma. Several experts volunteered their lived experience, and extensive existing research provided insights into user perspectives, though this warrants further examination (Lancaster et al., 2018; Luoma et al., 2013; Ventura et al., 2022). Convenience sampling limited Māori or Pacific Peoples representation among public participants, though best efforts were made in recruiting to a diversity grid. Interviewing family members of those with problematic meth-use would enhance understanding of associative stigma. I deliberately chose not to interview participants over 60 based on generational replacement theory, which suggests attitudes become progressively more accepting

generationally (Herek, 2015). Government investment is better directed towards younger generations where attitude change is more likely and less costly to achieve (Herek, 2015).

This research revealed several challenges requiring additional work. The definition of stigma remains a conceptual quagmire. Contrary to expectations, I found few generic stigma models adaptable for destigmatising methamphetamine users. Interviewed experts lacked strong opinions about effective campaign approaches, indicating another research opportunity. More robust stigma models explicitly linking stigma and discrimination to the SDOH or another well accepted model would prevent underestimation of stigma's impact which remains unquantifiable. Developing comprehensive models measuring and explaining interactions between structural, public, associative and self-stigma represents a valuable research goal.

My hope is for positive social change and social justice. People are getting trapped in the system and my recommendations suggest a pathway that would improve not only population health overall but address social good. This research has argued that addressing structural stigma first would most effectively ameliorate public stigma. Tackling public stigma alone would be less impactful and cost effective. Notwithstanding that we cannot yet measure it effectively, it is argued that structural stigma has a disproportionate impact (Link & Hatzenbuehler, 2016). A key strength of this project was the opportunity to compare and contrast the public participants' views with the nuanced perspectives of the experts, highlighting obvious misinformation and potential campaign pitfalls. For instance, while profiling recovered individuals could engender compassion and second chances amongst the public, careful implementation is essential as recovery is not a linear process, relapse is possible, and adequate support for those featured would be critical.

Although a comprehensive strategy exposition exceeded this project's scope, the MindMap generated provides an overview (refer Appendix I). Following thesis submission, I have offered to develop a destigmatisation campaign brief for NZDF, as well as voluntary media guidelines to reduce stigmatising coverage of people with problematic methamphetamine use.

6.6 Conclusion

The criminal-justice approach to drug harm prevention has failed, as evidenced by continued widespread substance use. Global recognition of this failure is driving momentum toward health-based approaches. ANZ has a proud history of leadership on social issues. It was the first country to give women the vote, the first to introduce social welfare, and one of the first to legalise a permanent drug checking service (Hutton, 2022). ANZ should continue this tradition

by overhauling the outdated MoDA 1975. History has repeatedly shown that progress occurs when public health issues emerge from the shadows (Adams & Volkow, 2020). A 2022 poll NZDF-commissioned poll revealed 2:1 support for decriminalization amongst New Zealanders (The Navigators, 2022, June).

Returning to the MoDA 1975, fifty years on it still has not been comprehensively updated, despite the Law Commission's (2011) recommendations. Ending the 'war on drugs' need not be a binary choice between prohibition and legalisation. Rather than a 'war on drugs' we require transformative change, creating evidence-based drug policies which put people and their rights centrestage, reducing harm and providing an effective health-based approach.

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Appendix A: Letter of Endorsement Stigma Research Stakeholders

Te Puna Whakaiti Pāmamae Kai Whakapiri
New Zealand Drug Foundation

To whom it may concern,

Re: Master's thesis on De-stigmatisation of Drug Use by Heather Cornish

The NZ Drug Foundation supports this Master's thesis on the destigmatisation of drug use in New Zealand.

Through our work with communities of people who use drugs, like you, we know that stigma, compounded by criminalisation, prevents people from seeking help. Stigma shrouds a person in secrecy and shame and prevents them from having honest conversations with loved ones and health professionals. Furthermore, people who are known to use drugs face barriers accessing health care, employment and housing.

The research which will include a literature review and expert interviews with poeple such as yourself.

We expect to use the findings of the the thesis directly in our work.

We would like to do a lot more to reduce stigma, which we see as a key barrier to health. Heathers thesis will be directly beneficial to the wider community we serve.

After the completion of the thesis, we will assist with the dissemination of findings to the communities affected.

Nāku noa, nā,

Sarah Helm
Executive Director

4/265 Wakefield Street
Te Aro, Wellington 6011

drugfoundation.org.nz
+64 4 801 6303

Appendix B: Facebook Recruitment Advertisement

Appendix C: Information Sheet Participant

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Exploring The Destigmatisation of People with Lived Experience of Methamphetamine Use in Aotearoa New Zealand

INFORMATION SHEET - PARTICIPANT

Researcher Introduction

Tenā koe. My name is Heather Cornish and as part of my Master of Arts Thesis in Psychology, I am doing research into the destigmatisation of people with lived experience of methamphetamine use in Aotearoa New Zealand. This project is being supervised by Associate Professor Clifford van Ommen from Massey University School of Psychology, College of Humanities and Social Sciences, and has the support of the NZ Drug Foundation (refer endorsement letter attached).

Project Description and Invitation

This project seeks to understand the perceptions of members of the public and experts regarding methamphetamine use. Improving our understanding of the participants' perceptions may assist in recognising any potential stigmatization and increasing access to evidence-based treatments and earlier interventions to both reduce harm and improve health outcomes. Outcomes from this research may suggest fruitful directions for key messages to be utilized in a public destigmatisation campaign, as well as potential guidelines for Media, Employers or Health Professionals.

You are invited to put forward your expression of interest to participate in this research (subject to selection). If you choose to take part, you will receive a $40 voucher/gift as a koha in recognition of your time.

Participant Identification and Recruitment

- **Selection criteria:** Depending on numbers who express interest in participating, participants will be selected either randomly/through convenience sampling or, if numbers allow, will be chosen in an attempt to gain a diverse sample group.
- **Inclusion criteria:**
    - Participants must be between the ages of 18-65.
    - Currently residing in New Zealand.
    - Interviews will be conducted in English.
    - Members of the public who have no direct/familial involvement with someone who experiences/has experienced methamphetamine use disorder.

Te Kunenga ki Pūrehuroa

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www.massey.ac.nz

Project Procedures

If you decide to take part in this study, you will be involved in a face-to-face interview with me, Heather. The interview will be semi-structured and conversational. Prior to interviews taking place, I will meet potential participants to discuss any cultural support needed, answer any questions and obtain your written informed consent. I expect that interviews will take approximately 60-90 minutes. The interviews will take place at a mutually agreed upon venue that will be private (e.g., a private room at a local library room), or via Zoom. You will be offered a $40 voucher/gift as a koha in recognition of your time.

Although it is not expected, some participants may find this conversation distressing, so they will be provided with a list of support services at the time of interview should they wish to discuss any concerns arising from the interview.

Data Management

These interviews will be recorded with your permission. I will transcribe these recordings and give you a copy of the transcript which you can edit or make changes to if you wish.

Your confidentiality and privacy are important and therefore all names or identifying information will be removed from the transcripts, data and write up of the research, with pseudonyms being used instead. If you decide to participate you will have the option of choosing your own pseudonym. Digital recordings will be destroyed after their transcription and after the transcripts have been followed up with participants. Digital notes from the research project will be retained on a password protected computer until my thesis has been graded. Any identifiable data (eg consent forms) will be stored separately from the de-identified data and kept on password protected devices and/ locked cabinets at Massey University. All data will be destroyed after five years.

A summary of project findings will be shared with participants if they so wish. This option will be communicated by the researcher at interview stage and a short synopsis of findings provided to interested parties once the research is complete. Because this project has the support of the NZ Drug Foundation, they may also potentially use its findings in their work or disseminate the findings to the communities affected.

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Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Decline to answer any particular question.
- Withdraw from the study up until two weeks after your interview.
- Ask any questions about the study at any time during participation.
- Provide information on the understanding that your name will not be used unless you give permission to the researcher.
- Be given access to a summary of the project findings when it is concluded.
- Ask for the recorder to be turned off at any time during the interview.

Project Contacts

Researcher: Heather Cornish drugresearchresponse@gmail.com

Supervisor: Associate Professor Clifford van Ommen C.VanOmmen@massey.ac.nz

Please feel free to contact the researcher and/or the supervisor if you have any questions about the project.

Thank you for taking the time to consider participating in my research.

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the ethical conduct of this research that you want to raise with someone other than the researcher(s), please contact Massey University Human Ethics by email: humanethics@massey.ac.nz.

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Appendix D: Letter of Endorsement Stigma Research

Te Puna Whakaiti Pāmamae Kai Whakapiri
New Zealand Drug Foundation

To whom it may concern,

Re: Master's thesis on De-stigmatisation of Drug Use by Heather Cornish

The NZ Drug Foundation supports this Master's thesis on the destigmatisation of drug use in New Zealand.

Through our work with communities of people who use drugs, we know that stigmatisation, compounded by criminalisation, prevents people from seeking help. Stigma shrouds a person in secrecy and shame and prevents them from having honest conversations with loved ones and health professionals. Furthermore, people who are known to use drugs face barriers accessing health care, employment and housing.

We appreciate the design of the research which will include a literature review and expert interviews.

We expect to use the findings of the the thesis directly in our work.

At the Drug Foundation, as part of our suite of public health and harm reduction programmes, we run a number of programmes and communications work to improve the health of people of who use drugs, including reducing stigma. We would like to do a lot more to reduce stigma, which we see as a key barrier to health. Heathers thesis will be directly beneficial to us, and also to the wider community we serve.

After the completion of the thesis, we also would be able to assist with the dissemination of findings to the communities affected.

Nāku noa, nā,

Sarah Helm
Executive Director

4/265 Wakefield Street
Te Aro, Wellington 6011

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Appendix E: Participant Consent Form

MASSEY UNIVERSITY
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AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Appendix E: Participant Consent From

PARTICIPANT CONSENT FORM

Exploring The Destigmatisation of People With Lived Experience of Methamphetamine Use in Aotearoa New Zealand

I have read, or have had read to me, and I understand the Information Sheet. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw up to two weeks after I have released my transcript to be used in the study.

1. I agree/do not agree to the interview being audio and video (if via Zoom) recorded.
2. I understand that I can ask for the audio-recorder to be turned off at any point in the interview.
3. I understand that the audio-recording will be destroyed once my interview has been transcribed.
4. I understand that all information I give will be treated confidentially.
5. I understand that I can read, discuss, and make edits to the transcript of my interview if I choose, for up to two weeks after receipt of the transcript.
6. I understand I will have access to a summary of the research at its completion.
7. I understand that this project has the support of the NZ Drug Foundation and potentially they may use its findings in their work or disseminate the findings to the communities affected.
8. I understand and am happy to participate in the research under the conditions described in the Information Sheet provided.

Declaration by Participant:

I, _____[print full name]_____hereby consent to take part in this study.

Signature:_____ Date: _____

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

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If you have any concerns about the ethical conduct of this research that you want to raise with someone other than the researcher(s), please contact Massey University Human Ethics by email: humanethics@massey.ac.nz.

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Appendix F: Public Questionnaire

INTERVIEW GUIDE - PUBLIC:

Introduction:

- Thank you so much for agreeing to be interviewed. I hope this research will be useful to the NZ Drug Foundation and the wider community.
- How this project came about, including answering any questions re the Information sheet, getting sign off on consent form.
- Refreshments / karakia offered.

Word Cloud Exercise:

1. Word Cloud of any words or phrases associated with:
    - A person who currently has a meth dependence problem
    - A person who has recovered and no longer has a meth dependence problem

Participants to write as many words as they can over a few minutes in relation to each – on two different coloured pieces of paper. These are then collected and loaded into a word cloud on a computer post focus group/interview.

General:

- When you think of illegal drugs, what kinds of images or words (ideas, emotions) come to mind?

- How would you describe a person with substance use disorder?

- What kinds of challenges do you think a person with substance use disorder would have to stop using?
    - Prompt on workplace, family, friends, and probe responses

Methamphetamine:

- Do you think that people who use meth are different to other drug users, and if so, in what ways? (vs previous description).

- How do you think the public typically makes sense of meth users? (Probe for stigma). What challenges would that present?

- What impact do you believe these ideas (stigma) have on meth users? (Probe: Do you believe that makes it harder for them to give up?)

- How would you feel if your daughter's boyfriend had problematic use? Or:
- How would you feel if your son's girlfriend had problematic use? Or:
- How would you feel if a new neighbour moved in next door and had problematic use?

- Do you think it would be useful to challenge certain ideas about meth users and if so, which ones?

- Why do you think this would be useful or not useful?
    - If yes, how would you go about doing this?
    - If no, do you think the idea is helpful in some way? (Probe law and order)

- What do you believe we as a society (community and government) could do to reduce the stigma and give people with methamphetamine use disorder a better chance of recovery? (Probe for ways certain ideas could be addressed.)

Person Recovered From Meth Dependence Problem:

- Do you believe the same perceptions exist for somebody who has already successfully stayed off meth for a period of time?

- Do you think people have similar ideas about recovered meth users as they do about those who currently have meth dependency issues? (Probe stigma).

- What do you think the impact of these ideas is for recovered meth users?

- What might be some ways to address these ideas if they are not useful?

- Would this kind of programme help to change your views about people who have had a drug use dependence in the past?

- Is there anything I haven't asked you that you think I should have, and if so, what?

Appendix G: Experts Questionnaire

INTERVIEW GUIDE - SUBJECT MATTER EXPERTS / THOUGHT LEADERS:

Introduction:

- Thank you so much for agreeing to be interviewed. I hope this research will be useful to the NZ Drug Foundation and the wider community.
- How this project came about, including answering any questions re the Information sheet, getting sign off on consent form.
- Refreshments / karakia offered.

Interview Guide:

- In what ways, if at all, do you think people who have a meth dependence problem are stigmatised?

- What are the consequences of stigmatization? For whom?
    - The person
    - Their recovery
    - Their whanau
    - Their community

- What are some of the things that drive the stigmatization of people with a methamphetamine dependence problem?

- Does stigmatization have any positive outcomes? (Deterrent)

- Is there a difference, in terms of stigma, between people who currently have a substance dependence problem and those who have recovered?

- What are the impacts of stigma for those who are either:
    - currently experiencing a meth dependency issue
    - recovering from methamphetamine dependency issues
    - or have recovered?

- What, in your experience, has been effective in reducing the stigma?

- What do you think about past and current responses to meth disorder (such as by the government?) Any examples of effective campaigns from around the world?

- What do you think they should do more of / less of / or differently? How much of a difference would it make?

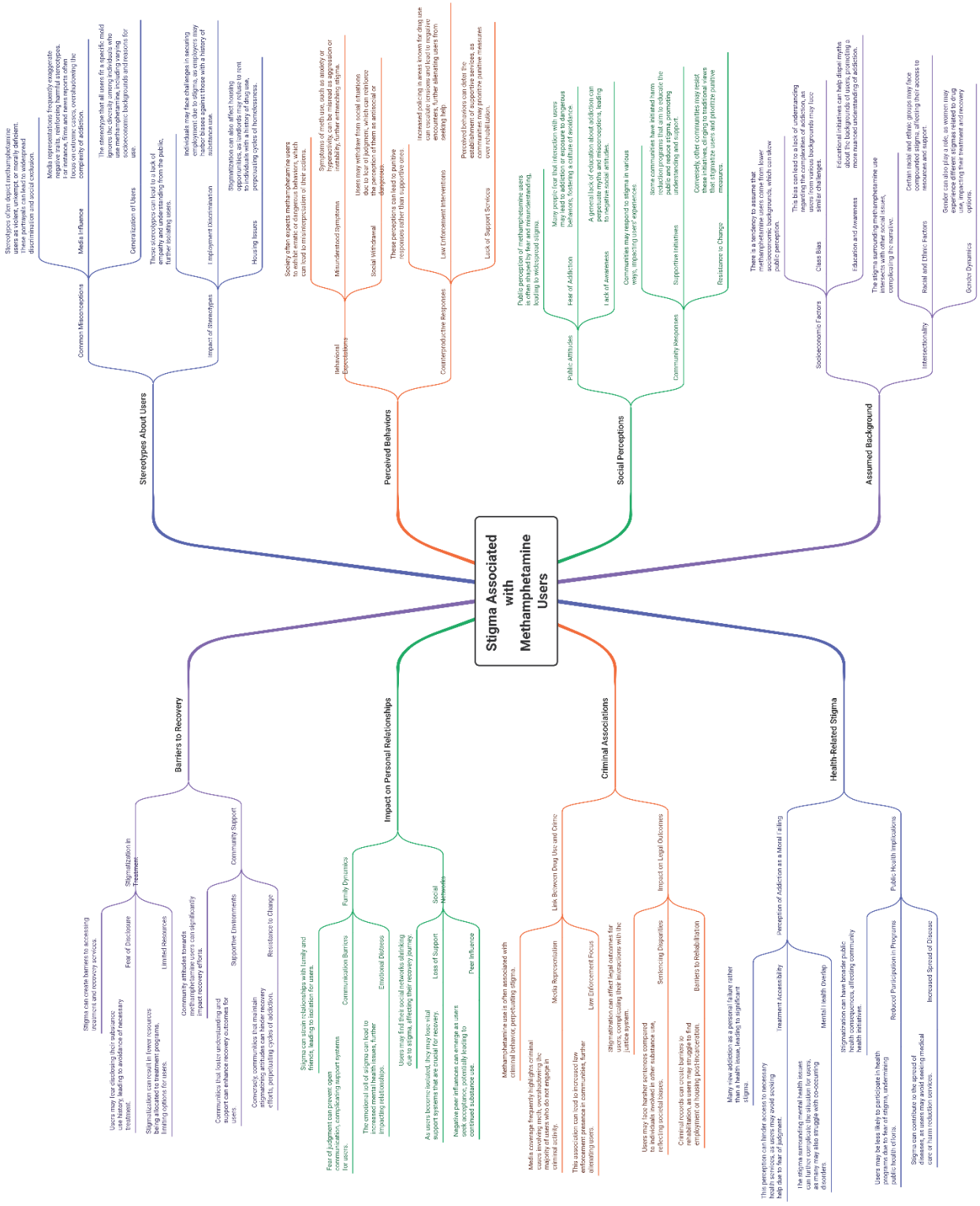
- Do you think this is something the government should be trying to do? Do you think it would have any chance of succeeding? How much of a difference do you think it would make?

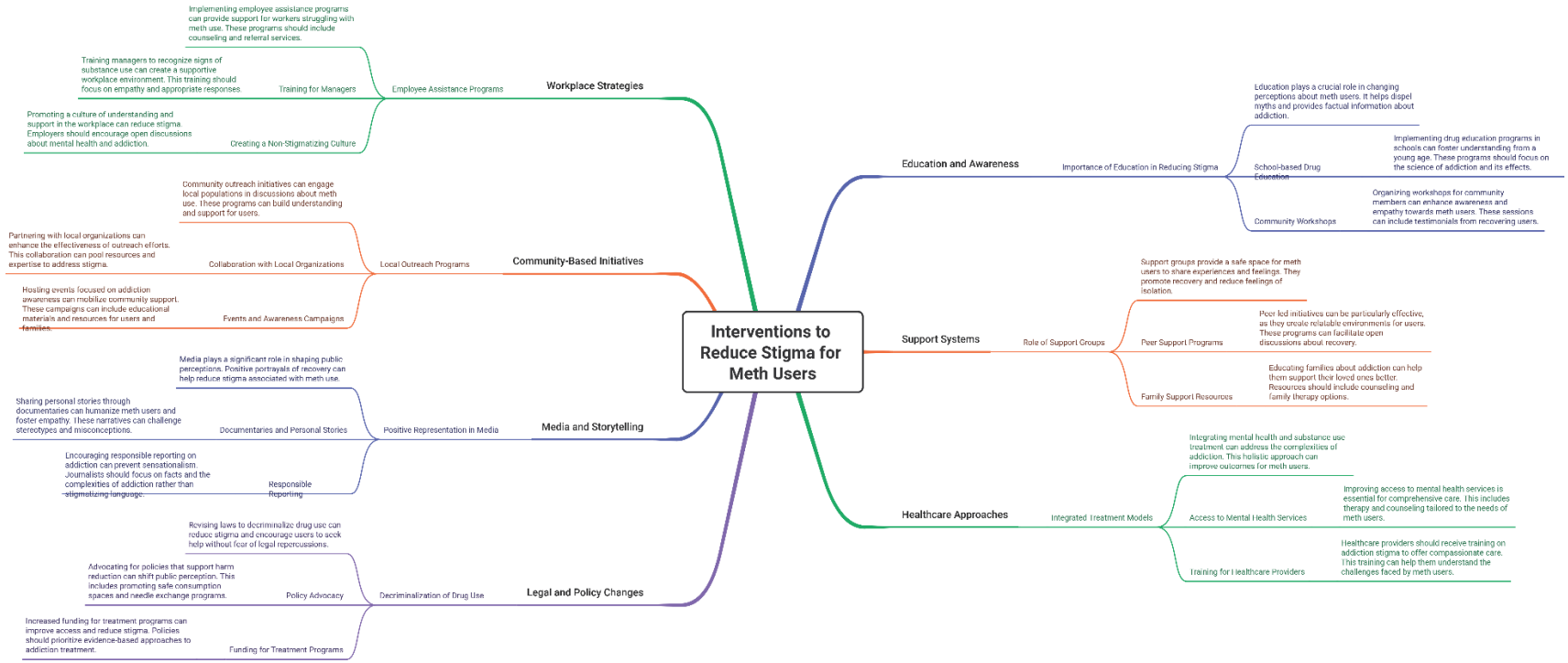
- What, if anything, frustrates you about responses (public, government & other) to meth use disorder?

- Is there anything I haven't asked you that you think I should have? If so, what?

	MARGOT	AMANDA	KATIE	BILLIE	GERMAINE	DAVE	WILLIAM	HANNAH	MAX	FG1	FG2
RECREATIONAL USE VERSUS ADDICTION											
Drugs as a response to boredom / peer pressure / may spill over into addiction	x										
Many people use drugs recreationally / not addicted / Recreational=intermittent use	x										
Some peer pressure to partake - flatmates / coworkers				x	x	x	x				
Young people more relaxed about recreational vs hard drugs				x	x	x	x				
Young people may seek to assuage anxiety (like 60s - nuclear threat) / escapism				x							
Marijuana chill out vs meth highly addictive/more serious/dangerous/life-changing		x									
Has tried cannabis/LSD/MDMA/ketamine/mushrooms. Won't try meth - risky/more intense/worse withdrawals					x						
Occasional / recreational drug use if fine, but not too much - see a difference in them/sad					x						
Meth is not as bad as fentanyl or heroin. Meth is on the borderline of recreational if not addicted to it.						x					
Meth is on the cheaper side of drugs, possibly because it is easier to get.						x					
People usually start with a baseline drug of cannabis, then ask dealer for other stuff						x					
Drug testing is a good service.						x					
Older generation is ok with cannabis, but not other drugs						x					
I can't think of a single person who hasn't tried the recreational drugs							x				
Peer pressure to take recreational drugs because it seems so normal / everyone is doing it							x				
Equates recreational drugs with cannabis, MDMA, LSD, ketamine, psychedelics. Harder drugs = meth, cocaine, heroin, opioids							x				
Cocaine popular overseas but expensive/less pure in NZ, so less popular here							x				
Belief you can't get addicted to recreational drugs. Whereas meth is well known to be highly addictive.							x				
Young people not bothered about recreational drugs - stigma only applies to harder drugs							x				
With recreational drugs there's no hangover, so better than alcohol							x				
Alcohol and marijuana viewed differently to other drugs										x	
Meth offers biggest bang for buck. Not cheap.										x	
Marijuana is more laid back - even the music is chilled. Meth is the opposite.											x
Heroin and cocaine are more elitist drugs, more expensive, more white collar.											x
Whereas meth is lower class. Lower class people buy less pure meth.											x

Appendix I: Mindmap Summaries




Interventions to Reduce Stigma for Meth Users
Workplace Strategies
Employee Assistance Programs
Implementing employee assistance programs can provide support for workers struggling with meth use. These programs should include counseling and referral services.
Training for Managers
Training managers to recognize signs of substance use can create a supportive workplace environment. This training should focus on empathy and appropriate responses.
Creating a Non-Stigmatizing Culture
Promoting a culture of understanding and support in the workplace can reduce stigma. Employers should encourage open discussions about mental health and addiction.
Community-Based Initiatives
Local Outreach Programs
Community outreach initiatives can engage local populations in discussions about meth use. These programs can build understanding and support for users.
Collaboration with Local Organizations
Partnering with local organizations can enhance the effectiveness of outreach efforts. This collaboration can pool resources and expertise to address stigma.
Events and Awareness Campaigns
Hosting events focused on addiction awareness can mobilize community support. These campaigns can include educational materials and resources for users and families.
Media and Storytelling
Positive Representation in Media
Media plays a significant role in shaping public perceptions. Positive portrayals of recovery can help reduce stigma associated with meth use.
Documentaries and Personal Stories
Sharing personal stories through documentaries can humanize meth users and foster empathy. These narratives can challenge stereotypes and misconceptions.
Responsible Reporting
Encouraging responsible reporting on addiction can prevent sensationalism. Journalists should focus on facts and the complexities of addiction rather than stigmatizing language.
Legal and Policy Changes
Decriminalization of Drug Use
Revising laws to decriminalize drug use can reduce stigma and encourage users to seek help without fear of legal repercussions.
Policy Advocacy
Advocating for policies that support harm reduction can shift public perception. This includes promoting safe consumption spaces and needle exchange programs.
Funding for Treatment Programs
Increased funding for treatment programs can improve access and reduce stigma. Policies should prioritize evidence-based approaches to addiction treatment.
Education and Awareness
Importance of Education in Reducing Stigma
Education plays a crucial role in changing perceptions about meth users. It helps dispel myths and provides factual information about addiction.
School-based Drug Education
Implementing drug education programs in schools can foster understanding from a young age. These programs should focus on the science of addiction and its effects.
Community Workshops
Organizing workshops for community members can enhance awareness and empathy towards meth users. These sessions can include testimonials from recovering users.
Support Systems
Role of Support Groups
Support groups provide a safe space for meth users to share experiences and feelings. They promote recovery and reduce feelings of isolation.
Peer Support Programs
Peer led initiatives can be particularly effective, as they create relatable environments for users. These programs can facilitate open discussions about recovery.
Family Support Resources
Educating families about addiction can help them support their loved ones better. Resources should include counseling and family therapy options.
Healthcare Approaches
Integrated Treatment Models
Integrating mental health and substance use treatment can address the complexities of addiction. This holistic approach can improve outcomes for meth users.
Access to Mental Health Services
Improving access to mental health services is essential for comprehensive care. This includes therapy and counseling tailored to the needs of meth users.
Training for Healthcare Providers
Healthcare providers should receive training on addiction stigma to offer compassionate care. This training can help them understand the challenges faced by meth users.

Appendix J: Mental Health Support Services

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Appendix J: Mental Health Support Services

Mental Health Services – Where to access support

If for any reason the interview raises issues that are particularly upsetting, there are a range of resources and services available to provide help, including phone and online services and information, as well as face-to-face support. Most services are free and provide information and confidential advice from trained professionals.

Support Agency Contact Details:

- Need to talk? Free call or text 1737 any time for support from a trained counsellor.
- Lifeline https://www.lifeline.org.nz/services/lifeline-helpline (0800 LIFELINE) or free text 4357 (HELP).
- Suicide Crisis Helpline https://www.lifeline.org.nz/services/suicide-crisis-helpline (0508 TAUTOKO).
- Healthline https://www.health.govt.nz/your-health/services-and-support/health-careservices/healthline or call 0800 611116.
- Samaritans https://www.samaritans.org.nz/
- Depression Helpline https://www.depression.org.nz/get-help. Call 0800 111757 or free text 4202.
- Vaka Tautua – Services offered in the languages of Samoa, Tongan, Cook Islands, Māori or English. Freephone 0800 OLA LELEI (652 535).

Te Kunenga ki Pūrehuroa

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