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Research Paper

Everyday discrimination in individuals seeking treatment/receiving support for substance use and caregivers

Andrew Jones [a,*], Diane Sharples [a], Sam Burton [a], Abigail K Rose [a], Suzanne H Gage [b], Patricia Irizar [a], Jay J Duckworth [a], Catharine Montgomery [a], Harry R Sumnall [a]

[a] School of Psychology, Liverpool John Moores University, Byrom Street, Liverpool, Merseyside, L33AF, United Kingdom
[b] Department of Psychology, University of Liverpool, Bedford Street South, Liverpool, Merseyside, L697ZA, United Kingdom

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ABSTRACT

Background: Experiencing stigma/discrimination is common in individuals who use substances. However, those with caring responsibilities for individuals who use substances may also be stigmatised and discriminated against (known as affiliate, or courtesy stigma, or stigma-by-association). Comparatively little research has examined the experiences of those who may experience courtesy stigma.

Methods: We conducted an online survey recruiting individuals who were seeking/ receiving treatment for substance use ($N = 175$); individuals who have caregiving responsibility for somebody seeking or receiving treatment for substance use ($N = 248$); and a demographically matched comparison group ($N = 363$). All participants completed measures of everyday discrimination experiences as well as the perceived source and cause for discrimination, and a measure of wellbeing (WHO-5).

Results: Individuals seeking/receiving treatment for substance use, as well as individuals with caregiving responsibilities reported higher levels of everyday discrimination vs the comparator group, when adjusting for socio-demographic factors. 40.7% of individuals with caregiving responsibilities reported their caring role as a cause of discrimination, and 52.5% of individuals seeking/receiving substance use reported this as a reason for discrimination. The main source of discrimination was from family and friends. Everyday discrimination had an indirect negative impact on subjective wellbeing in individuals who use substances and caregivers.

Conclusion: Courtesy stigma is commonly reported in caregivers to those who seek treatment for substance use, which may have negative consequences. A greater focus on those with caregiver responsibilities may positively benefit these individuals and the care they provide.

Introduction

Substance use disorders are a global public health concern (Tran et al., 2019). Although the reported prevalence of these disorders is high (~3.5 % globally, and ~3.1 % within the UK (Degenhardt et al., 2019)), these estimates may be unreliable, as individuals who use illicit drugs are often subjected to stigma (*social discrediting, dehumanization, negative attitudes, beliefs, stereotypes, and behaviours as a result of their use of substances*) and discrimination (e.g. *enacted stigma, rejection, and devaluation by others, or rejection by wider society:* Livingston et al., 2012). Experiencing, or the anticipation of experiencing, stigma/discrimination leads to individuals developing protective strategies, including not disclosing substance use, to prevent negative labelling and its consequences (Brener et al., 2024; King et al., 2024; Ma et al., 2024). This not only creates a significant barrier to help-seeking and engagement with treatment (Kulesza et al., 2014), but professional (by healthcare providers) and structural stigma leads to poorer quality care and outcomes from treatment (Gilchrist et al., 2011; Lancaster et al., 2017).

Both the general public and healthcare professionals report stigmatising attitudes and discriminatory behaviours towards individuals who use substances, including those in or seeking treatment (Cazalis et al., 2023; Pennington et al., 2023; Rundle et al., 2021). Experiences of substance use related stigma/discrimination are often more common than other routinely stigmatised conditions, such as mental health disorders (Kilian et al., 2021; Rundle et al., 2025; Yang et al., 2017). For instance, individuals who use substances and develop problems are frequently perceived by the public as more dangerous than other groups, and are more likely to be met with social distancing than those with a

* Corresponding author.
E-mail address: a.j.jones@ljmu.ac.uk (A. Jones).

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mental health condition.

Various models and types of stigma exist in relation to substance use. Early theories of stigma such as Goffman's (1963) symbolic interactionist perspective suggest the development and persistence of individual-level social stigma is based upon the interaction between stigmatized and 'normal' groups in the same situation (Aranda et al., 2023), leading to discrediting of the stigmatized group(s) and development of a stigmatized identity which can increase self-stigma (Şamar et al., 2024). Attributional models of stigma suggest individuals who use substances are seen as personally responsible for their condition and are therefore more likely to be blamed for harmful outcomes (Corrigan et al., 2003). Link and Phelan's (2001) stigma conceptualisation suggests for stigma to occur, power over the individual must be exercised (e.g. intentional status loss, exclusion). This suggests stigma can also be embedded structurally within institutions, such as criminal justice, treatment and medical treatment through policies, criminalization etc. (Hatzenbuehler & Link, 2014).

Individuals may also experience stigma/discrimination due to their association and caring responsibilities for a family member or friend who uses substances, i.e. the experience of stigma transfer. This has been labelled with multiple terms such as secondary-, courtesy-, affiliate stigma, or stigma-by-association (we use 'courtesy stigma' henceforth: Goffman, 1963). Multiple non-mutually exclusive explanations for courtesy stigma have also been proposed. For instance, Goffman suggests stigma is transferable and increases as a result of closer proximity through social disproval (Giordana & Caci, 2025). Whereas, attribution theory suggests family and friends to have some responsibility for that persons' behaviour or upbringing which might have contributed to their substance use (Corrigan et al., 2006). This leads to beliefs that the caregiver might be also be dangerous or unhealthy, and that they are 'contaminated' by their relative / friend's substance use (i.e. sharing the same values, attributes or behaviours: Park & Park, 2014). This stigma/discrimination can be internalised and has a negative impact on quality of life and help-seeking (Jones, Sharples et al., 2024; O'Dowd et al., 2025; Titlestad et al., 2021).

There is a relative lack of research into courtesy stigma/discrimination and its consequences, compared to other types of interpersonal stigma/discrimination, as well as individual and structural stigma/discrimination (Hatzenbuehler, 2016). Outside of the substance use field, courtesy stigma is more likely to be experienced by those who know more people with mental illness and having core ties to these people (e.g. family members and friends: Felix, 2025). Similarly, courtesy stigma is reported by parents of children with HIV and can be enacted by gossip, rejection and isolation, loss of social support and harassment (Nabunya et al., 2023). Within the substance use field, qualitative studies have noted people report experiencing courtesy stigma from multiple sources, including their friends and family (Liahaugen Flensburg, Torkel & Väfors Fritz, 2023; McCann & Lubman, 2018), and the experience of courtesy stigma is not limited to familial caregivers, but also individuals who work within alcohol and drug services such as counsellors, clinicians and peer workers (Caruana et al., 2025).

In quantitative studies, Corrigan and colleagues (2006) used vignettes to examine courtesy stigma towards family members of somebody diagnosed with drug dependence, schizophrenia (a mental health condition), or emphysema (a physical health condition), and demonstrated significantly higher stigma for the family members of an individual with drug dependence, providing support for attribution theory. Downey et al., (2026)) used a similar vignette design to examine courtesy stigma towards depicted parents of a child with a cannabis use disorder. They found stigma to be higher when deficit-based language was used (e.g. '*Jamie's mother /father allows Jamie to use cannabis in the home without consequence /enables Jamie's cannabis use*') and when the depicted parent was a mother (vs father). However, a limitation with both these studies was the use of a vignette design. In a survey of primary caregivers of individuals with alcohol or opioid use disorder increased discrimination was associated with poorer quality of life (Garg et al., 2019), and in a longitudinal design reports of stigma/discrimination were associated with worse behavioural outcomes (unhealthy eating, reduced physical activity, increased alcohol use and poorer social connections) as well as low mood, in caregivers (Jones et al., 2024). However, this was a small sample, and we did not include validated measures of discrimination or health outcomes.

As such, little is known about everyday levels of courtesy stigma/discrimination for those with caregiver responsibilities for a family member or friend with a substance use disorder. In this study, we examined whether participants seeking or receiving support for substance use - or those with caregiver responsibilities for people seeking or receiving support for substance use - reported higher levels of everyday discrimination, compared to an age/gender matched comparator group, when adjusting for other socio-demographic factors linked to stigma/discrimination (e.g., race, mental health, sexuality, socio-economic status: (Herek et al., 2007; Inglis et al., 2023). Including both groups (caregivers and those seeking or receiving support for their substance use) allows us to compare the magnitude of discrimination experienced by each group, but also to adjust for the possibility that individuals who provide care may also seek treatment or support for their own substance use also. We also examined any potential underreporting, given the possibility of concealment of courtesy stigma (Camacho et al., 2020). We hypothesised that receiving support for substance use, or reporting caregiving responsibilities, would be associated with increased perceived everyday discrimination. In exploratory analyses we examined whether the magnitude of experienced discrimination indirectly predicted wellbeing in line with previous literature reporting associations with poorer quality of life (Garg et al., 2019; Zhang et al., 2018)

Methods

Participants

A total of 738 participants provided data (mean age = 44.78, *SD* = 13.84). Of these, 175 (23.7 %) reported seeking or receiving support for substance use (our question did not separate seeking treatment or having a formal diagnosis); 248 (33.6 %) reported caregiving responsibilities for individual participants seeking or receiving support for substance use; and 363 (49.2 %) did not report caregiving responsibilities or treatment seeking / receiving support (comparison group). There were 51 individuals who reported seeking or receiving support for substance use and having caregiving responsibilities.

Our pre-registered hypotheses, protocol and analyses strategy are reported here [https://osf.io/xyqw5/]. We reached our a-priori, pre-registered sample size of a minimum of 600 participants which would allow us to explain ~3 % variance in everyday discrimination through our combination of predictor variables and covariates.

Materials

Alcohol Use Disorders Identification Test (AUDIT:(World health et al., 2001))

The AUDIT is a 10-item screening tool to identify potential hazardous / harmful drinking or those at risk for alcohol use disorder, with questions related to quantity and frequency of use (e.g. '*How often do you have a drink containing alcohol*') and alcohol-related problems (e.g. '*How often during the last year have you had a feeling of guilt or remorse after drinking?*'. It is scored from 0 – 40, with scores >7 typically being used to indicate hazardous or harmful drinking, and scores > 15 indicative of probable dependence. The AUDIT's psychometric properties are well established (Chen et al., 2024), and demonstrated excellent internal consistency in this sample (ω = 0.95).

Drug Use Disorders Identification Test (DUDIT: (Berman et al., 2005)

The DUDIT is an 11-item screening tool to assess patterns of drug use

and identify potential drug-related problems / substance-use disorder, using similar questions to the AUDIT (e.g. '*How often do you use drugs other than alcohol*'). It is scored from 0 – 44, with higher scores indicative of more severe drug problems. The cut off for problematic use is 6 for men and 2 for women. As with the AUDIT, the psychometric properties are well established (Hildebrand, 2015) and the internal consistency in this sample was ω = 0.97.

Everyday Discrimination Scale (Williams et al., 1997)

The everyday discrimination scale is a 9-item scale which asks about the frequency of discriminatory events in day-to-day life (e.g. '*You are called names or insulted*') from 'Never' to 'Almost every day'. The everyday discrimination scale has been used extensively in substance use research (Gilbert & Zemore, 2016), but also to identify discrimination across our covariates (e.g. gender, ethnicity: Yang & Henderson, 2024). The psychometric properties are well established (Berenbon, 2020). However, based on discussions with staff members at one of the organisations we recruited participants from, we included a 10th item ('*You are not invited to social/family events or activities*'). This item did not substantially influence the internal consistency of the overall scale (ω inc. item = 0.92, ω exc. item = 0.93) therefore we retained it in our analyses, but also report analyses of the original 9-item scale in supplementary materials (Supplementary Table 1).

If participants reported any experience of discrimination, they were asked what they thought the reasons for discrimination were [Your Ancestry / Gender / Race / Age / Religion / Height / Weight / Other aspect of appearance / Education or income / Your own substance use / Family or Friends substance use], and they could select as many as deemed appropriate. They were also asked from who they experienced discrimination [Friend / Family member / Member of the public / Health care worker / Colleague / Somebody providing a service (e.g. shop assistant) / other]. Again, they could select as many as were appropriate.

MacArthur scale of Subjective Social Status (Adler et al., 2000)

The MacArthur Scale of Subjective Social Status asks individuals to imagine a 10-rung ladder which depicts social status and asked to rank themselves on the ladder relative to other people ('*"At the top of the ladder are the people who are the best off, those who have the most money, most education, and best jobs. At the bottom are the people who are the worst off, those who have the least money, least education, worst jobs, or no job. Please place an 'X' on the rung that best represents where you think you stand on the ladder: 1 = worse off, to 10 = best off*').

World Health Organisation wellbeing index (WHO5: (Topp et al., 2015)

This is a 5-item measure designed to assess subjective wellbeing (e.g. 'I *have felt cheerful and in good spirits*') over the previous fortnight. Each item is rated on a 6-point Likert scale from (0 = at no time, to 5 = all of the time). The scale has been used to measure wellbeing in substance use disorder previously (Topp et al., 2015). The scale demonstrates good psychometric properties across different samples (Lara-Cabrera et al., 2022) and the internal consistency here was ω = 0.95.

Crosswise questions for assessing sensitive topics (Yu et al., 2008)

We included a crosswise question to assess potential underreporting of experiences of courtesy stigma/discrimination. Crosswise models provide two statements, a sensitive statement (e.g. '*I have been discriminated against, as a result of caring for a family member or friend's substance use*') and one non-sensitive but private statement (e.g. '*My mother's birthday is in June, July or August*'). Respondents are asked to choose a response option, from either: (i) both statements are true or neither statement is true, or (ii) one of the statements is true. They do not have to reveal their answer to the sensitive statement directly, reducing potential reporting biases. However, the non-sensitive question has a known probability (in the case above 92 days out of 265 or 92/365 = 0.25). As such, although we can only observe answers to the joint statement, population prevalence can be estimated to the sensitive attribute using the probability of the non-sensitive statement.

Procedure

The questionnaire was hosted online using QuestionPro (2025). If individuals could not access the questionnaire (no internet access) they completed a paper-and-pencil version (N = 24), and answers were manually uploaded to QuestionPro by the researchers. The study was distributed via national alcohol and other drug support charity mailing lists, case workers of these charities, or through word-of-mouth. These charities provide support those seeking treatment for their substance use, caregivers, or both. We first recruited from national charities (UK) to sample individuals who reported seeking or receiving support for substance use or those with caregiving responsibilities for an individual seeking or receiving support for substance use. All participants recruited from charities saw the same questionnaire and only differences were related to tailored participant facing documents for each charity, informing participants that they had been contacted specifically though the charity mailing list and their decision to participate or not would not impact any care or help they received via the charity. Once we had recruited ~400 participants, we examined the age and gender distribution of the combined sample and recruited a participant group who did not report either (assessed using a questionnaire screener) but with a similar demographic profile, via Prolific. The inclusion of a question for participants to provide their Prolific identification (necessary for payment) was included in this questionnaire.

For both survey formats, participants read an information sheet and provided informed consent. They then completed demographic information, including age, gender [male, female, non-binary/other], ethnicity [White, Asian/Asian British, Black/Black British, Caribbean or African, Mixed or Multiple ethnic groups, Other ethnic group], sexual orientation [Straight/heterosexual, Gay/Lesbian, Bisexual, Other sexual orientation]. They then completed the MacArthur Scale of Subjective Social Status and were also asked if they had ever received a mental health diagnosis or sought treatment for a mental health problem [yes (current diagnosis), yes (remission / recovered), no].

Participants were then asked whether they cared for someone who had been diagnosed with, or was seeking treatment for, an alcohol or substance use disorder [no, yes (a parent), yes (a child), yes, (other family, e.g. uncle), yes (a friend)]. If they stated yes, they were asked about the living situation of the individual (with you, alone / independently, in supported housing / residential rehabilitation), and what their primary substance of use was (alcohol, opiates, cocaine, stimulants/psychedelics, cannabis, other). Following this, they were asked if they had ever received a diagnosis of alcohol / substance use disorder or sought treatment [Yes (currently), Yes (in the past/in remission), No]. They then completed an attention check question ('What planet do you live on?'), to account for careless responding often observed in online studies. Four individuals (>1 %) failed the attention check; retaining their data did not significantly impact findings so we did so to improve generalisation (Jones et al., 2022, 2024).

Participants then completed the everyday discrimination scale, followed by the crosswise question for courtesy stigma/discrimination. Finally, participants completed the AUDIT, DUDIT, and WHO-5, before being debriefed.

Data analysis

Data was analysed using R with the following packages: 'tidyverse', 'estimatr', 'psych', 'strengejacke', 'lavaan' and 'performance'. There was a small amount of missing data (0.8 %) across all variables, which was largely due to some individuals not responding to the AUDIT/DUDIT if they confirmed they did not use alcohol or other drugs in the first question. Given the small amount of missing data, we did not use any imputation techniques. To examine predictors of everyday

discrimination across our sample we used robust linear regression. In this model we included binary variables for participants seeking or receiving support for substance use (1 = yes, 0 = no) and caregiving responsibilities for individuals seeking treatment or receiving support for alcohol / substance use (1 = yes, 0 = no). We also include age, gender, mental health diagnosis (yes vs no), sexuality (straight vs other), ethnicity (white vs other), AUDIT scores and DUDIT scores, as known covariates which might contribute to discriminatory experiences. To increase sensitivity, we also conducted (non-preregistered) analyses by limiting the seeking or receiving support for substance use and caregiver groups to those individuals that explicitly reported their use as a reason for discrimination, and limiting the individuals with caregiving responsibilities to those who report their family member's / friends substance use as a reason for discrimination (Supplementary Table 2). In further exploratory supplementary models (reported in detail in online supplementary materials) we also conducted a series of interactions between groups and ethnicity and gender (given these were exploratory we used $p < .01$ for statistical significance: Supplementary Tables 3 and 4).

We used simple proportions to examine prevalence of reported reasons for, and sources of, discrimination across groups. To examine potential bias in responding to sensitive questions (experience of courtesy discrimination) we applied the crosswise model technique, using the formula $[CW^{estimate} = (q-(1-p)) / (2^{*} p - 1)]$ outlined in Yu et al., Tian and Tang (2008). Where q is the proportion of individuals who responded both true or both false to the statements, and p is the known probability of birthdays in June, July or August. The crosswise design separates the known probability from the observed answers.

We conducted exploratory mediation analyses to examine whether (i) caring responsibilities and (ii) treatment seeking and /or diagnosis of alcohol / substance use disorder had a direct effect on wellbeing (compared to comparison group), but also whether this effect was mediated by everyday discrimination.

Data / analysis scripts are here [https://osf.io/xyqw5/files].

Results

See Table 1 for descriptive statistics split by group.

Predicting everyday discrimination in alcohol / substance use disorder and carers (see Table 2)

Descriptively, both individuals who were seeking / receiving treatment (mean difference: 4.88, $d = 0.77$ [95 % CI: 0.59 to 0.96]) and caregivers (mean difference: 3.30, $d = 0.47$ [95 % CI: 0.31 to 64]) reported greater discrimination than controls. There was also smaller difference between those seeking / receiving treatment and those who provide care (mean difference = 1.59, $d = 0.21$ [95 % CI: 0.01 to 0.40])

The robust regression model predicted 32.3 % of variance (Adjusted $R^2 = 0.323$) in everyday discrimination. There was limited evidence of multi-collinearity, as measured using variance inflation factors (all VIFs < 2). Having caring responsibilities for, and individuals directly seeking treatment or receiving support was associated with increased reporting of everyday discrimination (variance explained = 3.2 %) after adjusting for the included covariates. Covariates of (younger) age, having a mental health condition and belonging to an ethnic minority group were also associated with increased perceived everyday discrimination. Finally, increased AUDIT and DUDIT scores were also associated with perceived increased everyday discrimination. Exploratory interactions with gender or ethnicity were not significant.

Sensitivity analysis including only individuals who reported their substance use or a family member / friend's substance use as a reason for

Table 1
Demographic and alcohol / drug use split by groups.

	Control Group	Substance use	Caregivers
Age	43.96 (14.22)	43.33 (11.58)	46.62 (13.99)
MacArthur SES	5.25 (1.66)	4.70 (1.83)	5.32 (1.99)
AUDIT	6.19 (5.77)	11.10 (10.66)	7.32 (7.93)
DUDIT	1.95 (5.46)	7.99 (11.25)	4.51 (9.17)
WHO-5	19.41 (5.61)	16.55 (6.09)	16.92 (6.33)
	N (%)	N (%)	N(%)
Gender			
Male/Other	130 (36.8 %)	93 (53.1 %)	79 (31.9 %)
Female	233 (63.2 %)	82 (46.9 %)	169 (68.1 %)
Ethnicity			
White	314 (87.0 %)	148 (85.1 %)	209 (84.6 %)
Ethnic minority	47 (13.0 %)	26 (14.9 %)	38 (15.4 %)
Sexual Orientation			
Heterosexual	308 (86.0 %)	128 (73.5 %)	212 (86.9 %)
Other	50 (14.0 %)	46 (26.5 %)	32 (13.1 %)
Mental Health			
Yes	150 (41.4 %)	137 (78.2 %)	139 (56.2 %)
No	212 (58.6 %)	38 (21.8 %)	108 (43.8 %)

Legend: AUDIT = alcohol use disorder identification test; DUDIT = Drug use disorder identification test; WHO = World Health Organisation.

Table 2
Robust linear regression predicting experiences of everyday discrimination.

	Everyday discrimination			
Predictors	*Estimates*	*CI*	*p*	*VIF*
Treatment Seeking	1.51	0.40 – 2.61	**0.007**	1.26
Caregiver	2.67	1.68 – 3.67	**<0.001**	1.07
Age	−0.07	−0.11 – −0.03	**<0.001**	1.47
Gender [male]	0.47	−0.46 – 1.41	0.320	1.16
Mental Health [yes]	1.99	1.04 – 2.94	**<0.001**	1.29
Ethnicity [white]	−2.14	−3.39 – −0.89	**0.001**	1.16
Sexual orientation [straight]	−0.67	−1.94 – 0.59	0.295	1.30
AUDIT	0.16	0.09 – 0.22	**<0.001**	1.31
DUDIT	0.10	0.03 – 0.17	**0.003**	1.32
SES	−0.84	−1.13 – −0.56	**<0.001**	1.22
Observations	682			
R^2 / R^2 adjusted	0.333 / 0.323			

Legend: AUDIT = alcohol use disorder identification task; DUDIT = drug use disorder identification task; SES = perceived socioeconomic status, as measured using the MacArthur scale; VIF = Variance inflation factor.

Table 3
Reasons for, and sources of discrimination in carers, and individuals with alcohol / substance use disorders, compared to controls.

	Control	Treatment Seeking	Caregiver
Everyday discrimination	18.05 (5.99)	22.93 (6.83)	21.34 (8.05)
Reasons stated for discrimination	N (%)	N (%)	N (%)
Ancestors	27 (7.4 %)	19 (10.8 %)	29 (11.7 %)
Age	110 (30.3 %)	43 (24.5 %)	54 (21.7 %)
Gender	116 (31.9 %)	41 (23.4 %)	56 (22.6 %)
Height	22 (6.0 %)	17 (9.7 %)	14 (5.6 %)
Weight	48 (13.2 %)	28 (16.0 %)	26 (10.5 %)
Race	38 (10.5 %)	17 (10.7 %)	26 (10.5 %)
Religion	9 (2.0 %)	10 (5.7 %)	18 (7.3 %)
Appearance	86 (23.6 %)	58 (33.1 %)	59 (23.7 %)
Income/Education	58 (15.9 %)	36 (20.5 %)	41 (16.5 %)
A/SU own	10 (2.7 %)	92 (52.5 %)	39 (15.7 %)
A/SU family/friend	26 (7.1 %)	18 (10.2 %)	101 (40.7 %)
Source of Discrimination	N (%)	N (%)	N (%)
Friend	52 (14.3 %)	53 (30.2 %)	71 (28.6 %)
Family	69 (19.0 %)	77 (44.0 %)	117 (47.1 %)
Colleague	67 (18.5 %)	47 (26.8 %)	53 (21.3 %)
Health care worker	18 (4.9 %)	46 (26.2 %)	46 (18.5 %)
Service provider	90 (24.7 %)	56 (32.0 %)	48 (19.4 %)
Other	29 (7.9 %)	21 (12.0 %)	29 (11.7 %)

Legend: A/SU = Alcohol/Substance Use.

discrimination demonstrated the same pattern of results, however age was no longer a significant predictor (model adjusted $R^2 = 0.35$; see Supplementary Table 2).

Discrimination prevalence, cause and sources (See Table 3)

The most commonly reported cause for experiencing discrimination across all samples was gender (27.1 %), with women having four times the odds of reporting gender-based discrimination ($OR = 4.00$ [95 % CI: 2.96 to 6.09], $p < .001$). However, note that gender was not a direct predictor of everyday discrimination in our models. The most common sources of discrimination were from family and friends, particularly for participants seeking or receiving support for substance use, and caregivers of individuals seeking or receiving support for substance use.

For caregivers, the most common recipient of care was for a child (90 / 36.3 %), followed by a family member (77 / 31.0 %), friend (41 / 16.5 %), then a parent (41 / 16.1 %). In most cases the person they cared for lived with them (125 / 50.8 %), followed by lived alone or independently (95 / 38.6 %), followed by in s*upported housing or residential rehabilitation* (26 / 10.5 %).

Individuals with caring responsibilities reported that the circumstances of the person they cared for (treatment seeking or substance use) was a reason for experiencing stigma/discrimination 40.7 % of the time [95 % CI: 34.6 % to 47.1 %] when directly assessed. This was the most frequently reported reason. Crosswise models suggested this number to be 57.6 % [95 % CI: 51.4 % to 63.8 %], suggesting underreporting. For individuals who reported treatment seeking or receiving support for substance use 52.5 % reported this to be a reason for discrimination [95 % CI: 44.9 % to 60.1 %]. Again, this was the most frequently reported category. We did not include a crosswise model for this.

Exploratory analysis: does discrimination mediate the impact of caring responsibilities and treatment seeking / diagnosis of alcohol / substance use disorder

For individuals who reported caring responsibilities for individuals with alcohol / substance use disorder, there was a direct effect on wellbeing ($p < .001$), in that these individuals had lower wellbeing scores than the comparator group. There was also significant negative association between perceived everyday discrimination and wellbeing ($p < .001$). The indirect effect of everyday discrimination was significant ($B = -0.62$ [95 % CI: −0.97 to −0.26], $p < .001$), suggesting the negative effects of caring responsibilities on wellbeing were partially mediated by increased perceived discrimination (Fig. 1).

For individuals seeking treatment for or with a diagnosis of alcohol / substance use disorder there was the pattern of results was similar (see Fig. 2). The indirect effect of discrimination was significant ($B = -1.37$ [95 % CI: −1.89 to −0.84]).

Discussion

The aim of this study was to examine the impact of seeking or receiving support for substance use, as well as caregiving responsibilities for individuals seeking or receiving support for substance use, on experiences of everyday discrimination. Our findings demonstrate both caregivers and those seeking treatment or receiving support experience increased perceptions of everyday discrimination, versus a comparator group. The indirect effect of this experienced discrimination was associated with poorer wellbeing in both individuals seeking treatment and carers, further highlighting the detrimental impacts interpersonal stigma and discrimination have on individuals.

In line with multiple theories of stigma we note the presence of and considerable impact of stigma-by-association, or courtesy stigma (Aranda et al., 2023). Our observation of these experiences in a sample of caregivers for those who are seeking treatment or support for their substance use supports the wide-ranging experience of courtesy stigma across multiple populations, including family members of individuals with mental health conditions (Goldberg et al., 2023); and health-care workers in alcohol / substance use treatment facilities (Caruana et al., 2025).

To our knowledge, this is the first study which has quantitatively examined the experiences of everyday discrimination by caregivers. In this sample, a large percentage of individuals (~40 %) who reported caregiving responsibilities for somebody seeking treatment or receiving support for substance use report at least some discrimination as a result of their caring role. This is slightly larger than estimates of courtesy stigma for family members of these with a mental health condition (~33 %:Goldberg et al., 2023). Interestingly, our crosswise models suggest some underreporting of discrimination (crosswise estimates suggested ~57 % may have experienced discrimination), which is in line with under-reporting or possible concealment (Camacho et al., 2020). The identification of those at risk of discrimination but conceal this should be a topic for further study. Notably, the demographic profile of the caregivers in this study was broadly consistent with those reported in a similar study of caregivers of people with substance use or mental health disorders in the USA (largely female, white and aged 40+), and in both samples the most common recipient of care was a child (Timko et al., 2022).

For both individuals seeking treatment or receiving support the magnitude of discrimination was considerable (with effect sizes suggesting explanatory and practical importance (Funder & Ozer, 2019)). Notably there were smaller differences between caregivers and those seeking / receiving treatment suggesting that the experience of discrimination is somewhat higher for those seeking/receiving treatment compared to those providing care. Family and friends represented the primary source of stigma/discrimination, in line with previous research (Jones et al., 2024; Liahaugen Flensburg et al., 2023; McCann & Lubman, 2018). This suggests that interventions for reducing stigma (e.g. education campaigns) might be targeted towards these groups to

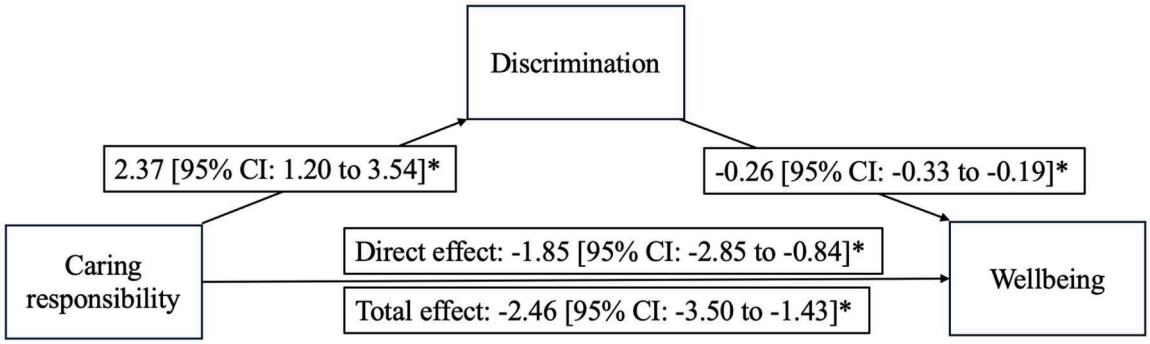

Fig. 1. Exploratory mediation model of the indirect effect of everyday discrimination on wellbeing in individuals with a caring responsibility.

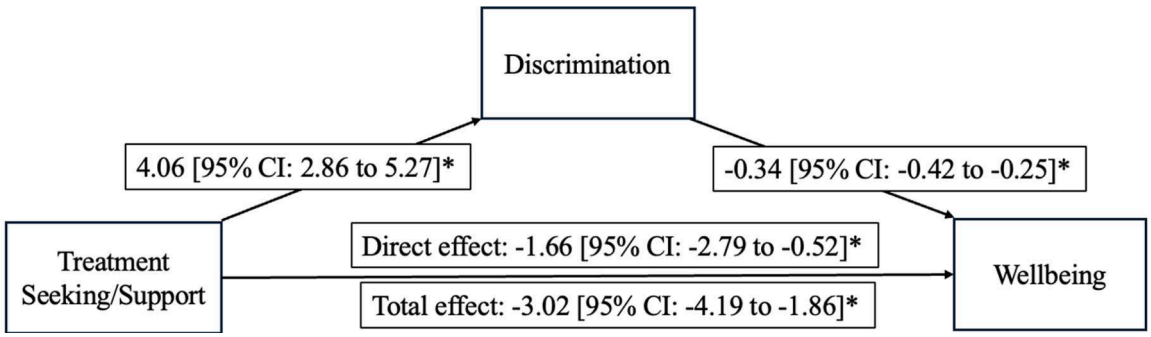

Fig. 2. Exploratory mediation model of the indirect effect of everyday discrimination on wellbeing in individuals seeking/receiving treatment or support.

have the greatest impact (Gronholm et al., 2017), although the long-term effectiveness of stigma reduction interventions is weak (Holland et al., 2024; Livingston et al., 2012; Thornicroft et al., 2016). Our findings also demonstrate the indirect effects of discrimination on wellbeing in both carers and individuals seeking treatment, further supporting the wide-ranging detrimental outcomes of experiencing stigma/discrimination, which supports previously reported observations between courtesy stigma/discrimination and quality of life (Garg et al., 2019; Zhang et al., 2018).

The implications of these findings suggest that more help should be provided not only to individuals who are directly seeking treatment or support for substance use disorder, but also their caregivers. Caregivers often provide considerable emotional and instrumental support, reducing costs to health-care providers and services (McGaffin et al., 2018), but their experiences and perspectives are often neglected (Settley, 2020). Caregiving can be a significant burden (Mikulić et al., 2023), with estimates from the USA suggesting that the average length of time spent caring is over 8 years, and over 30 h of care per-week, for mental illnesses including substance use disorder (Caregiving, 2016). Any impact on this (through distancing or mental/physical illness of the caregiver) may dramatically reduce the quality of care received, which in turn will impact the recipient's recovery (McGaffin et al., 2018). Recent evidence in the UK suggests that <2 % of local authority funding for tackling substance misuse is attributed to family support (Adfam, 2025). As such, greater assistance to caregivers to improve coping mechanisms and reduce impacts of stigma/discrimination should be a funding priority.

This study has several limitations. First, we cannot disentangle different forms of stigma/discrimination experienced, nor their relative impacts. Our focus was largely on individuals' perceptions and reactions to their experiences (*interpersonal stigma*), rather than structural or public stigma (Hatzenbuehler, 2016). Second, cross-sectional data is prone to biases in retrospective recall (Shiffman et al., 2008), and it is possible that these biases might impact the reported instances and reasons for experiencing stigma. For instance, individuals seeing a question related to caregiving might be anchored to report this as a reason for discrimination more readily. Related to the previous point, there are limitations to conducting our mediation analyses on cross-sectional data. Although much of the research supports our theoretical pathway of discrimination > wellbeing (Emmer et al., 2024; Schmitt et al., 2014), we cannot rule out reverse causality, and future research should attempt to clarify this relationship using longitudinal data collection. Third, we used a simple, short measure of wellbeing focusing on positive affect and general well-being. Future research might consider measures which provide a more complex view of wellbeing and quality of life, which consider different aspects (e.g. physical, psychological, social, and environmental) and allow for the impacts of discrimination across these subcategories (Bratu et al., 2023). Finally, due to the nature of our question we are unable to separate individuals into those who are seeking treatment vs those with a diagnosis of alcohol/substance use disorder, and examine the experiences and consequences of stigma/discrimination in these groups separately. This is important to disentangle in future studies as there may be differences within these individuals. For instance, as stigma may be a barrier to help seeking, and those who do seek help and receive treatment may have different experiences or increased resilience.

In conclusion, this research demonstrated considerable experiences of courtesy stigma/discrimination by individuals who care for somebody seeking treatment for an alcohol/substance use disorder, as well as direct stigma/discrimination experiences by those seeking treatment. This adds to the growing evidence base highlighting the negative impacts of courtesy stigma, and increased support for caregivers is warranted.

CRediT authorship contribution statement

Andrew Jones: Writing – review & editing, Writing – original draft, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Diane Sharples:** Writing – review & editing, Data curation, Conceptualization. **Sam Burton:** Writing – review & editing. **Abigail K Rose:** Writing – review & editing. **Suzanne H Gage:** Writing – review & editing. **Patricia Irizar:** Writing – review & editing. **Jay J Duckworth:** Writing – review & editing. **Catharine Montgomery:** Writing – review & editing. **Harry R Sumnall:** Writing – review & editing, Investigation, Formal analysis, Data curation.

Declaration of competing interest

AJ and CM have received funding from Camurus Pharmaceuticals for research into predictors of opioid treatment prescribing. All other authors report no conflicts of interest.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.drugpo.2026.105256.

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