



# The Power of Words

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Having conversations about alcohol  
and other drugs: A practical guide  
**Background Document**

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# 1 Executive summary

## 1.1 Purpose of the project and related materials

Stigma is a pervasive social phenomenon that negatively impacts people who have used or are using alcohol and/or other drugs (AOD).

In response, the Victorian Department of Health and Human Services commissioned a project to establish *The Power of Words* (Having conversations about alcohol and other drugs: a practical guide).

*The Power of Words* reflects the position that AOD use is a public health and social issue, rather than simply a criminal justice issue – a position that is validated by international thinking and human rights agreements.

The objective of the project is to create tangible change and reduce stigma related to AOD use. The project consists of four key outputs: this background document, a project summary, language guidelines (*The Power of Words*) and a brief document on how to use *The Power of Words*.

This collaborative project was undertaken by the Alcohol and Drug Foundation, the Association of Participating Service Users, Harm Reduction Victoria and Pennington Institute.

## 1.2 Target audiences

The project material is designed for:

- community, youth, and human services professionals
- health professionals, including medical doctors, nurses and pharmacists
- media professionals and organisations
- people interacting with people who use AOD
- policy makers
- people working in the AOD sector.

## 1.3 Understanding the evidence and consultation with community

This project involved two key research activities:

- a literary review of publications investigating AOD-related stigma, and
- community consultations with people who have used, or currently use, AOD.

The research identified the following key findings:

- **Who is affected by stigma?** Stigma is pervasive, and people who use/have used drugs, their friends and/or family are often subjected to stigmatisation. The stigma experienced may be influenced by a range of factors, including the type of drug used, the method of use, the individual's social status, perceived level of responsibility for choosing to use, community expectation and the people perpetuating stigma.
- **What impact does stigma have?** The impacts of stigma are negative and can include increased stress, reinforced differences in socio-economic status, delays in seeking support/treatment and people leaving support/treatment.
- **Who and what contributes to stigma?** Stigma is perpetuated across all levels of society, including the health sector, the media, social media, institutions within governments and the general public. Language plays a key role in creating stigma.

- **How can guidelines reduce stigma?** Although the research is limited in terms of demonstrating the effectiveness of guidelines in reducing AOD-related stigma, there is evidence to demonstrate the power of language. Working to reduce stigmatising language among the target audiences is an important step.

These findings indicate that a person-centred approach to reducing stigma is required. This approach places the overall health and wellbeing of the person as the key focus and involves them in decision-making.

#### 1.4 Opportunities for action and improvement

Based on the research and community consultation findings, a number of opportunities for action were identified:

1. **Improving language** – through the development of guidelines for language in the AOD context; adapting existing guidelines where appropriate, and adding content based on the expertise of the project working group and community consultations.
2. **Collaborative efforts towards increasing the use of existing guidelines targeting media** – the *Mindframe* Initiative being implemented by the Commonwealth Government will be cross-promoted within these guidelines.
3. **AOD use discussed as a health and social issue** – it is important for health professionals to be aware of a patient's AOD use when making an assessment, but the weight of such a consideration should be based on evidence, and not values. This key message will be incorporated into the guidelines, and any implementation work done as a result.

In addition to this work, there are a range of actions that can be taken within different sectors to reduce AOD-related stigma, which is outside the scope of this project. These actions include:

- promoting opportunities for complaint/repercussions for discriminatory treatment
- training of registered health professionals
- creating resilient and strong peer ambassadors
- identifying change advocates within sectors
- developing of a community of practice
- meaningful engagement with people who use/have used drugs .

# Part 1 Introduction to the project

## 2 Background

In 2019, the Victorian Department of Health and Human Services assembled a project team to develop *The Power of Words* (Having conversations about alcohol and other drugs: a practical guide). The purpose of *The Power of Words* is to support reductions in stigma related to AOD use.

The project team consisted of the following organisations:

- Alcohol and Drug Foundation (ADF)
- Association of Participating Service Users (APSU)
- Harm Reduction Victoria (HRVic), and
- Penington Institute
- Victorian Department of Health and Human Services.

### 2.1 Purpose of this background document

This background document:

- presents an integrated overview of the evidence gathered to inform development of the Power of Words
- includes the findings of a review of reviews, key messages from community consultations with people who use/have used drugs, recommendations for the development of the guidelines and supporting documents, and
- describes the process used to develop *The Power of Words*.

The background document may be used as a resource for people wanting to learn more about AOD-related stigma and its impacts.

### 3 Key terms and definitions

<b>Term</b>	<b>Definition</b>
<b>AOD</b>	Alcohol and other drugs
<b>BBV</b>	Blood Borne Virus
<b>Discrimination</b>	This is where someone has the lived experience of being stigmatised, resulting in negative material and social effects. <sup>1</sup>
<b>Drug</b>	Any substance, including alcohol, that when taken or administered into the body has a physiological effect. Using a drug may influence mood, behaviour, cognition, and/or perception. Drugs can be legal or illegal.
<b>Illegal drug</b>	A drug that is illegal in Australia.
<b>Illicit drug</b>	Includes illegal drugs, as well as legal drugs used in illicit ways (for example, non-prescribed or inappropriate use). <sup>2</sup>
<b>Prejudice</b>	'Prejudice involves preconceived negatively-biased thoughts or beliefs about individuals who belong to a particular group.' <sup>3</sup>
<b>Stereotype</b>	A set idea that people have about what someone or something is like, often oversimplified and based on generalisations. Stereotypes often lead to stigmatising practices, behaviours or language. <sup>4</sup>
<b>Stigma</b>	Stigma is a social process that happens when we categorise and label people, places, interactions and experiences to make rapid judgments about our environment. <sup>5</sup>
<b>SUD</b>	Substance Use Disorder – an accepted medical term used to describe dependence on a substance.

## 4 Methods

This document has been developed collaboratively using two key sources of information: a review of reviews and community consultations.

First, the researchers used existing systematic reviews to collate evidence, using a research methodology called a review of reviews. A systematic review is ‘an appraisal and synthesis of primary research papers using a rigorous and clearly documented methodology in both the search strategy and the selection of studies. This minimises bias in the results. The clear documentation of the process and the decisions made allow the review to be reproduced and updated.’<sup>6</sup>

Secondly, community consultations were undertaken to engage with people who have previously experienced or currently experience stigmatisation due to their alcohol and/or drug use.

### 4.1 Literature review

For the review of reviews, the search criteria were decided by the project group, and the search was undertaken in agreed electronic databases. Details of search criteria are outlined in Appendix A.

Systematic reviews and meta-analyses were included if they:

- were published from 1995 onwards in English
- met the search criteria, and
- investigated AOD, blood borne viruses, mental health or tobacco use and related stigma.

Articles were excluded if they investigated stigma related to other health conditions or characteristics, such as obesity or ethnicity.

The results of this search returned 536 articles. Duplicates were removed, leaving 516 articles. The first screen was completed by two authors who were blind to each other’s results and was based on the relevance of the title only. All articles that were included by at least one author were included in the next stage. This first screen excluded 233 articles, leaving 283. It was found that some duplicates remained, leaving 206 articles. The second screen involved a review of abstracts by at least one of the authors. This eliminated a further 144 articles, leaving 62 relevant articles. The final screening stage involved extracting relevant data (e.g. key findings, limitations and article details) from each of the included articles. This final step excluded a further 16 articles, leaving 46 relevant articles.

In addition to the initial search, specific targeted searches were completed as information gaps were identified. This has allowed the authors to identify articles that were not systematic reviews but provided insight into relevant research. The same search criteria were used to identify original research and grey literature relevant to the purposes of this project. Additionally, relevant literature known to the project group was included.

### 4.2 Community consultations – process of engagement

Participants were invited from the member bases of two key organisations:

1. **Association of Participating Service Users (APSU)** – a Victorian consumer representative body at the Self-Help Addiction Resource Centre (SHARC). APSU represents individuals who use or have used substances, and those impacted by their substance use (such as family and friends).
2. **Harm Reduction Victoria (HRVic)** – a peer-based drug user representative body and harm reduction service operating in Victoria. HRVic aims to advance the health and wellbeing of people who use/have used drugs by creating an environment in which individuals are empowered to realise their aspirations, meet their needs and participate fully in society.

Two community consultations were scheduled in metropolitan Melbourne, and one in Bendigo to reach participants in one part of regional Victoria. No identifying data was collected at consultation meetings.

### **Participants were eligible if they:**

- were from any age bracket (there is no age restriction to become a member of APSU and HRVic's membership databases), *and*
- identified as a person who uses drugs (current or historical), *and*
- had either used any kind of health service in the past 12 months, or felt they had experienced stigma from a health professional at some point and believed it is because of their drug use, *and*
- may or may not have had experience as a consumer of AOD-speciality health services.

### **The community consultation groups were structured around the following discussion points:**

- What is stigma/define stigma?
- What impact does it have? Participants were invited to share their thoughts and to provide practical examples.
- Who or what contributes to stigma?
- What have participants done to seek redress?
- What would participants want to be done?

To reduce the risk of retraumatising participants who may have had a negative experience involving stigma, these precautions were taken:

- information promoting the community consultation groups included a disclaimer that explained that these consultations were not a forum for registering complaints or resolving grievances, and
- referral to the Department of Health and Human Services (DHHS) resource, '*Not happy with an alcohol and other drug treatment service?*' was provided.<sup>7</sup>

### **4.3 Consumer consultation participants**

The community consultation participants consisted of 22 people (13 female; 8 male; 1 non-binary) aged between 24-47 (median age of 35).

Participants had a diverse range of experience with use of AOD and AOD health services. Four of the participants disclosed having accessed AOD-specialty health services available in Victoria, including counselling, withdrawal, rehabilitation, pharmacotherapy, and needle and syringe programs. Three participants disclosed that they hadn't accessed any of these services.

It should be noted that there was no participation by consumers at the Bendigo community consultation. This was understood to be due to a number of reasons associated with being part of a smaller community, where identification as someone who has previously used drugs or is currently using drugs may be perceived negatively. This emphasises the point that stigma has significant implications for participation in community life, particularly when people who use drugs are located in non-urban areas.

Some of the participants who took part in the two Melbourne-based community consultations were from regional Victoria and travelled to take part. This has provided some insight from regional Victoria.

Three key themes were identified: avoidance strategies; patient-centred approaches; and, attitudes/knowledge of health professionals. The findings of the consultations, including these themes were used to develop content within this document. Quotes from participants and the examples that they spoke about are included throughout, to further substantiate evidence and provide context where research is limited.

#### **4.4 Limitations and exclusions**

Search terms used in the review of reviews were identified by the group based on expert opinion and experience. However, many communities experience stigma and have taken steps to promote inclusion, in different ways. To manage the scope of this project, research focused on AOD-related stigma. As such, some information about the nature of stigma in other communities has been excluded. In addition, although the research undertaken for this project was thorough, it was not exhaustive. There may have been terms that were missed and therefore some relevant literature may not have been identified.

There are several resources which support the use of inclusive language related to people who use/have used AOD, including the *Mindframe National Media Initiative*, which focuses specifically on addressing AOD-related stigma in the media and includes a number of rigorous strategies to affect change.<sup>8</sup> To avoid duplication, *The Power of Words* resource is largely aimed at health and human services professionals who interact with people who use/have used AOD. However, the findings in this document are relevant to any members of the public who are interested in reducing the use of stigmatising language, including members of the media.

This project has a 12-month timeframe, including implementation. Further thought is being given to long-term strategies to support cultural change, beyond the scope of this project.

#### **4.5 Additional consumer consultations**

In addition to consultations for the purposes of informing this Background Document, consumers were consulted throughout the project. This included testing of the preliminary version of the Power of Words and the other associated products.

# Part 2 Understanding stigma

## 5 AOD use as a public health and social issue

AOD use is a significant and complex public health and social issue in Australia.<sup>9</sup> It is clear that acute and chronic harm related to AOD places a burden on the public health system.<sup>9, 10</sup> Risks and harms relating to AOD use that impact public health include:<sup>9</sup>

- acute risk of drug-specific mortality (overdose)
- drug-related mortality (physical trauma while impaired)
- chronic conditions, such as blood borne viruses
- other health conditions, like lung or liver cancer, and
- substance use dependence.

Some of these harms may have ongoing implications on the affected person, their family and the community, and may require significant public health resources.<sup>9</sup> The most recent National Drug Strategy Household Survey found that:

‘About 1 in 8 Australians had used at least 1 illegal substance in the last 12 months and 1 in 20 had misused a pharmaceutical drug.’<sup>9</sup>

From this survey we also know that the most commonly used illegal drugs in 2016 were cannabis, cocaine, ecstasy and meth/amphetamines.<sup>9</sup>

Based on 2016 census data, opioids (prescribed pain killers) and benzodiazepines (mild tranquilisers) were involved in more drug-induced deaths than illegal drugs.<sup>11</sup> This data also shows that a significant proportion of pharmaceutical drug-induced deaths are accidental.<sup>11</sup>

People use drugs for many different reasons, as outlined by literature<sup>12</sup>, and can be summarised as below:

- for pleasure
- to manage aspects of living
- to manage emotions
- to increase the sense of belonging
- to do what is regarded as ‘normal’ or ‘usual’
- to expand consciousness
- to countereffect the effects of another drug
- to maintain physiological dependence and/or avoid withdrawal.

Illicit substance use and dependence is highly stigmatised. The discrimination that stigma fuels has real world impacts on both individual and public health. However, it should be noted that the vast majority of people who use/have used AOD in Australia do not experience dependence.<sup>9, 13</sup>

It’s difficult to estimate the exact numbers of people who are affected by AOD-related stigma or 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. This combination may make them unwilling to interact with researchers or participate in population surveys or other methods to collect data. Thus, many people who have been and continue to be affected by stigma may be silent or lack a space in which to voice their experience.

In a cross-cultural study by the World Health Organization, illicit substance use dependence was ranked as the most stigmatised health condition and alcohol-dependence as the fourth-most stigmatised health condition.<sup>14</sup>

In Victoria, the provision of non-judgmental, inclusive services aligns with the Charter of Human Rights and Responsibilities Act 2006 (Charter) which recognises that all people are born free and equal in dignity and rights. The Charter is founded on the principle that human rights belong to all people without discrimination and that the diversity of people in Victoria enhances our community.

These principles are drawn from international human rights law.

In international human rights law, the right to health is protected by the International Covenant on Economic, Social and Cultural Rights (ICESCR), which Australia has ratified. ICESCR recognises 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (Article 12 of ICESCR).<sup>15</sup>

The right to health, which is protected at the international level, is closely related to and dependent upon the realisation of human rights which are protected in Victoria's Charter. For example:

- the right to recognition and equality before the law, which includes protection from discrimination (section 8)
- the right to life (section 9)
- the right to be protected from degrading treatment (section 10)
- the right to privacy and reputation (section 13)
- the right to freedom of movement (section 12)
- the right to freedom of expression (section 15)
- the right to peaceful assembly and freedom of association (section 16).<sup>15</sup>

The delivery of health and human services in a non-stigmatising environment promotes these Charter rights as well as fundamental human rights principles.

Given that some people who use/have used AOD may become involved in criminal matters, a range of other rights recognised in the Victorian Charter may be relevant to some people who use/have used AOD. These include the rights to liberty and security of the person, to humane treatment when deprived of liberty, of children in the criminal process, to a fair hearing, and in criminal proceedings.

Key United Nations' documents exist that recognise that discrimination takes place in many forms within health care settings. It is directed primarily towards the most stigmatised populations, including people who use/have used AOD.<sup>16</sup> It also places human rights at the forefront of drug policy and highlights that there is an obligation to ensure the right to the highest attainable standard of health.<sup>17</sup> In line with this right is the need to address social and economic determinants that support or hinder positive health outcomes related to AOD use.<sup>17</sup> This includes addressing stigma and discrimination.

## 6 What is stigma?

Stigma is a powerful and complex social phenomenon, where a person or group of people are perceived as less acceptable due to a specific trait or behaviour.

Stigma stems from the categorising and labelling of people, places, interactions and experiences, a process that allows people to make a rapid judgment of their environment.<sup>5</sup> Although this process is nurtured over time in various social contexts, stigmatisation of people or groups comes from this rapid labelling, judging and stereotyping.<sup>5</sup>

The process of stigmatisation can create barriers between people and undermine people's identity due to a difference or perceived difference. Stigma has the potential to leave the person or people subjected to it feeling alienated and marginalised.<sup>18</sup> Stigma involves the loss of status, which can result in negative outcomes for people across the socio-economic spectrum, such as limited employment and housing opportunities. Some groups of people may experience the negative consequences of stigma more than others, depending on a range of factors.

### 6.1 Types of stigma

There are three key types of stigma:

- **Social or public stigma** is a general or collective disapproval and/or exclusion of a person or group due to a trait or activity that is not considered part of the social norm, leading to prejudice and discrimination.<sup>19</sup>

*“You can be polite, saying you’re just following the book, and the outcome for me is still the same, I’m denied a health service.”*

- **Structural stigma** is where the rights and opportunities of people with a specific trait are taken away, either at a government or organisational level. The rules, policies and regulations that are put in place to discriminate against specific groups may be implemented by institutions, such as police forces and health services.<sup>20</sup>

*“Some of those [chemist] policies are inherently stigmatising, because there is criminalisation and the system is based this way. You can only get a certain number of takeaways [of pharmacotherapy], you have to take it in front of them, your tongue up in front of everyone, you’re not allowed to go in there with your partner or children...It’s not OK to make a policy that says: you will get served after everyone else.”*

- **Self-stigma** is internalised prejudice, where a person associates negative feelings with the trait or behaviour that they have or do, because it is perceived as deviant from what is accepted as the social norm.<sup>20</sup>



*“Stigma creates a cycle of self-stigma, shame, and unworthiness. A loss of health, a loss of life.”*

All three forms of stigma perpetuate negative attitudes towards and beliefs about the people who are being stigmatised. They often interrelate and have a cumulative effect.

## **6.2 Problem types relating to stigma**

There are three key problem types that relate and lead to stigma:

- **The problem of knowledge** refers to the level of ignorance or knowledge of a specific issue. In the case of AOD, the wider community has low levels of knowledge about different drugs and their effects, which can lead to fear of these drugs and people who use them.<sup>21</sup>
- **The problem of attitude** refers to prejudice, where people who use/have used AOD are unfairly stereotyped, creating hostility towards them.<sup>22</sup>
- **The problem of behaviour** refers to discrimination, where someone who uses drugs is intentionally or unintentionally denied social, educational or health opportunities because of their drug use. This refers to the lived effects of stigma.<sup>22, 23</sup>



*“All my health issues were seen as stemming from my drug use, rather than a lifetime of abuse and mental health concerns.”*

## 7 Who is affected by stigma?

Stigma can affect anyone, particularly people who use/have used AOD and their partners, family or friends.

Stigma can be associated with AOD use itself, and its associated behaviours, and is typically higher if a person becomes dependent on a particular drug.<sup>24, 25</sup> The level of stigma experienced may be influenced by a range of factors, including social status, type of drug used, method of use, perceived level of responsibility/community expectation, or the people enacting stigma.<sup>13</sup>

The intersectionality of individual characteristics may impact on the level of stigma that someone experiences with respect to current or past drug use. This means that the stigma can be complex and not necessarily attributable to one aspect of a person's life. For example, a young woman who identifies as Aboriginal and uses cannabis will experience stigma differently to an older non-Aboriginal man also using cannabis. Their different experiences of stigma would be as a result of their identity or perceived identity, not just their drug use.

Different groups of people who may experience specific kinds of stigma due to their current or past AOD use are briefly discussed below.

### 7.1 People who use illegal drugs

The legal status of particular drugs can lead to the perception that drugs should be treated as a criminal justice issue, rather than a health and social issue.<sup>1</sup> This can influence the stigma experienced by the people who use them.<sup>18</sup>

Drugs are not criminalised based on the level of harm experienced by an individual using them, or the level of harm they may cause a community. However, the fact that some drugs are illegal could lead to the social perception that people who use those drugs are dangerous simply because the drugs they use are illegal. This, in turn, compounds any existing stigma<sup>21</sup>, including self-stigma. Efforts to reform drug policies (e.g. decriminalise or regulate drug use) are also hindered by similar stigma.

### 7.2 People who inject drugs

People who inject drugs and the act of drug injection are both highly stigmatised and can invoke stronger emotional responses from the public than other forms of drug use.<sup>21</sup> Friends and family of people injecting drugs, the general public, the media, and health services can all perpetuate this stigma.<sup>19</sup>

Hepatitis C and HIV are both blood borne viruses, which are highly stigmatised in themselves, and are associated with unsterile injecting equipment. This perceived relationship between stigmatised conditions reinforces stigma and discrimination both for people who inject drugs and for people living with hepatitis C and/or HIV.

### 7.3 People who use pharmaceutical drugs

Multiple studies have investigated stigma experienced as a result of pharmaceutical drug use.<sup>26</sup> For example, studies have found that stigma is experienced by people when they do not take medication as advised.<sup>26</sup> They have also found that health professionals can experience difficulty prescribing painkillers due to potential harms, especially when patients may not have the health literacy to understand the risks.<sup>27</sup>

### 7.4 People who previously used drugs

People who have used drugs in the past may still experience stigma when they stop using. Some people may think that once a person has used drugs, they will always have a tendency towards harmful use, despite evidence that the vast majority of people who use/have used AOD in Australia do not experience dependence.<sup>9, 28</sup> For example, people with drug-related criminal records may not be able to secure employment, and politicians 'coming out' to the public about using drugs in the past may experience judgment due to past use.

## 7.5 People who use particular drugs



*“The campaigns made out all ice users are violent people, so I was met with violence and fear when using health services.”*

Different drugs have been demonised at different times. As social perceptions have shifted, so has the experience of stigma.

Particular drugs of current concern, such as crystal methamphetamine (ice), may also be considered riskier to health by those stigmatising others. People who use them experience stereotypes and stigma in ways that differ to people who use/have used drugs that may be considered less risky, like cannabis. This intensified stigma can exist in the media, with the general public<sup>21</sup>, and between different groups using different substances.

Regardless of the method of use, stigma may be differently associated with people who use heroin versus methamphetamine versus steroids or other performance or image-enhancing drugs. This was also emphasised in the community consultation groups through various examples, including:

- people who inject drugs being stigmatised by other people who use/have used drugs who do not inject
- people who used heavily stigmatised drugs, such as methamphetamine, being stigmatised by people who used other illegal drugs, and
- people who experienced health issues because of their use, such as an overdose that required an intervention. These participants described being stigmatised by their peers who did not have the same negative health outcome, even if the drug and route of administration was identical.

## 7.6 Young people who use/have used drugs

Younger people who use/have used AOD can experience stigma too. It is often assumed that younger people do not have the skills or knowledge to make choices around their own personal AOD use. Prevention campaigns and targets often focus on the importance of preventing young people from using AOD by demonising those who do, rather than empowering young people as agents of change who can help to reduce harms to the community.

## 7.7 Women and people with children who use drugs

Community consultation participants with children described feeling extreme anxiety and anticipating stigma when in situations where their use of drugs (past or present) is known. In one example, a solo mother described the stress of caring for her young child and managing the collection of her pharmacotherapy (opioid substitution therapy). Her pharmacy had implemented a new policy that disallowed clients from collecting their dose with company, including dependents.

Women may also experience stigma when they have a child who has been diagnosed with Fetal Alcohol Spectrum Disorder. These women may experience unfair judgment and blame since the cause of Fetal Alcohol Spectrum Disorder is fetal exposure to alcohol.<sup>29</sup> This stigma extends beyond birth mothers and may be experienced by the child and their siblings, adoptive parents, foster parents, carers, family and friends of parents.

## 7.8 The families of people who use/have used drugs

The impact of stigma on family members of people who use AOD will be different for every family. Not all parents or carers who use AOD have difficulty caring for children, and not all people who use AOD will have their familial relationships affected by that use.

In some cases, however, having a family member who uses illicit drugs, or has/is experiencing a dependence on AOD, is connected to experiencing ‘affiliate stigma’, ‘courtesy stigma’, or ‘associative stigma’.<sup>30-32</sup> That is, stigma by virtue of being connected to a stigmatised person. Therefore, use of appropriate language and support, to reduce stigma as much as possible, is appropriate for families of people who use illicit drugs or experience a dependence on alcohol and/or other drugs.

## 7.9 People with mental health issues

*“When I disclosed that I smoked cannabis I was told there was nothing that could be done for my anxiety until I stopped smoking and I wasn’t offered any support for my cannabis use either.”*

The interaction of stigma associated with mental health and AOD is particularly complex for reasons that are beyond the scope of this paper.<sup>33, 34</sup> It is often specific to a person’s context, including the nature and severity of their mental health issue, the type of drug they use or are dependent on, and other considerations such as experiencing homelessness or job loss.

For example, a person experiencing a major depressive episode and drinking heavily as a coping mechanism may be considered more compassionately than a person experiencing severe schizophrenic symptoms and smoking cannabis as a coping mechanism.

## 7.10 Cultural contexts

People from diverse cultural backgrounds may experience different levels of stigma, particularly around the types of drugs they choose to use. Drug use that is not commonly accepted in countries of birth may be accepted or legal in Australia, and specific cultural groups may be stigmatised for using particular substances. For example, among the Chin community in Melbourne, people who drink alcohol may experience stigma within their community, as it is not widely accepted in Myanmar, but is widely accepted and available in Australia. Some communities may also experience stigma for using a drug that is not commonly accepted in Australia.

## 7.11 People trying to access health care/people in drug treatment

Stigma and discrimination experienced by people who use/have used AOD in health care settings can result in the denial of services and affect the quality of health services provided.<sup>35</sup> For example, a person may not feel comfortable sharing their AOD use with their general practitioner due to anticipated stigma. This leaves people who use/have used AOD with a sense that using any health service may result in discrimination because of the health care provider’s stigmatising views. Guidelines that suggest accepted and non-stigmatising language have been developed specifically for health care workers and are referenced in Section 11.

## 7.12 Other individual characteristics

A person who uses AOD can be subject to stigma related to AOD, as well as one or more additional stigmas. This results in overlapping layers of discrimination.<sup>36</sup> Additional stigmas can stem from an individual’s perceived social identity – the groupings within society in which they or others believe they belong. Social identity is constructed 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.<sup>37</sup>

All these characteristics can have varying degrees of stigma attached to them based on community-derived assumptions and stereotypes about the type of person who might exhibit these characteristics. This can affect how a person is treated by other people, as well as their experience within established systems and structures.

Community consultation participants reported poverty as a significant factor that enhanced their vulnerability to the experience of stigma. People who were sleeping rough and had limited access to basic amenities were more likely to be assumed to use AOD when presenting to health services. Likewise, some participants felt stereotyped based on physical attributes (such as the clothes they wear, tattoos and piercings), which then resulted in them feeling interrogated rather than screened. These participants also felt that these stereotypes led health professionals to make discriminatory assumptions around methods used when taking drugs in the past, such as injection, even if they defined their past drug use as non-problematic.

## 8 What impact does stigma have?

Stigma primarily has negative impacts on people who use AOD.<sup>38</sup> These include an increase in stress, reinforcing differences in socio-economic status, delays in seeking support/treatment and people leaving treatment and support services.<sup>1</sup> The research that has been reviewed in developing the guidelines focuses on specific public health and social issues where stigma has a negative impact.<sup>39-42</sup> The following section focuses on the adverse impacts on various people and populations. The potential utility of stigma in terms of public health approaches is also briefly discussed.

### 8.1 Adverse impacts

Stigma significantly contributes to the negative health outcomes of people who use AOD. Research shows that the experience of stigma can be considered a social determinant of health.<sup>43-45</sup>

There are multiple adverse impacts of stigma that can span populations and settings, affecting people who use AOD, the people around them and the broader community.

#### 8.1.1 Impacts on people who use AOD

People who use AOD feel the effects of stigma in many different and compounding ways. Although this is not a complete list of all adverse impacts, it is a summary of key areas based on research findings:

- **Overall health** – research indicates that people who use/have used AOD will avoid seeking help regarding their use or other health matters for fear of being stigmatised by health professionals.<sup>35</sup>  
<sup>46</sup> This can include emergency department staff, general practitioners, nurses, dentists and pharmacists. This results in potential immediate short-term harms associated with their drug use, or long-term effects such as blood borne viruses or non-communicable disease.<sup>42, 47, 48</sup> Mental health and wellbeing are also affected by internalised feelings of shame, low self-esteem, and low self-efficacy associated with self-stigma.<sup>21</sup>
- **Barriers to accessing health services** – community consultations identified that some people (particularly in regional or rural areas) who use AOD may avoid accessing AOD-related and general health services due to a desire to remain anonymous. This is to avoid the real or perceived risk of being exposed to stigma by health professionals or other service users. If that happens, health needs may go unaddressed and can increase in complexity.
- **Avoidance strategies when receiving health treatment** – to some extent, all participants of community consultations expressed that they avoided disclosing, or selectively disclosed, their drug use to health professionals as a form of self-preservation. Some avoided seeking help and accessing health services entirely – even if that avoidance was detrimental to their health. Some said they avoided seeking help because they had experienced stigma in the past from health professionals when disclosing details about their drug use. Others chose not to disclose because they anticipated stigma or anticipated other flow-on effects from their disclosure. This could include examples like having health professionals report their drug use to other authorities, such as child protection services or the criminal justice system.
- **Impact on medical decision-making** – participants of community consultations expressed an awareness that disclosure of their AOD use may influence a health professional's decision-making. Many believed that drug use is often overstated as a root cause of any sign of unwellness when a person who uses AOD presents to a health service. Participants stated that the fear of being stigmatised because of their AOD use may create a barrier that prevents them from accessing health services.
- **Relationships** – stigma relating to AOD use may compound and result in adverse impacts on relationships between people who use/have used AOD and others. However, the impacts can vary from one relationship to another, and may not be negative every time. If the AOD use becomes a dependence, the relationship may become strained due to increased social stigma that further isolates people who use/have used AOD.<sup>30</sup> When isolation is combined with ongoing,

various forms of stigmatisation, the risk to the health of people who use/have used AOD may increase. Evidence suggests that strong relationships have a protective effect on the health of people who use/have used AOD.<sup>49</sup>

- **Employment opportunities** – people who have previously used or currently use AOD may experience stigmatisation at work or in the context of looking for work. It is possible that self-stigma, structural stigma and public stigma come into play in these contexts. Limited research indicates that some people may feel unsupported or discriminated against due to their use, and as a result reduce their hours or leave their job altogether.<sup>50</sup> Community consultations also highlighted that if AOD use is disclosed, people who use/have used AOD may struggle to find employment or risk jeopardising their existing employment. There is some research that focuses on the impact of stigma in employment contexts for specific professions. For example the use of AOD is often linked to sex work.<sup>51-53</sup>

## Case Study

**One of the participants shared an example of stigmatisation that they experienced which helps to demonstrate some of the themes discussed during community consultations. This participant presented to a health professional seeking to address their anxiety and disclosed cannabis use as part of the consultation. The participant was told their anxiety could not be treated until they ceased their cannabis use. The participant felt stigmatised for self-medicating with cannabis and felt that they did not receive all possible treatment options because they had disclosed that information.**

**In this case, if a treatment option available for anxiety is proven to contraindicate with cannabis, there would have been a valid reason to inform the person of that risk and exercise professional discretion. However, AOD use should not be used as an excuse to undermine the potential efficacy of, and access to, all anxiety management treatment options.**

### 8.1.2 Impact on family and friends of people who use/have used drugs

There is scant evidence of the impact of stigma on relatives and friends of people who use/have used AOD in the literature identified to inform this document. However, there is evidence to show that those who are connected to people who use/have used AOD may feel stigmatised by association.<sup>30-32, 54</sup> For example, this may include the shame that family members feel if this information is publicly known for fear of judgment. This judgment is often associated with the assumption that the supporting family or friends had failed their loved one, and therefore held the blame for their loved one's AOD use.<sup>54</sup>

### 8.2 Utility of stigma in public health approaches

In public health campaigns, stigma has been used as a mechanism for reducing the consumption of certain drugs – typically legal drugs. Although there may be some utility in this approach when addressing the use of some drugs, this has to be carefully weighed against the potential negative impact of stigma on people who use/have used AOD.

These public health approaches will likely not work in the context of illegal drugs, given that these drugs are still tightly bound up in the link between crime and nonconformity.<sup>20</sup> Using stigma to reduce illegal drug use is more likely to further stigmatise people who are already experiencing stigma.<sup>55</sup> The point of reducing stigma is to encourage people to seek help if they require it and decrease negative health outcomes, regardless of the drug type, pattern or method of use, or the person using drug(s).

## 9 Who and what contributes to stigma?

Stigma is perpetuated at all levels of society.<sup>19, 20</sup> However, there are certain environments where the negative impacts of stigma can be amplified.

### 9.1 Language

Language is a key contributor to the perpetuation of stigma across all areas of society. Specific words can have stigmatising effects on people who use/have used drugs. Terms that alienate people on the basis that they use a specific drug or drug-use method can have short and long-term effects. When used in formal contexts like health care settings, the media or policy, these terms become endemic and difficult to change. It is important for any anti-stigma efforts to provide clear guidance on avoiding stigmatising language across various levels of society and include appropriate examples of non-stigmatising language to use.<sup>55</sup>

### 9.2 Health care

*“What I’ve done to address stigma is not disclose [my use to health care professionals].”*

*“The impact of stigma is a breakdown of trust and honest communication with health professionals.”*

In consultations, participants expressed frustration that health professionals did not acknowledge or dismissed participants’ self-awareness about their use patterns, including where one drug was used to manage the effects of another. Participants often felt they would experience better health outcomes if health professionals were more willing to acknowledge the individual’s autonomy or expertise on the matter of their drug use when assessing the needs of a patient.

Consultation participants expressed disappointment in the lack of knowledge among medical doctors about AOD issues. This lack of knowledge has made people feel unsupported and affected their trust in the health care sector. Participants expressed that they thought medical doctors and other health professionals should be receiving more training regarding AOD, including stigma.

Medical doctors are the only registered health professionals in Australia who are required to undergo limited mandatory training on AOD treatment.<sup>56, 57</sup> There are 14 other professionally registered disciplines in health that are not required to complete any AOD-related courses as part of their qualifications, including nurses and psychologists.<sup>56</sup> Although there are opportunities to complete professional development relating to AOD treatment once they are qualified, this lack of curriculum-based training limits the awareness of stigma among health professionals. This can lead to a lack of understanding and result in inadvertent discrimination against people who use/have used AOD.<sup>21</sup>

An example of inadvertent discrimination (a form of structural stigma) is when a pharmacist may require a person on methadone to take their dose in front of other customers. While it is a legal requirement for a pharmacist to observe the person taking their dose of methadone, it is at the discretion of the pharmacist where and how that happens on their premises.<sup>58</sup>

It is important that non-health professionals working in health care settings are also made aware of the impacts of stigma in their work. People working in clinical settings, such as reception staff, may also use stigmatising language and behaviours which discourage people who use/have use alcohol and other drugs from using their services.

### **9.3 Media and the general public**

One of the fundamental drivers of stigma towards people who use/have used drugs is inaccurate and inflammatory media reporting.<sup>59</sup>

Content relating to AOD is regularly misrepresented, often providing sensationalised messages of the dangers associated with specific drugs.<sup>59</sup> Various forms of media also regularly portray issues around specific groups of people, as outlined in Section 7.

In response to this, the Commonwealth Government has developed the *Mindframe National Media Initiative* to encourage responsible reporting of issues surrounding suicide, mental illness and AOD use via specific guidelines in these areas.<sup>8</sup>

While *The Power of Words* project does not focus on specific guidelines for AOD reporting in media, its language guidelines are applicable to a wide range of audiences, including journalists and reporters.

### **9.4 Government policies and the criminal justice system**

The use of drugs is highly politicised and is often treated as a criminal justice issue rather than a health and social issue.<sup>1</sup> This means that health needs associated with AOD use may not be considered when creating or enforcing the law. For example, if someone is charged with an AOD-related offence, they may be exposed to self-stigma, public stigma and structural stigma due to their offence being linked to drug use.

Although the criminal justice system plays an important role in society regarding drugs, people who use/have previously used drugs are often caught in the middle between the health and legal systems.

# Part 3 Working to reduce stigma

## 10 How can guidelines reduce stigma?

There is evidence to suggest that the use of inappropriate language results in stigma.<sup>60, 61</sup> A range of guidelines have been developed internationally and nationally to help reduce the use of inappropriate language – these are set out in Section 11.

In addition to *The Power of Words*, particularly relevant guidelines in Australia are:

- **Mindframe** – guidelines for communicating about alcohol and other drugs (2019)<sup>8</sup> targeting media broadly
- **AOD Media Watch** – guidelines for journalists (2017)<sup>62</sup>, and
- **Language Matters** (2017) targeting non-government AOD workers in NSW.<sup>24</sup>

Guidelines to reduce the incidence of inappropriate language typically include suggestions about using person-centred language as a central focus.

Person-centred language is likely to be an essential component of efforts to reduce stigma. For example, a reduction in stigmatising language has been shown to break down barriers in equitable health care utilisation of people who use/have used drugs.<sup>63 14</sup>

While the research completed for this project did not identify evidence to demonstrate the effectiveness of these type of guidelines in reducing stigmatising language, other studies have investigated the impact of language on reductions in stigma. They are summarised below.

In a 2010 randomised trial, researchers presented otherwise identical scenarios in which people were described as ‘substance abusers’ or ‘people with a substance disorder’. The trial involved more than 500 mental health and addiction clinicians.<sup>14</sup> The study found that clinicians presented with the scenarios in which people who use drugs were described as ‘substance abusers’ were significantly more likely to judge that person as deserving punishment and being personally responsible, compared to the clinicians presented with an identical scenario but used the terms ‘person with a substance use disorder’. Thus, using stigmatising language was shown to increase stigma. In this situation, guidelines on using non-stigmatising language could have helped reduce stigma.

A report produced by the National Academies of Sciences, Engineering and Medicine (USA) evaluated three campaigns aiming to reduce stigma for people with mental and Substance Use Disorders. The varied campaigns took place in the USA, Canada and Australia and included guidelines encouraging responsible media reporting of suicide (the *Mindframe* guidelines described in section 11 below). The researchers were unable to conclude whether people experienced a reduction in stigma, but broader conclusions from the evaluation suggest the need for grassroots and local champions to convey non-stigmatising messages to reduce stigma.<sup>25</sup>

A recent systematic review investigated reductions of HIV-related stigma in health care settings. That review found moderate quality evidence that training popular opinion leaders is effective in reducing health care workers’ avoidance of treating people living with HIV and their prejudicial attitudes towards this group.<sup>64</sup> The same review found low quality evidence for each of the following strategies: using professionally-assisted peer group interventions; interactive training and education; self-guided assessments; workshops; and contact strategies that include information giving and empowerment.<sup>64</sup>

In addition to broader efforts to reduce stigma through language, it can also be decreased by encouraging pro-health activities.<sup>65</sup>

The distribution of take-home naloxone among peers is an example of empowering people who use drugs with the ability and motivation to reduce harm in the community. This highlights the role of people who use drugs in actively reversing opioid overdose,<sup>66</sup> reframing their perceived role in society.

An independent evaluation of a take-home naloxone program in Canberra highlighted the positive outcomes experienced by the people who use drugs and positive profile raising of the local drug user organisation as trusted to improve the lives of their peers.<sup>67</sup>

## 11 What are the existing guidelines?

Guidelines come in different forms, from direct language guidelines to reduce stigma to individuals, to recommendations to reform laws and policies to reduce structural stigma. Below are some examples of guidelines to reduce stigma, which include AOD-specific guidelines and other related fields from Australia. There are also broader guiding and recommendation documents from international organisations and agencies.

### 11.1 AOD specific anti-stigma guidelines

#### ***Mindframe* – guidelines for communicating about alcohol and other drugs (2019)<sup>8</sup>**

This is a practical resource for communicating about AOD use and related issues. It was designed to inform, support and empower media to report safely and responsibly on AOD. It highlights helpful and harmful ways to communicate about AOD and encourages the use of responsible language and the promotion of help-seeking behaviour. The *Mindframe* guidelines focus on the following areas of communication:

- communicating about someone who uses alcohol and other drugs
  - » e.g. 'When communicating about a person who uses drugs and who has broken the law, or about a drug-related crime, ensure that the information conveyed is factual and accurate and that sensationalist content is omitted.'
- helpful ways to communicate about alcohol and other drugs
  - » e.g. 'Harmful AOD use is a public health issue, not a moral failing and media portrayals should reflect this.'
- harmful ways to communicate about alcohol and other drugs
  - » e.g. 'Exaggerating facts and selective statistics associated with AOD can influence public perception, contribute to stigma about people who use drugs, and result in anxiety about the drug of concern.'
- inaccurate and irresponsible language
  - » e.g. 'Statements or phrases that describe people who use AOD as "hopeless" or similar may discourage users from seeking help.'
- help-seeking
  - » e.g. 'Include help-seeking information in all reporting and portrayals of AOD. For example, an AOD helpline and/or a specific website that contains relevant information to that particular story and location.'

**These guidelines can be accessed from:** <https://mindframe.org.au/alcohol-other-drugs/communicating-about-alcohol-other-drugs/mindframe-guidelines>

#### ***AOD Media Watch* – guidelines for journalists (2017)<sup>62</sup>**

This set of guidelines was originally created by the Australian Press Council (APC) and now-defunct Australian National Council on Drugs (ANCD) in 2007. They were expanded by the recently established 'AOD Media Watch' Reference Group, which aims to highlight poor examples of Australian journalism regarding AOD-related issues. The Reference Group has created guidelines for journalists that focus on avoiding stigma, highlight accuracy in reporting, and aim to minimise harm.

The guidelines include a two-page document (PDF), which focuses on:

- front-end discussion with supporting evidence on the impact of stigma
- focus on 'accuracy'
  - » do not rush to 'identify' a substance or speculate on cause of overdose

- » provide balance
- » avoid stereotypes
- » acknowledge counter-arguments
- provide context for responsibility of journalists regarding harm, and
- when working with people who use drugs
  - » provide a reasonable timeframe
  - » respect your sources.

**The guidelines can be found at:**

<https://www.aodmediawatch.com.au/guidelines-for-journalists/>

### **Network of Alcohol and other Drugs Agencies (NADA) and NSW Users and AIDS Association (NUAA) - *Language Matters* (2017)<sup>24</sup>**

This is a resource developed in consultation with people who use drugs for non-government AOD workers in New South Wales. It provides non-stigmatising, person-centred and respectful language for workers to use to empower clients, along with better practice guidelines for working with people who use drugs. A few examples of the language guidelines are provided below:

- instead of the terms 'abuse', 'misuse', 'problem use' or 'non-compliant use', try 'substance use' or 'non-prescribed use', and
- instead of saying 'drug user/abuser', say 'person who uses/injects drugs'.

**The resource can be found at:** [https://nuaa.org.au/info-for-health-professionals/language-matters/?doing\\_wp\\_cron=1554762873.2541470527648925781250](https://nuaa.org.au/info-for-health-professionals/language-matters/?doing_wp_cron=1554762873.2541470527648925781250)

### ***Joint United Nations Statement on Ending Discrimination in Health Care Settings* (2017)<sup>16</sup>**

This joint statement by various UN agencies highlights the widespread discrimination in health care settings globally and recommends:

- Supporting UN Member States to put guarantees against discrimination in place in laws, policies and regulations by:
  - » reviewing and strengthening laws to prohibit discrimination in the broader health sector
  - » reviewing and repealing laws that criminalise or prohibit drug use or possession of drugs for personal use and counter public health evidence, and
  - » monitoring health professional policies.
- Supporting measures to empower health workers and health care users through attention to and realisation of their rights, roles and responsibilities by:
  - » ensuring labour rights and standards are fully respected, protected and fulfilled
  - » by educating the health workforce on their roles, rights and responsibilities related to addressing discrimination, and
  - » by empowering health care users to be aware of and able to demand their rights.
- Supporting accountability and compliance with non-discrimination in health care settings by:
  - » guaranteeing access to effective mechanisms of redress and accountability, and
  - » strengthening mechanisms for reporting, monitoring and evaluating discrimination.
- Implementing the UN Shared Framework for Action on Combating Inequalities and Discrimination by:

- » providing sector-specific and joint guidance and practical tools to raise awareness of human rights standards for non-discrimination in health care settings.

The statement can be accessed from: <https://www.who.int/gender-equity-rights/knowledge/ending-discrimination-healthcare-settings/en/>

**Words Matter: How Language Choice Can Reduce Stigma: Substance Abuse and Mental Health Services Administration’s Center for the Application of Prevention Technologies task order (2017)<sup>65</sup>**

This tool was written by, and for, prevention practitioners in the context of the growing opioid crisis in the United States. It is a six-page document that focuses on:

- Understanding the impact of substance use disorder stigma
- Asking questions that a practitioner may pose to themselves, such as:
  - » checking yourself: are you perpetuating SUD stigma? Includes:
- Are you conflating substance use and Substance Use Disorder?
- Are you using technical language with a single, clear meaning instead of colloquialisms or words with inconsistent definitions?
- Are you using sensational or fear-based language?
- Are you unintentionally perpetuating drug-related moral panic?
- Breaking the cycle: Tips for avoiding stigmatizing language. Includes:
  - » performing a ‘language audit’
  - » critically reflecting on the types of information you disseminate
  - » every time you develop a prevention message, consider it as an opportunity to dispel myths and convey respect
  - » when developing new materials, seek input from various stakeholders, including people who use drugs, and
  - » train staff on issues related to substance use and stigma.

This tool can be accessed from:

<https://www.samhsa.gov/capt/sites/default/files/resources/sud-stigma-tool.pdf>

**Office of National Drug Control Policy Changing the Language of Addiction (The Office of National Drug Control Policy, 2017)<sup>63</sup>**

This document was developed as guidance to Executive Departments and Agencies by the Office of National Drug Control Policy (ONDCP) in the United States. It includes suggestions on appropriate terminology to use and defines the terms ‘substance use disorder’, ‘person with a substance use disorder’, ‘person in recovery’ and ‘medication-assisted treatment/medication’.

This document can be accessed from: <https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Memo%20-%20Changing%20Federal%20Terminology%20Regrading%20Substance%20Use%20and%20Substance%20Use%20Disorders.pdf>

**Statement and Guidelines Addiction Terminology (International Society of Addiction Journal Editors ISAJE, 2015)<sup>68</sup>**

These international guidelines are for prospective authors considering submission to various scientific journals. The guidelines encourage the use of non-stigmatising language. These guidelines are also recommended by Drug and Alcohol Review, Australia’s leading multidisciplinary scientific journal addressing issues related to AOD problems. The ISAJE suggestions include avoiding the terms ‘abuse’ and ‘abuser’ unless there is a particular scientific justification, and Drug and Alcohol Review encourages use of the term ‘alcohol and other drugs’ to reflect the status of alcohol as a drug.

The author guidelines can be accessed from: <http://www.isaje.net/addiction-terminology.html>

## 11.2 Anti-stigma guidelines from related fields

### ***Hepatitis Victoria - #LanguageMatters (2019)***<sup>69</sup>

This is a language guide developed for health professionals, researchers, advocates, the media or anyone else involved in viral hepatitis, which encourages the use of person-first language and provides suggestions for respectful language.

**This language guide can be accessed from:**

<http://www.hepvic.org.au/page/1303/language-matters>

### **International Network of People who Use Drugs (INPUD), MPact Global Action for Gay Men's Health and Rights (formerly MSMGF) and the Global Network of Sex Work Projects (NSWP) – *Community Guide: The Impact of Stigma on Discrimination on Key Populations and Their Families* (2018)**<sup>70</sup>

This is a community guide co-produced by the INPUD that highlights the barriers key population groups (people who use drugs, men who have sex with men, sex workers and transgender people) experience when becoming or wishing to become parents. It includes recommendations to reduce stigma and discrimination experienced by these key groups.

**The Community Guide can be accessed from:** <http://www.inpud.net/en/impact-stigma-and-discrimination-key-populations-and-their-families>

### ***Respectful Disability Language: Here's What's Up!* (National Youth Leadership Network and Kids as Self Advocates, 2006)**<sup>71</sup>

This document defines respectful disability language and suggests general guidelines for talking about disability.

**This document can be accessed from:**

[http://www.aucd.org/docs/add/sa\\_summits/Language%20Doc.pdf](http://www.aucd.org/docs/add/sa_summits/Language%20Doc.pdf)

## 12 Opportunities for action and improvement

Using the research findings and community consultation findings, the following actions will be taken to support the reduction of AOD-related stigma by the working group, as part of this project:

1. **Improving language (refer to Part 2 and Section 10 for detail)** – develop guidelines for language in the AOD context, adapting from existing guidelines where appropriate, and adding content based on the expertise of this working group and community consultations. The existing guidelines will include ‘*Language Matters*’ guidelines from NADA/NUAA. These guidelines will be intended for use in health and government institutions. This includes the criminal justice system, with the aim of reducing the use of stigmatising terminology when referring to people who use AOD and the methods/settings of drug use. This project will aim to promote the use of these guidelines within organisations and on externally facing platforms, such as websites, social media and general mass media. These guidelines will be promoted for use at various levels of organisations through targeted advocacy.
2. **Collaborative efforts towards increasing the use of existing guidelines targeting media (refer to Section 9.3 for detail)** – the *Mindframe* Initiative being implemented by the Commonwealth Government should be cross-promoted within these guidelines. This should be done to increase awareness of existing guidelines and help reduce stigma being portrayed to the general public.
3. **Reframing AOD use as a health and social issue (refer to Section 5 for detail)** – to some extent all participants of community consultations expressed frustration about the lack of awareness by health professionals about illicit drugs and the risks involved with their use. It is important for health professionals to be aware of a patient’s AOD use when making an assessment, but the weight of such a consideration should be factored-in based on evidence, and not values. Myths, stereotypes, and other negative narratives about drug use reduce an individual’s willingness to seek help. They can also impact the willingness of others to provide help, including health professionals. This key message needs to be incorporated into the guidelines, and any implementation work done as a result.

In addition to this work, there are range of actions that can be taken within different sectors to reduce AOD-related stigma, which is outside of the scope of this project. These actions include:

- **Promotion of opportunities for complaint/repercussions for discriminatory treatment (finding from consultation process)** – consultation participants wanted to see changes to allowed them to pursue a complaint pathway when a medical professional treated them in a discriminatory way. Existing complaint pathways should be promoted by relevant organisations that provide services for people who use/have used AOD.
- **Training of registered health professionals (refer to Section 9.2 for detail)** – early research identified opportunities to improve AOD-related education for health professionals. This could include the use of person-centred and non-stigmatising language, and aid in the reframing of AOD use as a health and social issue.
- **Resilient and strong peer ambassadors (based on experience within the project working group)** – this may involve organisations such as Harm Reduction Victoria, through the support and/or employment of people who have previously or are currently using AOD and can provide support to others.
- **Change advocates within sectors (refer to Section 9 for detail)** – for institutions or organisations across various sectors such as health, criminal justice and policy, there is opportunity to appoint specific advocates that work to implement approaches to reduce AOD-related stigma. For example, this may involve the implementation of person-centred language guidelines.
- **Development of a community of practice (based on experience within the project working group)** – there may be opportunity for communities of practice to be established to encourage collaboration between various sectors.

- **Meaningful engagement with people who use/have used drugs (refer to Part 2, supported by feedback from consumers)** – organisations across the health, policy and education sectors have an opportunity to engage with organisations such as APSU and HRVic to better understand the prevalence and needs of people who use/have used AOD and their families. This may include the delivery of training by people with a lived experience within appropriate contexts. This will assist in creating a more inclusive environment in which people who use/have used AOD and their families can participate in service provision, education and language on this important health and social issue.

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## 14 Appendix A – Literature review methodology

### Search terms:

From the below lists, strings will look like:

- 1 & 3 & 5 & 6 & 7
- 1 & 4 & 5 & 6 & 7
- 2 & 3 & 5 & 6 & 7
- 2 & 4 & 5 & 6 & 7

There may be other things which surface as the searches commence. Please let me know.

### Group 1

1. (drug\* OR alcohol\*) **OR**
2. (Ice OR heroin OR opioid/painkillers OR methadone OR crack cocaine)

AND

### Group 2

3. (overdose\* OR abuse OR inject) **OR**
4. (junkie OR addict\*)

AND

### Group 3

5. (guideline\* OR standard OR recommendation)

AND

### Group 4

6. (Stigma\* OR marginali\* OR social exclusion OR discriminat\*)

AND

### Group 5

7. (Systematic review OR meta-analysis)

Databases to search:

- Electronic databases available to ADF – choose as appropriate
  - » Informit Health
  - » Gale Health and Wellness
  - » Gale Academic Onefile
  - » Ebscohost (specific AOD single title journals)
  - » Elsevier Science Direct
  - » PubMed

- Potential external databases (need to identify appropriate ones)
  - » Legal database on therapeutic jurisprudence
  - » Media database (does Informit cover media – if yes, no need to include another one).

Inclusion/exclusion criteria

- Article publication date: 1995 and more recent
- Include: only articles published in English
- Not exclude: blood borne virus, mental health, tobacco – we will not specifically search for these but if articles are returned that cover our search criteria for these health conditions we will keep them in
- Exclude: stigma related to any other health or other condition (e.g. obesity, ethnicity)

## 15 Appendix B – Summary of included studies

1. Amare T, Getinet W, Shumet S, Asrat B. Prevalence and associated factors of depression among PLHIV in Ethiopia: systematic review and meta-analysis, 2017. *AIDS Research and Treatment* [Internet]. 2018 [cited 2019 July 8] ;2018. Available from: [https://apac-tc.hosted.exlibrisgroup.com/permalink/f/b2nqee/TN\\_doaj\\_soai\\_doaj\\_org\\_article\\_8db42f2df7144aeaa93118f12e1b5449](https://apac-tc.hosted.exlibrisgroup.com/permalink/f/b2nqee/TN_doaj_soai_doaj_org_article_8db42f2df7144aeaa93118f12e1b5449)
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