Reducing Alcohol and Other Drug Related Stigma in WA

Next Steps
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1. Background

According to the World Health Organisation, illicit drug addiction is the most stigmatised health condition in the world. Stigmatisation may also adversely affect the health of those who use illicit drugs, through exposure to chronic stress such as discrimination and as a barrier to accessing care[i]. Furthermore, Alcohol and Other Drug (AOD) stigma doesn't solely impact consumers. The families and carers of problematic AOD users are also adversely impacted by negative stigma and discrimination, as is the AOD workforce.

In its *2013 Logic Model Action Plan*, the Social Inclusion Action Research Group (SIARG) prioritised the promotion of social inclusion and the reduction of stigma and discrimination experienced by people who use AOD and those who work in, or are associated with, the AOD sector. As part of its approach, the SIARG set a goal of identifying strategies for addressing stigma in order to achieve a more socially inclusive community.

To this end, the WA Network for Alcohol and Other Drug Agencies (WANADA) commissioned Marketing for Change to assist with the management of a Drug and Alcohol Office (DAO) funded research project to further develop the evidence base surrounding the nature and extent of AOD-related stigma in the Western Australian community.

The research findings were to be used to inform a comprehensive Stigma Reduction Project, the aim of which being to: *"develop and implement evidence based strategies that aim to reduce stigma associated with alcohol and other drugs."*

The research would also provide a good opportunity for the AOD sector to gain actionable-insight into the ways in which negative stigma manifests in service delivery settings. Marketing for Change worked with WANADA and Colmar Brunton to ensure the research design explored AOD consumers' experiences of AOD and health related services. We wanted to better understand what barriers to services existed, and how those barriers might be overcome.

The findings of the research and associated recommendations have been provided to WANADA by Colmar Brunton. This paper draws on that research to inform prospective strategies, but does not seek to reiterate its findings.

We have also drawn on other peer-reviewed research and grey literature to inform our discussion and recommendations. Kim Eaton's work on the Stigmatisation of the Provision of Services[ii] and Clear Horizon's DAO-funded research on improving consumer involvement in the AOD sector[iii] were of particular interest given their recency and direct relevance to the strategic objectives of SIARG, DAO and WANADA. In the case of the latter, the extent to which consumers feel willing and able to engage with service providers is directly impacted by the level of stigma that exists within the sector.

It should also be noted that *The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* was launched for consultation two days prior to the submission of this paper. The plan provides the blueprint for the reform and development of WA's mental health and AOD system over the next ten years and will be of particular relevance to upstream efforts to address AOD-related stigma moving forward. However, analysis of just how this and the equally relevant *Mental Health Bill 2013* will impact SIARG and WANADA's work to address AOD stigma were not evaluated as part of this piece of work.

The primary purpose of this paper is to provide WANADA with a clear set of options for progressing SIARG's AOD Stigma Project. In addition, WANADA requested that Marketing for Change suggest some low-cost, easy to implement activities that it could use in the absence of substantive funding.

2. Defining Stigma

Colmar Bruton's research reinforced the existing evidence base that stigma exists in any number of settings including the home, workplace, wider community and public institutions. Stigma generally manifests at the structural, interpersonal and/or intrapersonal levels.

When considering barriers to equitable service access the manifestations are the same, although physical barriers to access also play a part.

The way in which we define stigma is important because it provides the foundation upon which any prospective stigma reduction initiatives are based. This is particularly the case for stigma given its relative complexity. Stigma is a multi-faceted and extremely complex psychosocial phenomenon that exists almost in the absence of any satisfying definition.

For our definition, we settled on those provided by The Mental Health Commission of WA (MHC), which defines stigma as: "a mark of disgrace that sets a person apart", and SANE Australia, which states that stigma is: "an opinion or judgement held by individuals or society." Notably, as was the case with most other sources, each then sought to further define stigma by citing examples of how it manifests itself.

The concepts of stereotyping, prejudice and discrimination are also relevant here – the table below provides a brief account of each.

Table 1[iv] – Comparing Definitions of Public and Self Stigma

Public stigma	
Stereotype	Negative belief about a group (e.g. dangerousness, incompetence, character weakness)
Prejudice	Agreement with belief and/or negative emotional reaction (e.g. anger, fear)
Discrimination	Behaviour response to prejudice (e.g. avoidance, withhold employment and housing opportunities, withhold help)

Self stigma	
Stereotype	Negative belief about the self (e.g. character weakness, incompetence)
Prejudice	Agreement with belief, negative emotional reaction (e.g. low self-esteem, low self-efficacy)
Discrimination	Behaviour response to prejudice (e.g. fails to pursue work and housing opportunities)

3. Our Approach

Marketing for Change is a mission-led social enterprise that specialises in the design, delivery and implementation of behaviour change programs. We support, enable and inspire people to change their lives for the better and work with organisations that aspire to do the same.

Our recommendations concerning WANADA's approach to progressing the AOD Stigma Reduction Project is grounded in the principles of social marketing, a planning framework which can be used to develop holistic approaches to complex behavioural challenges.

When used correctly social marketing is a robust, evidence-based discipline within which to plan, implement and evaluate social change programs. We also draw on other disciplines including behavioural economics, social psychology, community engagement and behavioural design to inform our behaviour change strategies.

The primary objective of the stigma reduction research project is to develop strategies to reduce AOD-related stigma in the wider community. In addition, WANADA and Marketing for Change agreed that consumers may also benefit from the development of strategies to address outcomes of AOD-related stigma, such as barriers to service access.

Our approach aims to address individual and structural determinants of prejudicial attitudes and resulting discriminatory behaviours.

Significantly, we propose that work to progress the project is carried out within three distinct activity domains, namely (i) advocacy, (ii) community-based communications, and (iii) place-based interventions.

Table 2 – Activity Domains

Activity Domain	Description
Advocacy (strategic social marketing)	Activities carried out in this domain will be used to address upstream determinants of behaviour, and primarily the policies, laws and practices of influential people and institutions
Community-based education and communication	Targeted messaging to address negative public attitudes through a range of population based communication strategies
Place-based interventions (pilots)	Social marketing/behaviour change interventions implemented at a selection of service delivery locations were barriers to service access are pronounced

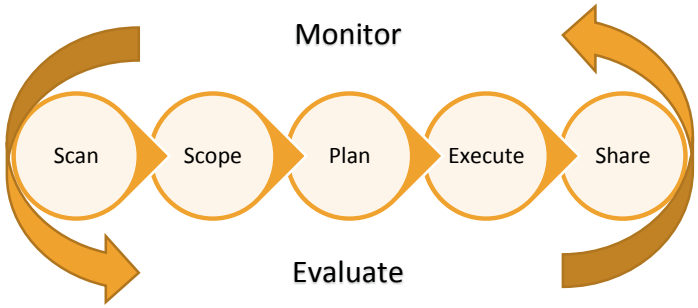
We also recommend WANADA (in conjunction with SIARG and other relevant stakeholders) develop an overarching implementation strategy for the project. The strategy might inform (or even constitute) SIARG's next Action Plan.

Within the implementation strategy would sit a minimum of three stand-alone implementation plans, one for advocacy, one for community-based communications, and one for each place-based intervention site.

Figure 1 – Implementation Strategy and Plans

The development of the implementation strategy and associated implementation plans would be carried out as part of an overarching planning process.

Figure 2 – Marketing for Change Planning Process



STAGE	**MAIN ACTIVITIES**
Scan	Clarify the challenge; assess available resources, analyse context, audience orientation
Scope	Stakeholder analysis, research, competition analysis, behavioural theory, segmentation, goal setting
Plan	Intervention mix, implementation plan, evaluation plan
Execute	Monitoring, opportunities, process evaluation, keep eyes-open to threats and opportunities
Share	Disseminate results and learnings to customers, stakeholders and publics
Monitor and Evaluate	Methodology, results and analysis, implications and recommendations

Further detail on activities needing to be undertaken to complete these plans can be found in Section 4: Next Steps, and in Annex 1.

3.1 Advocacy

Advocacy is a process to bring about change in the policies, laws and practices of influential individuals, groups and institutions[v].

The word 'advocate' comes from a Latin word meaning 'to be called to stand beside'. It can be thought of as "the pursuit of influencing outcomes – including public policy and resource allocation decisions within political, economic, and social systems and institutions – that directly affect people's lives."[vi]

Many of the strategies used in advocacy are communications based and, over time, may lead to changes in community attitudes and behaviours. However, the primary objective of any advocacy effort undertaken within the context of this project would most likely be to change upstream determinants of negative consumer experiences such as policy design and implementation, legislation, organisational practices etc.

Advocacy targets decision-makers and people in positions of influence, not the general public. This is an important distinction. The diagram below outlines some of the more commonly used advocacy tools that are available to WANADA.

Figure 3 – A Selection of Potential Advocacy Tools

Due to a relative shortage of AOD-related advocacy initiatives we drew quite heavily on mental health advocacy campaigns and the related literature. Most were based on one or more aspects of an approach recommended by Corrigan and Penn[vii] who state that the three most successful ways to reduce stigma are **education**, **contact** and **protest**.

- **Education** involves replacing misperceptions with actual facts.

- **Contact** involves changing public attitudes about mental illness through direct interactions with people who have experienced mental illness.
- **Protest** is used as a way to suppress negative behaviour, and is most commonly used to challenge the way that the media present mental illness.

We found several papers critiquing Corrigan and Penn's approach and found it to be generally well supported. However, some argued that educating the public may be an ineffective way of changing attitudes towards mental illness[viii], and paradoxically, those with more knowledge of mental health issues may hold the same or more stigmatising beliefs than the general public[ix].

More significantly, several articles questioned the role of protest in the advocacy mix and provided evidence that it could increase stigma in some cases[x].

We suggest that minor concerns about the efficacy of Corrigan and Penn's model are best managed by employing a variety of methods to the intervention mix, but urge against the use of protest.

3.2 Community-Based Education and Communication

Based on our review of relevant literature, and our knowledge of the behaviour change and social marketing sector, it is clear that for an anti-stigma campaign to be effective the following minimal conditions must be met:

- Campaigns must be adequately funded
- They should be considerable in intensity and duration (i.e. build year on year)
- Use a variety of methods and channels

3.3 Place-Based Behaviour Change Interventions (PILOTS)

When WANADA commissioned Marketing for Change to assist with the design of the AOD stigma research, a key consideration was the need to ensure the research provided actionable-insight that could be used to improve the quality of life for consumers.

Discriminatory attitudes and negative stigma will be addressed at the macro-level through initiatives including stigma reduction campaigning and advocacy. However, these are predominantly medium to long term strategies – attitudinal change in this context takes time.

The research findings support what WANADA, SIARG and many other AOD sector workers, stakeholders and consumers already know, that consumers face a plethora of barriers to accessing high quality services. Like AOD-related stigma, these barriers are the result of systemic, interpersonal and intrapersonal factors, but there are also practical barriers to service access that need to be addressed. These include a myriad of issues including financial constraints, infrastructural challenges (e.g. transport) and even a lack of personal identification.

Marketing for Change would like to work with WANADA to identify one or more appropriate settings where a targeted behaviour change program could be implemented with the overarching aim of improving service access and service experiences for consumers. The research undertaken by Colmar Brunton (and to a lesser extent Clear Horizons) provides WANADA with some clear indicators as to where such a pilot program could be implemented.

There are a range of considerations when choosing potential pilot sites, not least of which being clear about the primary objective(s) of the pilot. WANADA may elect to choose a pilot site where it believes a relatively 'easy win' can be achieved and then used to garner support/funding for further initiatives.

Alternatively, it could opt to design and implement a pilot program at a more challenging location (e.g. an operating A&E department). The latter is inherently more risky, but equally the potential rewards for consumers (and stakeholders) are higher.

The latter option may also be a more attractive proposition for prospective funders.

Other considerations include:

- Costs and benefits
- The potential and likely returns on investment
- The potential for positive impact(s), particularly in terms of outcomes
- Scalability
- Replicability
- The level of onsite stakeholder supports

4. Recommended Next Steps

The research undertaken provides the AOD sector with evidence as to the nature and extent of AOD-related stigma in the wider community. It also provides useful insight about how that stigma manifests in the form of discriminatory attitudes and behaviours towards consumers in community and service delivery settings. The following recommendations apply to all activity domains and are provided in tabular format with suggested timings in Annex 1.

4.1 Map Funding Options across all activity domains

WANADA should consider where it may be able to source funding for potential activities within each of the activity domains. There is little point wasting time and resources to select intervention strategies only to find that there is very little chance of securing the necessary funds to implement them. While the availability of funding shouldn't be the primary driver of any decision-making undertaking, it is nonetheless an important consideration.

We would also recommend that in addition to more established funding sources, WANADA consider other options such as crowdfunding, social impact investment, social enterprise etc.

4.2 Goal Setting – Be SMART

In its project brief[xi], WANADA states that it requires "targeted strategies to reduce the stigma and discrimination experienced by people that use alcohol and other drugs."

These goals were established based on the premise that strategies to reduce AOD-related stigma would be mass communications based, and target the wider WA community. They are therefore sound overarching campaign objectives. However, further consideration should be given to the specific aims and objectives.

We recommend that Marketing for Change continues to work with WANADA, the SIARG and other key stakeholders to develop and agree on clear SMART behavioural objectives for all activities it intends to implement.

Our experience has shown that while many organisations know what SMART objectives are, few actually use them. This can lead to difficulties in terms of measurement and the evaluation of outcomes, and can also adversely impact the efficacy of the initiative itself.

Smart objectives should be: **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**ime bound. Behavioural SMART objectives provide a clear articulation of the action you want your target audience(s) to take.

When developing SMART objectives, it is also useful to be clear about the specific components of any given behaviour.

Figure 4 – Components of Behaviour

Finally, consider what success looks like, and be sure that this definition of success includes an understanding of what that looks like for key stakeholders (including other organisations and potential funders).

4.3 Problem Definition (All domains)

While the overarching aim of the research project is clear, WANADA should consider more clearly defining the 'problem(s)' it is seeking to resolve. The aim here is to capture as much detail as possible about the nature and impact of the problem so that an appropriate strategy for addressing it can be developed.

Our experience has shown that while different stakeholder groups may agree on the overarching issue, they may have very different ideas about the exact nature of the problem itself. Problem definition can provide an opportunity for all parties to input and agree on the precise nature of the problem and the process often leads to useful insights that can be used to resolve it.

Our recommendation is that (at a minimum) problem definition be undertaken at the macro-level, and that alcohol and drug related stigma are treated as two distinct 'problems'.

We would also suggest that where practicable, problem definition be undertaken for each specific behavioural/attitudinal challenge WANADA seeks to address.

Some of the key issues we believe require particular attention when framing and defining 'the problem(s)' include being clear about:

- Harm reduction vs. harm minimisation
- Co-occurrence

- Health issue vs. social/human services issue
- Criminality of drug use
- Supply and demand (injecting facilities and counselling services)

4.4 Develop a Framework

To develop a comprehensive approach to any social problem, it is useful to develop a framework that encompasses and describes the structure of that problem[xii]. We recommend a simple tabular framework be developed which maps causative factors (upstream [external] and downstream [internal]) of each 'problem', as well as leverage points that can be exploited by WANADA and SIARG to address it.

For the purposes of this project, the development of this framework need not be complicated or particularly time consuming. The research already undertaken by Colmar Brunton, Clear Horizon and Edith Cowan University can be used to inform the initial content, which could then just be added to by WANADA, SIARG and other stakeholders.

The key output may simply be a table outlining causative factors which would include (but not be limited to) the following:

Downstream Factors	Upstream Factors
Psychobiological	Behavioural settings/place
Values and experiences	Proximal leverage points (individuals and institutions who can affect behaviour/attitudes)
Relationships to other groups	Distal leverage points (institutions, structures and potential influencers not in the immediate proximity)
Behavioural enablers	

By better understanding the structure of the 'problem' WANADA, SIARG and other stakeholders will be better positioned to identify leverage points where direct action can be targeted.

4.5 Targeting

Whether you're promoting a physical product, a service or an idea, identifying which audience(s) to target is critical. Deciding who to target requires negotiation and discussion and will ultimately depend on a myriad of factors including organisational motivators, available funding, political and environmental considerations and so on.

A stated goal of this project is to reduce the amount of negative AOD-related stigma in the wider community, and WANADA has indicated that it wishes to explore a range of mass communication based options to achieve this. However, WANADA is most likely to achieve positive outcomes if specific sections of the WA community are identified as its primary audiences.

For example, targeting 55+ males may be a poor use of resources given:

(a) the prevalence and entrenched nature of the negative attitudes held towards AOD consumers; and
(b) the fact that community attitudinal and behavioural change is likely to take two or more decades before reaching tipping point.

There are wide range of tools available to assist with the identification and prioritisation of target audiences, and each has its own strengths and weaknesses. For example, the TARPARE model, developed locally by Curtin University's Professor Rob Donovan, can be applied qualitatively or such that scores can be assigned to each segment. We recommend a qualitative application of the model, an outline of which is provided below:

T	Total **number: is the segment large** enough**?**
AR	Proportion of **at-risk** people in the audience (the group whose changed behaviour would result in the biggest reduction in costs)
P	Is the audience easily **persuaded**?
A	Is the audience easy to **access**?
R	Are the **resources** available sufficient to meet the audience's needs?
E	**Equity** (social justice considerations)

Like all models, TARPARE is not a solution in and of itself. However, it provides a useful framework and starting point for consideration about which groups to target.

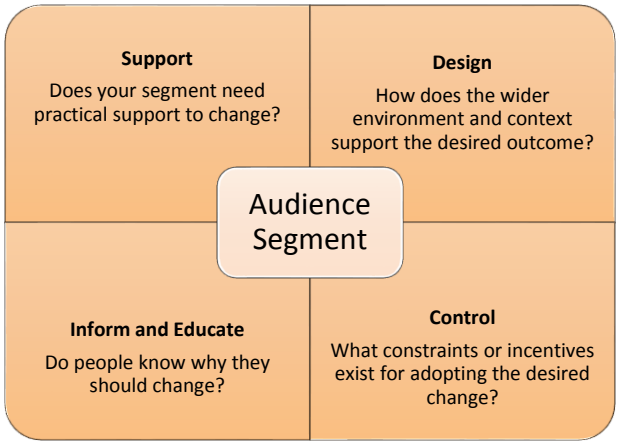
We do not recommend the use of TARPARE for advocacy-related targeting. It is best applied to place-based interventions, and may also be used as part of the decision-making process for community-based targeting. There are also a range of other targeting methods available which could be used equally effectively.

Once targets have been identified, audience segmentation is recommended.

4.6 Intervention Mix

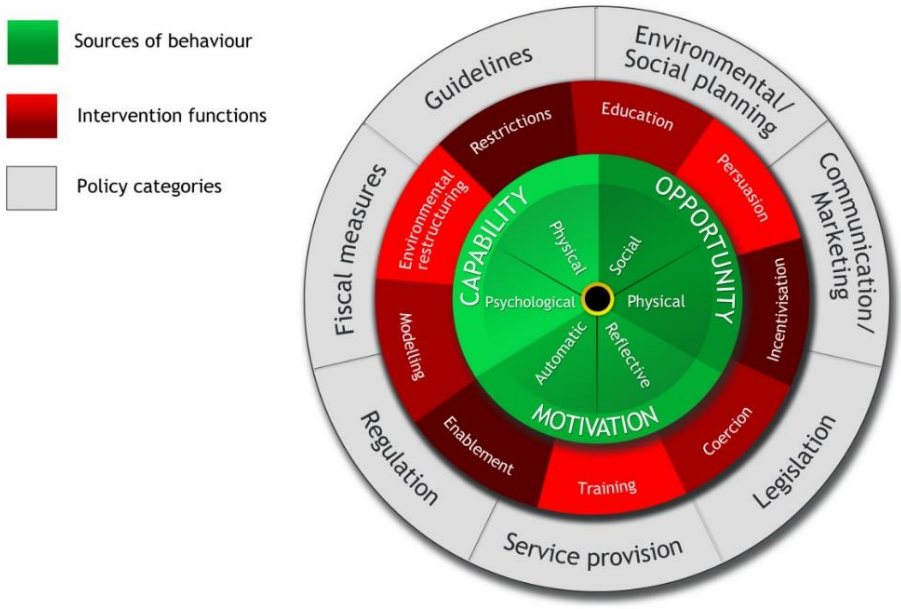
The intervention mix WANADA chooses to apply will differ according to the nature of the challenge and the activity domain within which the intervention is to be applied. For example, for simple place-based interventions The National Social Marketing Centre's 'Intervention Mix' provides a useful decision-making matrix comprising four elements (or levers) that can be manipulated to affect the desired outcome.

Figure 5 – The NSMC Intervention Mix



On the other-hand, more robust intervention frameworks should be considered when seeking to address community-wide AOD-related stigma. For example, the Behaviour Change Wheel was developed by Susan Michie at University College London (UCL). It comprises a synthesis of 19 behaviour change frameworks, including the World Health Organisations COM-B model (which forms the 'hub' of the wheel). Incidentally, Com-B stands for Communication for Behaviour Change.

Figure 6 – Behaviour Change Wheel



In its research report, Colmar Brunton classified stigma as being either **structural**, **interpersonal** or **intrapersonal**. The Behaviour Change Wheel is a useful tool because it focuses on upstream and downstream determinants as follows:

- Sources of behaviour – Intrapersonal/interpersonal
- Intervention functions – Interpersonal/structural
- Policy categories – Interpersonal/structural

The NSMC Intervention Mix and UCL's Behaviour Change Wheel are included to provide WANADA with examples of tools it could use to help it develop effective behavioural interventions.

4.7 Implementation Plans

Implementation plans should be developed for each attitudinal/behavioural intervention. We recommend that these are completed by Marketing for Change and WANADA with input from SIARG and other key stakeholders. These implementation plans should include (at a minimum) key actions; responsibilities; timings; budgets; risk analysis; communication; and evaluation plans.

Intervention plans also need to account for:

- The **TYPE** of stigma (structural, interpersonal etc.); and
- **PLACE** within which that stigma manifests (e.g. society, government, familial, peer-to-peer, self).

4.8 Pre-Testing

Feasibility and budgetary constraints aside, pre-testing of messaging, and in some cases materials, is recommended. Pre-testing can help to ensure that target audiences understand your key messages, and may also identify potential misinterpretations that might be damaging to the campaign and/or WANADA's brand. Pre-testing also reduces the likelihood of errors and, perhaps most importantly in the AOD context, may increase the likelihood that target audiences respond in the way you intend.

There are a broad range of pre-testing measures available, each of which differs in terms of cost and suitability.

4.8 Evaluation

A robust evaluation plan is a critical component of the implementation strategy. Ongoing monitoring and evaluation helps to ensure the effective use of resources while the program is running, and also provides opportunities to demonstrate the relative efficacy of your interventions. Good evaluation also allows us to measure the cost-effectiveness of each intervention using measures such as ROI and VFM.

It's also important to evaluate impact (sometimes called outcomes measurement) – that is, the changes that have happened as a direct result of the intervention. To this end, baseline data is critical. The research conducted by Colmar Brunton provides a good baseline in terms of community attitudes, but additional baseline data should be gathered for each stigma reduction initiative undertaken.

Effective evaluation provides evidence of program efficiency, identifies areas for improvement, and is needed to build a case for funding and/or new resources.

Marketing for Change recommends allocating approximately 10% of total program budget to evaluation.

5. Research-Driven Recommendations

This section comprises recommendations based primarily on the research findings of Colmar Brunton Social Research. We also reviewed Clear Horizons research report entitled *Improving Consumer Involvement in the Alcohol and Other Drug Sector,* and Kim Eaton's research on *The Stigmatisation of the Provision of Services for Alcohol and Other Drug Users*.

Recommendations provided in this section are in addition to those provided by Colmar Brunton and Clear Horizons. They are based on a critical analysis of those reports and our own review of relevant academic literature and grey research. Notably, there is relatively little campaign material and/or published literature on AOD-related stigma. We recognise that AOD-related stigma and mental health stigma are different phenomena, but given the equally obvious parallels we have drawn on mental health approaches as well as AOD-related material to inform our suggestions.

5.1 Focus Primarily on Negative Stigma Associated with Drug Use, Not Alcohol

Research indicates that the nature and extent of negative stigma associated with problematic alcohol use differs to the nature and extent of stigma directed towards problematic drug users. Therefore, in order to be effective, strategies to reduce negative stigma should be targeted at either (a) negative stigma surrounding problematic alcohol use, **OR** (b) negative stigma surrounding problematic drug use. It is unlikely that any single strategy could effectively address both.

Marketing for Change recommends that WANADA focus primarily on reducing stigma surrounding problematic drug use in the context of programs targeting community attitudes, for reasons including:

i. Negative stigma around alcohol use is less pronounced than the negative stigma associated with problematic drug use.
ii. Alcohol consumption in Australia is a cultural and social norm. Problematic drug use is not.
iii. Other government and community based apparatus (e.g. public health, community services, crime and safety) are already investing considerable time and money into alcohol-related programs.
iv. Working to reduce negative stigma and discriminatory behaviours towards problematic drug users (and their families) affords WANADA with a clear opportunity to realise a meaningful social impact and substantively improve the lives of consumers.

Marketing for Change recognises that over 50 per cent of persons accessing services are experiencing problems associated with alcohol. However, our view is that the high level of problematic alcohol use is not primarily the result of negative alcohol-related stigma.

Marketing for Change would be happy to assist WANADA develop targeted behavioural interventions to address problematic alcohol use, but this falls outside the scope of this project.

5.2 Consumer Engagement

The Drug and Alcohol Office recently commissioned Clear Horizons to undertake research to evaluate and make recommendations for improving consumer involvement. One of the report's key recommendations was for the development of a Consumer Involvement Framework[xiii]. DAO facilitated successful consumer and industry forums on the 6th and 7th of November 2014 to inform development of the framework. While Marketing for Change is not currently directly involved in this program of work, there is clearly cross-over with the stigma-reduction work.

We did feel it important to highlight that Colmar Brunton's research indicates that many consumers still feel efforts by government and service providers to 'engage' them can often be tokenistic. Whether this is a function of interpersonal and/or structural stigma is unclear, but is certainly something we recommend be investigated.

We firmly support the involvement of consumers in the design, implementation and evaluation of AOD-related stigma-reduction initiatives, be they upstream, community-wide or place-based. In all cases, due consideration should be given to the following:

- What does consumer engagement mean to us, to consumers?
- Why are we doing it?
- What does success look like?
- What level of participation/engagement is necessary?

- What are the risks associated with too much, too little engagement?

Our experience is that the default ways in which most bodies engage consumers is through workshops, surveys and public meetings. These are useful, but provide a relatively low level of engagement and/or influence on decision-making. Such techniques are primarily information gathering exercises, and are not truly consultative or partnership based approaches to engagement[xiv].

There is recognition amongst stakeholders that the work being undertaken by DAO to improve levels of consumer engagement should include strategies formulated as part of this project.

5.3 Choice

Marketing for Change has experience working with the British government and World Health Organisation to address social determinants of health and disadvantage. We were therefore drawn to research findings which showed a large proportion of respondents surveyed by Colmar Brunton believe persons who use alcohol and/or other drugs problematically 'actively choose' to do so. This is not necessarily the case. The social, economic and environmental conditions in which people live and work are significant determinants of individual behaviour.

The socioeconomic determinants of health, crime etc. are not concepts that are well understood by the wider community. And because many people think problems associated with AOD use are self-inflicted, there is a tendency to blame consumers for their 'bad choices' and dismiss their suffering as 'self-inflicted'. Consumers and sector-workers agreed that a lack of understanding of the issues, and a lack of empathy, are key drivers of AOD-related stigma in wider community and service delivery settings.

Given this context, social justice arguments (although valid) are likely to fall on deaf ears. Instead, WANADA needs to aggressively challenge community assumptions about decision-making and choice.

Activity within the advocacy domain must also reinforce the impact of structural determinants on individual choice. In its Qualitative Research Report, Colmar Brunton concluded that a perceived lack of funding in the health budget was felt to reflect social stigma.

If the wider community believes AOD consumers are to blame for their own poor health, there is little incentive for cash-strapped governments to increase funding to the sector.

5.4 Early Wins

Stigmatisation and discrimination towards AOD consumers is highly prevalent in the Western Australian community and the task of addressing negative stigma may at times seem overwhelming. Cultural and social norms surrounding alcohol and other drugs are entrenched, and community attitudes take time to change.

Add to this the evidence that some sector workers and consumers are almost resigned to the current status-quo and it becomes very clear that some early wins are needed in order to build meaningful sectorial support and momentum for this piece of work.

The research undertaken by Colmar Brunton uncovered several areas and/or barriers to access that may provide good opportunities to get some early wins on the board. Marketing for Change would like to work with WANADA to better identify where these opportunities exist as part of strategy development.

6 Low-Cost Options and Potential Techniques

This section provides a selection of low-cost options that WANADA could use as part of stigma reduction initiatives in any of the three activity domains. Suggestions are based on techniques that have been used in other mental health stigma reduction initiatives and in stigma reduction and social change programs more generally.

They are provided in response to WANADA's request to include low-cost options that can be implemented in the absence of substantive additional funding. The list is by no means exhaustive.

Marketing for Change strongly recommends that where practicable, these approaches are only applied when appropriate goal setting, planning and targeting has been undertaken.

6.1 Review of Previous Campaigns

Conduct a more robust scan of AOD- related stigma reduction campaigns that have been conducted (a) in Australia; and (b) globally. Such a scan may provide additional ideas, benchmarking opportunities and or best practice examples upon which a WA-based anti-stigma campaign could be based.

6.2 Storytelling

Storytelling has been used by people for millennia to change people's minds and attitudes. People make sense of the world through stories. They are an integral part of our culture and belief systems and consequently, an extremely effective means of influencing opinions, beliefs, attitudes and behaviours.

Storytelling could be used by WANADA and other AOD bodies to **educate** the general public, and/or used to **advocate** for change, more funding etc. Storytelling is not a strategy in and of itself. Rather, it's a communications based approach that should be integrated into specific campaign activities.

Stories might take the form of:

- Informative stories penned by WANADA and other AOD service providers. Third person narratives that **educate** through the narrative.
- Stories by sector workers and AOD employees of their experiences working with AOD users.
- Stories by people experiencing problems with AOD user use and their families.

*The most compelling stories are likely to come from AOD users themselves.

For the **GENERAL PUBLIC** it can be useful to position the problem(s) in the foreground and show how they have been overcome by the protagonist.

For **GOVERNMENT, FUNDERS**, etc. approaches might include outlining how challenges can be overcome, examples of what's working elsewhere and how they could be applied here, and focusing on the ROI/VFM that an investment in the proposed solution would deliver.

The medium through which the story is conveyed will be largely dependent on the target audience and budget.

Written stories **-** These may take the form of blog posts, articles or books. Written stories are relatively cheap to develop and disseminate.

Digital stories **-** These may be video, pictorial, animated, audio. Video stories are the most emotionally engaging and can be disseminated through a range of channels. It's best to keep video stories relatively short (no more than three to four minutes) unless the intent is to develop a short film, which can be useful for targeted advocacy and/or educational purposes.

Spoken narratives **-** Spoken stories at events, conferences and presentations.

Marketing for Change is aware that there are some sector specific issues around storytelling, and in particular, some very valid concerns expressed by members of SIARG about the personal health and well-being of those involved.

We agree that the use of personal stories needs to be managed with care and sensitivity, but we don't believe these concerns should prevent use of the approach. Indeed, it's already being used elsewhere in Australia, an example being the *Tell Your Story* website http://www.tellyourstory.org.au/ which is administered by the Australian National Council on Drugs.

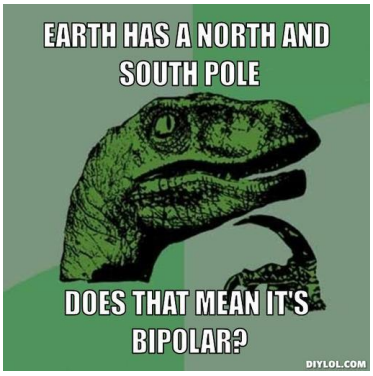
6.3 Contact

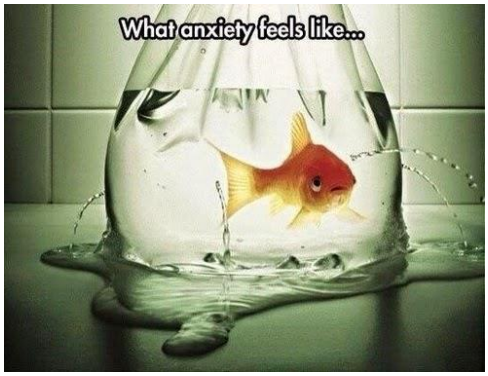
We found evidence in the literature that stigma may be diminished when members of the general public meet persons who are able to hold down jobs or live as good neighbours in the community. Research has shown an inverse relationship between having contact with a person with mental illness and endorsing psychiatric stigma[xv] and that opportunities for the public to meet persons with severe mental illness may discount stigma and that interpersonal contact is further enhanced when the general public is able to regularly interact with people with mental illness as peers.[xvi]

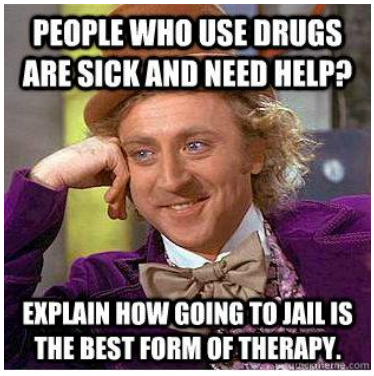
While the literature focused on stigma reduction in a mental health context, we recommend that WANADA consider ways in which contact between consumers and the wider community can be facilitated. This may include place-based interventions (e.g. removing barriers to contact in service delivery settings), or considering the introduction of programs such as work-place initiatives, social enterprise, etc.

6.4 Memes

A meme is an idea or usage that spreads via picture, video or other transmission mechanisms. Memes are typically humorous and are particularly prevalent on social media. Some examples of memes being used to combat mental health stigma are provided below:







While the use of humour is not without risk, particularly in the AOD space, it is also a proven means of preparing target audiences for subsequent impact messaging. In some cases, humour has also been shown to increase acceptance and positive feelings toward the message source[xvii].

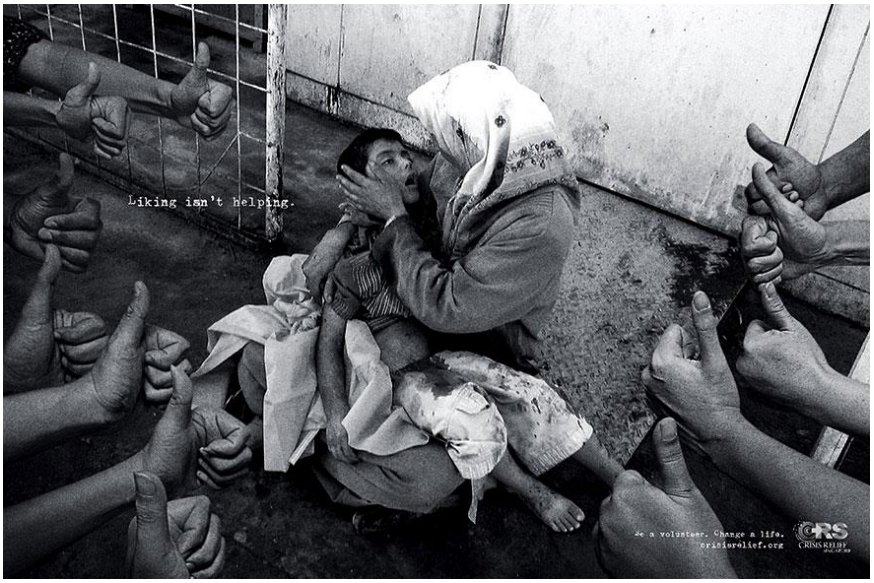
Pictorial memes are relatively cheap and easy to develop. There are several web-based meme generators that can be used for little or no charge, or memes can be created by an individual with basic graphic design skills. Pre-testing is strongly recommended.

6.5 Infographics

Infographics present data and information in a graphical format making the information easier for target audiences to digest. Infographic templates are available online for little or no charge, though the skills and software required to manipulate the templates are more advanced than that required for memes.

6.6 Poster Campaigns

Poster campaigns can be a reasonably cost-effective option and are particularly impactful when used for emotional appeals. Given consumers and sector workers universally identified the need to increase empathy amongst the general public, the use of posters (digital and print) should be considered.



6.7 Contact with Sector Workers/Health Workers

People with lived experiences of AOD-related stigma talk to frontline workers about their illness, the impact of stigma on recovery and what helps to make a positive difference.

6.8 Stigma Watch and Reporting

An organisation called Stigma Watch Australia publishes online details of organisations and individuals which do not display mental illness in an accurate manner. It also features examples of good practice within the media. This is an example of the **protest** approach.

The name and shame approach is not to our liking, and it would be problematical in the AOD context where social norms and public attitudes around drug use are very negative. However, an online repository of best practice within the media, services sector or the wider community may have merit.

6.9 Postcards and Letter Writing

Postcards and letter writing are useful lobbying tools because they can be relatively cheap to implement, and demonstrate to decision-makers that a section of the community feels strongly about a given issue. For example, as part of its *'It's only 1/100th of me'* campaign, the NSW Consumer Advocacy Group (CAG) – Mental Health, developed lobbying postcards which were issued during Mental Health Week. The postcard was designed for people to send directly to the Minister Assisting the Minister for Health to ask the government to implement a program to overcome mental health related stigma and discrimination. The Minister responded within days.

The same approach should be considered for lobbying the media. The '*Like Minds, Like Mine*' campaign (New Zealand) actively targeted print and electronic media outlets to encourage non-discriminatory journalism through letters to the editors.

6.10 Design and Publish an e-Book (public)

Designing and publishing an e-book can be a cost-effective means of disseminating information. As with any book, the success of the e-book will largely depend on its content. There are numerous easy to use e-book design tools available online that cater for all of the main publishing portals (Amazon, Apple, Android etc.) Examples are included below for reference purposes only:

- Calibre E-Book Design http://calibre-ebook.com/
- Kindle Direct publishing https://kdp.amazon.com/

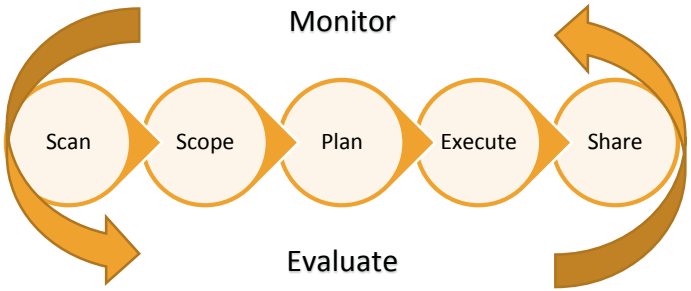
E-books provide considerable benefits, including:

- Development costs can be kept very low
- Publishing costs on some platforms is $0
- Very easy to sell and distribute
- Links, video and audio files can be embedded

For a basic e-book, WANADA could develop the content in MS Word or similar and then simply upload it to a conversion/design site for small amends and file conversion for publishing. The other option would be to outsource design of the e-book. This would be more expensive, but should lead to a more polished end product.

ANNEX 1: Next Steps

The table below outlines recommended next steps to be undertaken by WANADA to progress its work to reduce AOD-related stigma. Recommendations are based on the process used by Marketing for Change to plan, execute and evaluate behavioural and social change programs.



PHASE	TITLE	RECOMMENDATION(S)	WHEN
SCAN	Project Reference and Control Groups	• Establish/confirm Project Reference Group • Establish a Project Control Group	DEC 14
SCAN	Challenge statement	• Marketing for Change to assist WANADA to develop a challenge statement that captures key information about the issues to be addressed, who's affected etc.	DEC 14 – JAN 15
SCAN	Problem definition	• Marketing for Change to assist WANADA, SIARG, DAO and other key stakeholders to undertake a 'problem definition' exercise • Problem definition should, at a minimum, be undertaken at a macro level • Alcohol and drug related stigma should be viewed as two distinct 'problems' • Ideally, problem definition should be undertaken for each of the specific behavioural/attitudinal challenges WANADA seeks to address Key issues that require particular attention include: - Harm reduction vs. harm minimisation	JAN 15

		- Co-occurrence - Health issue vs. social/human service(s) issue - Criminality of drug use - Supply and demand (e.g. injecting facilities, counselling services)	
SCAN	Contextual analysis	• Conduct internal and external analysis to establish the context within which each of the three intervention types will be undertaken	DEC 14 – JAN 15
SCAN	Identify one or more place-based intervention options	• Marketing for Change to work with key stakeholders to identify one or more appropriate settings where a place-based behavioural intervention could be undertaken. Considerations to include: - Costs and benefits - Potential and likely ROI - Potential for positive IMPACT(S), esp. in terms of OUTCOMES - Scalability - Replicability - Level of onsite stakeholder support/engagement	FEB 15
SCAN	Commence work on simple framework	• Marketing for Change to work with WANADA and other key stakeholders to develop a simple framework that encompasses and describes the STRUCTURE of each problem to be addressed • The research already undertaken by Colmar Brunton, ECU and Clear Horizon to be used to inform initial content, which could then be added to by WANADA and other stakeholders • The key output might be the a simple table outlining causative factors including, but not limited to: - Downstream: Psychobiological, values and experiences, relationships to other groups, behavioural enablers etc. - Upstream: Behavioural settings/place, individuals and institutions that can affect behaviour/attitudes etc.	DEC 14 – MAR 15
SCOPE	Identify funding options	• Develop a map of potential funding options for selected actions within each of the three activity domains • In addition to traditional funding sources, consider options such as crowdfunding, impact investment, social enterprise (where appropriate) etc.	DEC 14 – JAN 15
SCOPE	Audience targeting and segmentation	• Marketing for Change to assist with audience targeting and segmentation for each of the three activity domains. The problem to be addressed, organisational motivators, available funding, environmental and political factors and research findings to date will impact decisions in this regard	FEB 15 – MAR 15
PLAN	Goal Setting - Establish **SMART BEHAVIOURAL** objectives	• Consult key stakeholders, potential funders and consumers to define WHAT SUCCESS LOOKS LIKE. Subsequent SMART objectives to be informed by these findings • Marketing for Change to work with WANADA and other key stakeholders to develop and agree on SMART BEHAVIOURAL and/or ATTITUDINAL objectives for all initiatives	APR 15
PLAN	Develop intervention mix(es)	• Marketing for Change to facilitate the development of an appropriate intervention mix for each of the following:	

		- Each place-based intervention - Advocacy - Community-based stigma reduction campaign • We recommend using Susan Michie's *Behaviour Change Wheel* to inform intervention mix methodology for community-wide AOD-related stigma and place-based interventions	APR 15 –MAY 15
PLAN	Develop implementation plans	• Develop an implementation plan for each attitudinal/behavioural intervention. At a minimum, implementation plans should include: key actions, responsibilities, timings, budget, risk analysis, communication and evaluation plans. - Implementation plans should account for the TYPE of stigma (structural, interpersonal, self) and the PLACE within which that stigma manifests (e.g. society, government, familial, peer to peer and self) - Pre-testing of all materials and messaging is strongly recommended, particularly given the complex and emotive nature of AOD-related stigma - Develop an evaluation plan as part of each implementation strategy - We recommend that at least 10 per cent of total funding secured for any given intervention is used to carry out monitoring and evaluation activities	APR 15 – MAY 15
EXECUTE	Carry out intervention(s)	• Implement strategies across activity domains and ensure ongoing monitoring	JUNE 15 →
EXECUTE	Evaluation report	• Measure outputs, outcomes and impact. The evaluation report should include: - Overview - SMART goals - Baseline measures - Evaluation methodology - Results and analysis - Demonstrated ROI and cost-effectiveness - Further recommendations	TBC (Dependent on intervention length)
SHARE	Share results	• Communicate outcomes and lessons to wider stakeholders	TBC

ANNEX 2 - General Recommendations*

#	TITLE	RECOMMENDATIONS
GR1	Work should be carried out across 3 separate activity domains	**GR1.1** All activities should be undertaken within three activity domains, namely - Advocacy (to address upstream determinants) - Community based stigma reduction (mass communications etc.) - Place-based behaviour change interventions (pilots) **GR1.2** A separate planning process, implementation plan, evaluation plan etc. would be developed for each activity domain **GR1.3** All activities undertaken within these domains would support the overarching project objectives outlined by WANADA/DAO/SIARG
GR2	Corrigan and Penn's advocacy model should be used as a framework, but PROTEST should only be used as a last resort	**GR2.1** Advocacy should be used to address upstream determinants and be based primarily on Corrigan and Penn's EDUCATE, CONTACT and PROTEST model **GR2.2** Further to GR2.1 we recommend that PROTEST is used sparingly, as a last resort due to concerns re. efficacy and suitability
GR3	Strategies should focus primarily on negative stigma associated with drug use	**GR3.1** The nature of the stigma surrounding alcohol use is very different to that surrounding other drug use. We recommend that each is addressed separately **GR3.2** Further to GR3.1 we recommend that any stigma-reduction campaign focus PRIMARILY on negative stigma surrounding other drug use

GR4	Consumer engagement to be informed by AOD-related stigma research findings	**GR4.1** AOD-related stigma research findings and considerations should inform the development of any consumer engagement framework **GR4.2** We also recommend that WANADA/DAO/SIARG fully consider the following questions: - What does consumer engagement actually mean? To us? To consumers? - Why are we doing it? What does success look like? - What level of participation/engagement is necessary? - What are the risks associated with too little, too much engagement?
GR5	Strategies should explore the notion of, and debunk myths relating to, consumer choice	**GR5.1** Stigma reduction initiatives need to aggressively challenge community (and influencer(s)) assumptions relating to decision-making and choice **GR5.2** Activities within the advocacy and community based stigma reduction domains should reinforce the impact of social/structural determinants on individual behaviour(s)
GR6	Initial focus should be on getting early wins	**GR6.1** The research indicates that many consumers and sector workers are almost resigned to the status quo. Early wins are needed to build meaningful sectoral support and momentum for the proposed stigma reduction initiatives
GR7	Prioritise storytelling as a methodology and enabler of change	**GR7.1** Mass media and advocacy initiatives should prioritise and preferentially resource storytelling techniques to EDUCATE audiences about the realities of AOD usage, and to illicit greater empathy and understanding toward problematic users of AOD and their families **GR7.2** The medium(s) though which stories are conveyed will depend on agreed target audience and budgets. They include: - Written stories (inc. blog posts, articles and books) - Digital stories (inc. video, pictorial, animated or video)

		- Spoken narratives (inc. stories at events, conferences and presentations)
GR8	Increase contact opportunities between target audiences and AOD consumers	**GR8.1** There is strong evidence that stigma may be diminished when people come into contact with members of the stigmatised group. We recommend considering ways in which contact between target audiences and consumers can be facilitated. Several options have already been identified in the consumer research

**Colmar Brunton Social Research and Clear Horizon's research.*

NB: A review of Clear Horizon's research was not within the scope of this project and so was carried out at no charge. As agreed with the client, we did not replicate/repeat recommendations already made by Colmar Brunton or Clear Horizons in their written reports. Many of their recommendations were useful and should be read in conjunction with those proposed by Marketing for Change.

ANNEX 3: Quick to Implement and Low Cost Options

Due to the uncertain funding environment and a need to push ahead with its stigma-reduction initiatives, WANADA asked Marketing for Change to suggest **low cost communication options** that could be used to address AOD-related stigma. The list below is by no means exhaustive. Typically, communication tactics and dissemination channels would only be selected following proper audience orientation.

#	Method	Activity Domain(s)	Notes
	Memes	Community based stigma	• Best used online, especially social media • Free pictures for use in memes readily available • No design skills required • Be mindful of humour
	Infographics	Community based stigma Advocacy	• Can be used in printed collateral and online, including social media • Free templates available • Minimal design skills required for basic infographics
	Poster campaign	Community based stigma Advocacy	• Can be very impactful when used for emotional appeals • May require professional photo shoot • Design would probably need to be outsourced • Use as print ads or online/social media to negate printing costs
	Publicity	Community based stigma Advocacy	• Community Newspaper Group, The West are always looking for good stories, and AOD is topical right now • Costs involved in generating releases and associated media liaison is relatively low • Scores of online news and blogging sites • Key considerations for this project: timeliness, local angle, human Interest • Also consider type of coverage – General news? Feature? Editorial?
	Social media	Community based stigma Advocacy	• Developing a simple social media strategy need not be expensive • Social media tools can be used for listening, engaging, telling your story, helping others tell their story, building community and more
	Speaking at events and conferences	Community based Advocacy	• May already be budget available for this type of activity • Captive audience • Allows for effective targeting
	Letter writing/email	Advocacy	• Targeted, personal

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