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Advocacy for People who use Drugs

The Development of a Digital Story Anti-Stigma Campaign: A Community-Based Participatory Research Approach

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Contents

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Foreword

The genesis for this report came from groups of people who are working towards creating change across communities, they are identifying some of the underlying causes behind poor outcomes for people who are drug dependent and are developing innovative, creative, and evidence-based responses. They are showcasing the critical analysis they have and the deep understanding of the structural nature of how we deal with drugs from a policy and service delivery perspective. The result of this report is a resource developed for policymakers, decision makers, services, state agencies, researchers and community members alike.

Members of communities have offered up their time, expertise and analysis to support change. They have taken risks and made sacrifices that none of us should have to make. They have navigated environments, structures and systems that have marginalised and excluded them through a lack of understanding informed by conscious and unconscious bias that have at times, created harm.

Who are this group that are on the front line in developing frameworks so we can build safer and stronger communities? They are people who we have been stigmatised, criminalised and in many cases denied their human rights because of a moral crusade against People Who Use Drugs. This report is their attempt to show the value, agency and power they have in being part of the solution.

They are People Who Use Drugs, and in more often people who use particular types of drugs and come from particular backgrounds. The report is informed by the UISCE Peer Partnership for Change framework which is a practical toolkit for ensuring high levels of participation from People Who Use Drugs, in the design, delivery and evaluation of service delivery and policy design with the aim of social change.

This framework informed a strong process in this project which democratised knowledge by involving peers in the research itself. It can promote social transformation rather than simply generating knowledge, or the acquiring of knowledge from a particular group, which limits their ownership over what is produced, and indeed the efficacy.

It’s a model of how to produce work that creates the conditions for a better, future, one we must build together.

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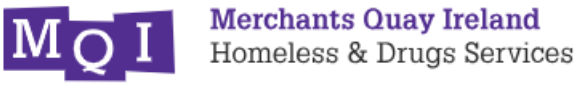
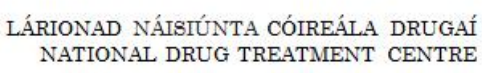

MQI
Merchants Quay Ireland
Homeless & Drugs Services


Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive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Executive Summary

Background

- Stigma manifests through the social, economic, and environmental conditions inhabited by People Who Use Drugs on a daily basis.
- Peers from UISCE, HSE National Drug Treatment Centre, and Merchants Quay Ireland co-produced a novel digital story to reduce stigma towards People Who Use Drugs.
- The project aimed to identify the impact of the collaborative design process, experiences of stigma, and solutions to reduce stigma.

Methods

- 15 peers from UISCE, HSE National Drug Treatment Centre, and Merchants Quay Ireland took part in the project.
- A combination of the photovoice technique, storyboarding, focus groups, and multimodal transcripts were used to design the final digital story.
- The project framework was underpinned by Community-Based Participatory Research (CBPR) approach and values from the Peer Partnership for Change Framework.
- The final story was created through consensus driven sessions showcasing democratic decision making amongst peers and academic partners in an equitable way.
- Peers took 198 pictures and shortlisted 70 for the final digital story.

Findings: Focus Group Interviews

- Pictures underwent Visual analysis, paying attention to the aesthetic, symbolic and abstract meaning of the photographs.
- A series of 7 focus groups were conducted. Discussions revolved around the experience with the process of photo taking and experience of stigma with associated solutions.
- Interview transcripts were analysed using codebook reliability deductive thematic analysis integrating intersectional stigma and harm reduction philosophy. There were six themes in total.
- **Theme 1: Invalidating hostile social systems**
    - This theme outlined how peers experienced internalised stigma which was reinforced through city policies on homelessness and hostile urban architecture. Experiences suggest the detrimental effects of social stigma on the family structure of People Who Use Drugs. All of this generated feelings of unbelonging.
- **Theme 2: Class and the accommodation sector**
    - Theme 2 outlined how national and local housing policies were perceived to reinforce a cycle of homelessness for People Who Use Drugs. Stigma in this context was experienced through class (lack of economic opportunity), community, and criminal justice orders (moving people on) which appeared to reinforce urban public aggression and

violence. Hostels were described as full of economic intimidation, violence, and overdose risk. Low income and pre-existing homelessness generated lack of opportunity to obtain housing in the private sector.

- **Theme 3: Inadequate national, local health, and social care systems**
    - Peer experiences suggest that stigma is reinforced between local city council policies of public needle disposal bins, and social stigma. Experiences of enacted stigma by emergency care providers were common. Class (low income) and strict rules for entry into psychiatric care together amplified desperation and thoughts of suicidal ideation. Lack of interagency care in rural areas and privacy when obtaining opioid agonist treatment increased exposure to social stigma. Gender-based discrimination in the social care system was detrimental to peers' mental health. Experiences of false claims to the social care systems led to situations of increased police surveillance and invasion of privacy, placing peers at risk for discrimination.
- **Theme 4: Criminalisation: "It's almost like racial profiling"**
    - Peers' experiences with the police suggests a multilevel, multidimensional and multidirectional form of stigma. Prior drug-related crimes generated a lack of economic opportunity. The absence of accommodation upon release from prison appeared to reinforce a cycle of class-based homelessness. There were common experiences of People Who Use Drugs being targeted by police based on class and prior drug history, including displays of power in the form of public humiliation and entering homes without a warrant. Police stations appeared to neglect medical issues and peers experienced violence by police. This reinforced experiences of trauma and drug use.
- **Theme 5: Inspiring social consciousness**
    - Despite these social and economic conditions, peer-to-peer initiatives transformed lives. This included peers becoming aware of their collective experiences, which motivated them to take direct action in their community. Knowledge exchange between higher education professionals, championing a peer-led overdose prevention strategy and presenting a community map which outlined preventable overdoses in Dublin generated feelings of equality. This allowed peers to establish a sense of belonging where they recognised their own resiliency to counter the effects of stigma.
- **Theme 6: Challenging and deconstructing systems of power**
    - Peers were able to identify ways to deconstruct stigma. This included recommendations that health care environments should take a non-judgemental and intersectional approach which will help improve the clinical experience. There were suggestions for a reduction in waiting times for psychiatric care and increase in mental health and drug services. Peers suggested that challenging stereotypes, showcasing authentic lived experience and rehumanise People Who Use Drugs are suitable topics for future anti-stigma campaigns.
- Peers were positively impacted by the research. For example, photography skills provided a sense of pride and empowerment and creative expression to process everyday life experiences as a People Who Use Drugs.

- The group process of creating the campaign was valuable in helping peers to raise awareness of the structures that enact stigma, identify their personal strengths, and process feelings of stigma in a supportive community.
- The results demonstrate the benefits of using an intersectional analysis as it identifies how multiple systems of power reinforce stigma as opposed to frameworks that only focus on cognitive attitudes.
- This analysis provided a detailed insight into ways to deconstruct stigma which will be used to inform the development and implementation of an anti-stigma training and public campaign.
- Clinicians should integrate an intersectional framework when providing therapeutic care for PWUD. This includes account for the nuances of gender and class related stigma for PWUD and use self-reflexivity to explore how their own intersectional identity can interact in the client-patient exchange.
- A list of recommendations is provided on the next page with attention to how it parallels recommendations from the Citizens' Assembly on Drug use 2023 (Citizens' Assembly on Drug use, 2024).

Recommendations

Recommendation 1:

Health and social care settings should use an intersectional approach when caring for People Who Use Drugs.

Explanatory Narrative: Health care systems (e.g. emergency care, hospitals), mental health systems (e.g. psychiatric offices, mental health clinics) and drug treatment systems (e.g. opioid agonist treatment clinics) should acknowledge the multiple marginalised identities People Who Use Drugs inhabit. This includes taking an intersectional lens in their approach to care involving the recognition of how systems of power may reinforce typical stereotypes of People Who Use Drugs and their families, the effects of class, and how this relates to maintaining wellbeing and quality of life. Ensuring approaches are trauma-informed based on multiple issues of ability (mental health, trauma) and gender focused care is imperative. In addition, practitioners should consider using self-reflexivity to explore how their own intersectional identity relates to the therapeutic process. This aligns with the Citizens' Assembly recommendations 2,15, 23 and 31.

Recommendation 2:

Peer-led anti-stigma training is needed to reduce stereotypes, prejudice, and discrimination towards People Who Use Drugs. Such trainings should take an intersectional approach aimed at health professionals, the housing sector, police, and social workers

Explanatory narrative: A peer-led anti-stigma training should be delivered to ensure adequate delivery of recommendation 1. Our digital story addresses these core issues and will provide authentic experiences, generate empathy, and build relationships which will effectively change attitudes. Recent evidence demonstrates that peer-led training can reduce stigmatised attitudes in health professionals, members of the public, and police (Eaton et al., 2018; Greer et al., 2018; Russinova et al., 2014). This recommendation aligns with Citizens' Assembly recommendations 2, 9,10, 15 ,22 and 29.

Recommendation 3:

Coordinated public stigma campaigns are needed to reduce intersectional stigma towards People Who Use Drugs.

Explanatory Narrative: Public stigma campaigns aimed at rehumanising, challenging stereotypes and showcasing the intersectional experience of People Who Use Drugs is called for. There is some evidence that social media campaigns show efficacy in reducing negative public stigma (Bonnevie et al., 2022; Treloar et al., 2017). This includes use of videos, digital stories, and other media to achieve campaign aims (Holland et al., 2024). Other alternatives include a cross coalition of community groups working together to mobilize around a stigma campaign. This may

involve community messaging, posters, and or media. These types of campaigns show evidence of reducing stigma (Lefebvre et al., 2020). This aligns with the Citizens' Assembly recommendations 2, 9,10, 15 ,22 and 29.

Recommendation 4:

Harm reduction interventions should be aligned with modern evidence-based international practices. This includes deregulation of naloxone, increase of needle disposal and exchange, street level drug checking, and safe consumption spaces across Ireland.

Explanatory narrative: The most up to date evidence showcases that direct access to naloxone can prevent drug-related deaths. One way to achieve this is through deregulation. Such examples include community pharmacies dispensing over the counter naloxone (Eldridge et al., 2023) and the use of naloxone vending machines (Allen et al., 2022; Wagner et al., 2022). Research has also demonstrated the success of street level drug checking across 20 different countries in reducing overdose deaths (Barratt et al., 2018). In addition, as drug trends shift to include different substances and routes of administration, a safer consumption site is needed rather than just a medical supervised injection facility. Such measures align with Citizens' Assembly recommendations 31 and 32.

Recommendation 5:

Drug-related offenses should be decriminalised and there should be a reduction in police surveillance based on drug use, socioeconomic status, gender, and class.

Explanatory Narrative: People Who Use Drugs are over policed and under protected and this leads to police and wider society seeing violence as acceptable with no recourse for action. People Who Use Drugs face significant discrimination, particularly in their interactions with law enforcement. Gardaí (Irish police) often disproportionately target People Who Use Drugs, perpetuating harm through criminalization and aggressive policing practices. This systemic approach has wide-ranging negative impacts, not only on the individuals involved but also on their families and broader communities. This is evident in several reports conducted in Ireland (Irish Penal Reform Trust, 2019). This aligns with Citizens' Assembly in recommendation 16 and 17.

Recommendation 6:

Opioid agonist treatments should be expanded in rural areas. A thorough review and removal of strict entry requirements for mental health and drug treatment needs to occur so People Who Use Drugs can access the care they need.

Explanatory Narrative: Peers described several barriers to treatment including strict rules for accessing mental health services due to pre-existing drug use. This is often not obtainable and realistic as brings shame in People Who Use Drugs and drives

poor mental health and continual drug use for those who are not able afford treatment.

Recommendation 7:

Local city councils should reduce hostile architecture in the urban environment and incorporate more community-based art projects that are inclusive of People Who Use Drugs. This will acknowledge their value and role in implementing strength-based responses to community identified issues.

Explanatory Narrative: It is recommended that the City of Dublin eliminate hostile architecture in environments frequented by People Who Use Drugs, including outside of important health care centres such as opioid agonist treatment clinics. Instead, the integration of peer-led artwork in the city centre will create a sense of community and enable conditions for people to move from being excluded and having no voice or sense of value to being included, having a voice, value and a role in our communities.

Recommendation 8:

Relevant authorities, State bodies and service providers should ensure their commitments under the Public Sector Duty and the National Quality Standards Framework for Homeless Services in Ireland are adhered to. This includes an independent evaluation that is led by people with current living experience of emergency accommodation and drugs to ensure accountability. The private accommodation sector should ensure that People Who Use Drugs are not discriminated against for housing opportunity, in line with national policy Housing First.

Explanatory Narrative: These accommodation spaces should ensure a human rights framework is incorporated to address current negative experiences and poor outcomes for people in emergency accommodation and align their policies with the national drug strategy, which includes allowing People Who Use Drugs to carry, train peers and use naloxone if needed in the accommodation they live in. Hostel staff could benefit from training on how to work with people with multiple marginalised identities such as anti-stigma training (recommendation 2). In addition, changing housing policies to incorporate non-discrimination clauses based on class and prior criminal history would support People Who Use Drugs entry into the housing market.

Recommendation 9: Increased investment in community-based groups is needed. This includes funding to improve access to education and opportunities for employment for People Who Use Drugs.

Explanatory Narrative: There has been progress along health interventions for People Who Use Drugs, however their economic circumstances lag behind. There is a need for more community-based programs that can help improve the standard of living of People Who Use Drugs that include access to educational programs and equitable employment independent of criminal history.

Section I: Project Background and Methods

Caption: Peers brainstorming on experiences of stigma and ways to reduce stigma

Project Background

People Who Use Drugs in Ireland experience significant marginalisation due to social and structural stigma, which affects their access to healthcare, social support, and policy decisions that impact their lives (Livingston, 2020; Livingston, 2021). Stigma creates barriers to harm reduction services, ultimately contributing to poorer health outcomes (Hatzenbuehler et al., 2013). People Who Use Drugs in Ireland often possess multiple marginalised identities based on socioeconomic status, class, and gender furthering their vulnerability to drug use, violence, and crime (Leonard & Windle, 2020; Windle et al., 2022). This suggests that People Who Use Drugs may experience multiple forms of stigma simultaneously or more simply intersectional stigma- which involves social and structural stigma based on identity (e.g. age, gender, class, ability and race). This challenging landscape is further compounded by Ireland's high rate of drug-related deaths. Between 2019 and 2020, drug-related fatalities increased by 9.5%, with 69% of deaths in 2020 linked to opioids (Health Research Board, 2023). Stigma and drug-related mortality highlights the urgent need for evidence-based, person-centred responses that challenge prejudice and improve health and social outcomes for People Who Use Drugs.

Research exploring the prevalence of social stigma in Ireland consistently demonstrates endorsements of negative stereotypes, fear, dread, lack of sympathy and willingness to discriminate towards People Who Use Drugs by the public (Bryan et al., 2000; Citywide, 2016; Miller et al., In Press). Prejudice was the strongest predictor of lack of support of evidence-based policies to reduce drug-related deaths (Miller et al., In Press). Structural stigma includes policy delays for implementing evidence-based harm reduction interventions such as direct access to naloxone. Delays in the opening of the medically supervised injecting facility (MSIF) further illustrates how structural stigma obstructs harm reduction efforts (Atkin-Brenninkmeyer et al., 2020; Miller et al., 2023). Despite years of advocacy from peers and harm reduction organisations for the establishment of a drug consumption room, political and bureaucratic barriers repeatedly stalled its progress. When finally opened, it was restricted to injecting drug use only and introduced on a pilot basis, falling short of the comprehensive, low-threshold service that advocates had fought for. This has been echoed in delays in executing recommendations from the latest Citizens' Assembly on Drug Use such as the decriminalisation of drugs (Citizens' Assembly on Drug use, 2024; Joint Committee on Drugs Use, 2024).

The evidence base for intersectional stigma demonstrates that this stigma is higher for PWUD who from the lower class as compared to middle or upper class PWUD (Chavanne et al., 2023; Wood & Elliott, 2019). Women Who Use Drugs are consistently more stigmatized than their male counterparts (Meyers et al., 2021; Vu et al., 2019). Internalised stigma increases for gay men who have HIV and who use substances (Batchelder et al., 2021). The psychosocial impact of intersectional stigma includes poor mental health outcomes, increased social isolation and shame (Austin et al., 2021; Hook et al., 2022). Methods to explore intersectional stigma

include the use of creative methodologies such as photovoice-where members of a community document their experiences in photographs- and digital storytelling. This method can outline the structure and spatial relationships of sustaining the various aspects of stigma and also how to deconstruct the stigma to inform stigma training and campaigns (Earnshaw et al., 2022).

In response to this prevalence of stigma, peers with lived and living experience of drug use from UISCE, Merchants Quay Ireland, HSE National Drug Treatment Centre and researchers from the University of West London collaborated on the design of a novel anti-stigma digital story campaign from June 2024-December 2024. Using a Community-Based Participatory Research (CBPR) (Israel et al.,2005) underpinned by the Peer Partnership for Change Framework (Kelly et al., 2024; UISCE, 2022), the lived and living experience of People Who Use Drugs were placed at the centre of the design process.

The research focused on addressing the following questions:

1. What is the experience of using a CBPR approach to reduce stigma?
2. How does community and drug related stigma manifest?
3. How can stigma be overcome using the digital storytelling?

Methods

Design

The campaign design incorporated the photovoice technique, storyboarding, and focus group interviews to make the final digital story. CBPR was used as a framework to monitor the level of peer engagement throughout the training and campaign development (Israel et al.,2005) (Figure 1). Underpinning this process were the key values of the Peer Partnership for Change Framework (Kelly et al., 2024; UISCE, 2022).

Peer researchers

15 peers were recruited, all of which were existing volunteers with UISCE, Merchants Quay Ireland and HSE National Drug Treatment Centre. The project was approved by the University of West London Ethics committee (UWL/REC/PSW-01589). All peers provided informed consent and provided basic demographic data as follows:

- Average age was 52.5 years old.
- 11 people reported as being Male with 4 reported being Female.
- 12 people lived in the Urban environment with 3 living in the Suburban environment.
- Range in length of being a peer was from 3 weeks to 2 years.

Photovoice Procedures

Peers were recruited through snowballing techniques where the UISCE peer coordinator Andy O'Hara (AOH) provided information about the study to the UISCE peer-led outreach team, Merchants Quay Ireland peers and the HSE National Drug Treatment Centre Peer-led Advisory Board to recruit participants. Peers were trained in the Photovoice technique by Nicole M Miller (NMM). The training consisted of two 5-hour photovoice trainings, followed by 2 digital storytelling workshops.

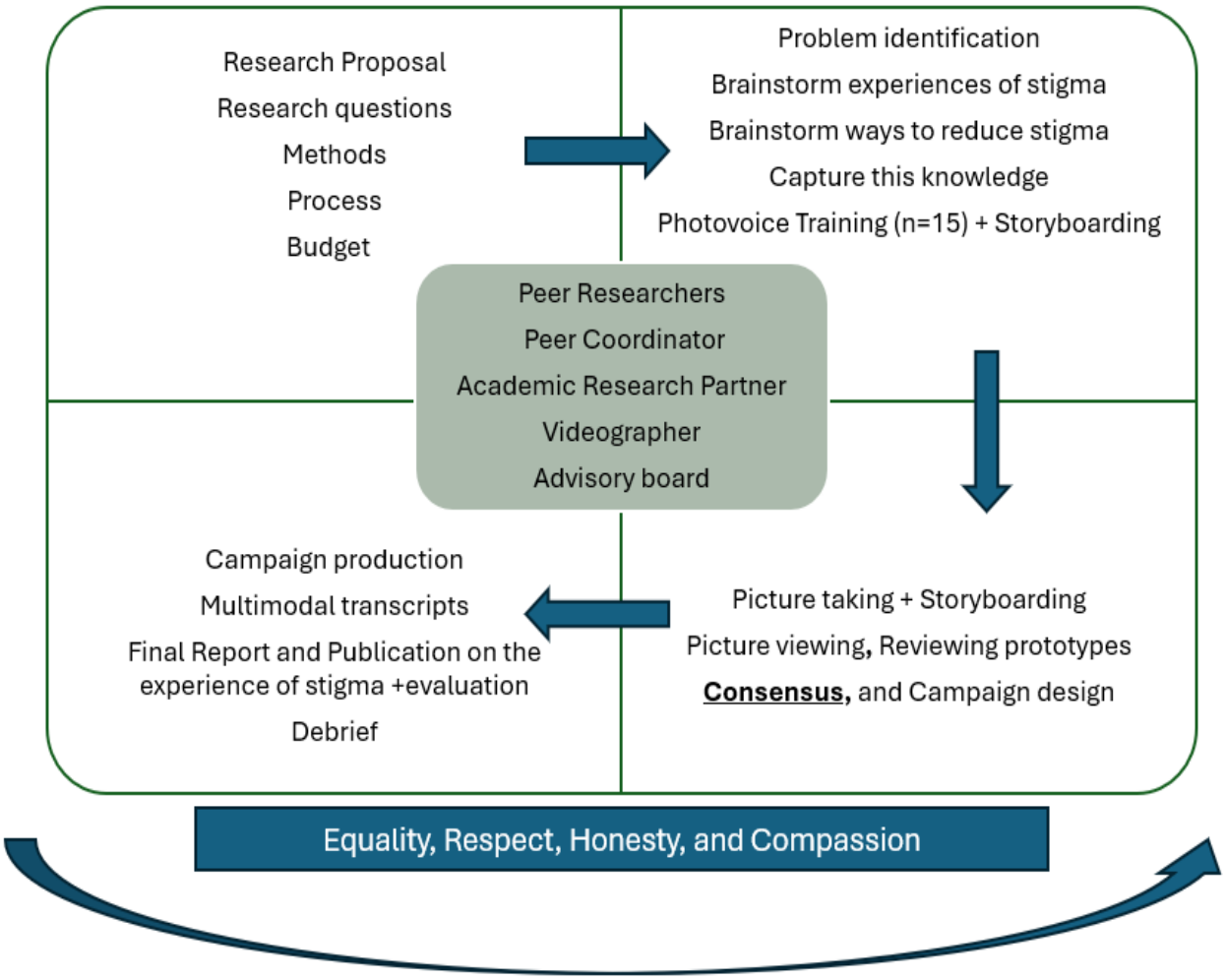
The photovoice training started with peers brainstorming about their experiences of stigma and solutions to reduce stigma. Peers were then educated on photo literacy including concepts (e.g. subject, space, contract, light and shadow) and ethics of photography. Peers engaged in taking and discussing pictures and learned how to caption pictures to express meaning. The peers were asked to take pictures of stigma and solutions to reduce stigma upon completion of the training. The peers were instructed to upload their own pictures and captions online to the Padlet application. UISCE coordinators helped peers with taking and uploading pictures as needed. Peers engaged in focus group interviews to discuss pictures. Finally, peers engaged in two consensus building sessions to shortlist pictures for the final digital story.

Storyboarding Procedures

Peers were trained by AOH in the 7 steps of storyboarding (Lambert, 2013) to help them express their feelings of stigma. Storyboards were developed based on the brainstorming session during the photovoice training. This included exploring what is stigma, its impact, how to change it and integrate this into a storyline (beginning, middle and end). Peers used their storyboard to assist with picture taking for throughout the project.

In the spirit of CBPR approach, steps were taken to ensure training materials were adjusted, considering different reading and levels of understanding. Peers who were not confident using a camera or did not have access to one were able to work with another peer for equitable engagement. The Community Engagement in Research Index (CERI) was used to monitor peer engagement and ensure the project kept to the principles of CBPR (Khodyakov et al., 2013) The project produced a CERI score of 10.6; demonstrating a high level of peer engagement. Figure 1 demonstrates the level of peer engagement throughout the research process. This included providing feedback at all levels of the project (arrows) across various domains of the research.

Figure 1. Application of Community-Based Participatory Research and Peer Partnership for change



Analysis

Visual analysis (Collier, 2001) was conducted for every picture by the main authors (NMM, RB) and checked by a member from UWL research team. Analysis for each stage was placed into an iconography matrix table which included open viewing of the pictures and inventory of the images. The last stage was a structured analysis involving a review of the photograph captions with notation of the description of the picture, its symbolic or metaphorical meaning and notations of how the caption related to the literature on stigma (Corrigan et al., 2017).

There were 7 focus groups in total. The focus groups averaged 50 minutes in length (range 42-64 minutes). The interviews were semi-structured and conducted by NMM. The following questions were asked when exploring the photographs:

1. Describe your picture
2. What is happening in your picture?
3. Why did you take a picture of this?
4. What does this picture tell us about stigma?
5. How can the picture provide opportunities reduce stigma?

The interviews were coded and analysed by NMM using codebook reliability deductive Thematic Analysis (Braun & Clarke, 2019) and hybrid coding techniques (Fereday, & Muir-Cochrane, 2006). Codes were developed by combining Intersectional frameworks on stigma which conceptualises stigma as occurring across systems of power (multilevel) which are enacted across multiple marginalised identities (multidimensional) such that one level of power can shape and reinforce stigma at another level (multidirectional) (Collins et al., 2019; Earnshaw et al., 2022). Attention to social and economic conditions relevant to Harm Reduction philosophy was incorporated throughout the entire analysis (Roe, 2005; Smith, 2012; Vakharia, 2024). All transcripts were second coded by a UWL staff member to ensure trustworthiness of the data. The results of the visual analysis were combined with the focus group interviews to provide a comprehensive narrative. Adhering the CBPR checks, the results were finalised with the co-author AOH. The findings of this will be presented in Section II.

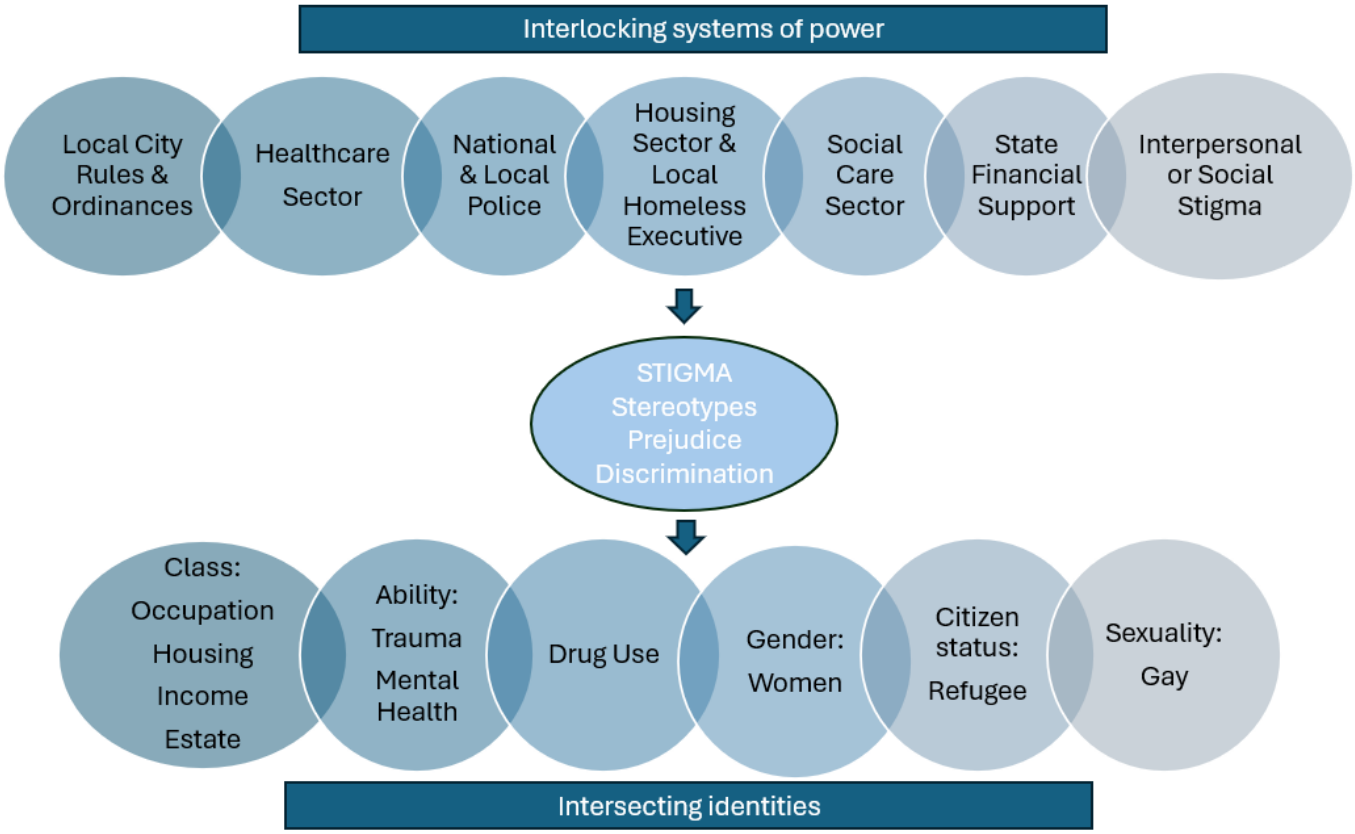
Section II: Results

Results

The experiences of the peers suggest that interlocking systems of power across multiple levels of society can enforce and sustain stigma. Peers describe stigma being enacted through stereotypes, prejudice, and discrimination based on their status as an existing or past drug user and multiple intersectional identities. These experiences were often multidirectional or where one level of stigma reinforced another. The analysis identified six major themes. Figure 1. demonstrates the key structures and identities discussed in the interviews. Themes one through four represent the experiences of stigma across these social structures. Themes five and six demonstrate how stigma is deconstructed based on peer-led solutions for social change.

Figure 1.

Model explaining how interlocking systems of power enact stigma on the intersectional identities of People Who Use Drugs.



Theme 1: Invalidating hostile social systems

Peers described experiences of hostile social and environmental conditions demonstrated in subthemes of *Invisible split sense* of being and *Spaces of unbelonging.*

Invisible split sense of being

Peers described experiences of internalised stigma feeling *“not part of society”* (Focus Group 7, Peer 1). Internalised stigma was experienced through their class (homelessness). For example, a peer described being unhoused and perpetually asked to move out of public spaces by local council workers and police” *Like, you'd be terrified of council workers in vests and everything. It's virtually sleepwalking and cops shining torches in your eyes being like you can't sleep here. And you're just like where do I go*? (Focus Group 7, Peer 1). This led to questioning their sense of self generating feelings of desperation and shame. A peer took a picture (Figure 2) of “*Anti homeless architecture*”. The picture became a symbol of low self-worth that was reinforced daily in the city centre. This experience suggests that interlocking policy structures—city policies on homelessness and city urban architecture—can sustain and reinforce internalised stigma.

Figure 2.

Caption: Tho it sposeda be our fault n evryone judges us, we aint alowed to follow or even try to better ourselves. aint even allowed to survive. When the cops move you on all day when your just tryna sleep ,time after time, you can be shakin with exhaustion n its stil,you cant stay here, even in public spaces like librarys n parks no one wants us and we get harassed just for existing. these spikes is the window opposite my methadone clinic,im always exhausted n still feelin sick leaving so i try find somewhere to sit n roll a smoke, n dis is the first sight confronts me every morn. reminding me it dont matter how crappy I feel, takin a breath n a rest aint for the likes of me . it makes me sad every time.

Spaces of unbelonging

The peers experienced hostile social conditions within the city centre, neighbours, and amongst the family. This appeared to invalidate their identity, and generated feelings of unbelonging. Peers experienced public and economic discrimination in shopping areas thereby limiting economic opportunities and obtaining resources needed for their wellbeing. For example, some peers were removed by security in local stores "*They won't even allow you in*" (Focus Group 2, Peer 3) and "*They'd make a show in front of everybody*" (Focus Group 2, Peer 1). One peer took a picture to demonstrating how managers can use their power to remove people (Figure 3). This power was perceived to be used indiscriminately against People Who Use Drugs. A peer describes their experience:

> They're all over town. And what happens there is, as soon as, as soon as somebody takes a look at you and they think, this persons on drugs, right, they're not allowed in here…. You cannot go on to the premises if they think you're a drug user. And you're immediately discriminated against. You see them everywhere all over town" (Focus Group 6, Peer 2)

Figure 3.

Caption: Discrimination.

There were also experiences of destruction of property owned by People Who Use Drugs. One peer described how a friend went into the hospital and returned home to find their toilet destroyed, describing it as a "*deliberate and vandal act*" (Focus Group 6 Peer 2). A picture of a toilet (Figure 4) became a metaphor for the broken social and economic structures that erode basic human functioning for People Who Use Drugs, "*Imagine, you don't have access. You don't have access to a toilet. So, it's two o'clock in the morning, suddenly you've got diarrhoea. How do you deal with that?*" (Focus Group 6 Peer 2).

Figure 4.

Caption: This toilet was in a house in Dunne street, where people regularly smoked crack. The girl who owned the house ended up in hospital. People smashed up the toilet. The stigma that people tell her it was perfectly okay for them to do this.

Social stigma impacted the family in several ways. Either society stigmatised family members or family stigmatised their own members. This demonstrated how social stigma can erode the family system and be detrimental to the structure of a person's familial identity- a vital resource for belonging. To start a peer described how community members aimed negative judgements at their mother about their drug use:

> I'm the only person who used drugs, and for her whole life, she had to be approached by people saying things about me. And she had to stand up and say, no, that didn't happen and pick up for me. And sometimes it might have happened. And just because I was her son, She took the stigma. Do you know what I mean? (Focus group 1, Peer 3)

This resulted in experiences of depression and shame as symbolic by the hunched shoulders and hands covering the face in Figure 5.

Figure 5.

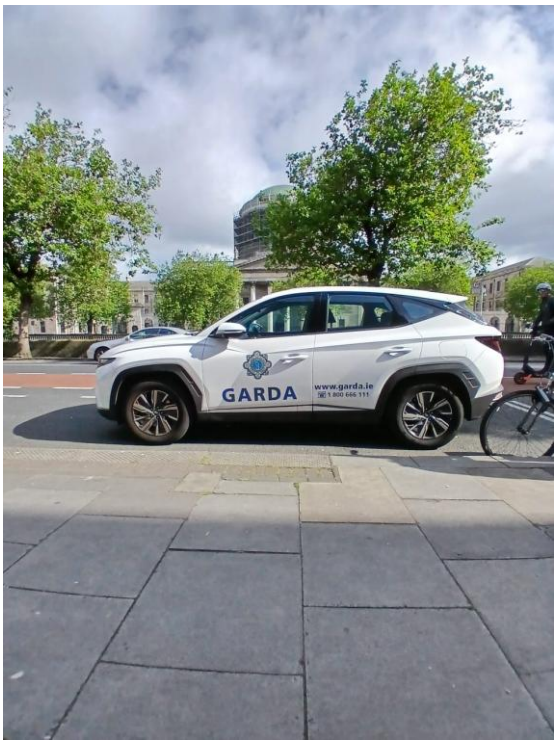
Caption: My mother took allot of stigma in the area over my drugs use.

Other members of the family endorsed typical stereotypes of People Who Use Drugs and enacted stigma on their loved ones "*My family stigmatised me because I was addicted to those tablets like I was a junkie. I was a everything…every name you can call under the sun for being on drugs*." (Focus Group 3, Peer 2). This stigma continued after they stopped using drugs "*Even when you're doing well. It's still there.*" (Focus Group 3, Peer 1). Family fears were aired "*I think they're afraid that when I do fully, when I do fully finish with the methadone that I'll probably go back to heroin, but I'll never go back to heroin, no*." (Focus Group 3, Peer 1) along with accusations of being on drugs when they were not on them *"But when they start saying things to me. Saying like you're fairly loud you must be on something or you're talking too much you must be on something"* (Focus Group 3, Peer 2). Peers were also discriminated against by family members based on their alcohol use and sexuality "*I've been down the street that night and seen them leaving the pub…and he's seen me, he is against me for my sexuality, so he blamed me.*" (Focus Group 2, Peer 3). This suggests a hostile family system full of fear and suspicion.

Last, class-illegal employment and criminalizing drug policies appeared to reinforce associative stigma, passing it down through generations. One peer described how their family had a history of engaging in illegal employment "*I carry the sins of my parents because both my parents were prolific, you know, my father*

was a drug dealer and shoplifter." (Group 5, Peer 1). These family members were known by the police and as a result the peer was guilty by association "*But the guards then, because of the hatred for my parents, that automatically was projected onto me It's such and such and such and such's daughter."* (Focus group 5, Peer 1). The police car then becomes a metaphor to experiences of generational trauma and criminalisation (Figure 6). This experience suggests a multidirectional relationship between two systems of power, class and criminalisation, can work to enact stigma.

Figure 6.



Caption: The stigma and the criminalisation of People Who Use Drugs needs to end. How are we ok as a Society targeting our most Vulnerable, Traumatised and Marginalised members of our society.... Nobody should be punished for taking drugs.

Theme 2: Class and the accommodation sector

Theme 2 outlines experiences of class, national and local housing policies and the private accommodation sector interacting to reinforce stigma towards People Who Use Drugs. The first subtheme *National policies, street level homelessness, and interpersonal stigma* describe the experiences the national and local level accommodation sector and how this relates to social stigma and class. The second subtheme *Hostels as risk environments, full of violence and intimidation* explores how hostel accommodation is full of aggression and overdose risk. The third subtheme *Class-based discrimination within hostels and estate agents* explores how class- namely being homeless and on low income relates to lack of opportunity to gain housing the private sector.

National policies, street level homelessness, and interpersonal stigma

Peers described their perceptions of the accommodation sector. When discussing why there is not enough beds in hostels and other rental spaces, one peer said it was due to the "*national attitude… It's like we have actually come to accept and it's perfectly alright to throw bodies all over the city.*" (Focus Group 6, Peer 1). Continuing the conversation, the peer described it as being caused by rent freezes and the private accommodation sector increasing rent. This suggests awareness of the macro level economic processes related to housing. They stated:

> I actually think there is ample space to address what they call the homeless situation. I just think that money Uh, property owners want as much as they can get. And it's like, we had a rent freeze for three years in this city. There were all sorts of agitation over the three years to get it removed…they eventually took it off, which basically gives plans to landlords to up the rents…and then people can't pay. (Focus Group 6, Peer 1)

In addition, peers believed multiple marginalized identities were related to homelessness, showing awareness of their own social status and how it relates to the wider social and economic conditions they face. Two peers describe:

> Right. Nine times out of ten, people that were experiencing homelessness have either got a criminal record, or are in addiction, or ill, and poverty stricken. (Focus Group 6, Peer 1).

> The most stigmatised people are IV drug users, people with, um, the, some of the diseases that result, long term homeless, especially street dwellers and, uh, working girls. (Focus Group 7, Peer 1)

There were numerous photographs (Figure 7 and 8) showcasing the connection between homelessness and social stigma.

Figure 7.

Caption: This is Henry Street. The people in the photo are just chatting. They live on Henry street, they sleep, they beg there. They are harassed by police. The stigma attached to homelessness.

Figure 8.

Caption: Walked over. Judged for being in a sleeping bag regardless of who they are.

Peers recognised that their community "*shouldn't have to live like that"* (Focus Group 3, Peer 2). This was important for specific areas in the city where people "*on the canal in tents like in the winter, a big gush of wind could put you in that water*" (Focus Gorup 3, Peer 1). There were also experiences that demonstrated the connection between class (homelessness and begging), social stigma and criminal justice orders to perpetuate stigma. One peer took a picture of a woman begging to describe this interaction (Figure 9) along with accounts of verbal, physical aggression, and abuse:

> With shops because you're sitting outside like business and that. They come out and they throw water and dirt. Oh, you can't sit there, or they'll go to ring the guards and get you moved on… And if it's not the businesses, its people walking past, like there could be a gang of a youths gone past and they'd start with the girl, and they kick her and throw stuff around her." (Focus Group 3, Peer 2)

Figure 9

Caption: This girl was stigmatised for being homeless.

Hostels as risk environments, full of violence, and intimidation

Hostels were perceived as places that did not provide an opportunity for People Who Use Drugs to break out of the cycle of drug use and homelessness. Instead, these spaces were considered holding points for moving forward in their lives:

> Like you said, when we're in the hostels, your life is on hold. You can't maintain family relationships with your partner, your children, because. of the rules and regulations. (Focus Group 5, Peer 1)

These hostels were also full of economic intimidation, violence and overdose risk:

> like about how hellish hostels are and it's not the fault of the staff. A lot of the staff on the ground are trying their best but the violence is horrific and bullying and drug use, like you're forced into it a lot of the time because people want your money… As soon as you go into a hostel, they know you want disability or job seeker, what day do you get paid, you literally get followed to the fucking ATM. You know, you can't stay clean in those places (Focus group 7, Peer 1)

One peer described a hostel catered to "*foreign nationals*" where they found a person lying in an unnatural position on the steps (Figure 10). They later found out that the person had died:

> Yeah, he was at the bottom of those steps…this guy was there, but nobody was reacting to him. Well, it, it was, I couldn't understand why there were people standing within two feet of this hotel where this guy is just, it was weird. It surreal. They then picked the guy up, He was blue. It was a real death color. like, so somebody can die in Dublin and it doesn't cause a ripple, like, so I don't, I, you know, there's parish meetings too, that's somebody's son. Yes, somebody's son. Some, yeah, some, somebody's son. (Focus Group 6, Peer *1)*

Figure 10.

Caption: I photographed these steps because again this hotel caters for refugees and homeless people. A few months ago, I saw a man who was in what appeared to be an awkward position, no one was reacting even though they were smoking and talking a few feet away and the police later said the man was dead.

Class-based discrimination within hostels and estate agents

The private accommodation sector was perceived to reinforce stigma. For example, letting companies had "*glass doors*" (Focus group 7, Peer 2) where agents were perceived to judge people based on their physical attributes. Other forms of discrimination were idle promises, delays and, economic based discrimination with people on social welfare payments. This led to frustration and "*back into the cycle of homelessness, drug use*" (Focus group 7, Peer 2) Some peers shared:

> I was promised help and pre-approved for me and my daughter, and I still have no phone calls to this day. (Focus group 7, Peer 3)
>
> You're coming from homelessness, you're coming from drug addiction, you're not going to be looking all flashy, getting out a BMW, rocking up with loads of money in your bank account. You're going to be looking rough, and they already have their opinion, their mind made up, that you're not going to get anywhere… İt doesn't help people who want to get help of a situation. (Focus group 7, Peer 2).

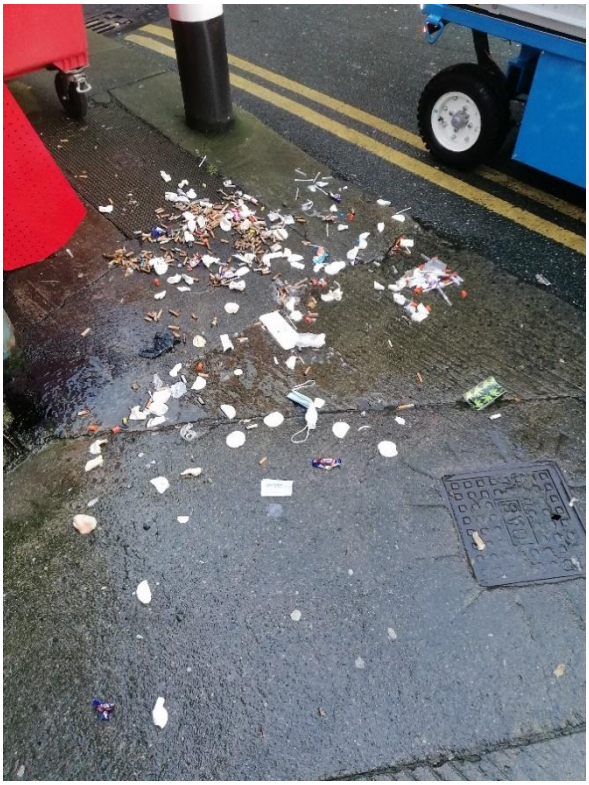
Theme 3: Inadequate national, local health and social care systems.

Reduced access to evidence-based care

Peers describe several consequences to the delay of the medically supervised injection facility. This included "*no safe places*" (Focus Group 5, Peer 3) to use drugs where members of their community had to continue to use in alleys and in open streets "*Probably four times out of week it's going to rain. You don't want to be in a bush f**ing taking your drugs*" (Focus Group 1, Peer 3). This further increased stigma and shame, suggesting how structural stigma can manifest in drug-related harms.

Peers described how the city council denied safe areas to dispose of needles because it was "*giving permission*" and "*advertising*" drug use. This appeared to fuel public stigma which increased stereotypes that People Who Use Drugs are reckless, dangerous, and dirty. One peer described the picture in Figure 11 "*You see if people are walking past that…they're saying to themselves, these f**king junkie scumbags just don't give a f**k. They're just leaving everything everywhere*." (Focus Group 1, Peer 3).

Figure 11.



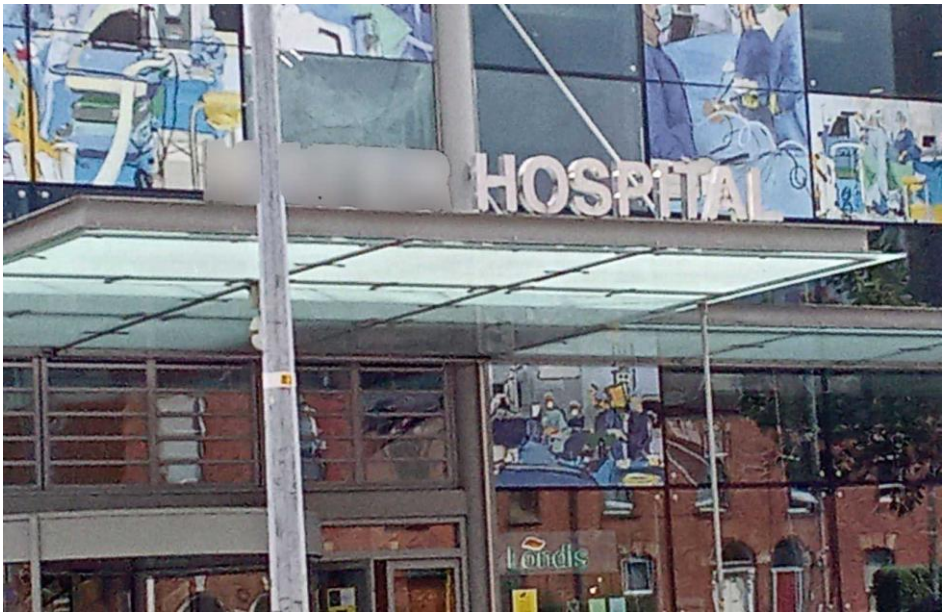
Caption: Ground zero-This reminded me of my old life as there's allot of paraphernalia which shouldn't be there but that's what happens when people have nowhere to go. So, we really need the SAFE INJECTION FACILITY NOW.

In order to cope with this problem, the city council would send the sanitation department to clean the area. It was perceived this *"Stigmatizes the life out of* People *Who Use Drugs because they are everywhere…*" (Focus Group 1, Peer 3). All of this suggests a multidirectional relationship between local city council policies and availability of public needle disposal bins.

Peers also described the need for direct access to naloxone in the form of deregulation or over the counter naloxone obtained at a pharmacist. The current regulations were perceived to demoralised People Who Use Drugs and their families to "*beg for something to save a life*" as opposed to "*it would* be *easier just to go in and ask for* it" (Focus Group 1, Peer 2).

Interpersonal and structural stigma within medical hospitals, mental health clinics.

Figure 12



Caption: I was stigmatised by the hospital when they found out I was on drugs.

Almost all of the peers had negative experiences within the medical system, including emergency rooms (Figure 12) and mental health clinics. One peer described being discriminated against by a trainee doctor. This included the doctor ignoring the peer's knowledge about their own body when attempting to access veins during a blood draw. The peer attributed these actions based on stigma, "*I've been treated like that because they thought I was still fully on drugs*" (Focus Group 3, Peer 1):

> I was just saying like he was horrible at me trying to get blood. And I kept telling him you will not get a vein there, I know for fact you will not get a vein there, but he just kept trying and trying. But he was really hurting me, and I kept telling him you're really hurting me…and because he couldn't get blood, he put a big needle through my wrist… he had to go into an artery. He chose that option for blood instead of going to a different part of my body…The doctor came down and actually gave it out to him for doing that thing in my artery. Cause the doctor said you should've just gone straight to her neck. The doctor done it himself then and straight away the doctor got it. (Focus Group 3, Peer 1)

Stigma in this context was detrimental as peers would actively avoid going to the hospital. This was apparent for those who had both mental health and drug use issues. One peer described experiencing several overdoses because of poor mental

health and always having to call an ambulance. The ambulance was the only safe space where they never felt stigmatised because "*I have been stigmatized when it comes to the hospital*" (Focus group 1, Peer 2).

Other peers described being in mental health environments that had strict and unrealistic rules about getting access to care "*The (name removed) Departments of Psychiatry will not help you, mentally, at all, unless you are not using drugs*" (Focus Group 7, Peer 3). Because of lack of income (class) they could not pay privately and had to use state services, which involved long wait times "*So instead of you getting dealt with there that day it could take you 18 months to have a problem that makes you want to feel like you want to put a gun up to your head*". This often resorted to lying to the doctor in order to get help. This lying was detrimental for those who had anxiety and a past history of trauma "*They're anxiety…possible PTSD. I've been self-medicating with drugs to help*" (Focus group 7, Peer 3) as mental health services were needed to help prevent depression and suicidal ideation.

Gender-based stigma within the social care system.

There were common experiences of gender-based discrimination involving the social care system. Peers who identified as women reported being in "*constant fear of losing our children*" (Focus Group 5, Peer 1). This also limited the ability to ask for support if they wanted to stop using drugs "*I feel that women, you know are more fearful and reluctant to reach out for help due to that stigma*". Instead, they encountered experience of being punished by the social care system, which lead to further marginalization. One peer stated:

> Because women, like, with kids, automatically are terrified your kids are going to be took. That's what happened with me, because I wanted to get into treatment, even though I was still clean. Yeah. It didn't matter. The kids were still taken till I got out of treatment like that" (Focus Group 4, Peer 4).

In addition, some of the peers had traumatic experiences within the care system itself including discussions about being abused by those in authority, suggesting woman are more vulnerable in these institutional settings. These experiences were reinforced with a symbolic picture depicting women standing with their backs to the camera representing feelings of shame (Figure 13).

Figure 13.

Caption: Women who use drugs can't ask for help they have to hide the fact that there are addicted due to discrimination and Stigma, We live in constant fear of losing our children.

Experiences of punishment continued long after social care cases were closed. This was intensified by the estate (class) they lived in and prior drug use history (drug policy) and gender. One female peer described the effects of a false complaint about their child's safety. To start, the peer described living in a "*no go area*" (Focus Group 4, Peer 4) that was known for being lower class and criminal activity. In addition, stigma was attached to the breed of her dog as it was associated with drug dealing (Figure 14). All of this combined lead to an overreaction where "the *guards were at my house four times that day to do a welfare check*" suggesting unnecessary surveillance. In addition, they invaded her privacy by asking neighbours about her character:

> They also went and actually done door-to-door inquiries to all my neighbours. Asked them, was there any change in me, what was I doing, and everything else. So that was another thing. Even though I haven't been in trouble in two and a half years, they still reacted within minutes. (Focus group 4, Peer 4)

Figure 14

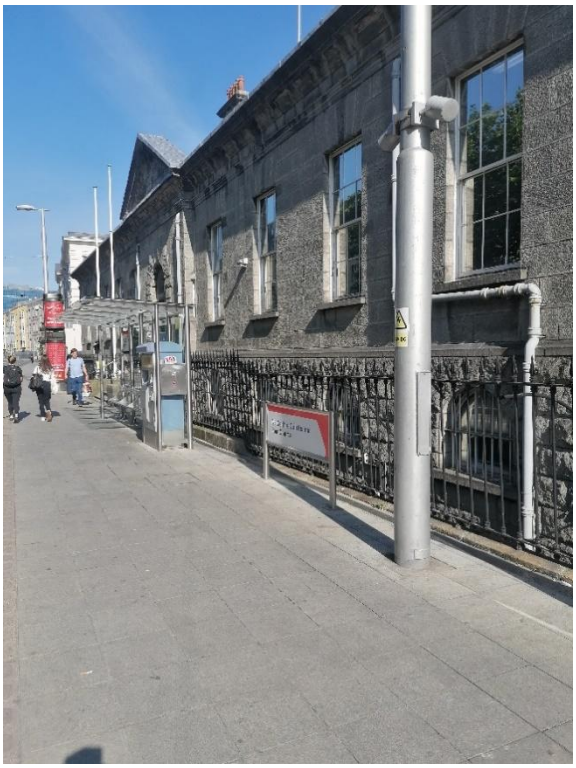
Caption: Drug dealer because of a family pet- Nowadays people are breeding "Bully dogs" but people have this perception that if you have this dog you're involved in drugs. In the Guards eyes I went from being a drug user, to being a drug dealer because I had this type of dog.

Theme 4: Criminalisation- "It's almost like racial profiling"

Misuse of Power

Peers' experience with criminal justice system suggests a multilevel, multidimensional and multidirectional form of stigma. For example, peers described how a drug record "*stays with you for life*" (Focus Group 1, Peer 1) and having a history of incarceration is like a skin that can "*never shed*" (Focus Group 2, Peer 1). Prior drug history reduced opportunities to access proper employment "*you can't get a job*" and reduced the ability to connection with family. Visual analysis of captions reinforced this theme as prison created economic vulnerabilities, including seeking illegal employment to survive (Figure 15).

Figure 15.



Caption: Criminalized-In my drug use the four courts were ye went (the bridewell) and at the start I was only a shop lifter but going to jail criminalised me more as I turned more ways to commit crime and was stigmatized over my drug use.

Peers were falsely led to believe they would get social assistance such as access to a bed and other transitional services to help with reintegration when leaving prison. Instead, peers were referred to the "*free phone*" (Focus Group 4, Peer 1) a government support service meant for people experiencing homelessness. The referral process was a dead end, taking away hope, fuelling disappointment, and reinforcing a cycle of homelessness and sleeping rough on the streets. A few peers shared:

> My life is in that bag, and that's the way I've lived for 10 years before I was in prison. I got eleven and a half a year, with a year and a half-suspended sentence so I've done seven out of that when I got out, The first thing that's supposed to get you to these places when you're in prison, but they don't. They just throw you out, and you have to ring the free phone (Focus Group 4, Peer 1).
>
> I'd ring the free phone, and if the free phone hadn't got a bed for you, go such and such and get a sleeping bag (Focus Group 4, Peer 2).

Other experiences included being targeted by the police while in the community, describing it *"like racial profiling*" (Focus Group 6, Peer 2). Encountering the police on the street and being under the influence made things worse *"But the minute they*

hear you're using drugs; it's like a microscope is put on you" (Focus Group 4, Peer 1). Discrimination was justified based on having a drug related record "*even now, when I'm not using drugs and haven't come to police's attention or haven't caused any problematic behaviour. Once I present into a system, my history is brought into it.*" (Focus Group 5, Peer 1). A peer provided accounts of being unjustly arrested by the police under the influence of alcohol, suggesting reinforcing criminalisation stereotypes:

> I mean, I've been arrested, I don't know how many times, for the wrong reasons…because I had the alcohol on me, I'd be the one taken out the door. Automatic rejection and victimized just because the smell of drink got on me, I was the one put in handcuffs and taken away (Focus Group 1, Peer 2).

There were accounts of having police come to a home and entering without a warrant "*They come into my home like they shouldn't have come into my home. They hadn't got a warrant to come into my home. But they come into my home anyway.*" (Focus Group 3, Peer 1). Lastly, there were accounts of stop and searches based on them living in a specific estate (class). These experiences involved public humiliation. One peer described being stopped, searched, and assaulted by a police officer in front of their mother:

> And they always justify it by your background…from living in, uh, living in XX Me and my little brother and one of my best mates from the flats …And that, any time we were seen, we were stopped and searched even in front of our mother, and that used to be shame for the kids, yeah, getting searched in front of your mother. Then you'd be getting battered… (Focus Group 6, Peer *2).*

Police stations: An environment of medical negligence, traumatic degradation, and invalidation

Peers described an aggressive and medically negligent environment while in police stations (Figure 15). One peer was denied access to their methadone medication, suggesting a denial of Irish National policies that support health-led approaches to drug use. When asked about access to medication they were accused of being "*aggressive*" (Focus Group 3, Peer 1). Peers were subjected to long waiting times for receiving medical care, in particular if arrested over the weekend:

> They'd leave you waiting there for hours and they wouldn't call the doctor straight away…they don't ring for a doctor there and then… So, I went into prison, and I was left a whole weekend without any medication because it was a Friday. By the time I got through like reception it was too late for a doctor. Yeah, so it was Monday by the time I got sorted (Focus Group 3, Peer 1).

Figure 15.

Caption: Stigmatised by the Guards every time in the police station because I was on drugs.

Peers also encountered physical violence by the guards while in jails or prison. Police denied wrongdoing, invalidating these experiences and instead blamed them. Two peers describe their experiences:

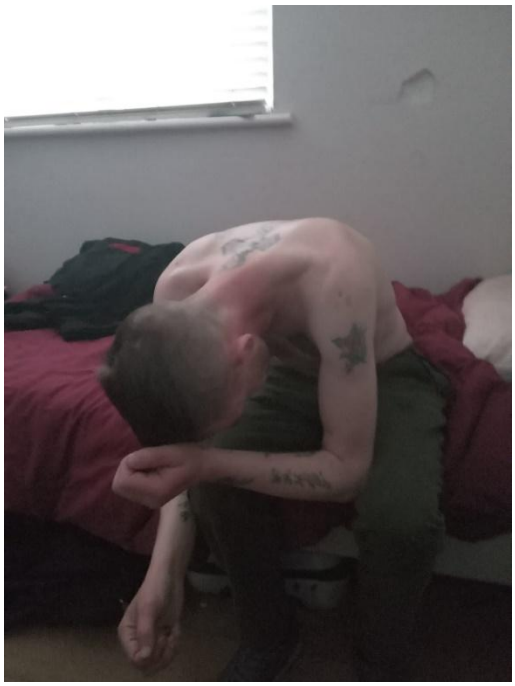
> But they battered me that night and I went to court the next day, black and blue. And my solicitor said it to the judge that she seen me at 8 o'clock that night. And I was grand, but the next morning she seen me, I was black and blue. And, but the guard says that I am, I was banging my own head off the wall and, uh, I made all the injuries up myself." (Focus Group 5, Peer 3)

> "But yeah, here you are with a woman, a female in handcuffs, and you had to give her such a dig into the side of her ribs. You've broken her ribs…. this guard is trying to say that I've done it to myself, But it wasn't, it's not physically, it wasn't physically possible." (Focus Group 5, Peer 1)

Other experiences included degradation of their bodies. A peer described an experience of another peer who had to strip and endure being searched by the police- a traumatic experience. The picture shows the devastation these experiences can have (Figure 16) with an accompanied narrative:

> The guards brought him down to see if he got drugs, and he had to drop, take off all his clothes. and uh, squat and all that. You know what I mean? And the stigma of that and all that. Made him go to the Garda station in the jail and want to buy drugs and he did. He came back up and he actually broke down in front of me. He was crying because like his had like what attack happening and tighten his throat." (Focus Group 5*, Peer 3)*

Figure 16.



Caption: Looked down at for being on drugs and homeless and no support because he is just looked down on and judged instead of been supported

This experience suggests that police use their power to unnecessarily subjugate People Who Use Drugs. The most degrading of the experiences- a peer discusses being told to review their faeces for drugs:

> But the guards, you know, put you on the toilet and all. You need to go through your faeces and all that, don't you? While you're handcuffed to a toilet. Where is the human, you know, where's your rights? (Focus Group 5, Peer 2)

Theme 5: Collective Identity and Action

Peers reported that being a part of UISCE peer-to-peer initiatives provided awareness of how systems of power operate to shape their lives. This framework generated a sense of *Collective Identity and Action*. Indeed, engaging in peer-to-peer work appeared to deconstruct systems of power that create unbelonging allowing peers to realise their own community and inspire a sense of social consciousness.

Peers described that attending UISCE and engaging in peer work enabled conditions for peers to analyse their own lived experience. Open discussions amongst peers produced awareness of how systems of inequality relate to stigma. Figure 17 demonstrates a session of peers coming together to share opinions.

One of the peer's shared:

> Since I've been here, and before I came here, I wouldn't have known what stigmatizing was or criminalize or decriminalize. I wouldn't have known any of that. Only since I came here so for me, this is like stepping into a new life. (Focus Group 5, Peer 3)

Figure 17.

Caption: Shared Opinions

This space enabled different perspectives which created a sense of commonality and a feeling of *we-ness*. For example, when discussing group activities, a peer stated, "*You meet other people that would be in the same situation or in worse situations, but you're still all one at the end of the day.*" (Focus Group 4, Peer 4). In addition, the community discussions created a sense of empowerment and value between peers "*Well, it empowers you and it gives you value. Uh, because you realize you're not the only one in the room. there are a few of your peers there*." (Focus Group 4, Peer 3). More importantly was the context, the environment was described as "*A safe space where there is no stigma and there is no shame*." (Focus Group 4, Peer 1). This reduced feelings of embarrassment, increased feeling of safety which helped to support a sense of belonging.

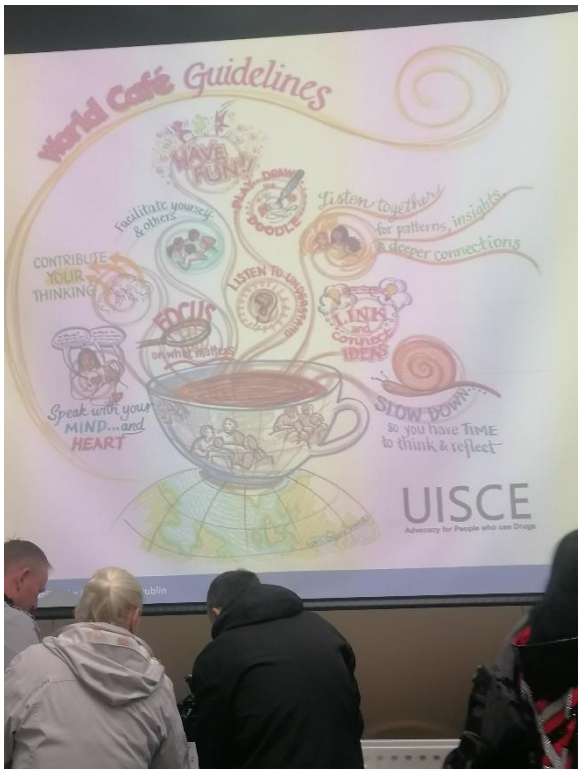
Peers stated:

> We have all different backgrounds and different ways of doing things. In UISCE, it's, you're with the people that have lived the experience …and if you haven't lived the exact same thing, somewhere down the line they have and they can say, oh, I identify with that. (Focus Group 5, Peer 1)

> And here, you can say that and be who you want and just be yourself. Do you know what I mean? You don't have to hide it. Because you have nothing to hide. You can be open here with the staff, with the bosses and everything like that, and it's, you know, there should be more places like this…. This is the only place that I, I came, and I feel welcome, and I feel like that I'm able to express *what, what I'm feeling. You know what I mean? (Focus Group 5, Peer 2)*

Collaborative activities generated a sense of agency, which inspired peers to take collective action through engaging in discussions with dominant power systems, such as Higher Education Institutions, policy makers, members of the health service sector, police, local businesses and community members. To start, engaging with academics on their lived experience in knowledge cafes (Figure 18) was an opportunity for peers to discuss their lived experience as a form of knowledge exchange where "*people who, who use drugs are being let into places where they never thought they'd be"* (Focus Group 4, Peer 1). This inspired a sense of value and deeper connection to a wider community which helped to mobilise them as a collective to engage in discourse on the topics that matter most in their lives. These spaces all provided a sense of equality as "*our input had value*" (Focus Group 4, Peer 1).

Figure 18.



Caption: If we have more cafes like this, so we can get heard by the right groups and work out the issues between us

In response to the high levels of overdoses the peers developed their own peer-led overdose response strategy that was implemented before the first HSE red alert in November 2023. This was informed by a community mapping project which outlined their knowledge of the high level of preventable overdoses and drug related deaths in Dublin, and subsequent responses needed (Figure 19). The community mapping project was presented to various stakeholders including members of the community, health service sector, and policy makers.

Figure 19.

Caption: Mapping project as a solution to hotspots in Dublin

Peers describe how policy makers listened to their experiences which helped them to feel validated as a member in the community.

> *She* actually pulled us to the side and made time to talk to us and we explained our situation. She was amazing. We actually have a photograph at home with the minister. (Focus Group, 3, Peer 1).

In addition, the feedback from members of health and service structures helped to reduce internalised stigma – which in itself also reduced negative stereotypes that People Who Use Drugs are reckless and incapable of change. A peer describes their experience:

> Then, we have the mapping projects for solutions to hot spots in Dublin. It was a combination between a mapping project and an art project. So, we've done that collaborating with each other. So, when the representative of the HSE and council and things like that came in and they were all like, wow, is this what you've done and all that? That's when stigma walls are being knocked

down because you can show we are not only the drugs, but we are also capable of so much more (Focus Group 4, Peer 3)

Additional community projects were discussed. One in particular involved engaging with police and members of the business community to discuss issues related to People Who Use Drugs. This involved peers having mutual positive experiences with the police "*It was the first time that I had engaged with Guards without being in a police station or on the street. So, I, like, it was like, I was able to build relationships on a personal level.*" (Focus Group 5, Peer 1). It provides a space for knowledge exchange where both parties were on an "*equal footing*" where they could experience a feeling of "*humanity*". A peer shared a picture of this event in Figure 20.

Figure 20.

Caption: Building relationships with Garda and businesses and sharing information in trying to safeguard our peers and our community.

Finally, peers suggested more funding for peer-to-peer initiatives as this type of knowledge was considered a "*lethal combination*" for change. A peer stated: "*I believe that there should be more money put into the organizations like UISCE and peer to peer participation and peer research, you know, because then the outcome could be a lot different*." (Focus Group 5, Peer 1).

Theme 6: Challenging and deconstructing systems of power

The peers were able to deconstruct stigma by outlining solutions to weaken its power over their community. Subtheme 1 *Solutions for change,* peers' experiences of solutions to stigma in the health environment, housing and food sector, national policies surrounding naloxone and the police. Subtheme 2 *Public messaging* demonstrates the intention of changing public attitudes in larger campaigns.

Solutions for change

As described in the first 4-themes some of the peers have multiple marginalised identities, this has important implications for utilising health care services. In particular the connection between ability (mental health) and class (unemployed). Some peers described having lifelong trauma. One peer described "*When you come from somewhere that's been abused you are constantly living in the past…* I *also suffer with mental health and self-harm and things like that, extreme mental health. Now I've always been on disability.*" (Focus Group 1, Peer 2). Another peer described living in adverse conditions such as growing up in environments where parental figures engaged in crime (class-illegal employment). This experience lead to having nightmares and hypervigilance:

> Apparently, I speak in my sleep. Bad and…I have full on conversations. He came to wake me up cause I had a nightmare. He goes XX, he didn't touch me or anything. XX, are you alright? And I just jumped from the bed, put my hand under the pillow, took the knife, jumped up, pulled him down. And he's like, it's Dave, it's Dave. And I'm like, uh, sorry bro. Put him in bed, put the knife there. (Focus Group 1, Peer 1)

Peers also described witnessing domestic violence growing up. One peer describes their experience:

> Yeah, well it was like, drink for me caused most of my trauma. When I was a child, because I was watching my dad beat my ma when he was drunk, and my grandad beat my nanny, and my uncles beating their wives, and I was just normal, normal (Focus Group 1, Peer 3)

Trauma was also generational. As one peer describes how they had a long history in the care system as a child. This experience was transferred to her children as being a woman (gender) who was used drugs left her in a vulnerable position to lose her children as an adult. This left a heavy burden on her emotional health*" I carried the stigma of my parents, you know, and my children carry the stigma of me, you know? Its generational trauma*" (Focus Group 5, Peer 1). All of these experiences demonstrate how trauma informed care is important for People Who Use Drugs, in addition to the sensitivity of how class conditions surround and impact their life stories.

One way to advance this aim is taking a non-judgemental approach when providing care. Peers described the need for professionals to have genuine response and inquiry into their personal circumstances. One peer states "*Just get to know me… Yeah. Instead of judging…ask, maybe and just talk*." (Focus Group 1, Peer 2). This also included pausing for reflection before automatically judging People Who Use Drugs, "*But if you stop and look around, you see other things around and that might be a way, a gate for you to understand that it's more to this life than he's good and he's bad."* (Focus Group 1, Peer 3). One peer demonstrates the need for genuine listening in a picture in Figure 21.

Figure 21.

Caption: (Name removed) needs to listen to their clients and not just refer to us as "junkies" if they got to know us and listen to us, they would see that we are normal people that just suffered trauma

With an accompanying narrative:

> I was pulling my ear to represent the solution that (the service name removed) need to listen to us and not judge…. And they need to work more with the person rather than be on top of them. (Focus Group, Peer 4)

In addition, rules surrounding entry to treatment were suggested as an avenue for change. This included providing support for people independent of current drug use, "*There needs to be more supports for people out there. Whether you're using, whether you're trying to get clean, there needs to be supports out there*." (Focus

Group, Peer 4). This included taking away the requirement to have "*three clean urines*".

Peers described the need for low-cost food options. This was important as most of the participants came from low socioeconomic backgrounds. These options would bring a sense of comfort from the dire social and economic conditions they faced. Two peers discuss this:

> Uh, it's not very expensive. It's like penny dinners, like you can get a dinner for a few euros if you're homeless…So, folks will help you there, they'll let you use their phones. If you need anything, they'll help you with anything. Yeah. A cup of tea or coffee is about 20 cents. Yeah. So, you're not out the door spending money. (Focus Group 7, Peer 2)

> So, we've got soup, uh, we call them soup runners. Yeah. Soup Runs. They're on the side of the street, free food services. And then you've got these places like Focus Cafe, where you've got penny dinners. (Focus Group 7, Peer 3)

In terms of housing peers reported that national policies should ensure hostel accommodation support is not crowed. A peer commented:

> To me, solution is pretty basic. Yeah. You make rents, you make rents affordable.**:** You stop, um, judging people that come, you know what I mean, you make it mandatory that people, um, are accommodated. And not 12 to a room, or 20 to a room, as they're doing with foreign nationals (Focus group 6, Peer 1)

In terms of national policies, peers reported that naloxone should be deregulated and be made financially affordable for direct access. Peers discuss how police should be trained in naloxone as they are the first responders at the site of an overdose. Peers dialogued about this around the picture (Figure 22) in Focus group 4:

> Peer 4: And also, they should be trained on naloxone as well.

> Peer 1: Absolutely, 100%. Because it's not mandatory for guards to carry naloxone. Now some of them do carry it, but I think it should be mandatory. Yeah, it should be mandatory. It should be. Because they're first responders. Yeah. They're first responders, you know, so if an ambulance can't get there in 10 minutes and there's a Garda car around the corner that can go and respond to it and having naloxone there.

> Peer 3: In this way, if you have space on a belt to put handcuffs and something to hit you with, they can have space to put naloxone.

Figure 22.

Garda station under reconstruction.

Caption: This shows a Garda station under reconstruction, to me I think Gardai need to fix the way they stigmatize us, so the garda need to listen to us before they judge us on our past

There were other important elements of how police worked on the streets and communicated. Peers reported wanting to be "*treated like anyone else* "(Focus Group 3, Peer 2) and that they still have rights as a People Who Use Drugs.

Public messaging

Peers empathised the importance of changing public attitudes. This included debunking stereotypes that people who use drugs cannot change. For example, a peer describes how although they made mistakes in the past, they regret these experiences and have changed. "*I feel really bad that people perceive me like that because I'm not who I used to be and I would never do what I was ordered to do ever again in my life*." (Focus Group 1, Peer 3). Figure 23. demonstrates a tree as a symbol of growth.

Figure 23.

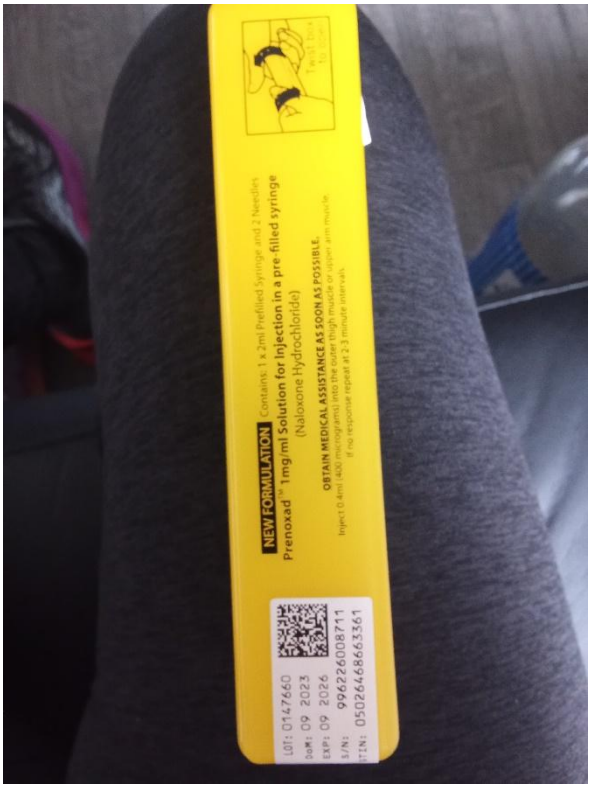
Caption: Reach for the sun- Now I feel since I stopped and changed, I grow every day the same ways as a tree.

This also involved suggesting that the public make attempts to see the good in others "*Trying to see that even if people stigmatize me. In society, you have good and bad people. You have to learn to live with both. So, acknowledging the bad with the good, it's, you know what I mean?* (Focus Group 1, Peer 1).

Peers also demonstrated through their actions that they are responsible and can be vital actors for change in their community. This was empathised in their training other peers in using naloxone (Figure 24).

> The first thing we do yeah? Because as we go out there and give it, we help train people with it. The first thing people say to us when we say, do you want to do some naloxone training? (Focus Group 1, Peer 2)
>
> He made it out of the darkness and now he's helping other people, so that it's possible like. (Focus Group 2, Peer 2)

Figure 24.



Caption: Solution

Targeting family members of People Who Use Drugs were also discussed as prior themes have demonstrated the knock-on effect of social stigma into family life. Although some attempts were made by bringing family along to peer-related events, this was often met with mixed outcomes.

> They don't understand this. Do you know what I mean? We tried to explain it. They even came to that presentation day, my mother and his sister and [Name removed]'s sister who passed away. He came like, that's like, that's when my mother seeing the real. My mother understood like. (Focus Group 3, Peer 2)

Last, there was also discussion of reducing stigma based on class. For example, peers described how specific estates are stigmatised but "*But there's genuinely nice people down there like. Absolutely*." (Focus Group 2, Peer 2). This also related to how people who were homeless were treated. There was a call for the public to re-humanise people who were homeless "*because you don't know where someone has come from*" (Focus group 7, Peer 3). This included seeing people who are homeless as regular people who have a story relating to why they have become homeless. This was thought to counteract buying in to negative public sentiment towards People Who Use Drugs:

> Like that could be, could have been a working man, family man, don't take many drugs, divorced, lost his home. Yeah. And ended up homeless…very

> ignorant people towards this because they don't understand everything about this, they just, they only go off of what they hear, they don't actually know of the whole situation that they're going through, so they're being pointed out as what they're being seen like, they're just being judged before they're even dealt with. (Focus Group 7, Peer 3)

Some of the solutions also included acknowledging people who were homeless and who were also begging with kindness who also have basic human needs. Two peer's state:

> Because I'm hungry, you know, people think starvation doesn't exist. I have needed, like, Hygiene products. I begged for tampons, sanitary towels, soap, hand sanitiser, lip balms… it starts with society challenging its attitudes and actually turning to look at us. (Focus Group 7, Peer 1).

> That's what I'm saying like there is people. Like people who will go for a sandwich and a cup of tea or coffee daily, and they'll even ask like or even not, they don't even ask you to just go and get it in case you're embarrassed. We give to people like that. I just see him tapping all the time and I was in McDonald's myself. But then [Name removed] ordered too much food. And instead of putting it in the bin, I bagged it up and I brought it over to the man and he was delighted with that (Focus group 3, Peer 1)

Final Digital Story

Peers engaged in consensus building and dialogue over what pictures would create the final story. This included peers choosing 4 of their own pictures, placing the pictures on a table, discussing their meaning, prioritising their story and re-arranging the pictures into themes. These pictures were then placed into a multimodal transcript developed by NMM and RB. The multimodal transcript contained relevant text, photographs, related content from videos from previous campaigns and voice overs for the final digital story. These scripts were given to a videographer to create the digital story. Below shows the extensive work of the peers in producing 198 photographs, shortlisting 70, and creating 9 themes.

Start of Story themes

- Cost to the individual such as being invisible
- Effects of stigma: Internal, economic and social (family)
- Stigma cost to the individual: Space/Environments

Middle of the story themes

- Police
- Health and Social Care services
- Access to housing

End of the story themes

- Advocacy Community Engagement and Equality
- Change policies
- Person centred health care systems
- Community strengths: Resilience and Personal growth

Peer experiences

The experience of engagement in the research and how it would reduce stigma was discussed throughout the project. The analysis of these experiences resulted in two themes.

Theme 1: Improved self-efficacy, ownership, and resiliency.

The feedback from the peers on the project was overall positive with comments such as *"I actually love doing the project*" (Peer #8) and "*the anti-stigma program went brilliant today"* (Peer #9). The project helped peers become aware of their own inner resources to overcome challenges involved in learning a new skill and processing feelings of stigma. For example, peers described having initial trouble with how to take pictures of stigma. However, as they began to practice their skill, they became confident suggesting increased self-efficacy. Peers used ethics in their photography ensuring that they asked permission even if their face was not shown "*Been an interesting, oh, an interesting picture. So, I asked him, could I?*" (Peer # 9). This suggested awareness of good practice and personal ownership of the process.

Some participants described that the project allowed them to process memories of stigma. Although this was perceived as emotionally challenging, they were able to reframe the experience based on recognising their own resiliency. Indeed, photography helped peers to understand their own internal resources, and inspired feelings of empowerment over their lived and living experience, suggesting this framework can reduce internalised stigma. Some peers state:

> But then when you're told to put it in a photograph, it's not as easy as you think but then once you get into it and I think it was pretty enjoyable. (Peer # 1)

> Like we'll look back at six months and say well…This is where we were at six months ago. Look where we've got, you know…We are moving on… (Peer #3)

Theme 2: Value of peer-led work: Critical reflection, purpose, and raising consciousness for social change.

The value of being involved in a peer-led project was emphasized throughout, suggesting the importance of authentic peer engagement in research to help facilitate social change. The UISCE environment was key for peers to be able to critically reflect and analyse their experience. A peer comments "*We've given the critical analysis of the system, but we've also given the solution based as well. I totally enjoyed it*" (Peer #8). One peer described that being treated with respect and dignity while doing peer work were important mechanisms for feeling purpose in their lives "*Since I came into UISCE, it's after giving me a purpose. I feel independent, my self-esteem and confidence are lifted (Peer,4).* Equality and exchange of knowledge between peers helped to raise consciousness of their common struggles with structural stigma. This experience suggests that equitable community participation inspires collective identity- an important factor in mobilizing for action. Finally, peers described being confident in their lived experience to deliver the digital story anti-stigma training suggesting readiness and capability to engage in social change for their community "*It should be peer delivering the training because who else better to, you know, to communicate that than people that have endured it and lived through it"* (Peer, #8). Below are some peer accounts of the process:

> It's more enjoyable when you're with people like that because everyone knows what page they're on, what everyone's talking about. (Peer #5)

> Actually, you know, it kind of, it opened my eyes to, you know, you can say I've been stigmatized, I've been stigmatized, and it's communicating and getting people to hear you. (Peer # 7)

> I think it was powerful because you can see the picture and you can see the reason why the person has done the picture. You can hear the, I suppose, you know, how it has affected them. You know, I'm able to tell you stories where I can give you the problem and the solutions. (Peer #8)

Impact: Peer-led Stakeholder event

UISCE hosted the ***Close the Gap- How to Create Peer-led Partnerships for Change*** event to showcase peer initiatives soon after the design of the final digital story. This included a presentation of elements of the digital story consisting of the peers, AOH and NMM. As a group they outlined the process of creating a multimodal digital story through their own living experience which included a presentation of three videos which described the beginning, middle and end of their collective story. The mix of showing the videos and unpacking them in a panel discussion showed how creative tools can be used to identify and communicate to audiences the structural nature of stigma, how it manifests into harmful approaches or treatment and what we can do to address it. As the peers had ownership over the process, and therefore the production of resources along with this being their story led to the high level of engagement. There were follow up comments by the crowd in a scheduled Q&A, direct contact with the peers by many members of the audience, including requests for peers to deliver session to projects and official contact with UISCE on accessing resources, training and support into the future.

Discussion

The results show that stigma was intensified by *class*- lack of employment and housing, *gender*- being a woman, *ability*- experience of mental health, substance use and trauma, and one account of *sexuality*- identifying as gay. The multilevel structures involved in stigma included *individual level*- social stigma, *interpersonal*- social stigma, *policy environment* (drug policy, policing, housing, council regulations and city architecture), the *health care environment* (medical and mental health), *economic* (social welfare system) and *social care system* (family and child agency). The interaction of some of the levels were also multidirectional where one level of stigma (e.g. housing policies) reinforced stigma in another (e.g. city infrastructure). All of this points to the many methods that social power can be used to subjugate People Who Use Drugs and reinforce an environment of stigma and drug-related harms in the Irish context. In addition, the results outlined how spatial environments within the urban city centre can reinforce stigma, the relevance of discrimination in public spaces and the continual negative effects of having a past criminal history.

These results mirror similar research exploring intersectional stigma towards People Who Use Drugs including experiences of internalised stigma, shame, and negative health care interactions (Austin et al., 2022; Batchelder et al., 2021). In addition, this research provides a qualitative in-depth analysis of how class and gender-based stigma operates as opposed to cross sectional survey or experimental studies (Chavanne et al., 2023; Meyers et al., 2021; Vu et al., 2019; Wood & Elliott, 2019). The experiences of the family stigma provide deeper insight into how stigma can be a form of slow social violence that is passed on across generations (Barnwell, 2019). Lastly the results outline experiences of intersectional stigma on the lives of People Who Use Drugs that has not been explored in the Irish context (to the best of the authors knowledge). The evidence suggests the need for an intersectional approach when engaging with PWUD across the health and social care system and in drug policy reform. This includes how systems of power may reinforce typical stereotypes of PWUD, their families, the effects of class, and how this relates to wellbeing. Health care professionals should also engage in self-reflexivity to identify how their social location make influence the therapeutic relationship. Finally, we aim to use this body of work to inform the implementation of a peer-led anti-stigma training and the roll out of a wider public campaign to reduce stigma.

There are several strengths and limitations to this study. Some strengths include the integration of the CBPR monitoring which ensured that there was equitable engagement of the peers in the research process. Peers felt a part of the design, were empowered by learning a new skill and bonded emotionally as community members. This is important as often community involvement and or peer work/ research can be tokenistic and reinforce stigma. As mentioned, the intersectional approach allowed for identification of fine detail of how stigma operates across the social environment, while helping to outline key stigmatising processes

that are often not captured in other frameworks. Data was checked by other members of UWL to ensure robustness of the analytical process. In terms of limitations, qualitative analysis is context dependent, and the experience cannot be generalised to all peers across Ireland. In addition, the peers who provided feedback have previous experience of advocacy and may have knowledge of power structures that affect the lives of PWUD, as opposed to peers who are not advocates. Although these stigmatising experiences connect to structures of power, these structures are not inherently stigmatising.

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