Position Paper

Stigma and Discrimination

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Introduction

People who use alcohol, tobacco and other drugs routinely experience stigma and discrimination as a result of their drug use.

People who use alcohol, tobacco and other drugs are not an homogenous community. Subsequently, each individual’s experience of discrimination and stigma varies and is impacted upon by other factors in their lives.

Radcliffe et al. reveal, “...the reasons for drug use are as complex and varied as the numbers of people who engage in drug taking itself. There is not one type of drug use or drug user and ... we must change the attitudes of the wider community to drug users.”

Use of alcohol, tobacco and other drugs can compound experiences of stigma and discrimination on other grounds such as:

- Social issues (education, literacy, housing, family relationships);
- Economic circumstances (employment, financial status);
- Health – (living with a blood borne virus (BBV), co-occurring diagnoses such as mental illness);
- Justice – (the impact of past or continuing involvement with police and justice systems).

The emotional effects of stigma on any grounds vary, but can include:

- Low self esteem;
- Feelings of isolation;
- Disempowerment;
- Internalised phobia – the development of self hate;
- Stress;
- Exclusion from the community;
- Social vulnerability;
- Physical and psychological distress;
- Depression;
- Feelings of helplessness.

These experiences can become entrenched, having a lasting effect on mental and physical health outcomes for individuals.

Stigma and discrimination on any grounds should not be tolerated in our community. In recent decades we have seen the success of many campaigns which have lead to a reduction in stigma based on mental health, race and gender (for example). However widespread discrimination against those in our community who use alcohol, tobacco and other drugs is still disturbingly prevalent and must be addressed.

Discrimination towards people who use alcohol, tobacco and other drugs is perpetuated by the negative portrayal of drugs and the people who use them, within the media. Persistent focus on the

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links between drug use and crime, rather than drug use as a health issue, serves to reinforce negative stereotypes.

The involvement of consumers at the policy development, planning, delivery and evaluation levels of services and treatment programs will inevitably lead to a more consumer rights focussed alcohol, tobacco and other drugs sector. If meaningful consumer participation is achieved, stigma and discrimination will reduce.

This paper will explore the daily life experiences of stigma felt by people who use alcohol, tobacco and other drugs, from within the community and in their interactions with health professionals. It will conclude with recommendations for removing the stigma faced by people who use drugs.

**Legislative background**

In Tasmania, discrimination is dealt with by the *Anti-Discrimination Act 1998*. Discrimination will be contrary to the Act if it is based on a wide range of attributes including gender, sexual orientation, marital status religion or disability (for example).³

Section 3 of the *Act* defines disability to include *(f) a disorder, illness or disease that affects a person’s thought processes, perceptions of reality, emotions or judgement or that results in disturbed behaviour.*

‘Addiction’ is deemed a ‘disability’ under both the Tasmanian Act, and under the Commonwealth *Disability Discrimination Act 1992*. Therefore discrimination against someone on the grounds of their addiction to alcohol, tobacco or other drugs is unlawful under both Tasmanian and Commonwealth law.⁴

In 2004, the then Federal Government attempted to amend the *Disability Discrimination Act* to make discrimination against drug addicted people lawful. The Bill’s aim was to make it “possible for a person to be lawfully discriminated against in relation to his or her current addiction to a prohibited drug”.⁵

The Bill ultimately failed to pass the Parliament, and so addiction remains considered a disability under the Act, and protection against discrimination remains entrenched in law on that ground.

³ *Anti-Discrimination Act 1998* (Tas) Section 16.
⁵ Explanatory Memorandum to the *Disability Discrimination Amendment Bill 2003* (Commonwealth).
The impact upon people who use drugs.

Illicit Drug Use

The Australian Injecting and Illicit Drug Users League (AIVL) examined the history and development of discrimination against people who inject drugs in their recent publication *Why Wouldn’t I discriminate against all of them?* AVIL explains discrimination is institutionalised and pervasive and argue the industrial revolution of the 19th Century is one key point in time for tracing the development of contemporary attitudes to people who inject drugs.

According to the analysis, factors such as the growth of cities, the beginning of urban planning, the proliferation of factories and the development of statistics gathering (and thereby the process of ‘othering’) all played a role in the process of pathologising people who inject drugs.

Furthermore, they explain that the development of professional societies for the medical profession meant that people with few resources “had to visit doctors and pharmacists in order to obtain products that had previously been available in their local store.” They explain that opiates in particular had been “freely available, and relied on in most homes as a valuable remedy.” However with the development of professional societies for doctors and pharmacists, availability diminished and attitudes towards drug use became increasingly medicalised, and the perception of drug users as being ‘sick’ has prevailed in many parts of the medical profession ever since.

The ‘Barriers and Incentive to Drug Treatment for Illicit Drug Users National Research Project* uncovered the fact that people who inject drugs had reported experiencing discrimination as follows:

- By family members – 63%
- By staff at pharmacies – 63%
- By friends – 62%
- By doctors and nurses – 54%
- By other health workers – 36%
- By landlords - 36%
- By co-workers – 34%

These concerning statistics display the fact that community attitudes to people who inject drugs are overwhelmingly negative and impact on more than just their own health and wellbeing.

Discrimination against people who inject drugs by landlords, employers and workmates, for example, has the effect of limiting the housing, employment and social opportunities for people who inject drugs. This discrimination also has the very real effect of impacting negatively upon the lives of others such as partners and children.

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6 *Why Wouldn’t I discriminate against all of them?*, A report on stigma and discrimination towards the injecting drug user community, Australian Injecting and Illicit Drug Users League [AIVL] 2011, Canberra, Australia.
7 Ibid at vii.
8 Ibid at 7.
This points to a need for further community education on issues surrounding injecting drug use, as well as pathways for people who inject drugs, to address stigma and protect their rights not to be discriminated against.

Another area in which discrimination against people who inject drugs is commonplace is within custodial settings. While there are many people working within the prison system who recognise the positive opportunities for medical treatment that incarceration can provide, there is still a certain level of genuine disrespect for prisoners who use drugs and this is exemplified here:

For many years Alex was an injecting heroin user. He began a pharmacotherapy program, and while he was still on the program he was sentenced to time in prison. Once incarcerated, correctional officers labelled him a ‘junkie’ and told him to “toughen up”. He then began purchasing drugs from other prisoners to avoid withdrawal.

Case study provided by an ATDC member organisation.

Alcohol

Stigma and discrimination against people who use alcohol to excess comes in many forms. There is stigma associated with anti-social public drinking, as well as with the less visible forms of drinking, ranging from heavy drinking at home to more severe alcohol dependence.

Room identifies that part of the difficulty in addressing alcohol use in Australia is that “drinking is closely associated with many positively valued and high prestige activities and statuses ... champagne for a wedding reception, or complimentary drinks for first-class passengers.” Similarly, in 2010, Schomerus told us that “…drinking alcohol is a social behaviour that is often associated with inclusion in a social grouping; it may even be a signal of power and status..., and often, even heavy drinking is socially accepted behaviour, examples are wedding receptions, business meetings and parties.” Shomerus explains that stigma can have a preventative effect upon the development of alcohol or drug dependence, meaning people alter their drug use to avoid the effects of stigma. However he goes on to explain that stigma evoked when a person’s drinking behaviour violates social norms may be too late to have such a preventative impact.

Stigma against people experiencing alcohol dependence is entrenched in many ways. Stigma associated with alcohol use is also likely to aggravate the negative effects of alcohol dependence on social behaviour, social interactions and the social environment, and can “…hinder the seeking of professional and lay help, because people fear being labelled alcoholics and subsequently experiencing loss of status and discrimination”.

Schomerus identified that alcohol-dependent patients are held much more responsible for their condition than people suffering from other forms of mental disorder such as depression or schizophrenia, or other substance-unrelated mental disorders. This attribution of blame for the sufferer’s condition adds to the likelihood that people suffering alcohol dependence are less likely to

12 Ibid at 105.
seek medical help or treatment. They identified that alcohol dependent people are particularly severely stigmatised because alcohol dependence was “seen as a voluntary condition and [not] as an illness.” People who use alcohol are “less frequently regarded as mentally ill and are held much more responsible for their condition.”

Furthermore, in a European study, Santana found that among nine categories of ‘disadvantaged people’ in Portugal, those identified as alcoholics were, along with the homeless, the least likely to have used health services, despite 100% having less than good health.

These studies clearly illustrate that people experiencing alcohol dependence have poorer health outcomes and are less likely to seek treatment because of the stigma they face as a result of their alcohol use.

**Tobacco**

Tasmania’s smoke free legislation has been a well recognised success in reducing smoking levels and ‘denormalising’ smoking, particularly in public places. While this has overwhelmingly positive effects on the general health of the community as well as smokers themselves, there is little research on the possible negative consequences of the changes.

Ritchie et al. examined Scotland’s smoke free legislation and found that “…smokers perceived the smoke-free legislation to have increased the stigmatisation of smoking”. They found that while “there was little reported direct discrimination, there was a loss of social status in public places”.

While the benefits of a reduction in smoking rates is extremely positive and can in large part be attributed to smoke-free legislative frameworks, at least some thought must be given to the possibility of increased stigma and how this is factored into public policy as well as treatment options for smokers.

While “smoke-free policies could be creating more social distance and social exclusion...other evidence suggests that smokers who experience unfavourable public sentiment are more motivated to quit”. Users of tobacco and other drugs need a supportive and constructive environment which will encourage and facilitate the management, reduction or ceasing of their drug use.

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13 Ibid at 109.
   In Room, R. “Stigma, Social inequality and alcohol and drug use” *Drug and Alcohol Review*, (March 2005), 24, 143-155, at 147.
15 Ritchie, D. Amos, A. Martin, C. “But it just has that sort of feel about it, a leper – Stigma, smoke-free legislation and public health.” *Nicotine & Tobacco Research*, Volume 12, Number 6 (June 2010) 622-629, at 622.
16 Ibid at 622.
17 Ibid at 623.
Attitudes of professionals

Health professionals such as GPs, nurses, social workers and pharmacists, as well as para-professionals such as counsellors and case managers are a central part of the frontline workforce providing key services to individuals who use alcohol, tobacco and other drugs (e.g. screening and brief interventions, counselling, information and referral). The attitudes of professionals in regard to alcohol, tobacco and other drug issues are often a crucial barrier to accessing services.\textsuperscript{18}

Joe was a regular user of narcotics, was unemployed, unlicensed and lived in a rural area with limited public transport. Despite there being three doctors surgeries and a chemist in his rural township, none would deliver pharmacotherapies. Joe found it easier and cheaper to return to buying illicit drugs and resorting to petty crime to fund his drug dependence.

Case study provided by an ATDC member organisation.

Skinner has found that a “significant proportion of health professionals hold negative stereotypic or stigmatized attitudes towards individuals who experience problematic alcohol, tobacco and other drug use, and consequently report lower willingness to provide health services to these individuals compared with individuals with other health issues”.\textsuperscript{19}

The National Centre for Education and Training on Addiction (NCETA) show us that many factors impact on the willingness of health professionals to intervene with individuals who use licit or illicit drugs. These factors include knowledge, training, organisational policies and procedures and previous positive or negative experiences.\textsuperscript{20}

In their training resource for professionals, NCETA identifies some of the negative judgements held by some medical professionals. These include attitudes such as:

• “Drug users don’t deserve medical treatment as much as other people.”
• “It’s their own fault that they are experiencing problems.”
• “They chose to use the drug and now they have to live with the consequences”.

Radcliff argues that mainstream drug treatment programs operate on highly punitive models, which “attempt to fit the drug user into a rigid model that does not acknowledge the differences in people who use drugs. This results in many drug users choosing either to never have contact with treatment services or to leave before they have achieved any positive outcomes for themselves or reached their identified treatment goals. This has the effect of marginalising those who access those services as being ‘a certain type of drug user’- the ‘out of control junkie’ who cannot afford to engage in discourses about stereotypes and stigmatised identities.”\textsuperscript{21}

\textsuperscript{19} Ibid at 253.
\textsuperscript{20} National Centre for Education and Training on Addiction (NCETA), Flinders University, Health Professionals’ Attitudes Towards Licit and Illicit Drug Users – A Training Resource, 2006.
\textsuperscript{21} Radcliffe, P., and Stevens, A., Ibid at pp7-8.
Gilchrist found that health professionals often report caring for substance users to be unrewarding and unpleasant. Their study showed that staff reported a significantly lower regard for substance users than for patients with depression or diabetes. But importantly, they also identified that “staff with fewer than 10 years’ experience showed higher regard for working with drug users than those who had worked between 10 but fewer than 20 years in their profession”.

Grey reinforces that negative perceptions by health care professionals that drug use is within the control of the individual, who is therefore to blame for their condition, mean that drug users are more likely to receive poor health care and be denied access by health professionals.

The findings above point to the very real possibility that by providing education and training for health professionals during their degrees or diplomas, and increasing the requirement for ongoing professional development in the alcohol, tobacco and other drugs field, attitudes can be changed.

By equipping health professionals with positive experiences and reinforcing positive attitudes to people who use alcohol, tobacco or other drugs and their treatment, overall change within the sector is possible. This in turn will lead to better health outcomes for clients in the alcohol, tobacco and other drug sector.

As Skinner points out, “…culture change tends to occur gradually over time, therefore strategies to support and maintain culture change should be planned for the longer term”, and lasting change will occur via changes in “everyday work behaviours, interactions and practices, for example, the day-to-day behaviour of managers can create and shape organizational culture.”

Work can be done to change attitudes to drugs and the people who use them in other professional areas as well. Areas such as social work, counselling, child protection and education are all areas where the attitudes of workers will impact upon the daily lives of people who use drugs.

For example, the attitudes of young people in secondary schools as well as the attitudes of the teachers who work with them can play a fundamental role in more widespread attitudinal change in the community.

Targeted training provided to people studying teaching and other education related degrees and diplomas as well as quality information being delivered to students in relation to alcohol, tobacco and other drug use and the effects of stigma and discrimination would greatly assist in altering the language used to describe drugs and the people who use them, and would contribute to a reduction of ‘othering’ of people who use drugs.

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24 Skinner, Ibid at 241 & 244.
Conclusion

Users of alcohol, tobacco and other drugs routinely experience stigma as a result of their drug use. This stigma is often compounded by other areas of their life in which they also experience stigma such as homelessness, lack of financial security and so on.

Stigma comes in many forms and is felt from friends and family, colleagues and the general community. However of significant concern is that stigma is often felt from health professionals right across the health sector for example from GPs, pharmacists and other health professionals.

This stigma in particular acts as a distinct barrier to accessing services including health, community and social services.

Schomerus asserts that individuals who use alcohol, tobacco and other drugs “...have the right to be judged by their personal behaviour, not by the stereotypes attached to a diagnostic label...” We need to move towards a widespread recognition that the issue of dependence upon alcohol, tobacco and other drugs is primarily a health issue, not a moral issue, nor a law and order issue. Access to quality accessible treatment suitable to each relevant client base should be seen as a basic right of all Tasmanians, and should not be clouded by any particular moral stance on any individual drug or the use of drugs in general.

Moving the moral goalposts will take time. However the opportunity is here for a more positive attitude to people who use alcohol, tobacco and other drugs to be fostered.

25 Schomerus, Ibid at 110.
ATDC Position Statement

The ATDC believes that **stigma and discrimination on any grounds should not be tolerated in our community.**

We recognise that social change and the altering of attitudes in the community happen incrementally. We believe there are clear steps that can be taken today which would support change, leading to a reduction in stigma and discrimination faced by people who use alcohol, tobacco and other drugs.

These include (but are not limited to):

- Supporting **consumer participation** in policy development, planning, delivery and evaluation of services.
- Combatting the negative **media portrayal** of people who use alcohol, tobacco and other drugs;
- Altering the **language used** to describe drugs and people who use them. (for example avoidance of offensive terms such as ‘junkie’, but also recognising the linguistic difference between phrases such as ‘people who inject drugs’ vs. ‘injecting drug users’. This in turn will lead to a reduction in the ‘othering’ of people who use drugs;
- Changing the **attitudes of professionals**. This would be facilitated in two ways; i) providing training in alcohol, tobacco and other drugs, including issues of stigma and discrimination, to students of medicine, pharmacy, education and other health and community related fields.
  ii) providing ongoing targeted professional development in alcohol, tobacco and other drugs including stigma and discrimination to all relevant professions.
- Supporting **family, friends and educators** to understand and respond to issues of stigma and discrimination associated with alcohol, tobacco and other drug use.