

Alcohol and other drugs: Stigma.

A background paper

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Contents

Stigma: An introduction	3
Why does stigma matter?	4
What is stigma?	5
What impact does stigma have?	8
What can we do about stigma?	9
Let's start with a conversation	11
References	12



Stigma

An introduction

For people who use alcohol and other drugs (AOD), stigma is a real problem. Other people's actions and language can make them feel unwelcome and unsafe. That can stop them from seeking the services they need, which can negatively impact their health, wellbeing, employment and social outcomes.

Stigma is a complex and powerful social phenomenon that manifests as strong feelings of disapproval.

The World Health Organization has ranked illegal drug dependence as the most stigmatised health condition globally. Alcohol dependence is listed at number four.¹

By reducing stigma overall outcomes can be improved by increasing rates of help-seeking and decreasing negative impacts on individuals.

To sustainably tackle the stigma around illicit drug use and alcohol and other drug (AOD) dependence – and minimise its impact on people's physical and mental health – stigma needs to be better understood. It also needs to be addressed holistically with initiatives targeted at the three types of stigma: social, structural and self-stigma.

This paper provides an evidence-based review of the stigma associated with illicit drug use and AOD dependence. It also calls for a much-needed course of action for public health intervention. This paper is not designed to be the solution, but it will hopefully start the conversation.



Why does stigma matter?

Stigma associated with alcohol and other drug (AOD) contributes to health inequalities and adverse health outcomes.^{2,3}

Impacts of stigma can include increased stress, reinforced differences in socio-economic status, delays in seeking support/treatment and people leaving support/treatment.

Research and user experience surveys suggest that experience of stigma could be considered as a social determinant of health.⁴

Stigma has been shown to worsen stress, reinforce differences in socio-economic status and delay help-seeking. It can also lead to people leaving treatment and support services.

It's difficult to estimate the exact number of people who are affected by AOD-related stigma or to quantify the harms they experience because of it. Some of the most at-risk people who use illicit drugs or experience a dependence on AOD may also experience homelessness or unstable living.

Many people affected by stigma are silent or lack a space in which to voice their experience. Others are reticent to interact with researchers.

While the impact of stigma may be more damaging in already marginalised communities, discrimination and prejudice can affect anyone. The Australian Government's *2017–26 National Drug Strategy* notes:

Approaches and policy responses aimed at reducing alcohol, tobacco and other drug harms in priority populations should be informed by evidence as it develops and should be reviewed regularly. It is also important that any responses do not inadvertently or unintentionally further marginalise or stigmatise people who are at higher risk of experiencing alcohol, tobacco and other drug related harm.

What is stigma?

Stigma is a social process that occurs when a person is deemed by others to possess a trait or status that makes them less acceptable.

Being stigmatised can reduce someone “from a whole and usual person to a tainted, discounted one”.⁵

Stigma marginalises and alienates the people who are subjected to it.

Stigma comes from the social process of labelling, judging and stereotyping. We categorise and label⁵ naturally because it is an efficient way to process new experiences quickly. Because of our experiences, biases, influencing factors and social norms, we then often attach judgments and stereotypes to these labels.

Stigma associated with AOD

People who use illicit drugs or are experiencing a dependence on AOD tend to be subjected to greater stigma than those with other health conditions, including people with a mental illness.

Other key factors that contribute to stigmatisation include perceived danger, insufficient information, perceived level of responsibility, age, lack of contact and cultural factors.

Although alcohol is a drug, the general social acceptability of alcohol use means people who use alcohol, but are not dependent on it, tend to be less stigmatised.

The stigma associated with a drug typically increases with a lack of understanding about the drug and how it works, as well as its legal status and social acceptability. This is evidenced by a 2014 Australian study that found that people are generally more comfortable if they encounter an alcohol dependent person than a person dependent on heroin.⁶

Stigma is sometimes used as a social tool to discourage and marginalise certain behaviours and, by extension, the people who engage in them.

The varying levels of stigma associated with different drugs is also reflected in public approval of policy approaches. For example, more people support coerced treatment for people with a dependence on heroin and fewer people support coerced treatment for people with a dependence on alcohol.³

Varying degrees of stigma

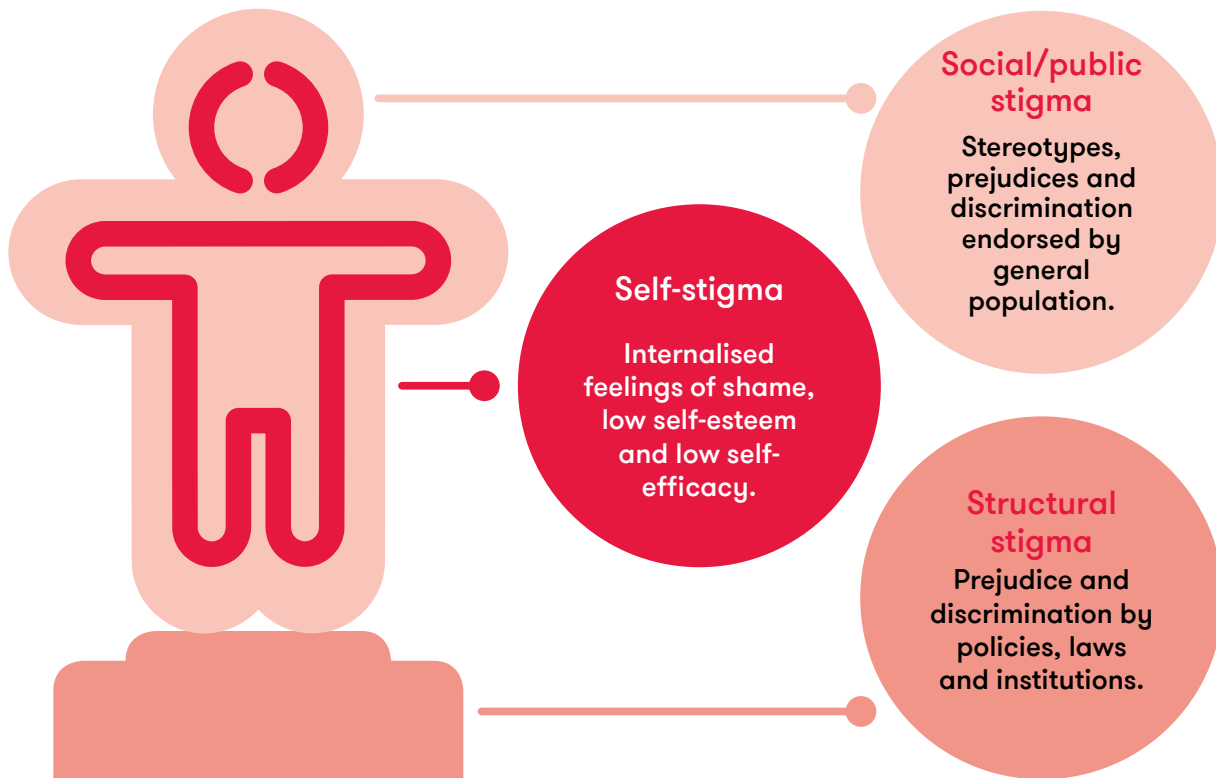
The regularity of drug use influences the degree of stigma that may be experienced. For instance, a person who uses cannabis a few times a year may be viewed very differently to someone who uses cannabis daily.

The type of drug also impacts the degree of stigma. For example, the stigma – including self-stigma – associated with heroin use is higher than that associated with cannabis use.⁷

Stigma also varies with different methods of consumption. Intravenous drug use carries significantly greater stigma than smoking, snorting or swallowing drugs.⁸ People who inject drugs are often seen as ‘irresponsible and dangerous’ and stereotyped as engaging in criminal behaviour to pay for drug use.^{9,10,11} Internalised shame, or self-stigma, is also commonly reported amongst people who inject drugs.⁸ This can increase risk-taking behaviour (such as sharing needles and self-harm).¹¹ It can also impact mental health and self-esteem, leading to a greater potential for increased severity of dependence.^{8,10}

Types of stigma

Stigma manifests in three primary forms:¹²



Causes of stigma

Factors that contribute to stigma are complex. However, there are three main problem types: knowledge, attitude and behaviour.

Type	Cause	Impact
Problem of knowledge: Ignorance	A lack of understanding creates fear about illicit drug use and dependence on AOD. Media coverage also has a key role to play in either increasing or decreasing stigma related to AOD.	This can deepen societal distrust of people who use illegal drugs as it reinforces stigmatising labels and perceptions.
Problem of attitude: Prejudice	Some people blame people who use AOD for other health, economic, and social issues they have. This is because they believe the behaviour is a personal decision. Another issue is social perceptions of controllability. Language is also important in forming attitudes. It can also affect how a person is treated by medical professionals in a clinical setting.	The lack of understanding about AOD and their effects, and why people use them, can lead to inaccurate generalisations, antipathy, hostility, negative attitudes and prejudices. ¹³
Problem of behaviour: Discrimination	Discrimination may arise because of behaviour at an interpersonal level, but also because of established rules and systems.	This discrimination can lead to restricted access to resources or opportunities or render the group powerless. ^{14,15}

Language is important in forming attitudes.

There are obvious discriminatory and dehumanising words that are used to denigrate and insult people who use illicit drugs or experience a dependence on AOD. These can create an alienating “us” and “them” mindset. There are also more subtle language issues where words have negative connotations, such as referring to someone who is no longer using illicit drugs as being “clean”.

Language can also affect how a person is treated by medical professionals in a clinical setting. A 2009 study demonstrated that even highly trained mental health professionals, when exposed to a subtle shift in language (“substance abuser” versus “substance user”), applied different judgments and attitudes in their response.¹ Advocates of person-first language recognise that the order of the words, not just the words used, affects the images that are generated about the person or group being described.¹⁶



Communication structures and procedures

in the health system (e.g. triage systems) have been found to increase the stigmatisation of people who use drugs. This was demonstrated in a study which included people with a positive diagnosis of hepatitis C. Having that diagnosis changed the way a person experienced the health system. As part of that study, several members of an emergency department staff admitted that they maintained a list of the names of people they suspected of drug seeking. They acknowledged that when they recognised the name of a patient as a drug seeker, they tended to discount the patient’s symptoms.¹⁷



More than one stigma

People who use alcohol and other drugs (AODs) can be subject to additional stigmas, resulting in overlapping layers of discrimination.

Additional stigmas can stem from an individual’s perceived social identity. Social identity comes from characteristics such as class, gender identity, sexual orientation, ethnicity, age, history of interactions with the justice or child protection systems, religious or spiritual beliefs, mental health status, dis/ability, body type, literacy and numeracy, and educational qualifications. All these characteristics can have varying degrees of stigma attached to them.

When a person has multiple social identities that are stigmatised, their experience of stigma, discrimination and exclusion can be intensified.

For example, a person who has a dependence on AOD may be stigmatised for their dependence. If that person is also non-literate in English, they may be further stigmatised because of that. That person’s experience of exclusion may be further compounded if they also have poor mental health.

Stigma and social identities are complex. Because of this, there are no hard and fast rules about what an individual’s experience is going to be.

What impact does stigma have?

Impact of social/public stigma

- Social stigma leads to social segregation and exclusion.¹⁸
- The alienation of people who use illicit drugs or experience a dependence on AOD can lead to poorer mental and physical health outcomes, and the impacts can be far-reaching.¹⁹
- Social stigma can also be a partial driver of the creation of sub-cultures.

Impact of structural stigma

- Policies and institutional structures can intentionally or unintentionally restrict opportunities of people who use illicit drugs or experience a dependence on AOD.
- The attitudes of health care professionals may also influence the overall quality of treatment received by any patient.^{20,21,22}
- Negative attitudes can result in reduced access to accurate health assessments.^{3,14,15,17}

Impact of self-stigma

- Some people who use drugs have a fear of being treated differently, expectations of being dismissed or rejected, and experience feelings of internalised shame and a loss of self-worth. These can result in people delaying treatment which can lead to increased harms from AOD.^{3,23}

Impact on families and friends

- The impact of stigma on the family of people who use illicit drugs, or are experiencing a dependence on AOD, will be different for every family.
- Stigmatisation within families can degrade relationships, further marginalise the person experiencing a dependence on AOD and reduce the remaining social support they may have.^{24,25,26}

What can we do about stigma?

There are three primary problems that lead to stigma. They are attitudes, knowledge and behaviour.

These problems interact with and influence each other in complex ways. Changing one of these may or may not change the others.

Knowledge, attitudes, and behaviour also occur in, and are shaped by, the context of external environmental factors, such as laws, policies and social norms (Figure 1). The individual characteristics of knowledge, attitudes and behaviour also influence those external factors. Changes in public attitude towards cannabis use, for example, have resulted in decriminalisation and legalisation in several countries. Drug laws also strongly influence societal perceptions about different drugs, and by extension the people who use them.

Given the interaction between knowledge, attitudes, behaviour and environment, a long-term, holistic approach is likely to demonstrate the greatest impact in reducing stigma. Such an approach could involve simultaneously:

- changing the environment (social norms, policies and public discourse)
- increasing knowledge (reducing ignorance)
- shifting attitudes (reducing prejudice) to change behaviours (reducing discrimination).

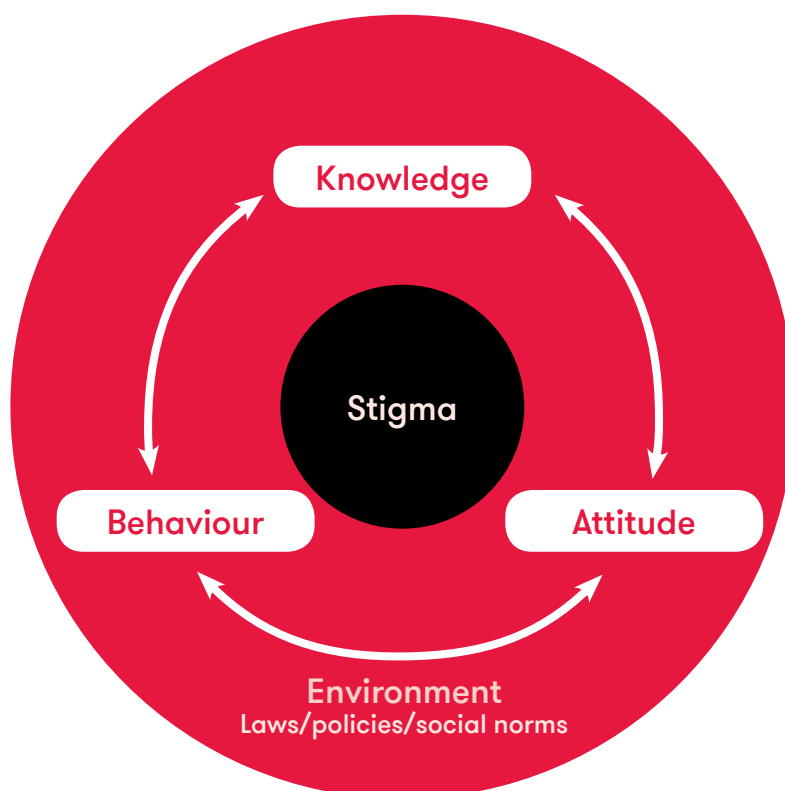


Figure 1. The model of change addresses the key stigma factors.

Key opportunities for action in Australia include:

01. Research to **identify the drivers** of stigma

- > Explore the key drivers of stigma, including knowledge, attitudes and behaviours, and how people who use AOD or have a dependence may experience stigma
- > Identify key audience segments where these drivers are particularly relevant
- > Identify the types of activities which may be most appropriate to key audience segments.

02. **Improve knowledge and understanding** among the general public and dispel myths about AOD use and dependence

- > Ensure provision of accurate, factual, objective and unbiased information about drugs and their effects to the public – this information should be accessible in multiple languages and dispel commonly held myths
- > Influence and improve the way media uses language and reports on AOD issues by leveraging existing guidelines
- > Provide evidence-based education programs in schools to enhance knowledge and reduce stigma
- > Identify evidence of previous effective and unsuccessful stigma reduction campaign approaches to inform the development of future campaigns designed to reduce AOD-specific stigma.

03. **Strengthen training and workforce development** across the range of professionals who work with people who use drugs

- > Embed AOD-specific training in health professional and emergency services curriculum
- > Investigate opportunities to embed contact-based programs that involve direct involvement with people experiencing AOD issues, within undergraduate, post-graduate and professional development training opportunities, to determine their feasibility and potential utility.

04. **Support and promote help-seeking behaviour** within a framework that recognises some members of every segment of society use AOD, and the experience of dependence varies between individuals

- > Ensure a variety of treatment and support options are available, including peer-based recovery support services and groups, contact with peer role models, self-help support groups for family members, as well as harm reduction
- > Support people who are seeking help with alcohol or other drugs issues to access and choose a treatment pathway most appropriate for them.

05. Investigate and implement opportunities to **decrease structural stigma**

- > This would include legislative and administrative restrictions within society including facilities that provide support and treatment to people who use drugs.

Let's start with a conversation

To reduce stigma, it's necessary to recognise and understand why ignorance, prejudice and discrimination towards people who use AOD exists. It is also necessary to identify the extent of the problem and the impact that it has on the lives of people.

Stigma must be addressed holistically with a multi-pronged approach. This approach should feature initiatives targeted at social, structural and self-stigma. Such an approach will create the greatest and most sustainable impact.

Illicit drug use, and experience of dependence on AOD, are emotional and value-laden topics. Many people hold strong opinions about them. The messaging of any initiatives to change knowledge and attitudes must be carefully constructed so that attitudes will shift.

Information and evidence alone are not enough to change attitudes and behaviours.²⁷ Strategies also need to be developed for different target populations. For example, providing young people with evidence-based AOD education in school

may help address the problem of knowledge (ignorance) by equipping them with facts from a young age. This is a useful element of a long-term strategy to reduce stigma. However, addressing the existing problems of knowledge (ignorance) and attitudes (prejudice) in adults, who may have firmly held beliefs and attitudes about the issue, requires a more nuanced approach.

One thing is certain: it's going to take many conversations.



References

1. Kelly JF, Westerhoff CM. *Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms.* International Journal of Drug Policy. 2010 May 1;21(3):202-7.
2. Hatzenbuehler ML, Phelan JC, Link BG. *Stigma as a fundamental cause of population health inequalities.* American Journal of Public Health. 2013 May;103(5):813-21.
3. Lancaster K, Seear K, Ritter A. *Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use.* Sydney: UNSW, 2017.
4. Liamputtong P, Kitisriworapan S. *Deviance, difference, and stigma as social determinants of health. Health, illness, and well-being: Perspectives and social determinants.* 2012:242-56.
5. Goffman, E. *Stigma: Notes on the Management of a Spoiled Identity.* New York: Prentice Hall, 1963.
6. Meurk C, Carter A, Partridge B, Lucke J, Hall W. *How is acceptance of the brain disease model of addiction related to Australians' attitudes towards addicted individuals and treatments for addiction?* BMC psychiatry. 2014 Dec;14(1):373.
7. Brown SA. *Stigma towards marijuana users and heroin users.* Journal of Psychoactive Drugs. 2015 May 27;47(3):213-20.
8. Paquette CE, Syvertsen JL, Pollini RA. *Stigma at every turn: Health services experiences among people who inject drugs.* International Journal of Drug Policy. 2018 Jul 31;57:104-10.
9. Conrad S, Garrett LE, Cooksley WG, Dunne MP, MacDonald GA. *Living with chronic hepatitis C means you just haven't got a normal life any more.* Chronic Illness. 2006 Jun;2(2):121-31.
10. Cama E, Brener L, Wilson H, von Hippel C. *Internalized stigma among people who inject drugs. Substance use & misuse.* 2016 Oct 14;51(12):1664-8.
11. von Hippel C, Brener L, Horwitz R. *Implicit and explicit internalized stigma: Relationship with risky behaviors, psychosocial functioning and healthcare access among people who inject drugs. Addictive behaviors.* 2018 Jan 1;76:305-11.
12. Livingston JD, Milne T, Fang ML, Amari E. *The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review.* Addiction. 2012 Jan;107(1):39-50.
13. Lloyd C. *Sinning and sinned against: The stigmatisation of problem drug users.* London: UK. 2010.
14. Thornicroft G, Rose D, Kassam A, Sartorius N. *Stigma: ignorance, prejudice or discrimination? The British Journal of Psychiatry.* 2007 Mar;190(3):192-3.
15. Beyond Blue. *Beyondblue Position Statement: Stigma and Discrimination.* n/d.
16. Blaska J. *The power of language: Speak and write using "person first". Perspectives on disability.* 1993:25-32.
17. Paterson B, Hirsch G, Andres K. *Structural factors that promote stigmatization of drug users with hepatitis C in hospital emergency departments.* International Journal of Drug Policy. 2013 Sep 1;24(5):471-8.
18. Blendon RJ, Young JT. *The public and the war on illicit drugs.* Jama. 1998 Mar 18;279(11):827-32.
19. Lancaster K, Santana L, Madden A, Ritter A. *Stigma and subjectivities: Examining the textured relationship between lived experience and opinions about drug policy among people who inject drugs.* Drugs: Education, Prevention and Policy. 2015 May 4;22(3):224-31.
20. Van Boekel LC, Brouwers EP, Van Weeghel J, Garretsen HF. *Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review.* Drug and Alcohol Dependence. 2013 Jul 1;131(1-2):23-35.
21. McGillion J, Wanigaratne S, Feinmann C, Godden T, Byrne A. *GPs' attitudes towards the treatment of drug misusers.* Br J Gen Pract. 2000 May 1;50(454):385-6.
22. Skinner N, Feather NT, Freeman T, Roche A. *Stigma and discrimination in healthcare provision to drug users: The role of values, affect, and deservingness judgments.* Journal of Applied Social Psychology. 2007 Jan;37(1):163-86.
23. Lloyd C. *The stigmatization of problem drug users: A narrative literature review.* Drugs: Education, Prevention and Policy. 2013 Apr 1;20(2):85-95.
24. Earnshaw V, Smith L, Copenhaver M. *Drug addiction stigma in the context of methadone maintenance therapy: an investigation into understudied sources of stigma.* International Journal of Mental Health and Addiction. 2013 Feb 1;11(1):110-22.
25. Marshall O. *Associative stigma among families of alcohol and other drug users.* 2013.
26. Tamutiene I, Laslett AM. *Associative stigma and other harms in a sample of families of heavy drinkers in Lithuania.* Journal of Substance Use. 2017 Jul 4;22(4):425-33.
27. Kahan DM, Braman D. *Cultural cognition and public policy.* Yale L. & Pol'y Rev. 2006;24:149.



