MONOGRAPH 26

REDUCING STIGMA AND DISCRIMINATION FOR PEOPLE EXPERIENCING PROBLEMATIC ALCOHOL AND OTHER DRUG USE

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THE DRUG MODELLING POLICY PROGRAM

This monograph forms part of the Drug Policy Modelling Program (DPMP) Monograph Series.

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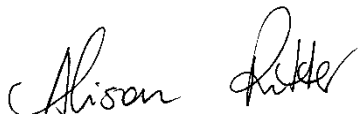
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DPMP strives to generate new policies, new ways of making policy and new policy activity and evaluation. Ultimately our program of work aims to generate effective new illicit drug policy in Australia. I hope this Monograph contributes to Australian drug policy and that you find it informative and useful.

Alison Ritter

Director, DPMP

ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

Project Aims

This project aimed to understand experiences of stigma and discrimination for people experiencing problematic alcohol and other drug (AOD) use in Queensland. Specifically, the research examined:

- Experiences of stigma and discrimination;

- The potential for legislation to be stigmatising;

- The settings and sectors in which stigma and discrimination occur;

- The impacts of stigma and discrimination on health and wellbeing and in particular on recovery and the ability to reconnect with the community; and

- Circumstances where stigma is not experienced, and evidence of what works to address stigma and discrimination.

In this report, stigma and discrimination are defined as follows:

> Stigma is labelling and stereotyping of difference, at both an individual and structural societal level, that leads to status loss (including exclusion, rejection and discrimination).

> Discrimination is the lived effects of stigma – the negative material and social outcomes that arise from experiences of stigma.

> Both stigma and discrimination rely on societal structures and systems that facilitate and create the conditions for their operation (for example unequal power is one such condition).

In this project we sought to identify effective ways to reduce stigma and discrimination and provide recommendations derived from the research findings to support implementation actions by the Queensland government.

Methods

The project consisted of three interrelated components. These were:

1. Literature review;

2. Analysis of legislation; and

3. In-depth qualitative interviews and analytical case studies based on interviews.

The literature review involved analysing international and Australian research pertaining to: definitions of stigma and discrimination; manifestations and experiences of stigma; how stigma is experienced by people who use AOD; considerations of stigma and the law; and effective

stigma-reducing interventions (drawing on findings from across the AOD, mental health and HIV/AIDS fields).

The analysis of Queensland legislation involved a three-step methodology to capture the full range of legislative provisions that deal with AOD in Queensland, establishing the focus of these provisions, and then examining the stigmatising and/or discriminatory potential of law.

Using in-depth qualitative interviews (N = 21) with people experiencing AOD problems in Queensland, the third component of the project involved documenting participants' perceptions and experiences of how stigma presents and manifests (including positive experiences where it was not experienced) and identifying the settings and sectors where stigma and discrimination occurs in participants' lives (including but not limited to health services, housing, justice, education and employment, other social support services and in the broader community). Analytical case studies were built using narrative techniques. Interview participants were recruited through treatment services and needle and syringe programs across Queensland.

Results

Identifying experiences of stigma and discrimination for people with problematic AOD use in Queensland:

- Experiences of stigma and discrimination were a common occurrence in the everyday lives of participants. Every participant could describe, in detail, multiple specific times that they had been judged, treated badly, looked down upon or excluded because of problematic AOD use;
- When participants were asked how experiences of stigma and discrimination made them feel, they described feelings of degradation, shame and anger;
- The frequency and commonplace nature of these experiences did not make them any less distressing for participants. These experiences had profound effects in participants' lives. These effects were not superficial and cannot be dismissed as insignificant. Experiences of exclusion, marginalisation, and discrimination impacted on participants' access to health care (including treatment) and other services, fair treatment in the justice system, employment opportunities, and relationships with family, friends and community;
- Stigma affected drug use. It did not discourage AOD use and was not a motivator for getting help. Many participants talked about how stigma and discrimination made them feel worthless and hopeless, which in turn triggered them to use alcohol or other drugs or give up on seeking change in their lives;
- Stigma was a barrier to help-seeking, even at times when participants had felt they really needed it. Experiences of stigma and discrimination at the moment of help-seeking (for example, from health care workers, doctors, psychologists, welfare services, or even AOD treatment providers) discouraged participants from seeking help again;
- Not all problematic AOD use was stigmatised in the same way. Some individuals felt that particular groups of people and behaviours were more stigmatised and marginalised than others, even amongst those with experience of problematic AOD use. This accords with what has been described in the literature as 'within group' stigma;
- Participants could also identify interactions and experiences where stigma had not been present. When participants spoke about these positive experiences, they felt understood and experienced a different kind of 'care'. Being seen as a 'normal' patient in clinical

settings, not as a 'just a drug user' or 'just an alcoholic' was particularly important. Positive experiences in work environments were characterised by employers being supportive of participants' requests to take a leave of absence to seek help, pathways into support such as access to confidential counselling through employee assistance programs, and a sense that employers had their best interests at heart.

Identifying law that has the potential to be stigmatising:

- Queensland law was analysed with a view to assessing its stigmatising and/or discriminatory potential, which was defined for the purposes of this study as: the enabling conditions for the manifestation of stigma and/or discriminatory practices;
- The stigmatising potential of law is increased wherever the law isolates certain individuals, practices, activities and behaviours associated with AOD, enabling key stakeholders to exercise power and authority over them (including in ways that are potentially arbitrary or insufficiently defined), without sufficient protections for the target;
- A total of 222 provisions in Queensland were identified that were relevant in some way to people who experience problematic AOD use. A proportion of provisions in Queensland law have the potential to stigmatise and/or discriminate against people experiencing problematic AOD use;
- Relevant provisions appeared across 11 different areas of law, with provisions most often being found in the domains of: substantive criminal law, employment law and professional regulation, public health, and public order;
- Only 33% of provisions define the targeted practice, activity or behaviour, with the remainder of provisions targeting practices, activities or behaviours that are not defined. The lack of definitional precision and clarity is a problem, because it may allow for highly subjective and variable assessments to be made;
- The provisions convey decision-making powers and/or authority to a wide range of decision-makers, bodies and authorities. In some instances these decision-makers are familiar, highly trained and regulated (e.g. the police) but in others, powers are conferred upon private citizens and organisations who may be less familiar, well trained or well versed in the exercise of power (e.g. mining operators, employers, sellers of goods);
- The stigmatising and/or discriminatory potential of law was reduced when targets were offered protections in law. While most provisions provide some protections for the target, 30.94% do not;
- The stigmatising and/or discriminatory potential of law might be alleviated or reduced where the protections in individual provisions are included and strengthened, or where overarching legal protections are provided for people who use AOD (for example a Human Rights Charter or anti-discrimination protections).

Identifying settings where stigma occurs:

- Participants experienced stigma across a range of settings including health care, policing, employment, child services, courts, welfare and support services, as well as in relationships with family and friends, and in the general community;

- These experiences created inequitable barriers in the most fundamental aspects of people's lives including health care, justice, family connection, employment opportunities, welfare, housing, and community belonging. Every participant could recall such experiences across multiple settings in their own lives, and described these experiences as being the norm;
- Drawing together findings from across the literature review, the analysis of legislation and the interviews, stigma and discrimination were found to most commonly and pervasively manifest in five specific settings: 1. Health care/public health; 2. Welfare and support services, including housing; 3. Police, public order and criminal law; 4. Employment; 5. Society at large.

Identifying 'what works' from the literature:

- Stigma-reducing interventions can be universal (addressing an entire population) or can be targeted and delivered in particular settings;
- Stigma-reducing interventions need to be focussed on both the social, political and economic causes of stigma, as well as on changing individuals' discriminatory attitudes and behaviours;
- Approaches must be *multifaceted* to address the extensive mechanisms which produce discriminatory outcomes, but also *multilevel* to address issues of both individual and structural discrimination;
- Circumscribed interventions that target only one mechanism at a time are unlikely to bring about change because they fail to address broader contextual factors;
- Mass media interventions are ineffective for preventing drug use. Such campaigns aim to stigmatise drug use and create fear so as to deter drug use, and lead to further separation and stigmatisation of people who use drugs. Extreme and stigmatising depictions in such campaigns may prevent people from seeking help;
- Mass media campaigns aimed at reducing stigma may reduce prejudice, but there is insufficient evidence to determine their effects on discrimination;
- Educational interventions in schools have limited evidence as to their effectiveness;
- Community-based interventions have been designed to reduce stigma amongst the community closest to people affected by stigma and discrimination, for example amongst close family members, and aim to increase knowledge, and equalise the relationship between people and their families so as to reduce stigma and discrimination. Such programs in the HIV field have been shown to reduce experiences of stigma for people living with HIV and change the attitudes of people living close to them;
- Interventions for health professionals and service providers focus on changing the attitudes and behaviour of health care workers at an individual level, as well as addressing stigma and discrimination in health care settings at both interpersonal and structural levels. Changing professional behaviours that may stigmatise people can be accomplished by (1) increasing awareness of stigmatising aspects of clinical practice (e.g. being conscious of the power of diagnosis and labelling processes, rejecting negative outcome beliefs, and enhancing communication with clients), (2) meaningfully involving service users and family members, (3) taking on a public advocacy role in challenging stigma (and

seeing this as part of the profession), and (4) campaigning at a policy level for adequate clinical resources and research in the field. The existing evidence on effectiveness of these interventions shows that workplace education without organisational support is ineffective;

- Interventions relating to treatment uptake focus on reshaping clients' experience of the clinic or treatment service environment and holistically addressing health issues (rather than just focussing on AOD problems). In the HIV field, these types of interventions have been found to effectively reduce the fear and stigma experienced by clients, especially the fear of being 'seen' at the service, and have been shown to improve communication at the service;

- Interventions relating to internalised stigma seek to decrease the impact of stigma on individuals and enable coping by restructuring erroneous beliefs about perceptions of enacted stigma and increasing self-esteem. Such interventions have been shown to increase perceptions of self-efficacy to cope with stigma, decrease avoidance strategies and improve self-esteem and quality of life;

- Health conditions (such as hepatitis C and HIV/AIDS) come to be inextricably associated with (and as such bear the stigma of) illicit drug use. This suggests that interventions which seek to reduce the stigma associated with drug use ought to not only be directed towards drug and alcohol workers but also other health care providers in other fields;

- Involving people with lived experience of AOD use in policy and practice is an important ethical consideration and can help challenge discriminatory or uninformed opinions. Consumer participation should be 'core business' for treatment services, health services, and other welfare and social support services that regularly engage with people experiencing problematic AOD use;

- While much of the intervention literature has focussed on changing the attitudes and behaviours of *individuals*, the literature also shows that in order to bring about meaningful change *structural factors* must also be understood and addressed.

Recommendations for change:

The research findings led to 34 recommendations. Some of the recommendations focus on educating and changing the attitudes of individuals (for example practitioners), some focus on reforming legislation, and some focus on structural arrangements (such as organisational policies). For success, interventions aimed at ameliorating individuals' discriminatory attitudes and behaviour need to be implemented *alongside* structural and systemic reforms aimed at addressing stigma and discrimination.

The recommendations for change are as follows:

Recommendation 01: Implement a Queensland Human Rights Charter
Recommendation 02: Conduct anti-stigma awareness training across all relevant workforces
Recommendation 03: Ensure consumer participation in policy and actions designed to reduce stigma and discrimination
Recommendation 04: Increase the access and availability of AOD treatment

Recommendation 05: Improve the marketing of AOD treatment

Recommendation 06: Better support family members of those in AOD treatment, through education and information resources

Recommendation 07: Invest in improvements in the physical facilities within AOD treatment services

Recommendation 08: Employ peer workers/liaison officers in health care settings

Recommendation 09: Audit complaints mechanisms in health care settings

Recommendation 10: Conduct consumer rights 'training'

Recommendation 11: Develop and disseminate clear clinical advice about pain management in people with opioid dependence for emergency departments and primary health care settings

Recommendation 12: Develop and disseminate clear clinical advice about access to medications for those with concurrent physical and mental health disorders and AOD use

Recommendation 13: Ensure consumer participation mechanisms are not just part of health care service provider's accreditation, but are implemented

Recommendation 14: Review reporting and monitoring systems to ensure anti-stigma actions are part of organisational Key Performance Indicators

Recommendation 15: Develop and implement programs aimed at resilience to internalised stigma for people experiencing problematic AOD use and AOD treatment clients

Recommendation 16: Consider introducing a supervised injecting facility, denoting that society cares, and providing a compassionate and practical health service

Recommendation 17: Consider reform of the 'notifiable conditions' sections of public health law

Recommendation 18: Amend legislation pertaining to HIV/hepatitis C

Recommendation 19: Apply the recommendations from health care to welfare and support services

Recommendation 20: Encourage police to be aware of and where possible facilitate access to services

Recommendation 21: Consider a pilot of tracking police encounters

Recommendation 22: Ensure Memoranda of Understanding are in operation between police and health care and harm reduction service providers

Recommendation 23: Reform areas of criminal law where the definition of the behaviour has the potential to be stigmatising or applied in discriminatory ways

Recommendation 24: Decriminalise the personal use/possession of drugs, removing the stigma of a criminal record

Recommendation 25: Amend laws regarding peer distribution of injecting equipment

Recommendation 26: Review policies regarding criminal history checks at pre-employment

Recommendation 27: Encourage uptake of clear employer guidelines regarding AOD use in the workplace and how to best respond

Recommendation 28: Improve access to Employee Assistance Programs

Recommendation 29: Develop and support pathways into employment for people completing AOD treatment

Recommendation 30: Encourage and support flexible work hours policies

1. PROJECT BACKGROUND

In this report, we present our research findings regarding stigma and discrimination for people experiencing alcohol or other drug (AOD) problems, which has a negative impact on the mental health and wellbeing of Queenslanders. Specifically the research examined:

- How stigma and discrimination presents and manifests, including where it is not experienced;

- The settings and sectors in which stigma and discrimination occur including but not limited to health services, housing, justice, education and employment, other social support services and in the broader community;

- The impacts of stigma and discrimination on mental health and wellbeing and in particular on recovery and the ability to reconnect with the community;

- The potential for legislation to be stigmatising; and

- The evidence of what works to address stigma and discrimination.

1.1 Project Aims

Our research, and the approach taken (see below), aimed to support implementation actions by the Queensland government, and inform the development of a position paper and an action plan. The work undertaken aimed to deliver the following outcomes:

- *Identify experiences of stigma and discrimination for people with problematic AOD use in Queensland:* We interviewed 21 people from across a range of settings to find out about their experiences of stigma and discrimination;

- *Identify priority settings:* We identified systemic issues in particular settings and sectors which contribute to stigma and discrimination;

- *Identify problematic law:* We identified key structural elements in Queensland legislation that have the potential to negatively impact on people experiencing problematic alcohol and other drug use;

- *Identify 'what works':* Drawing on both the evidence base and the lived experience of participants we identified effective approaches to reduce the stigma and discrimination experienced by people with problematic alcohol and/or other drug use; and

- *Make recommendations for change:* Based on these data and analysis, we made recommendations for change by identifying options for reform and effective actions that may be taken to address stigma and discrimination.

2. METHODS AND APPROACH TO ANALYSIS

The project consisted of three interrelated components. These were:

1. Literature review;

2. Legislative review; and

3. Interviews and analytical case studies based on interviews.

An iterative approach was taken across these three project components. The findings of the literature review helped inform the domains of in-depth focus in the legislative review, as well as the sampling in the interviews and focus of the analytic case studies. For example, the literature review identified drug treatment services as a key site of concern internationally, thus we sought to ensure that people with experience of drug treatment were included in our interview sample to capture and describe that experience locally. Similarly, where interview participants identified housing or family law as key sites of concern in their lives, this finding informed selection of domains of in-depth focus in the legislative review. In doing so, we iteratively focussed our approach by reference to the evolving findings of each component throughout the research process to ensure that domains of most concern were prioritised. We also sought feedback from the Queensland Mental Health Commission and Advisory Board throughout this process.

Here, we outline the methods and approach to analysis used in each of the three components.

2.1 Literature review

The literature review involved five parts:

- Definitions of stigma and discrimination;
- Manifestations and experiences of stigma;
- How stigma is experienced by people who use alcohol and other drugs;
- Considerations of stigma and the law; and
- Effective stigma-reducing interventions.

The literature review updated and expanded upon a literature review undertaken in 2010 by the UK Drug Policy Commission regarding the stigmatisation of people with lived experience of problematic drug use (Lloyd, 2010, 2013). For this project, we updated the review to encompass research more recently published, expanded the scope to include alcohol (the earlier review focussed on illicit drug use), and also sought to capture research which has documented positive encounters or settings where stigma is not experienced.

A key focus was also to identify initiatives, programs or other mechanisms which have been developed to address the stigma and discrimination experienced by people with problematic AOD use. We focussed here on both what has been shown to work in the AOD field, but also examined evidence from the mental health and HIV/AIDS fields, and considered the possible generalisability of successful approaches.

As such, the review encompassed not only literature describing experiences of stigma (and the wider social context in which it occurs), but also literature on pragmatic approaches and strategies aimed at addressing stigma.

Following the methods previously used by Lloyd (2013), we used targeted searches and narrative literature review methods. This approach is useful for describing and interpreting the diverse range of research and other literature in this domain. We identified relevant papers by searching across academic databases, initially using search terms used by Lloyd (2010) including 'drug', 'substance abuse', 'stigma' and 'discrimination', but also building upon these to include 'alcohol', 'dependence' and 'addiction'. Whereas Lloyd only included papers published in peer-reviewed journals and book chapters, we also conducted a search of grey literature to examine not only academic studies but also government and community programs to fulfil the objectives of both parts of the literature review.

To identify literature relating to effective stigma-reducing interventions, we used search terms including 'anti-stigma intervention', 'anti-stigma program', and search strings such as 'stigma' and 'change' or 'prevent' or 'intervention' or 'reduction'. Only English language publications were included.

2.2 Legislation review

Through the legislation review component of the project, we aimed to:

- Capture the full range of legislative provisions that deal with AOD in Queensland; and
- Establish how these provisions might be linked to people's experiences of stigma and/or discrimination, through a focus on what we call the 'stigmatising and/or discriminatory potential' of law.

We met these aims using a three-step approach.

Step 1: Mapping AOD under Queensland law

In the first phase, we undertook a mapping exercise, documenting provisions that may influence stigma and discrimination experienced by people with a lived experience of problematic AOD use. Given the scope of this undertaking and the likelihood that a large number of statutes would be identified, we limited our mapping to Queensland law, with a view to confining the scope to identifying recommendations.

We identified all Queensland law statutes and regulations in force (as at 18 July 2016) that would likely have an impact on people who use AOD. Searches were conducted using the web-based open access AustLII database, using a variety of search terms. The full list of search terms were:

> drug; drugs; alcohol; intoxic*; drunk*; under the influence; blood alcohol concentration; BAC; prescribed concentration; permitted concentration; liquor; alcohol limit; tobacco; cigarette*

This search string identified 2582 relevant sections of QLD law. The search results were catalogued and screened for relevance. Sections that dealt only with specific, narrow procedural elements pertaining to licensees or authorities in regard to AOD (rather than consumers) were excluded (e.g. provisions pertaining to the process of applying for a license under the *Liquor Act 1992* were excluded, while provisions pertaining to the powers of licensees to eject consumers were not).

Step 2: Establishing the different areas of law in which AOD is relevant

The second step of this mapping exercise was to assign a 'focus area' to each provision. This was an exercise designed to establish which areas of law the provisions fell within (i.e. were they all substantive criminal law provisions, or did they fall into other categories, such as health, or

employment law)? In undertaking this first level of analysis, we aimed to ascertain just how many different areas of law were implicated in the regulation of AOD use, possession, risks, and so on. We then sought to undertake a much more detailed analysis of the legislative provisions. For this, we adapted a system for coding legislative provisions we had sourced from Corrigan et al. (2005) and combined it with another system developed by Quilter et al. (2016a) (see Step 3).

Step 3: A framework for analysing the relationship between law and stigma

We adopted aspects of a coding approach developed by Corrigan et al. (2005) (an approach which sought to explore the relationship between legislation pertaining to people experiencing mental illness and structural stigma or discrimination) and combined them with aspects of a methodology designed to map and analyse Australian laws dealing with intoxication (Quilter, et al., 2016a; Quilter, McNamara, Seear, & Room, 2016b). Our coding schedule appears at Appendix A.

By adapting elements from Corrigan et al.'s research (2005) and combining it with insights from Quilter et al. (2016a, 2016b), the coding schedule sought to establish:

1. What kinds of practices, activities or behaviours were targeted in Queensland law;
2. Whether and in what ways those targeted practices, activities or behaviours were defined;
3. Who had the capacity to make determinations or exercise powers pertaining to the targeted practices, activities or behaviours;
4. What the decision-maker or authority identified at step 3 is able to do;
5. Whether the law offers protections to those individuals whose practices, activities or behaviours are the targets of law; and
6. Whether those laws offer protections to others.

This approach allowed for a rich and thick description of each provision and allowed for an analysis, among other things, of whether targeted behaviours are arbitrarily or ill-defined in law, whether there are clear requirements for the exercise of power in relation to AOD, and whether the law provides (or is intended to provide) protections to the targets of the law.

(Further detail about the theory and rationale underpinning our development and application of this coding schedule is included in the literature review and the legislation review results section below.)

The coding schedule in Appendix A was applied to all provisions we identified. We note that our analysis is necessarily limited in at least two ways:

- It does not include Commonwealth statutes that touch upon AOD use but which might be somehow relevant to the lives of people who live in Queensland; and
- It does not capture more generic legislation that does not deal, specifically, with AOD, but which might somehow touch upon or impact people who use AOD in Queensland.

2.3 Interviews and analytical case studies based on interviews

Through the interview component of the project, we aimed to:

- Elicit participants' perceptions and experiences of how stigma presents and manifests (including positive experiences where it is not experienced);

- Identify the settings and sectors where stigma and discrimination occurs in participants' lives (including but not limited to health services, housing, justice, education and employment, other social support services and in the broader community);
- Understand the impacts of stigma and discrimination (including impacts on mental health and wellbeing, and on participants' ability to seek help).

A semi-structured interview guide was developed (see Appendix B). A narrative approach was taken whereby participants were encouraged to tell 'stories' (that is, describe specific events or encounters, as well as the circumstances of their life's journey). Qualitative researchers argue that "stories are particularly suited as the linguistic form in which human experience as lived can be expressed" (Polkinghorne, 1995). A flexible approach to interviewing was also taken, whereby probing and follow-up questions were used, as appropriate, to yield rich data and uncover new insights (Minichiello, Aroni, & Hays, 2008). The interviewer played an active role in building conversation about a particular issue, responsively changing the wording or ordering of questions, and allowing for the emergence of individual perspectives (Patton, 1990).

Interviews were conducted in accordance with national ethical guidelines governing human research (National Health and Medical Research Council, 2007). Participants were given a Participant Information Statement and Consent form to sign, explaining the study, and were offered $40 as reimbursement for their participation. Interviews were on average between 30 minutes and one hour in length and were all conducted by the same member of the research team (KL). Interviews were digitally audio-recorded and then transcribed verbatim by a professional transcribing service (Smart Docs). To maintain confidentiality and anonymity, all interview data were de-identified prior to analysis. The project was approved by the University of New South Wales Human Research Ethics Committee (Approval no. HC16538) and registered by Monash University's Human Research Ethics Committee (Approval no. 1128).

The foundational principles of thematic qualitative analysis (Braun & Clarke, 2006) were initially applied to analyse the interview data. Interview data were read and separately coded by two members of the team (KL and KS). Following discussion, interview transcripts were then re-coded and organised with the aid of NVivo 11 data management software. Both deductive and inductive approaches to coding were undertaken. That is, throughout the coding we identified key concepts derived from the literature review, as well as allowing other concepts to emerge. As the interviews were also used to generate analytic case studies, we also used narrative analysis techniques to analyse the data (Polkinghorne, 1995). Narrative accounts were drawn either from within the one participant's experience, or by the research team building illustrative case examples by collating similar narratives from across interviews where participants have given similar accounts. The aim here was to draw disparate sections of interview data together into a coherent whole case study or storied account. This analytic technique is used not to directly reproduce observations, but rather provide a dynamic framework in which to connect and bind disconnected data segments in a coherent and explanatory way (Polkinghorne, 1995).

3. LITERATURE REVIEW

This review considers and summarises a diverse literature about stigma and discrimination. Stigma affects people's lives in material ways. Stigma is a fundamental social cause of health inequalities (Hatzenbuehler, Phelan, & Link, 2013). As Hatzenbuehler et al. (2013, p.5) argue, stigma "thwarts, undermines, or exacerbates several processes (i.e. availability of resources, social relationships, psychological and behavioural responses, stress) that ultimately lead to adverse health outcomes. Each of these stigma-induced processes mediates the relationship between stigma and population health outcomes." Stigma has been shown to worsen stress, reinforce differences in socio-economic status, delay or impede help-seeking and lead to premature termination of treatment (Hatzenbuehler, et al., 2013; Link & Phelan, 2001; Schulze, 2007). Research suggests that greater attention should be paid to stigma as a social determinant of population health (Hatzenbuehler, et al., 2013).

The first section of this review provides the various definitions of stigma and discrimination that have appeared in the literature to date, ending with our own working definitions for the purposes of this project.

The second section considers different manifestations and experiences of stigma – felt, enacted, and internalised (self) stigma. It is important to understand these different conceptualisations of stigma, as each of them provides a different window into experiences of stigma. The third section focuses on AOD specifically by reviewing the international literature which describes and analyses how stigma is experienced by people who use AOD. The fourth section discusses considerations related to stigma and the law.

The fifth and final section examines the existing literature on how to systematically address the issue of stigma through effective interventions. We have spent most of our time focussed on this literature because: this literature has not been thoroughly reviewed to date; and the project aims concerned generating recommendations for QHMC which need to be informed by the existing literature on what works.

3.1 Definitions: what are stigma and discrimination?

Stigma is a complex phenomenon (Corrigan & Kleinlein, 2005). 'Stigma' has been conceptualised in different ways and there is considerable variation in the definitions put forward in the literature (Clement, et al., 2013; Link & Phelan, 2001). This variation is partly due to the wide range of contexts in which the concept has been explored, and the multidisciplinary nature of stigma research which has led to different theoretical frames of reference being applied (Link & Phelan, 2001).

Goffman's (1963) seminal book *Stigma: Notes on the Management of Spoiled Identity* has been influential for understanding not only the markers of stigma but more importantly the processes of stigma; how stigma is produced through social interactions and its structural preconditions. In this work, Goffman conceptualised stigma "as an attribute that discredits an individual in the eyes of society and results in the person being devalued, discriminated against, and labelled as deviant" (Butt, Paterson, & McGuinness, 2008, p.205).

More recently, Link and Phelan's (2001) definition has also been taken up widely. In their conceptualisation, stigma can be said to exist when several interrelated components converge:

> In the first component, people distinguish and label difference. In the second, dominant cultural beliefs link labelled persons to undesirable characteristics – to negative stereotypes. In the third, labelled persons are placed in distinct categories so as to

accomplish some degree of separation of 'us' from 'them.' In the fourth, labelled persons experience status loss and discrimination that lead to unequal outcomes. Finally, stigmatisation is entirely contingent on access to social, economic and political power that allows the identification of differentness, the construction of stereotypes, the separation of labelled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination. (Link & Phelan, 2001, p.367)

It is important to note here that this definition of stigma encompasses more than just labelling, stereotyping or assumptions. Stigma also involves status loss ("a downward placement in the status hierarchy": Link & Phelan, 2001, p.379) and discrimination means that stigmatised people experience a range of negative material and social outcomes which require scrutiny and assessment.

Corrigan and Kleinlein (2005) put forward a model of stigma which distinguishes between 'public stigma' and 'self-stigma,' each involving three components: stereotypes, prejudice and discrimination. Stereotypes are "knowledge structures" which are learned by members of a given social group, which become an "efficient" way of categorising information about social groups (Corrigan & Watson, 2007, pp.440-441). Prejudice only occurs when individuals endorse negative stereotypes. Prejudice then leads to discrimination; that is, affective responses are turned into behaviour (Corrigan & Watson, 2007, p.441). Clement et al. (2013, p.6) propose a slightly different formulation of the three components of stigma and suggest that stigma comprises "ignorance (lack of knowledge), prejudice (stigmatising attitudes) and discrimination (being treated unfairly, a behaviour concept)."

Corrigan and Kleinlein (2005) argue that individual level analysis of stigma provides only a partial picture of the effects of stigma. They identify two levels of stigma in society: "institutional policies" and "social structures" (Corrigan & Kleinlein, 2005, p.29). These societal forms of stigma differ from stigma at the individual level through "the emergence of social forms and structures that restrict the life opportunities of people" (Corrigan & Kleinlein, 2005, p.29). Across these various definitions we can draw together some common threads. Stigma is enacted at both the individual level, and through institutions and structures. Stigma is more than simply stereotyping or over-generalising about a group or characteristic; it also involves the prejudicial endorsement of those stereotypes leading to loss of status, discrimination or unfair treatment.

Unlike stigma (which has been widely theorised), the concept of discrimination is rarely framed in relation to any particular theoretical tradition (Parker & Aggleton, 2003). Discrimination is often discussed in tandem with stigma, and its meaning taken almost for granted (Parker & Aggleton, 2003). In common usage discrimination is often simply equated with being 'treated unfairly,' however sociological definitions focus more on structural patterns of power, dominance, oppression, and social inequality (Scott & Marshall, 2009). In law, discrimination has a distinct meaning. Typically, a person has been discriminated against unlawfully where they have been treated differently and unfavourably because of some attribute that they possess (e.g. because of their race, religious beliefs, or gender).

In keeping with the focus of the stigma definition chosen above, for the purposes of this project we employ a sociological understanding of the term 'discrimination.' In doing so, we focus our analysis on identifying structural patterns of discrimination and the social conditions which allow it, not just 'unfair treatment' at the individual or interpersonal level.

The definitions employed for this research project are:

Stigma is defined as: "elements of labelling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them." (Link & Phelan, 2001, p.377).

Put into our own words, stigma is labelling and stereotyping of difference, at both an individual and structural societal level, that leads to status loss (including exclusion, rejection and discrimination).

Discrimination relates to: structural patterns of power, dominance, oppression, and social inequality. (Scott & Marshall, 2009)

Put into our own words, discrimination is the lived effects of stigma - the negative material and social outcomes that arise from experiences of stigma.

Both stigma and discrimination rely on societal structures and systems that facilitate and create the conditions for their operation (for example unequal power is one such condition).

3.2 'Felt', 'enacted' and 'internalised' stigma

There are a number of different manifestations and types of stigma, described in the literature. These include the concepts of 'felt' versus 'enacted' stigma, along with 'internalised' stigma. Each of these has the potential to play out differently for people with AOD issues.

Theorists and researchers have separated the concept of stigma into 'felt'[1] stigma, and 'enacted' stigma (Brown, Macintyre, & Trujillo, 2003). 'Felt' stigma refers to "real or imagined fear of societal attitudes and potential discrimination arising from a particular undesirable attribute, disease (such as HIV), or association with a particular group or behaviour" (e.g. problematic drug use), whereas 'enacted' stigma refers to "the real experience of discrimination" (e.g. where disclosure leads to the loss of a job or social exclusion) (Brown, et al., 2003, p.50).

The concept of 'self-stigma' or 'internalised stigma' has also been described. Research has demonstrated the ways in which self-stigma or internalised stigma is conceptually and empirically distinct from enacted stigma (Luoma, et al., 2007). Self-stigma refers to "negative thoughts and feelings (e.g. shame, negative self-evaluative thoughts, fear) that emerge from identification with a stigmatised group" (Luoma, et al., 2007, p.1332) which has been shown to impact negatively on behaviour, for example avoiding treatment, lack of employment seeking, and avoiding close contact with other people. Internalised stigma shapes an individual's subjectivity (how they see themselves and their place in the world). (We take up the AOD literature on this topic below).

3.3 Stigma and AOD

Even in Goffman's (1963, p.4) early work on stigma, problematic alcohol and other drug use ("addiction, alcoholism") was included in a list of 'discrediting attributes' that almost inevitably give rise to discrimination. While there is no necessary or inherent reason why drug use should give rise to stigma, some aspects of drug use including intoxication, dependence and being engaged in treatment attract "near-universal stigma and marginalization" (Room, 2005, p.144). In

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[1] The concept of 'felt' stigma is also sometimes referred to as 'perceived' stigma.

many ways drug use behaviour becomes conflated with the person. That is, people who use drugs become seemingly inseparable from their behaviour and are labelled as "drug users" or "addicts" and not, as in other health-related discourse, "a person [who] has cancer, heart disease, or the flu" (Link & Phelan, 2001, p.370).

There are a range of reasons why AOD use is thought to be frequently associated with stigma and discrimination, not least because the behaviour is regarded as immoral, illegal, and deviant. This leads to tensions in the way that dependence is thought about and described. As Room (2005, p.146) notes, drug and alcohol dependence are "on the one hand, from the perspective of medical nosology and public health, categories in the international classification of health disorders" and on the other hand "thoroughly moralised and derogated categories."

There has been a debate in the literature about whether or not stigma might be regarded as a public health 'tool' and might therefore be ethically acceptable in some situations (Bayer, 2008). Some commentators have argued that stigmatisation or de-normalisation of alcohol, tobacco and other drugs use might serve a positive public health function, in that such approaches can change social norms (the changing social norms around the acceptability of smoking are one example) (Bayer, 2008; Bayer & Fairchild, 2015). However, even those who advocate discussion of stigma as a public health tool nonetheless recognise that stigma will affect different groups and individuals disproportionately, and will marginalise some people (Bayer & Fairchild, 2015). Other researchers have strongly opposed the suggestion that stigma is an appropriate public health tool. Noting Bayer and Fairchild's observation that some populations will be disproportionately affected and be marginalised, other researchers have pointed to the long term implications of stigma for provision of and access to health services, and the ethical tension between seeking to empower citizens across health contexts and undermining them (even temporarily) through stigma and shame (Williamson, Thom, Stimson, & Uhl, 2015).

A body of literature has sought to describe how stigma and discrimination is experienced by people who use drugs (and particularly people who inject drugs) and how it manifests (e.g. AIVL, 2011b; Corrigan, Kuwabara, & O'Shaughnessy, 2009; Lloyd, 2010, 2013; Radcliffe & Stevens, 2008; Room, 2005; Simmonds & Coomber, 2009; UKDPC, 2010). Room (2005, p.151) suggests that discussion of the experiences and effects of stigma in the alcohol and other drug field has actually been quite confined and "have primarily been clinically-orientated considerations of the stigma on those treated for alcohol or drug problems, from the perspectives of stigma as a barrier to coming to treatment, managing the stigma post- treatment, or documenting or decrying public attitudes."

The most comprehensive review of this literature internationally was conducted by Lloyd (2010, 2013) as part of a project for the UK Drug Policy Commission (UKDPC, 2010). Lloyd (2013) identified 185 published papers pertaining to the stigmatisation of problematic drug use and analysed the literature thematically according to the following nine categories: public attitudes; the attitudes of health professionals; the pharmacy as a setting for stigmatization; drug treatment services; the particular stigma of methadone; policing and public shame; stigmatising the stigmatised; the impact on problematic drug users; and stigma and recovery.

Here, we summarise Lloyd's findings and integrate other literature to inform the QMHC project more specifically. As Lloyd's review focussed on illicit drugs and not alcohol, we conducted a further literature search to locate papers which discuss the issue of alcohol and stigma specifically. We located a further 57 papers using search terms including: alcohol, alcoholism, alcohol disorder, alcohol and problem, alcohol dependence, stigma, and discrimination. We also updated Lloyd's earlier review of the drugs literature by searching for articles published from 2013 onwards.

Public attitudes

Lloyd (2013) described the literature examining general populations surveys which have included questions pertaining to public attitudes towards people who use drugs. Surveys undertaken in the UK, USA and other countries have shown that the public apportion blame to people who use drugs, and hold more stigmatising attitudes towards problematic drug use than to mental health (and, correspondingly, were more likely accept discrminatory practices and to oppose policies aimed at helping people experiencing problematic AOD use: Barry, McGinty, Pescosolido, & Goldman, 2014). Analyses of these general population surveys also demonstrate that public attitudes towards problematic drug use are complex and at times contradictory, with people being able to simultaneously blame people who use drugs whilst also reporting that they believe that people who use drugs come from difficult or disadvantaged backgrounds. Similarly, alcohol-related stigma is often associated with the belief that individuals are responsible for their own behaviour and alcohol use, and therefore do not deserve sympathy (Erofeeva, 2016). In a review of population surveys from Europe, North America, New Zealand, Brazil and Ethiopia, Schomerus et al. (2011) found that compared with people living with other mental health problems, people experiencing problematic alcohol use were highly stigmatised: they were less frequently regarded as being mentally ill, were more likely to be held responsible for their own condition, more likely to provoke social rejection and negativity, and were at special risk for structural discrimination (see also: Schomerus, Holzinger, Matschinger, Lucht, & Angermeyer, 2010). Van Boekel et al. (2013) found that underlying negative attitudes about personal responsibility for drug and alcohol problems, as well as feelings of anger and fear, explained public intentions to impose discriminatory restrictions on people experiencing problematic AOD use (including removing children and excluding people from holding public office). It is important to note, however, that public attitudes do not necessarily stay constant over time. In one study examining population surveys in Germany, the authors found that while negative attitudes towards people with alcohol dependence did not change significantly between 1990 and 2011, the image of people who had received treatment for alcohol use problems had improved over time, indicating an increased acceptability of professional treatment (Schomerus, Matschinger, & Angermeyer, 2014; Schomerus, Matschinger, Lucht, & Angermeyer, 2014).

In addition to analyses of population surveys, other research into public attitudes has also been undertaken. In one experimental study, researchers examined implicit and explicit beliefs about people who inject drugs. The authors found that participants associated people who injects drugs as deserving publishment as opposed to help (Kulesza, et al., 2016). Public attitudes also come into play when considering stigma in the workplace. One international mixed methods study examining employers' attitudes in Chicago, Hong Kong and Beijing found that employers' attitudes were more negative when health conditions were seen to be 'behaviourally driven' (that is, when alcohol and other drug problems were regarded as the result of personal choices and behaviour)(Corrigan, Tsang, Shi, Lam, & Larson, 2010). Interestingly, an Italian study found that this negative attitude of personal responsibility and blaming individuals for their own alcohol-related problems remained even when alcohol dependence was described as an illness or a disease (Piras, et al., 2016), which suggests that the disease model is not necessarily less stigmatising than other constructions of problematic alcohol and other drug use. That said, other studies have shown a strong correlation between stigmatisation of alcohol disorders and agreement with socio-dynamic explanations of alcohol problems (rather than neurobiological explanations) (Heberlein, et al., 2014).

Police and public shame

Lloyd (2013) notes the literature which has described experiences of public shame in interactions with police. This literature describes adversarial and coercive interactions, with police actions often seen to be unjust and punitive by people who use drugs (and especially by those who were

in recovery). In a large study examining street-level policing of people experiencing problematic drug use, Lister and Wincup (2007) found that interactions with police were often adversarial, and people reported often feeling like they were the targets of unwanted police attention (either informally or within formal police powers). Participants reported that they felt like police defined them in terms of their drug use, which had a demoralising effect. People who were seeking treatment often continued to be the subject of police attention, due to their past drug use, which was an impediment to recovery and reintegration into society (Lister & Wincup, 2007). This body of literature also highlights how particular populations may experience even greater discrimination and undue police attention, for example based on race and ethnicity, which further compounds drug-related stigma (Khenti, 2014).

Stigma, drug treatment and help-seeking

Stigma as a barrier to help-seeking has been widely recognised across different fields (e.g. in mental health: Corrigan & Kleinlein, 2005; Schulze, 2007). There is evidence to suggest that this is also the case in the alcohol and other drug treatment sector. For example, research shows that people experiencing problematic alcohol use are less likely to access and utilise treatment services if they perceive higher alcohol-related stigma (Keyes, et al., 2010). For adolescents, alcohol-related stigma can exacerbate alcohol-related problems and limit access to treatment and social supports (Aviram, 2006). Fear of being treated differently, expectations of rejection and self-stigma have been shown to be associated with delayed treatment seeking as well as lower self-esteem and greater drug dependence (Cama, Brener, Wilson, & von Hippel, 2016; Luoma, et al., 2007; Semple, Grant, & Patterson, 2005). Beyond individual factors, varied conditions of social and gender inequality, as well as contexts of violence and abuse, have been identified as stigma-related structural barriers which constitute obstacles to treatment (Mora-Ríos, Ortega-Ortega, & Medina-Mora, 2016). Research has shown that people who use drugs will delay seeking treatment not only for substance use disorders but also for trauma, infections and other conditions to avoid being stigmatised for drug use (Regen, Murphy, & Murphy, 2002). People who use drugs reported fears that disclosing their drug use and seeking help would have adverse effects including employment problems and legal penalties (for example when in violation of parole conditions), and did not trust health services to keep their medical details confidential. Instead, people who use drugs turn to informal networks for advice, treatment and referrals so as to seek non-judgmental care instead of seeking formal treatment (Regen, et al., 2002).

Lloyd's (2013) review highlights the particular stigma associated with drug treatment. The ways in which drug treatment services are stigmatised and 'marked' as services 'for junkies' means that would-be help seekers seek to distance themselves from such settings (Radcliffe & Stevens, 2008) or from assumptions that they were a dependent drug user, an 'addict' or had a significant drug problem. Lloyd notes that these negative connotations have practical implications, and are a barrier to early interventions and treatment seeking. One solution may be increased provision of drug treatment through primary care settings to reduce the stigmatising effect of specialist treatment settings (Lloyd, 2013). Within the literature examining the stigmatising effects of drug treatment and treatment settings, there have been a number of studies documenting the stigma associated with methadone (Lloyd, 2013). The shame associated with standing in line at methadone clinics and humiliating drug testing (including urine testing) have been described (see also Crawford, 2013; Fraser & valentine, 2008). Research shows that people continue to experience drug-related stigma from multiple sources after entering methadone maintenance treatment and while in recovery, including from family and friends, co-workers and employers, health care workers, and government employees (including family services) (Earnshaw, Smith, & Copenhaver, 2013).

Room (2005, p.152) notes the high degree of marginalisation and stigmatisation for people engaged in alcohol and other drug treatment, and argues that "improving the social reintegration

of such treated populations […] will require a better understanding of how and under what conditions the marginalisation and stigmatisation happens." This is a crucial point: understanding and responding to stigma is essential to assisting long term change and recovery for people seeking help with alcohol and other drug problems. Indeed, Luoma et al. (2007, p.1342) have hypothesised that greater levels of stigma make it "more difficult to succeed in recovery" and more likely that individuals will discontinue treatment, which in turn leads to a greater chance of relapse and multiple treatment episodes. Stigma impacts on recovery both in terms of internalised blame and lack of self-worth, as well as through structural barriers such as discrimination by employers (which creates a barrier to returning to working life) (Lloyd, 2013). The stigma associated with having experienced problematic alcohol and drug use, even for those in long-term recovery, can impact for a lifetime (Lloyd, 2013).

Stigma and health care settings

Beyond AOD treatment settings specifically, stigma and discrimination can occur within generalist health care settings. Lloyd (2013) examined the literature describing the attitudes of health professionals. Lloyd notes that there is a sizable body of research on the stigmatising attitudes of health professionals towards people who use drugs, across many different countries. Surveys of health professionals have shown the lack of education received by health professionals in medical schools about drug and alcohol issues. The belief held by some doctors that treating people who inject drugs would be "futile" (Ding, et al., 2005; Lloyd, 2013, p.87) meant that a substantial minority of doctors reported that they would prefer not to treat this client group. Qualitative research has also shown that nurses' accounts of caring for a similar client group were laden with fear, prejudice and stigma. Lloyd (2013) describes studies documenting significant levels of distrust between doctors and patients. Doctors reported being concerned about being deceived by opiate dependent patients, while the patients themselves were concerned that they would not receive adequate pain relief and appropriate treatment due to assumptions about their addiction and 'drug-seeking.' Accounts of people who use drugs being treated 'differently' from other patients in hospital are also given in the literature. Lloyd notes that these negative experiences are not universal, and the literature documents both positive and negative encounters with health professionals. Positive experiences "tended to be where care providers listened and were sympathetic and compassionate" as opposed to situations in which clients were told to stop using drugs, had their symptoms dismissed, or were simply treated as to blame for their own health conditions (Lloyd, 2013, p.88). Adequate pain relief would appear to be a central issue in the literature, however, which often leads to conflict between clinical staff and clients with a history of problematic drug use (Lloyd, 2013). Research has shown that having been refused medical care or having being verbally abused are factors associated with people who inject drugs subsequently avoiding health care services. This indicates the need to address broader structures in the health care system to ensure that people experiencing problematic AOD use can access care (Heath, et al., 2016).

In his review, Lloyd (2013) also identified pharmacy settings as a key site of discrimination. Negative attitudes by pharmacy staff were reportedly related to concerns about theft and shoplifting. Some pharmacists also saw 'other' customers as 'more important' than customers who may be collecting methadone does or injecting equipment, and would sometimes introduce systems to 'separate' 'drug using clients' from other clients by means of separate doors, cubicles or allocated spaces within the pharmacy. Lloyd (2013) argues that the stigma experienced in pharmacies has a range of practical implications for people who use drugs, including their ability to access injecting equipment and methadone maintenance treatment retention.

Research has shown health care workers' perceptions of injecting drug use as a 'controllable' behaviour heavily influences negative attitudes towards health care clients who have a history of injecting drug use. Moreover, when health care workers believe than injecting behaviour is within

a client's control or that it is a choice, health care workers are more likely to assume that health problems are caused by a person's injecting drug use status and not any other underlying health issue (Brener, Hippel, Kippax, & Preacher, 2010). Where clinicians and health care professionals stigmatise clients, access to effective health treatment is limited and the consequences of stigma worsen (Varas-Díaz, et al., 2013).

Co-stigmas

The stigma associated with drug use also compounds the stigma associated with diseases such as hepatitis C (HCV) and HIV/AIDS. Fraser and Seear (2011) argue that HCV is a stigmatised condition in part because of its symbolic and literal associations with injecting drug use and 'addiction'. Harris (2005) argues that the virtual conflation of injection with infection is an important factor in HCV stigmatisation. The connections between HCV, injecting drug use and stigma are well documented in the literature (see, for example: Anti-Discrimination Board of New South Wales, 2001; Fraser & Treloar, 2006; Harris, 2005; Krug, 1995; Pugh, 2008). Reviews of the extant literature on HCV stigmatisation, including stigma associated with treatment experiences, point to a range of factors associated with stigma, including individual, structural, social and institutional forces (Butt, 2008; Paterson, Backmund, Hirsch, & Yim, 2007; Treloar & Rhodes, 2009). It has been suggested that the stigma associated with HIV/AIDS is also "layered upon the co-stigmas" (Chan, Stoové, & Reidpath, 2008) associated with injection drug use, marginalisation and other "norm-violating behaviour" (Bos, Schaalma, & Pryor, 2008, p.452).

Since injection drug use is the predominant mode of HCV transmission in western democracies, people living with HCV (regardless of how they may have acquired the virus) may experience drug-related stigma and become associated with attributes such as criminality, untrustworthiness and non-compliance (Butt, et al., 2008). The assumption that people living with HCV not only use illicit drugs but also must be 'irresponsible users' to have contracted the virus via sharing injecting equipment means that people living with HCV often experience discrimination by health workers, or withdrawal of care and support (Butt, et al., 2008). In this way, the stigma associated with illicit drug use (and injecting practices in particular) has implications for other areas of health including blood borne virus prevention and treatment. Similarly, research has shown that transgender people who use drugs may experience this kind of layered co-stigma when accessing health services and drug treatment (Lyons, et al., 2015).

Research has shown that stigma can differ by drug type. For example, the stigma associated with heroin use is significantly higher than levels of stigma associated with cannabis (Brown, 2015). In considering such findings, it is important to note that society's attitudes towards particular drug types are constantly shifting. For example, recent discussion of the legalisation of cannabis or increasing rates of opioid overdose can impact the stigma associated with particular drugs (Brown, 2015). An Australian study also found that respondents would be more comfortable encountering an alcohol dependent person than a heroin dependent person in the workplace or at a dinner party (Meurk, Carter, Partridge, Lucke, & Hall, 2014). These differing public attitudes towards different drug types was also related to different levels of support for various policy interventions including treatment and criminal punishment. For example, the authors found less support for coerced treatment for alcohol dependence than for heroin dependence (Meurk, et al., 2014). The ethnicity and gender of the person who uses drugs may also contribute to the stigma associated with particular drugs (Sorsdahl, Stein, & Myers, 2012). What people believe about the 'causes' of conditions such as alcohol dependence, for example, has been shown to be different across men and women. In one study, participants were more likely to say that 'bad character' was a cause of alcohol dependence in women (Lale, Sklar, Wooldridge, & Sarkin, 2014).

In documenting and describing these various experiences and manifestations of drug-related stigma, it is also important to note that within group stigma has also been identified. Research

has shown that some groups are seen as 'worse' or 'more problematic' by others within the drug using community (AIVL, 2011b; Lloyd, 2013; Radcliffe & Stevens, 2008; Simmonds & Coomber, 2009).

Stigma has material effects in the daily lives of people who use drugs, and can affect the way an individual sees themselves and the world around them, as well as their views of treatment and other drug policies (Lancaster, Santana, Madden, & Ritter, 2015). While the stigmatisation and alienation of people who use drugs is certainly associated with poorer mental and physical health than that in the general population (Ahern, Stuber, & Galea, 2007), the impacts are more far reaching than this, with broad implications for citizenship and political subjectivity (Fraser & valentine, 2008; Lancaster, Santana, et al., 2015).

3.4 Considerations of stigma and the law

Given this project's focus on identifying key structural elements in Queensland legislation that have the potential to negatively impact on people experiencing problematic AOD use, it is important to consider the literature relating to stigma and the law.

Room (2005) argues that AOD stigmatisation and marginalisation stems from three main sources. These are: 'intimate processes of social control and censure among family and friends', as well as 'decisions by social agents and agencies, which tend to focus attention on the most problematic cases and to amplify their marginalization' and finally, 'policy decisions at the local or national level which result in marginalization'. Room is not alone in drawing attention to the role of policy and law in the production of stigma. Law is understood to have an important relationship with stigma. According to Nussbaum (2004), for instance, the law can be an important 'bulwark' that protects people from stigma (e.g. through laws that prohibit discrimination against particular individuals, groups, behaviours and attributes). It can also produce stigma through processes of labelling and categorisation (e.g. branding certain practices as deviant or illegal). In both respects, the law has an important 'expressive function' (Sunstein, 1996) in that it articulates values and norms. In a similar vein, Burris (2006, p.529) suggests that:

> There are three broad areas where law affects the operation of stigma in society. Law can be a means of preventing or remedying the enactment of stigma as violence, discrimination, or other harm; it can be a medium through which stigma is created, enforced, or disrupted; and it can play a role in structuring individual resistance to stigma.

Burris elaborates on these three categories. In relation to the law's potential to prevent or protect against stigma, he notes that the law can 'blunt' stigma's effects where it deters harmful conduct and allows for recompense when damage has been done. In relation to its potential to propagate stigma, Burris notes that the law can enforce stigma by, for example, excluding people with HIV from being soldiers. In relation to individual resistance, Burris (2006, p.530) argues that we should consider:

> How law affects the day-to-day experience of stigma at the individual level, specifically whether law affects whether individuals accept or resist a 'spoiled identity', and the ways they can resist.

Burris poses a series of questions regarding the law's structuring capacity regarding individual resistance and enacted stigma. He asks (2006, p.531):

> Can law promote resistance by reducing the risks of resistance and by changing self-conception? Can law facilitate activism by acting against discrimination and providing a script to guide social interactions? Can it mobilise collective action? Clearly, resistance to

stigma needs to become more prominent in any thinking about how a law can address the problem.

Of course, it is also important to acknowledge that – following Sunstein's observations on the symbolic or expressive function of the law – there are different views on the value, or worth, of the law's capacity to produce stigma. Burris notes that the propagation or enactment of stigma is sometimes categorised as either 'positive' or 'negative'. As Room (2005, p.150) has pointed out, there are indeed "two literatures on stigma, operating on very different premises". According to the first approach, "stigma is taken for given as a discriminatory social evil" (Room, 2005, p.150). This literature emphasises the "negative effects of stigma on the stigmatized person" (Room, 2005, p.150), and tends to focus on how those effects can be minimised or eradicated. In contrast, the second approach often views stigma 'benignly'; "aligned with this literature, too, are public policy initiatives, including those which frequently justify their provisions by the need to 'send a message' about what is and is not considered tolerable behaviour" (Room, 2005, p.150). Acknowledging these different approaches Burris (2006, p.530) nevertheless argues that:

> Sensitivity to the way stigma operates, particularly through self-lacerating shame and self-discrimination, invites reflection on whether it is morally acceptable to use stigma as a means of social control, even for public-health purposes.

Sunstein (1996, p.2025) makes a similar point, arguing that "the expressive function of law makes most sense in connection with efforts to change norms and that if legal statements produce bad consequences, they should not be enacted even if they seem reasonable or noble". In this sense, Sunstein and Burris share a concern with the potential for law to generate shame, self-discrimination or adverse consequences, and suggest pause for thought where laws can be proven to produce these kinds of effects.

3.5 Interventions for reducing stigma

While the experiences and effects of stigma have been extensively documented, there has been less focus on how to systematically address these issues through effective interventions (Neema, et al., 2012). As part of the UK Drug Policy Commission's work on stigma (Lloyd, 2010; UKDPC, 2010, p.9), they identified five priority actions to reduce stigma towards people who use drugs:

- Improve the knowledge and understanding among the general public about drug dependency and recovery to reduce the levels of fear and blame;
- Ensure training and workforce development across the range of professions who work with people with drug problems to improve service responses;
- Remove the legislative and administrative restrictions which reinforce stigmatisation towards people with drug dependency and addictions;
- Support and promote self-help and mutual aid bodies and the nascent drug-user recovery communities as vehicles for reintegration and 'normalisation' of recovery; and
- Engineer new ways to support and promote community participation and increased contact with recovering drug users in order to foster more constructive perceptions.

The extent to which these recommendations have a supporting evidence-base was not specifically explored in the UKDPC work.

In this section we first provide a general overview of stigma-reducing interventions and systematic reviews to date, but then move to consider specific interventions: mass media interventions; educational and school-based interventions; community-based interventions; interventions for health professionals and service providers; interventions relating to treatment uptake; interventions relating to internalised stigma; considerations of co-stigma; involving the affected community in policy and practice; and, changing cultural constructions.

Anti-stigma interventions can be universal (addressing an entire population) or can be targeted and delivered in particular settings (Buechter, Pieper, Ueffing, & Zschorlich, 2013). From the health promotion literature we know that interventions are more likely to work if they are based in social and psychological theories (Bos, et al., 2008).

Stigma-reducing interventions should be attendant to the social, political, and economic causes of stigma, as well as individual and interaction-level stigmatisation and discrimination (Bos, et al., 2008). Link and Phelan (2001) argue that given the extensive mechanisms which produce discriminatory outcomes, interventions designed to reduce stigma must also be broad ranging. Approaches must be *multifaceted* to address these many mechanisms, but also *multilevel* to address issues of both individual and structural discrimination. More than this, efforts to bring about change must "either change the deeply held attitudes and beliefs of powerful groups that lead to labelling, stereotyping, setting apart, devaluing, and discriminating, or it must change circumstances so as to limit to power of such groups to make their cognitions the dominant ones" (Link & Phelan, 2001, p.381). These authors suggest that circumscribed interventions that target only one mechanism at a time are unlikely to bring about change because they fail to address broader contextual factors.

To consider what kinds of interventions may be effective for reducing stigma and discrimination against people who use drugs, we can consider the evidence from related fields including mental health and HIV/AIDS. The alcohol and other drugs field potentially has much to learn from evaluation of interventions in these fields. Like the stigma associated with problematic alcohol and other drug use, mental health-related stigma and HIV/AIDs-related stigma is widespread and has been shown to adversely impact on the lives of people living with these conditions. Moreover, the stigma associated with these conditions (like the stigma associated with problematic alcohol and other drug use) can impact on help-seeking, and treatment. In the mental health field, three general strategies have been identified to reduce stigma and discrimination: education, contact and protest (Corrigan, et al., 2001). Education involves "overcoming myths" and "replacing them with facts"; contact involves "introducing people with mental illnesses to the public or other people who may stigmatise" by sharing experiences in person or via media; and protest "aims to challenge inaccurate and negative representations" (Buechter, et al., 2013, p.2; see also Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012; Corrigan & Watson, 2007). These strategies have become known as Corrigan's principles of strategic stigma change and have been applied to fields outside of mental health, including HIV-related stigma (e.g. Rao, et al., 2012).

Corrigan et al. (2012) conducted a meta-analysis of strategies designed to change public stigma. In this analysis of 72 articles representing 79 independent studies, the authors found that both 'education' and 'contact' strategies effectively reduced stigma in both adults and young people. However contact was more effective than education for adults, and education was more effective than contact among young people. Importantly, they found that face-to-face contact (rather than contact mediated through video) had the largest effect. That said, while face-to-face contact had better effects, mediated contact was nonetheless effective and has much broader reach and greatly increases exposure (Corrigan, et al., 2012).

In the HIV/AIDS field, there have been a variety of strategies employed to address "actionable causes of stigma and discrimination" (Wariki, Nomura, Ota, Mori, & Shibuya, 2013) including behavioural, educational and social interventions which create awareness of what stigma is, how it is produced and its implications. Brown et al. (2003) conducted a review of 22 studies which tested the effectiveness of interventions to reduce HIV-related stigma among the general population, among health care workers, and within at-risk groups. These studies tested a range of interventions including information-based approaches, skills building, counselling approaches, and contact with the affected groups (many studies employed multi-intervention approaches across these four categories, based on the assumption that no one approach is sufficient). The authors found that most of the studies showed that information along with skills building is more effective for increasing knowledge and reducing stigmatising attitudes, as compared to information alone. Similarly, contact with people living with HIV was found to be a promising strategy for reducing stigma, but it is not sufficient without information approaches (Brown, et al., 2003). However, the authors concluded that while some interventions work to some extent in the short term, the long term impacts of many interventions are still unknown (Brown, et al., 2003). A more recent systematic review conducted to determine the effectiveness of HIV-related stigma-reducing interventions analysed the results of 19 studies (Sengupta, Banks, Jonas, Miles, & Smith, 2011). Of these 19 studies, 14 demonstrated statistically-significant effectiveness in reducing HIV-related stigma. However, only 2 of these 14 studies met an overall quality rating of 'good.' This highlights the ongoing need for good quality, methodologically rigorous evaluation of stigma-reducing interventions.

In both the HIV/AIDS and mental health fields, intervention designs have mainly been based on cognitive-behavioural and social-cognitive models, with a particular focus on education and contact strategies (Paterson, et al., 2007). Much of this research assumes that increased knowledge will reduce stigma. However, this individualistic focus has been critiqued by researchers who argue that more attention should be paid to the interplay of social and structural factors (Paterson, et al., 2007; Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005). It has been suggested that continuing to focus on the behaviour and attitudes of individuals "functions as a substitute for sustained organisational attention to the stigmatisation that is embedded in everyday institutional practices" (Paterson, et al., 2007, p.371). Moreover, the focus of much of the research to date has been on how stigma manifests and can be addressed in health care settings. Examination of how stigma might be addressed in other institutional settings (for example, education and criminal justice) is also required (Paterson, et al., 2007).

Mindful of this critique and with an awareness of the limitations of the extant literature, in the following sections we outline the literature on stigma-reducing interventions from the AOD field as well as the HIV and mental health fields.

Mass media interventions

Mass media interventions are communications designed to reach large numbers of people via print media, radio, cinema, mobile devices and Internet technologies, without being reliant on one-to-one personal contact. Government or community groups and other organisations may use such interventions. They can vary in their intensity, and may be targeted at a specific time or run over a longer period (Clement, et al., 2013). Such mass media or social marketing campaigns can potentially influence not only individuals but also communities and policy makers (Clement, et al., 2013). It is important to note that our discussion here focuses on mass media campaigns designed to reduce stigma and discrimination, and not mass media campaigns aimed at preventing drug use per se. A systematic review of the effectiveness of drug prevention mass media campaigns (in this review termed 'anti-illicit drug public service announcements') by Werb et al. (2011) concluded that there was limited evidence to support the use of mass media campaigns for illicit drug prevention and that such campaigns were ineffective. A recent study

examined what people who had used methamphetamine themselves thought about two well-known anti-methamphetamine campaigns: *Faces of Meth* and *The Meth Project*. Participants said they could not relate to the depictions of physical and behavioural change in the campaign, and that they had not had a deterrent effect (Marsh, Copes, & Linnemann, 2017). Such campaigns aim to stigmatise drug use and create fear so as to deter drug use, and yet they are ineffective and lead to further separation and stigmatisation of people who use drugs. Extreme and stigmatising depictions in such campaigns may prevent people from seeking help because they do not identify with the depictions of "'real' addicts" (Marsh, et al., 2017, p.60).

There is a separate body of literature examining the effectiveness of stigma-reducing mass media campaigns, however. There has been one comprehensive systematic review of the effectiveness of mass media interventions for reducing mental-health related stigma (Clement, et al., 2013). This review of 22 randomised controlled trials (RCTs), cluster RCTs and interrupted time series studies of mass media interventions examined the findings of these studies in relation to discrimination outcomes and prejudice outcomes. The findings of these studies were mixed, and the quality of the evidence was low. The authors concluded that mass media interventions "may reduce prejudice, but there is insufficient evidence to determine their effects on discrimination" (Clement, et al., 2013, p.2). (None of the studies addressed the question of the cost-effectiveness of these interventions). The authors suggested that particular kinds of messaging in mass media campaigns may be more effective than others. For example 'first-person narratives' and social inclusion/human rights messages show some promise, however messages depicting acute symptoms may increase prejudice and therefore should be avoided.

Mass media interventions can also have diverse effects. For example, in the HIV field it has been found that mass media interventions aimed at reducing HIV-related risk behaviours had the dual effect of also reducing stigma by increasing knowledge (Kerr, et al., 2015). This is because knowledge is an "antecedent to stigma reduction" (Kerr, et al., 2015, p.154). This same study indicated that education programs delivered in the regions where mass media interventions were also being broadcast were more effective, suggesting that mass media interventions can augment the effectiveness of other educational interventions when delivered concurrently (Kerr, et al., 2015).

Another mode of intervention within mass media is through the implementation and monitoring of journalistic and broadcast Codes of Practice, ensuring that any clauses relating to discrimination within these codes relate to alcohol and drugs (UKDPC, 2010). We could not locate any evidence of the impact or effectiveness of these Codes of practice for stigma-reduction.

Educational and school-based interventions

Schachter et al. (2008) conducted a systematic review of the effects of school-based interventions on mental health-related stigma. Their analysis of 40 evaluation studies was limited by the overall poor quality of the studies and the lack of RCTs which meant that they were unable draw conclusions about which interventions were more effective. However, they suggested that interventions "should likely involve experiential activities, which in facilitating students' interaction with other human beings, engage students' feelings and behaviour, not just cognition-based points of view" and noted that "given how early in life discriminatory viewpoints and behaviours can appear, early intervention is a reasonable aim" (Schachter, et al., 2008).

Focussing on educational interventions aimed at young people, Yamaguchi et al. (2011) analysed 40 studies involving three types of educational interventions (educational condition, video-based contact condition, and contact condition). They found some positive effect on knowledge, changes in attitude, and young people's awareness of mental illness, however the majority of

studies did not measure behaviour change. These authors concluded that educational programs should have information that can address beliefs about the dangerousness of people with mental health problems, and include components which balance information about both psychological and biological causes of mental illness. However the long term effects of interventions on discriminative behaviour and help-seeking is unknown.

In another field, there has also been examination of how interventions may reduce ethnic prejudice and promote diversity among young people (Keenan, Connolly, & Stevenson, 2016). Keenan et al. (2016) describe types of approaches: cognitive development approaches; socio-emotional development approaches; social-learning approaches; awareness-raising approaches; and anti-bias approaches. These different types of approaches emphasise different explanations for patterns of stigma and prejudice in young people: internal processes (cognitive); external factors through inter-personal interactions (social learning); and locating the acquisition of prejudice within broader structural and sociological factors (ecological) (Keenan, et al., 2016).

One key point, which can be taken from the literature on ethnic prejudice, is that challenging existing stereotypes and discriminatory behaviour is only one aspect of reducing stigma. It is also important to understand and work to address wider, ingrained institutional processes and practices that reinforce inequalities (Keenan, et al., 2016).

Community-based interventions

Community-based interventions have been designed to reduce stigma amongst the community closest to people affected by stigma and discrimination, for example amongst close family members. In the HIV field, one such intervention involved a two-day workshop firstly with people living with HIV, followed by a three-day workshop involving both people living with HIV and their family members together (Pretorius, Greeff, Freeks, & Kruger, 2016). The aim was to increase knowledge, and equalise the relationship between people living with HIV and their families so as to reduce stigma and discrimination. This intervention assessed the outcomes using qualitative measures, and found that people living with HIV reported feeling accepted and respected following the intervention, and family members reported being aware of stigmatising behaviour and showed more compassion (Pretorius, et al., 2016). Another similar community-based stigma-reduction and wellness-enhancement intervention consisted of a two-day workshop initially only with people living with HIV, followed by six 3-day workshops involving both people living with HIV as well as people living close to them, in the form of small group activities and presentations (French, Greeff, Watson, & Doak, 2015). The workshops aimed to share information about HIV, balance relationships between people living with HIV and other people in their community through contact and interactions, and empower participants to become community leaders who challenged HIV-related stigma and implemented programs in their communities. Again, this intervention was assessed qualitatively, and the authors found that this kind of intervention succeeded in reducing experiences of stigma for people living with HIV and changed the attitudes of people living close to them (French, et al., 2015).

Interventions for health professionals and service providers

Educational interventions can also be targeted at particular groups or professionals likely to come into contact with people who use alcohol or other drugs. Studies have noted that the lack of education about alcohol and other drug use in professional education and training courses for health care workers is a concern (Harling & Turner, 2012). It has been suggested that deficits in knowledge may contribute to stigmatising attitudes and reluctance to engage with people who use drugs. However, studies examining the effects of curriculum based interventions with health care students find moderate effects. In one study students continued to hold stigmatising attitudes towards people with substance use disorders, and also reported that they thought that

these attitudes were commonly held by other health care workers and would not influence the quality of care they could offer (Crapanzano, Vath, & Fisher, 2014). Thus, it has been found that workplace education without organisational support is ineffective for improving the attitudes of qualified nurses (Harling & Turner, 2012). Indeed, identifying the structural factors behind stigmatisation in health care settings is essential. One study in the AOD field sought to identify the structural factors specific to hospitals which contribute to the stigmatisation of people who use drugs and are HCV positive (Paterson, Hirsch, & Andres, 2013). Paterson et al. (2013, p.471) describe structural stigmatisation as "the structures (e.g. policies, practices, rules, norms) of institutions or departments that intentionally restrict the access of care of particular people." Paterson et al. (2013) found that communication structures, departmental and institutional structures (including triage systems and lack of privacy in physical spaces within emergency departments), as well as external structures in the hospital settings and emergency departments studied, contributed to the stigmatisation of people who use drugs. In terms of interventions, this research indicates that traditional educational strategies to reduce stigma in health care settings are unlikely to be effective when implemented alone, without an awareness of these structural issues and attempts to review commonly accepted practices (Paterson, et al., 2013).

Acceptance and Commitment Training (ACT) and multicultural training have also been trialled with alcohol and other drug counsellors (Hayes, et al., 2004). This approach addresses not so much a lack of knowledge or contact, but rather more ingrained and culturally conditioned biases. Hayes et al. (2004) compared the effectiveness of ACT and multicultural training with a biologically-oriented educational program and found that ACT and multicultural training changed stigmatising attitudes.

In the HIV field, it has been noted that the consequences of stigma are more severe when stigma emanates from people who are important in the lives of people living with HIV, and particularly the health care professionals tasked with their care and treatment (Varas-Díaz, et al., 2013). Stigma reduction interventions have been developed and trialled to improve service providers' knowledge about HIV/AIDS and willingness to treat people living with HIV/AIDS. Moving beyond passive forms of formal training and didactic formats, small group behavioural interventions have also been used which encourage participation, role-plays, group discussion and interaction (Wu, et al., 2008). When trialled in health care settings in China, Wu et al. (2008) found that participants engaged in this kind of participatory intervention reported stronger beliefs in protecting patient confidentiality and right to testing, reduced fear of people living with HIV, and better knowledge, as compared to the control group. A similar workshop-style intervention ('the SPACES intervention') was developed and trialled with medical students in Puerto Rico (Varas-Díaz, et al., 2013). This workshop intervention addressed knowledge of HIV stigma and its consequences, the role of negative emotions in HIV stigma, and behavioural skills for stigma-free interaction with people living with HIV. The results of the randomised controlled trial showed significantly lower stigma levels among students at follow-up, and the authors suggested that such an intervention should be incorporated into medical schools and training policies (Varas-Díaz, et al., 2013). In subsequent research, Varas-Díaz, et al.(2016) demonstrated the provision of information alone was insufficient and that the emotional dimension of this stigma-reduction intervention was a significant underlying mechanism of change.

The acceptability and feasibility of introducing a brief stigma-reducing intervention into nursing students' curriculum was trialled at a nursing college in India (Shah, Heylen, Srinivasan, Perumpil, & Ekstrand, 2014). This intervention was delivered in two sessions, one targeting instrumental stigma by building knowledge and the second targeting symbolic stigma and was co-facilitated by a person with lived experience of HIV. Shah et al. (2014) found that participants in the intervention group reported an increase in HIV-related knowledge and a reduction in misconceptions and stigmatising attitudes towards people living with HIV (however the

intervention had a greater effect on nursing students' willingness to perform low risk activities than those involving higher risk of infection, and it is not known what effect such an intervention would have over time). Interventions focussing on reducing HIV-related stigma amongst health professionals have also been successfully trialled in low-HIV prevalence settings (Lohiniva, et al., 2016).

While many stigma-reducing interventions have focussed on changing the attitudes and behaviour of health care workers at an individual level, others have also tried to address stigma and discrimination in health care settings at both interpersonal and structural levels (Li, Liang, Wu, Lin, & Guan, 2014). One such intervention did so by training respected service providers within hospital settings, with the aim that these individuals would then be influential among other health care workers. The authors found that this approach was effective, but also identified regional differences which means that attention should be paid to variation across sites when implementing interventions (Li, et al., 2014).

In the mental health field, attention has only recently turned to the attitudes of mental health professionals because the focus on stigma-reducing interventions has been more firmly focussed on changing attitudes of the public. However, mental health professionals can be perpetrators of stigma (Schulze, 2007). Schulze (2007) suggests that changing stigmatising professional behaviours that may stigmatise people with mental health issues can be accomplished by (1) increasing awareness of stigmatising aspects of clinical practice (e.g. being conscious of the power of diagnosis and labelling processes, rejecting negative outcome beliefs, and enhancing communication with clients), (2) meaningfully involving service users and family members, (3) taking on a public advocacy role in challenging stigma (and seeing this as part of the profession), (4) campaigning at a policy level for adequate clinical resources and research in the field, and (5) synthesising stigma-reducing interventions.

Given that stigma has been shown to occur widely in medical settings and given that it is a barrier to help-seeking and appropriate medical care for people who use drugs, it has been suggested that this group's health needs might be better addressed outside of medical settings. Research has shown that people who use drugs seek advice and help through informal and lay networks (Regen, et al., 2002). As such, it has been suggested that health workers should infiltrate peer networks and provide information and referrals (Regen, et al., 2002).

We are aware of one program currently running in Queensland which provides training with the aim of reducing stigma among health care workers, professionals and students. The 'Putting together the Puzzle' program was developed by the Australian Injecting and Illicit Drug Users League (AIVL) and is delivered in Queensland by QuIHN (Queensland's peer-based drug user organisation). Since 2014, this program has been delivered in a variety of settings including Australian Winter School Conference, different pharmacy groups, Probation and Parole, Department of Child Safety, as well as youth workers, nurses, GP's, community workers and with staff and volunteers at QuIHN and QuIVAA. An abridged version of the program has also been delivered to the Queensland Police Force as part of a more generalist AOD training session. There are also plans underway to deliver the training to the Pharmacy Guild and for NSP/OST pharmacists and pharmacy staff early next year. This program is designed to be delivered by people with lived experience of drug use (see AIVL, 2016). We are not aware of any plans to evaluate the effectiveness of the program in Queensland.

Interventions relating to treatment uptake

In the HIV field, barriers to HIV testing and HIV treatment have been studied, especially as they pertain to stigma. There may be useful lessons for AOD treatment uptake here, especially in relation to early intervention and the settings in which treatment takes place. In the HIV field,

there have been concerns that HIV-related stigma may be a barrier to testing, despite the increasing availability of testing and improvements in technologies (Crawford, et al., 2016). In order to remove barriers to HIV testing, pharmacy-based interventions using a comprehensive health framework that promoted testing of a range of chronic diseases as well as HIV were trialled. The intervention evaluated by Crawford et al. (2016) involved a computer-based video in which fictional and real-life HIV and chronic disease advocates were portrayed to (1) normalize HIV and HIV testing, (2) increase educational awareness about drug use, (3) destigmatize drug use by providing information on how HIV affects the entire community, not just the drug-using population, and (4) promote HIV testing and awareness of one's HIV status as part of general health awareness that also encompasses being aware of hypertensive, diabetic, and hypercholesterolemic status. Overall, Crawford et al. found that there was an increase in HIV testing among participants who viewed the computer-based intervention and were offered HIV testing packaged with other health screening tests, as opposed to being offered HIV testing alone. The authors suggested that combining testing for HIV with testing for other less stigmatised diseases may have normalised testing. For alcohol and other drugs, this suggests that interventions which holistically address health issues (rather than just screening for alcohol and other drug problems) and the use of a social cognitive model of intervention may be promising for reducing stigma.

Interventions have also been introduced which aim to reshape clients' experience of the clinic environment. While these interventions have been trialled in HIV clinics, such approaches may be of relevance to alcohol and other drug services as well given some of the similarities in settings and issues to be overcome. For example, Neema et al. (2012) describe sombre and busy services, with stressed staff and sometimes long waiting periods which mirrors the experiences documented in some Australian alcohol and other drug services as clients queue and wait to be seen (e.g. Crawford, 2013; Fraser, 2006). Neema et al. (2012) evaluated a 'Creativity Initiative' intervention which provided activities in the clinic while clients waited, with the aim of reducing the stigma felt by clients. This intervention was found to effectively reduce the fear and stigma experienced by clients, especially to fear of being 'seen' at the service, and improved communication at the service.

Interventions relating to internalised stigma

While many stigma-reducing interventions (including those described above) are largely targeted at public stigma, or reducing stigma and discrimination perpetrated by specific people such as health care workers, there have been fewer interventions developed which are aimed at addressing internalised stigma (that is, when individuals take on and endorse public stigma within themselves) (Rao, et al., 2012). Interventions which aim to address internalised stigma are important as internalised stigma can impact long term by increasing psychological distress and hinder help-seeking or medical care (Harper, Lemos, & Hosek, 2014). Moreover, it has been suggested that internalised stigma may be a more appropriate target for stigma-related intervention because it is associated with measures of functioning and quality of life (Luoma, et al., 2007).

Rao et al. (2012) adapted the HIV Stigma Toolkit (a participatory group format workshop program which has primarily used to reduce public stigma) to target internalised stigma for African American women living with HIV. Rao et al. (2012) found that the intervention was feasible and acceptable to the target group, helped the women to foster social support, and was effective for reducing internalised stigma. Another intervention was aimed at decreasing the impact of stigma on individuals and enabling coping by restructuring erroneous beliefs about perceptions of enacted stigma and increasing self-esteem (Fuster-Ruizdeapodaca, Molero, & Ubillos, 2016). The program combined educational information with cognitive-behavioural techniques over four 4-hour sessions. The intervention was found to increase perceptions of

self-efficacy to cope with stigma, decrease avoidance strategies and improve self-esteem and quality of life (Fuster-Ruizdeapodaca, et al., 2016). Harper et al. (2014) evaluated the impact of a group-based intervention which was aimed at young people newly diagnosed with HIV, which aimed to address personalised stigma, disclosure concerns, negative self-image, and concern with public attitudes. This intervention was based on a model developed in the disability field which incorporated skills-building activities guided by social cognitive theory. The program was found to produce small overall reductions in personalised stigma, disclosure concerns and negative self-image (however these reductions were not maintained at 3 month follow up for personalised stigma or disclosure concerns) (Harper, et al., 2014).

Considerations of co-stigma

As noted above, particular health conditions (such as HCV and HIV/AIDS) come to be inextricably associated with (and as such bear the stigma of) illicit drug use. This suggests that interventions which seek to reduce the stigma associated with drug use ought to not only be directed towards drug and alcohol workers but also other health care providers in other fields (Chan, et al., 2008). As Chan et al. (2008) argue "since the stigmatisation of [people living with HIV/AIDS] can largely be traced back to the stigmatisation of high risk behaviours including drug use, it seems logical that reducing the stigma of those behaviours would be crucial to lowering the stigma of [people living with HIV/AIDS]."

While most interventions aimed at reducing stigma have focussed on individual factors which contribute to stigma, an increased awareness of intersectionality ("the ways in which social identities (e.g. ethnoracial identity, gender, sexuality) converge to produce unique forms of marginalisation": Loutfy, et al., 2015, p.2) means that interventions ought to be designed to address these intersecting forms of marginalisation and intersectional stigma.

Involving the affected community in policy and practice

Another aspect to be considered is how people who use alcohol and other drugs may be meaningfully included in policy and practice. In other areas of public health it has been argued that including marginalised individuals in the policy-making process is one way of seeking to alleviate or minimise stigma and discrimination (Gollust, Apse, Fuller, Miller, & Biesecker, 2005). Including the voices of the affected community in decision-making is regarded as an important ethical consideration in other policy domains (Childress, et al., 2002). Meaningfully involving the community most directly affected by particular policies and practices can help challenge discriminatory or uninformed opinions (Childress, et al., 2002; Gollust, et al., 2005; Lancaster, Ritter, & Stafford, 2013; Lancaster, Sutherland, & Ritter, 2014).

The notion of consumer participation at the service level in the Australian drug treatment sector has been explored within the Australian drug sector, and barriers to meaningful involvement are continually documented (AIVL, 2008, 2011a; Rance & Treloar, 2015; Treloar, Fraser, & valentine, 2007; Treloar, Rance, Madden, & Liebelt, 2011). The Treatment Service Users Project developed and evaluated practical models for consumer participation in different drug treatment contexts (including pharmacotherapy, residential rehabilitation and inpatient detoxification settings), and provided education and training to build consumer participation capacity and skills (AIVL, 2011a). The final report identified increasing awareness and understanding of consumer participation, making consumer participation 'core business' for treatment services, developing a stronger theoretical basis for consumer participation in drug treatment services, understanding power and empowerment in the drug treatment context, and engaging drug user organisations in consumer participation, as the key priority areas in all Australian treatment services (AIVL, 2011a). Analysis of another NSW-based consumer participation project introduced within drug treatment services found that both clients and staff described decreases in adversarial

relationships through the program. Significantly, service users said that the opportunity to 'have a voice' and be heard disrupted the routine dehumanisation that consistently characterised their usual experience in treatment spaces (Rance & Treloar, 2015).

Changing cultural constructions

In the long term, changing cultural constructions of stigmatised groups is essential for reducing the political and structural stigmas that have negative health consequences (Clair, Daniel, & Lamont, 2016). Stigmatising cultural constructions also serve to legitimate laws and policies which exclude and discriminate against particular groups (either intentionally or unintentionally). Redefining stigmatised groups can improve beliefs and attitudes, increase positive interactions which lead to increases in resources and opportunities, and convey norms which in turn structure behaviours (Clair, et al., 2016). While much intervention research has focussed on how to reduce stigma at the individual level, developing interventions which reshape cultural constructions that manifest in institutions and norms is an important endeavour (Clair, et al., 2016). For governments, this might include systematically evaluating how policies can be changed to produce equivalence and contribute to destigmatisation. Other central institutional actors (such as legal experts, social scientists and the media) could also be enjoined to foster social conditions which contribute to the making of new cultural constructions of stigmatised groups (Clair, et al., 2016).

Another aspect related to changing cultural constructions is challenging, or reshaping, how the problem of alcohol and other drugs is understood within society. Research has examined whether portraying stigmatised conditions like alcohol and other drug problems as *treatable* health conditions might improve public attitudes towards people living with these stigmatised conditions. One study found that portrayals of untreated and symptomatic conditions increased negative public attitudes, whereas portrayals of successfully treated conditions led to less desire for social distance, greater belief in the effectiveness of treatment and less willingness to discriminate against people living with these conditions, suggesting that this is a promising strategy to reduce stigma and discrimination and improve public perceptions (McGinty, Goldman, Pescosolido, & Barry, 2015). In recent years, an Australian website 'Lives of Substance' (http://www.livesofsubstance.org/) has been developed by researchers with the aim of informing the public by sharing personal stories of people who consider themselves to be alcohol or drug dependent. The aim of this website is to challenge media stereotypes, open up public discussion of AOD problems, and counter stigmatising misconceptions.

The use of person-centred language is another way that communication about drug use can be destigmatised. Research shows that language can shape how the public thinks about substance use and recovery, and perpetuate stigma (Broyles, et al., 2014). The US Office of National Drug Control Policy (2017) under the Obama Administration issued a memorandum to all government departments and agencies about changing the use of terminology regarding substance use and substance use disorders in all government communication. According to this memorandum, all internal and public government communication about drug issues should conform with current medical terminology (rather than using terms like 'drug habit' or 'abuse' which research shows negatively shape public perceptions about drug use, and construct the person as being to blame for their problems), and similarly, use person-first or person-centred language when discussing people experiencing AOD problems (as we have also done throughout this report) to respect the dignity and worth of all people, rather than using stigmatising terms such as 'addict' or 'alcoholic' which depersonalise and disgrace individuals (Broyles, et al., 2014; Office of National Drug Control Policy, 2017).

Conclusion

While much of the intervention literature has focussed on changing the attitudes and behaviours of individuals, the literature also shows that in order to bring about meaningful change structural factors must also be understood and addressed (Paterson, et al., 2013). Link and Phelan's (2001) definition of stigma (discussed at the opening of this literature review) is important to keep in mind. By bringing together both sociocognitive and structural elements, this framework emphasises the need for interventions to incorporate both sociocognitive and structural approaches recognising that social, political and economic power inequalities perpetuate stigma (Misir, 2015).

4. LEGISLATION REVIEW

There are an extremely broad range of possible laws that may impact on experiences of stigma and discrimination. This includes but is not limited to international and interstate legislation directly relating to drug laws (such as laws that prohibit the possession of specific substances), but also a plethora of other intersecting domains which affect people's lives including health, employment, family law, housing etc. In earlier work we (KS) comprehensively mapped all statutes in Australia that incorporate reference to alcohol and other drug (AOD) 'intoxication' (see: Quilter, McNamara, Seear, & Room, 2016a; Quilter, McNamara, Seear, & Room, 2016b). That earlier research identified over 500 provisions across Australia which deal with 'intoxication' either directly or indirectly (Quilter, et al., 2016a). Even this vast body of law only relates to 'intoxication' and does not capture the many other ways in which AOD use might feature in legislation; nor other (perhaps seemingly unrelated) laws that potentially contribute to stigma and discrimination for people with AOD dependence or problematic use. Moreover, it is not enough to merely identify legislation that pertains to AOD. Legislation needs to be operationalised and it is in this process of moving from 'law on the books' to the *law as interpreted and implemented in practice* that stigma and discrimination can occur in both anticipated and unanticipated ways, impacting either directly or indirectly in people's lives. Our previous work (KS) has demonstrated the way that the minutiae of legal practices, rules and processes, definitions and language can enable the production and entrenchment of certain stereotypes about people who use drugs, and how these processes may be linked to both stigma and discrimination (Seear, 2015).

The approach we used was designed to capture, first, the full range of provisions that deal with AOD in Queensland; and second, to explore how these provisions might be linked to people's experiences of stigma and/or discrimination, through a focus on what we call the 'stigmatising and/or discriminatory potential' of law. This was established through a three-step methodology (see the methods section of this report).

4.1 Mapping AOD under Queensland law

In Step 1 of the research (the mapping exercise), we located a total of 222 provisions that we determined were in some way relevant to AOD in Queensland. These provisions were then sorted into two categories: 'principal' provisions (which had substantive content pertaining to AOD) and 'auxiliary' provisions (linked provisions that contained only procedural content or other protections). An example of each appears in Table 1, below. In this instance, as we can see section 68 of the *Health Ombudsman Act 2013* provides the health ombudsman with the ability to make an order prohibiting a practitioner from practising in certain circumstances (an example of a 'principal' provision). On the other hand, section 69 allows the practitioner to make a submission in their defence (an 'auxiliary' provision).

Table 1: Sample of 'auxiliary' and 'principal' provisions coded under coding schedule in Appendix A

Principal provision	s68	Provides for the health ombudsman to issue an initial prohibition order if a practitioner is practising their profession unsafely, incompetently or while intoxicated by alcohol or drugs
Auxiliary provision	s69	Provides that a practitioner can make submission in their defence as outlined above.

4.2 Establishing the different areas of law in which AOD is relevant

Each provision was assigned a general focus area (in accordance with Step 2, see method section), which identified 11 relevant areas of law:

- Child protection;
- Civil Liability;
- Corrections;
- Criminal Procedure[2];
- Substantive criminal law;
- Employment law/professional regulation;
- Public health;
- Public order;
- Purchase and sale of goods;
- Residential tenancy; and
- Wills and estates.

Table 2 contains an example of a provision for each of these 11 areas of law.

Table 2: Sample provisions for each area of law

Area/s of law	Section and Law	Example provision
Child Protection	Section 95 of the Child Protection Act 1999	(For the purposes of child protection): (8) Also, the police commissioner may give the chief executive a copy of, or extract from, the police commissioner's records in relation to— (a) the commission or alleged commission of the following offences by the person— (i) a personal offence against anyone; (ii) an offence against the Drugs Misuse Act 1986 ; (iii) an offence against section 162, 164, 166, 167 or 168; or (b) an application for a protection order under the Domestic and Family Violence Protection Act 2012 in which the person is an aggrieved or respondent under that Act.
Civil liability	Section 41 of the Civil	The protection from personal liability conferred on a volunteer by this subdivision in connection with any

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[2] Criminal procedure relates to the conduct of criminal proceedings in court (e.g. processes relating to complaints, summonses, and warrants; evidence, witnesses, remands/adjournments etc.) and is distinguished from substantive criminal law.

Area/s of law	Section and Law	Example provision
	Liability Act 2003	community work does not apply if the volunteer— (a) was intoxicated when doing the work; and (b) failed to exercise due care and skill when doing the work.
Corrections	Section 6 of the Corrective Services Regulation 2006	Each of the following acts or omissions if committed by a prisoner is a breach of discipline— […] wilfully consuming or inhaling something likely to induce an intoxicated state, other than medication taken as prescribed by a doctor.
Criminal procedure	Section 423 of the Police Powers And Responsibilities Act 2000	(1) This section applies if a police officer wants to question or to continue to question a relevant person who is apparently under the influence of liquor or a drug. (2) The police officer must delay the questioning until the police officer is reasonably satisfied the influence of the liquor or drug no longer affects the person's ability to understand his or her rights and to decide whether or not to answer questions.
Substantive Criminal law	Section 9A of the Drugs Misuse Act 1986	(1) A person who unlawfully possesses a relevant substance or thing commits a crime. Maximum penalty—15 years imprisonment. (1A) It is a defence to a charge of an offence against subsection (1) for a person to prove that the person has a reasonable excuse for possessing the relevant substance or thing. (2) In this section— relevant substance or thing means— (a) a substance that is, or contains, a controlled substance and the gross weight of the relevant substance is of, or exceeds, the gross weight specified in the Drugs Misuse Regulation 1987, schedule 8A in respect of the relevant substance; or (b) substances that together are, or contain, a controlled substance and the total gross weight of the relevant substances is of, or exceeds, the total of the gross weights specified in the Drugs Misuse Regulation 1987, schedule 8A in respect of the relevant substances; or

Area/s of law	Section and Law	Example provision
		(c) a thing specified in the Drugs Misuse Regulation 1987, schedule 8B.
Employment law and professional regulation	Section 84 of the Mining and Quarrying Safety Regulation 2001	(1) A person must not carry out operations at a mine, or enter an operating part of a mine, if the person is under the influence of alcohol, or is impaired by a drug, to the extent the alcohol or drug impairs, or could impair, the person's ability to safely carry out the person's duties at the mine. (2) A person must not consume alcohol at a mine other than in— (a) an accommodation facility; or (b) a recreation area designated, in writing, by the site senior executive for the purpose under a written procedure for designating the area.
Public health	Section 70 of the Public Health Act	(1) A doctor must, under subsection (2), notify the chief executive if an examination of a person by the doctor indicates that the person— (a) has or had a clinical diagnosis notifiable condition; or (b) has or had a provisional diagnosis notifiable condition. Maximum penalty—20 penalty units. (2) The notice must— (a) comply with the requirements prescribed under a regulation; and (b) be in the approved form. (3) Subsection (1) does not apply if the examination was carried out in a hospital.
Public order	Section 188 of the Transport Operations (Marine Safety) Act 1994	(1) In this section— *master* includes a person authorised by the master. (2) A ship's master may refuse to allow a person to board a ship if the master is of the opinion, on reasonable grounds, that the person may annoy or injure other persons on the ship because of the person's intoxicated condition or disorderly or violent behaviour. (3) A ship's master may refuse to allow a person to board a

Area/s of law	Section and Law	Example provision
		ship for another reasonable reason (including, for example, that the ship was full). **(4)** A ship's master may ask a person to leave the ship at a convenient port if the master is of the opinion, on reasonable grounds, that the person is likely to annoy or injure, or further annoy or injure, persons on the ship because of the person's intoxicated condition or disorderly or violent behaviour.
Purchase of sale and goods	Section 156 of the Liquor Act 1992	(1) A person must not, on premises to which a licence or permit relates— (a) supply liquor to; or (b) permit or allow liquor to be supplied to; or (c) allow liquor to be consumed by; a person who— (d) is a minor; or (e) is unduly intoxicated or disorderly. (2) A person must not, on a street or place adjacent to premises to which a licence or permit relates, or in a public place supply liquor, or cause or permit liquor to be supplied, to a minor. (3) A person must not send, or cause or permit to be sent, to premises to which a licence or permit relates a minor with a view to the minor or another person being supplied with liquor . Maximum penalty for subsections (1) to (3)— (a) for an offence committed by the licensee or permittee of, or an approved manager working at, the premises— (i) if the person to whom the offence relates is a minor—250 penalty units; or (ii) if the person to whom the offence relates is unduly intoxicated or disorderly—500 penalty units; or (b) for an offence committed other than by the licensee or permittee of, or an approved manager working at, the premises— (i) if the person to whom the offence relates is a minor—80 penalty units; or

Area/s of law	Section and Law	Example provision
		(ii) if the person to whom the offence relates is unduly intoxicated or disorderly—80 penalty units.
		(4) Subsection (2) does not apply to the supply of liquor to a minor in a public place, designated under section 173C, if the minor is accompanied by a responsible adult who is responsibly supervising the minor.
Residential tenancy	Section 268 of the Residential Tenancies and Rooming Accommodation Act 2008	(1) A provider may make house rules for rental premises about any of the following matters— (a) using shared facilities; (b) parking motor vehicles; (c) drinking alcohol or illegally consuming other drugs; (d) smoking; (e) making noise; (f) keeping pets; (g) guests; (h) another matter prescribed under a regulation. (2) A rule made under subsection (1) has effect as a house rule for the rental premises only if— (a) it is consistent with— (i) the prescribed rules; and (ii) the provider's obligations and the resident's rights under this Act; and (b) the rule is made under division 2. (3) Subsection (2)(b) does not apply to the making of a rule when there are no residents for the rental premises. (4) A provider must not make a rule about a matter not provided for under subsection (1). Maximum penalty for subsection (4)—20 penalty units.
Wills and Estates	Section 65 of the Public Trustee Act 1978	(1) Where, upon the application of the public trustee, the court is satisfied that a person who is under 18 years— (a) by reason of age, disease, illness, or physical or mental infirmity or of the person's taking or using in excess alcoholic liquors, or any intoxicating, stimulating, narcotic, sedative or other drug is, either continuously or intermittently— (i) unable, wholly or partially, to manage the person's affairs; or

Area/s of law	Section and Law	Example provision
		(ii) subject to, or liable to be subjected to, undue influence in respect of the person's estate, or any part thereof, or the disposition thereof; or
		(b) is otherwise in a position which in the opinion of the court renders it necessary in the interest of that person or of those dependent upon the person that the person's property should be protected;
		the court may make a protection order appointing the public trustee manager to take possession of and to control and manage all or such part or parts as the court directs of the estate of that person.
		(2) Notice of every application under this section shall be served upon the person whose property is sought to be protected, unless the court in any special case otherwise directs.
		(3) Upon such an application the court may receive in evidence a report by the public trustee and may have regard to the matters contained therein (including any medical or other reports incorporated therein).

We then undertook a basic analysis of the frequency for area of law. Table 3 contains a summary of these data. Our analysis suggests that the most common areas of law are: substantive criminal law (33.78%), employment law and professional regulation (20.72%) and public health (17.12%).

Importantly, a number of provisions could have been coded in more than one area of law. A number of provisions that were substantive criminal offences (i.e. substantive criminal law) pertained to the maintenance of public order. Although public order is the fifth most frequent category, when these overlaps are taken into account, it becomes the fourth most frequent category, above criminal procedure.

Table 3: Analysis of frequency of areas of law

Area of law	Total Number of provisions	Total as %
Child Protection	1	0.45
Civil liability	6	2.70
Corrections	2	0.90
Criminal procedure	22	9.91
Employment law and professional regulation	46	20.72
Public health	38	17.12
Public order	14	6.31
Purchase of sale and goods	6	2.70
Residential tenancy	5	2.25
Substantive criminal law	75	33.78
Wills and Estates	7	3.15

NB: total may not add to 100%.

4.3 Analysing the relationship between law and stigma

We then undertook a further analysis using the coding schedule we developed (see methods section Step 3, and Appendix A), to examine the *stigmatising potential* of each provision. As noted in the methods section earlier, the approach we developed and used here requires some more detailed explanation.

In a paper on mental health law in the United States, Corrigan et al. (2005) sought to explore the relationship between legislation pertaining to people experiencing mental illness and structural stigma or discrimination. They define structural discrimination as 'formed by sociopolitical forces and represents the policies of private and governmental institutions that restrict the opportunities of stigmatized groups' (Corrigan, et al., 2005, p.557). Their research aimed to isolate, in the first instance, all 'legislative activities' (a slightly wider category of interest which included bills introduced into parliament) related to mental illness in the United States in the year 2002 (a process similar to our mapping exercise, described above). In the second instance, using a comprehensive coding schedule designed to assess the extent to which those legislative activities were stigmatising, they analysed and coded all legislative activities. They then drew a set of conclusions about the relationship between law and stigma. Their research used a combination of methods (collection and analysis of laws and focus group interviews) through which they devised an approach in which bills were characterised in one of three ways:

> […] those that expand or contract liberties (the intent or goal of a bill is to deal with procedural or substantive rights of persons with mental illness with respect to refusing

treatment or restrictions on physical liberty), those that expand or contract protections against discrimination (the bill deals with protections for people with mental illness in terms of housing, employment, or other benefits or services), and those that expand or contract privacy (bills that deal with privacy or confidentiality for persons with mental illness). (Corrigan, et al., 2005, p.558)

Importantly, 'the target of bills related to liberties or discrimination protections was [also] coded in terms of whether the bill referred to people with a diagnosis of a mental illness or to people who were disabled or incompetent' (2005: 558). In this study, Corrigan et al. (2005, p.558) note that their intention was not to establish what 'the actual or practical effect of the legislation once implemented' was. Instead, the focus was on the 'intended effect' of legislation. We suggest this is an important and complementary approach to those of Burris (2006) and Bacchi (2009), in that it encourages a focus on the subjects (e.g. 'the mentally ill') of legislation, thus revealing, in the process, potential assumptions regarding the nature of problems and problem cohorts and the ways to solve those problems.

Corrigan et al. assume that law should offer protections to people who experience mental illness wheresoever they are targeted. In the context of laws that target varied aspects of AOD use, this might seem controversial. It might be argued, for instance, that it is not the *targets* of those laws who require protection, but the many others who may be impacted by AOD use and AOD-related harms. How governments approach these issues depends in part on the extent to which they subscribe to Burris' (2006) view, on the merits of stigmatising individuals, activities, behaviours and practices through law, and also how governments approach the task of balancing these competing considerations. Quite often, in any event, legislative systems provide overarching protections for both targeted populations/ individuals and for others. There are many ways that laws offer such protections. In both the United States (where Corrigan et al. 2005 were working) and Australia, there are overarching legislative protections provided to individuals in the form of anti-discrimination laws. In a simple sense, anti-discrimination legislation is designed to provide a form of 'check and balance' against the potential exercise of power over individuals on the basis of identified attributes (e.g. sexuality and race). There are also two Australian jurisdictions (the Australian Capital Territory and Victoria), in which human rights acts have been implemented.[3] These acts seek to provide broad, overarching human rights protections to individuals in certain circumstances, including, in particular, where so-called 'public authorities' (such as the police) make decisions that impact upon them. In this sense, human rights laws are intended to act as a 'backstop' – or a check and balance – against infringements of certain basic rights and the use of excessive power by public authorities.

Of course, the provision of legal rights and protections is often a balancing act (between different rights or perceived rights, for example). In general terms, and wherever possible, however, the potential for law to stigmatise and/or discriminate against people who use AOD will be reduced where such law offers protections to those whose practices, activities and behaviours are the targets of that law and where there are clear principles and guidelines pertaining to the enforcement of those laws.

We take as valuable Corrigan et al.'s focus on targeted populations and protections. As outlined in the methods section earlier, we thus adopted aspects of the Corrigan et al. approach and combined them with aspects of a methodology designed to map and analyse Australian laws dealing with intoxication (Quilter, et al., 2016a, 2016b). Quilter et al.'s work examined how

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[3] These are the *Human Rights Act 2004* (ACT) and the *Charter of Human Rights and Responsibilities Act 2006* (VIC), respectively.

Australian criminal law attached significance to the fact of 'intoxication'. As we noted earlier, their research identified more than 500 provisions across Australia which deal with 'intoxication' either directly or indirectly (Quilter, et al., 2016a). Although the nature and meaning of 'intoxication' might be thought to be self-evident, (Quilter, et al., 2016a) argued the use and significance of 'intoxication' in the criminal law changed over time, becoming wider and more complex, and extending to a range of different drugs. It was important, in this sense, to consider not only how and why the criminal law attached significance to 'intoxication', but whether the law defined 'intoxication', how it defined it, what approaches were used to its definition (i.e. was a biological detection test required, or something else?), and what the implications of defining and not defining intoxication might be. They found that 41 per cent of provisions examined contain no definition or a limited definition of intoxication, that statutory language lacked precision and was often inconsistent. They concluded that:

> […] where criminal punishment or the deployment of coercive state powers is a consequence of the label 'intoxicated' being applied, it is reasonable to expect that the line of demarcation should be drawn with clarity. Indeed, it might be expected that the proliferation of statutes that attach significance to intoxication might be associated with a trend towards greater specificity as to the *meaning* of intoxication. To the contrary, our analysis shows that: under-definition is widespread; there is considerable variation both within jurisdictions and nationally as to how intoxication is defined; and the language used to define and describe intoxication is frequently ambiguous, leaving considerable scope for subjective assessments to be made by persons in authority. (Quilter, et al., 2016a).

Importantly, Quilter, et al., 2016a acknowledged that ambiguity and flexibility might on occasion be appropriate (where the appearance of 'intoxication' in legislation is designed to protect intoxicated persons – as with provisions that prevent police from questioning intoxicated persons, for instance). Before such conclusions can be drawn, however, it is important to assess what the targeted activity or behaviour is (e.g. intoxication), whether it is defined (and how), and the purpose of the provision (e.g. to protect intoxicated persons from the exercise of a coercive power). We took the view that this method aligned with and built upon that of Corrigan et al., noted earlier, and added it to the methodology we ultimately utilised.

The coding schedule we developed sought to establish: (1) what kinds of practices, activities or behaviours were targeted in Queensland law; (2) whether and in what ways those targeted practices, activities or behaviours were defined; (3) who had the capacity to make determinations or exercise powers pertaining to the targeted practices, activities or behaviours; (4) what the decision-maker or authority identified at step 3 is able to do; (5) whether the law offers protections to those individuals whose practices, activities or behaviours are the targets of law; and (6) whether those laws offer protections to others. This approach allows for a rich and thick description of each provision and allows for an analysis, among other things, of whether targeted behaviours are arbitrarily or ill-defined in law, whether there are clear requirements for the exercise of power in relation to AOD, and whether the law provides (or is intended to provide) protections to the targets of the law. Read together, these results can tell us a great deal about the *stigmatising and/or discriminatory potential* of law, by which we mean: the enabling conditions for the manifestation of stigma and/or discriminatory practices. We suggest that the stigmatising potential of law is increased wherever the law isolates certain individuals, practices, activities and behaviours associated with AOD, enabling key stakeholders to exercise power and authority over them (including in ways that are potentially arbitrary or insufficiently defined), without sufficient protections for the target. Importantly, even where law has stigmatising potential, it may be that that potential can be justified on public policy grounds (e.g. because of significant risk to the public).

The coding schedule in Appendix A was applied to all provisions we identified. Table 4 contains an example of how the coding schedule was applied against a provision from each of the 11 focus areas detailed in Table 2, above. For ease of reference, we use the same provisions that were listed in Table 2.

Table 4: Sample provisions coded using coding schedule in Appendix A

Area of law	Section and Law	Summary of the provision	What (or who) is the target of the law?	Is the target defined?	How is the target defined?	Who is the decision-maker/ authority?	What can the decision maker or authority do?	Protections for target?	Protections for others?
Child Protection	Section 95 of the Child Protection Act 1999	Allows the police commissioner to disclose criminal history to the chief executive of CPS for a report or recommendation made to the Children's Court. In particular allows disclosure for any offence made under the *Drugs Misuse Act 1986* (QLD)	Parent who has a child which authorities believe is in need of protection	Yes, somewhat	Parent is defined in s11 as encompassing many kinds of relationships. Section 11 defines "child in need of protection" as one who (a) has suffered significant harm, is suffering significant harm, or is at unacceptable risk of suffering significant harm; and (b) does not have a parent able and willing to protect the child from the harm.	Chief executive or Court	Decides whether it require the information and the significance of the information on any order.	It is up to the discretion of the chief executive and the court as to whether the information is required.	Designed to protect the child at risk.
Civil liability	Section 41 of the Civil Liability Act 2003	Provides *against* excluding civil liability of an intoxicated volunteer	An intoxicated volunteer	Yes	Dictionary - intoxicated, in relation to a person, means that the person is under the influence of alcohol or a drug to the extent that the person's capacity to exercise proper care and skill is impaired.	Judiciary	Decides whether the elements of negligence are met and the quantum of damages.	s41(b) states that the mere fact that a person is intoxicated isn't enough to expose them to personal liability; they need to have	Protects the general public from intoxicated volunteers.

Area of law	Section and Law	Summary of the provision	What (or who) is the target of the law?	Is the target defined?	How is the target defined?	Who is the decision-maker/ authority?	What can the decision maker or authority do?	Protections for target?	Protections for others?
								failed to exercise due care and skill when doing the work.	
Corrections	Section 6 of the Corrective Services Regulation 2006	Details what constitutes a breach of discipline under the Correction Services Act. A list of prohibited items is listed in s20 and includes drug, medicine, syringe or drug taking device.	A prisoner who possesses or conceals anything not allowed. The wilful consuming or inhaling some likely to cause intoxication. As well as possessing, taking, giving or administering medication without approval.	No	N/A	Corrections	Take disciplinary action against the prisoner / separate criminal offence / seizing property	Yes. Section 113 of the Corrective Services Act 2006 allows a discretion in applying discipline noting at s113(2) that: A corrective services officer need not start proceedings against a prisoner for a breach of discipline if the officer considers the proceedings should not be started having	Protects corrections from civil liability. Protects fellow prisoners from intoxicated fellow inmates.

Area of law	Section and Law	Summary of the provision	What (or who) is the target of the law?	Is the target defined?	How is the target defined?	Who is the decision-maker/ authority?	What can the decision maker or authority do?	Protections for target?	Protections for others?
								regard to— (a) the trivial nature of the breach; or (b) the circumstances surrounding the commission of the breach; or (c) the prisoner's previous conduct.	
Substantive Criminal law	Section 9A of the Drugs Misuse Act 1986	Provides an offence for possessing relevant substances or things	A person who unlawfully possesses a relevant substance or thing	No, but drug quantity defined	s9A(2) relevant substance or thing means— (a) a substance that is, or contains, a controlled substance and the gross weight of the relevant substance is of, or exceeds, the gross weight specified in the Drugs Misuse Regulation 1987, schedule 8A in respect of the relevant substance; or (b) substances that together are, or contain, a controlled substance and the total gross	Law Enforcement / Judiciary	Offence with up to 15 years imprisonment as penalty.	Standard criminal protections apply.	Protect the public from drug-related harm.

Area of law	Section and Law	Summary of the provision	What (or who) is the target of the law?	Is the target defined?	How is the target defined?	Who is the decision-maker/ authority?	What can the decision maker or authority do?	Protections for target?	Protections for others?
					weight of the relevant substances is of, or exceeds, the total of the gross weights specified in the Drugs Misuse Regulation 1987, schedule 8A in respect of the relevant substances; or (c) a thing specified in the Drugs Misuse Regulation 1987, schedule 8B.				
Employment law and professional regulation	Section 84 of the Mining and Quarrying Safety Regulation 2001	Prohibits somebody from carrying out operations at a mine, or enter an operating part of a mine, if the person is under the influence of alcohol, or is impaired by a drug, to the extent the alcohol or drug impairs, or could impair, the person's ability to safely carry out the	A person who is under the influence of alcohol, or is impaired by a drug, to the extent the alcohol or drug impairs, or could impair, the person's ability to safely carry out the person's duties at the mine.	No	N/A	Mining Operators	Prohibit someone from working	Standard employment protections	Protect workplace health and safety

Area of law	Section and Law	Summary of the provision	What (or who) is the target of the law?	Is the target defined?	How is the target defined?	Who is the decision-maker/ authority?	What can the decision maker or authority do?	Protections for target?	Protections for others?
		person's duties at the mine.							
Public health	s70	Provides that a doctor must notify the chief executive if after examining a person reaches a clinical diagnosis or a provisional diagnosis of a notifiable condition. Penalises non-compliance.	A person with a notifiable condition	Yes	Section 64 notes that a notifiable condition is one prescribed by Schedule 1 of Public Health Regulation 2005. See http://tinyurl.com/jxbp8y8	Doctor	Requires disclosure when reaching a diagnosis of a notifiable condition	Section 77 of the Act penalises the disclosure of confidential information except as provided by the Act.	Protect the public from transmissible disease.
Public order	Section 188 of the Transport Operations (Marine Safety) Act 1994	Provides that a ship's master can refuse entry of a person onto a ship or ask someone to leave if the person may annoy or injure other persons on the ship because of the person's intoxicated condition.	A person entering or on a ship in an intoxicated condition.	No	N/A	Ship master	Eject or refuse entry onto ship	No	Protect ship passenger from alcohol related disturbance

Area of law	Section and Law	Summary of the provision	What (or who) is the target of the law?	Is the target defined?	How is the target defined?	Who is the decision-maker/ authority?	What can the decision maker or authority do?	Protections for target?	Protections for others?
Purchase of sale and goods	Section 156 of the Liquor Act 1992	Penalises a licensee for supply / allowing liquor to be consumed by somebody who is unduly intoxicated or disorderly.	A person who is unduly intoxicated or disorderly.	Yes	Section 9A defined unduly intoxicated if (a) the person's speech, balance, coordination or behaviour is noticeably affected; and (b) there are reasonable grounds for believing the affected speech, balance, coordination or behaviour is the result of the consumption of liquor, drugs or another intoxicating substance.	Proprietor of Licensed Premises	Allows refusal of liquor to certain people	No	Minimise alcohol related harm and public disorder
Criminal procedure	Section 423 of the Police Powers And Responsibilities Act 2000	Provides that the police must delay questioning of a person who is apparently under the influence of liquor or a drug.	A person who is apparently under the influence of liquor or a drug.	No	N/A	Police	Regulates whether police can question a person	Protect the person under the influence	Protects the integrity of due process
Residential tenancy	Section 268 of the Residential Tenancies and	Provides for providers of rooming	A resident of a rooming house	No	N/A	Rooming House Provider	Breaching of a rooming house rule will	Section 272 allows a resident to	Protects fellow residents

Area of law	Section and Law	Summary of the provision	What (or who) is the target of the law?	Is the target defined?	How is the target defined?	Who is the decision-maker/ authority?	What can the decision maker or authority do?	Protections for target?	Protections for others?
	Rooming Accommodation Act 2008	accommodation to make house rules on smoking, drinking alcohol or illegally consuming other drugs					constitute a breach of the rooming accommodation agreement. Section 368 provides that notice will be given to the resident to remedy the breach, and if not remedied Section 369 allows for a notice to leave to be served.	object to a proposed rule change at a rooming house if "unreasonable". Section 274 allows a resident to challenge an existing rule for being unreasonable via an application to the tribunal.	from drug and alcohol related harm.
Wills and Estates	s65	Provides for a court to make a protection order for a person under 18 years if they are unable to manage their affairs or are liable to undue influence "by reason of age, disease, illness, or physical or mental	A person unable, wholly or partially to manage their affairs or are liable to be subject to undue influence due to "taking or using in excess alcoholic	No	N/A	Judiciary	Can appoint a public trustee manager to take possession of and to control and manage all or such part or parts as the court directs of the estate of	Section 69 allows for the protection order to be amended or varied on application of the protected person or the public trustee.	Appears solely designed to protect the incapacitated person.

Area of law	Section and Law	Summary of the provision	What (or who) is the target of the law?	Is the target defined?	How is the target defined?	Who is the decision-maker/ authority?	What can the decision maker or authority do?	Protections for target?	Protections for others?
		infirmity or of the person's taking or using in excess alcoholic liquors, or any intoxicating, stimulating, narcotic, sedative or other drug is, either continuously or intermittently"	liquors, or any intoxicating, stimulating, narcotic, sedative or other drug is, either continuously or intermittently"				that person.		

In the next section we present a summary of the findings across all laws, detailing results from our analysis using the coding schedule at Appendix A. We outline who the targets of the laws are; whether the targeted practices, activities or behaviours are defined; who is empowered to make decisions or exercise powers; what kinds of decisions or powers can be exercised; and what kinds of protections are offered.

Targets of law

The analysis revealed a wide range of terminology to describe targeted practices, activities and behaviours relevant to AOD. These included:

- Persons who *consume* alcohol;
- Persons who *possess* alcohol;
- People *possessing or consuming* alcohol within a residence in a community area;
- People who are *unduly intoxicated* or *disorderly*;
- *Intoxicated* volunteers;
- People who are *adversely affected by an intoxicating substance;*
- People who are *drug dependent*;
- People who *unlawfully produce* a relevant substance or thing;
- Persons who have in their *possession* anything (not being a hypodermic syringe or needle) – for use in connection with the administration, consumption or smoking of a dangerous drug;
- People *affected by* alcohol or drugs, including prescription medications, in ways that *impair their capacity* to undertake certain activities;
- People *consuming* liquor;
- People who *appear to be* drunk or adversely affected by a drug;
- People who are *under the influence of alcohol*, or *impaired by a drug, to the extent the alcohol or drug impairs, or could impair* their ability to undertake certain activities;
- People *apparently under the influence* of liquor or a drug;
- Persons with a *notifiable condition*;
- Persons who are unable to manage their affairs or are liable to be subject to undue influence due to *taking or using in excess alcoholic liquors, or any intoxicating, stimulating, narcotic, sedative or other drug*;
- Persons *incompetent due to drunkenness* or incapacity;
- Persons *purchasing liquor* while in uniform;
- Persons *wishing to purchase* drug paraphernalia;
- Persons *smoking*;
- Persons *over the prescribed limit* of alcohol;
- Persons who are *habitually drunk*;
- Persons who are *addicted* to deleterious drugs; and
- Persons who *unlawfully traffic* in drugs.

These findings overlap with findings by Quilter et al. (2016a, 2016b), where legislation that attaches significance to the fact of intoxication was found to use a wide array of variable language to describe intoxication (as in: intoxicated, unduly intoxicated, apparently intoxicated, affected by and under the influence). As the above list reveals, however, Queensland law not only targets the use, consumption, possession and trafficking of both AOD and AOD 'paraphernalia', but other activities, including smoking, habitual drunkenness, addiction, purchasing AOD (or paraphernalia) and wishing to purchase AOD (or paraphernalia).

Definitions of the targeted practices, activities and behaviours

Of the 222 provisions we identified, a proportion was ancillary and thus not coded for definitions. Of the remaining 181 coded for definitions, most (67%) had no definition, while 33% had a definition or partial definition of the targeted practice, activity or behaviour. An example of a provision that targets a practice, activity or behaviour that is defined in the legislation is section 328A of the *Criminal Code 1989*. That section provides an offence for someone who dangerously operates a vehicle whilst adversely affected by an intoxicating substance. In this instance, the targeted behaviour undertaken 'while adversely affected by an intoxicating substance' is defined in the Act, at section 365C. That section provides that:

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(1) A person is taken to be adversely affected by an intoxicating substance if—

(a) the concentration of alcohol in the person's blood is at least 150mg of alcohol in 100mL of blood; or

(b) the concentration of alcohol in the person's breath is at least 0.150g of alcohol in 210L of breath; or

(c) any amount of a drug prescribed by regulation is present in the person's saliva; or

(d) the person fails to provide a specimen as required under the Transport Operations (Road Use Management) Act 1995, section 80 as applied under the Police Powers and Responsibilities Act 2000, chapter 18A.

In this first example, the targeted practice, behaviour or activity is one that attracts a criminal penalty. By way of contrast, another example relates to a practice, activity or behaviour that attracts a penalty, but in a way that reduces (mitigates) a person's culpability and their eventual sentence. Section 8 of the *Drugs Misuse Act 1986* makes it an offence to unlawfully produce a dangerous drug. However, section 8(b) of the Act provides that a person found guilty of that offence can be imprisoned for up to 25 years, or – if they are a 'drug dependent person' – up to 20 years. The meaning of 'drug dependent person' is defined in section 4 of the Act, as follows:

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drug dependent person means a person—

(a) who, as a result of repeated administration to the person of dangerous drugs—

(i) demonstrates impaired control; or
(ii) exhibits drug-seeking behaviour that suggests impaired control;

over the person's continued use of dangerous drugs; and

> (b) who, when the administration to the person of dangerous drugs ceases, suffers or is likely to suffer mental or physical distress or disorder.

In this example, we note two things of interest. First, each example adopts a different approach to defining the targeted practice, activity or behaviour (in the first example the definition uses a form of *biological detection*, whereas the second uses *observation of behaviours in accordance with established criteria*, see Quilter et al. 2016a).

An example of a provision that targets a practice, activity or behaviour that is not defined in the legislation is section 173B of the Liquor Act 1992. That section provides that:

> (1) A person must not consume liquor in—
>   (a) a public place that is—
>
>   (i) a road; or
>
>   (ii) land owned by, or under the control of, a local government (other than a regional park (general) under the Nature Conservation Act 1992); or
>
>   (iii) relevant land prescribed under a regulation; or
>
>   (b) a doorway, entrance or vestibule that gives access to premises from a public place mentioned in paragraph (a).
>
>   Maximum penalty—1 penalty unit.

In this example, the meaning of 'consuming liquor' in a public place is not defined. In some instances where targeted practices, activities or behaviours are not defined in law (as with offences relating to possession or consumption) this may be because there is case law establishing the parameters of, for instance, possession, or because the meaning of each element of the offence appears to be identifiable as a matter of 'common sense'. In other cases, however, the undefined targeted practice, activity or behaviour may be significantly less precise, or require an evaluation as to the degree or extent to which a person's behaviour can be said to fit the requirements of the Act.

So, for example, section 18(3) of the *Major Events Act 2014* provides that:

> A person who appears to be drunk or adversely affected by a drug must not enter a major event area.
>
> Maximum penalty—20 penalty units.

In this example, the targeted behaviour (the appearance of being drunk or adversely affected by a drug) is not defined. The addition of two qualifying factors – *appearing* to be drunk, *adversely affected* – necessitates the need for a judgment call to be made by the relevant decision-maker or authority tasked with determining whether a person has fallen foul of the law.

Who makes decisions and what kinds of decisions can be made?

Our analysis suggests that a wide range of decision-makers, authorities and bodies can make decisions or exercise powers in relation to targeted practices, activities and behaviours, and that the kinds of decisions that can be made are extraordinarily broad. Relevant decision-makers or authorities include:

- Law enforcement officials;
- Judiciary;
- Corrections staff;
- Education providers;
- Certain regulatory boards (e.g. Veterinary Surgeons Board);
- Staff from the Department of Health;
- Health practitioners;
- The Health Ombudsman;
- Proprietors of licensed premises;
- Venue operators;
- Mining operators;
- Employers;
- Sellers of goods;
- Second-hand brokers;
- Rail safety officers;
- Environmental health officers;
- Licensees; and
- Firing range operators.

As this list reveals, a wide range of figures are implicated in decision-making processes that might affect the lives of people who use, consume, possess (etc.) AOD. The range of decisions that might be made is also broad. These include:

- The ability to impose a condition on a person's bail;
- The ability to mitigate (reduce) an offender's sentence;
- The ability to determine whether a person is criminally responsible;
- The ability to refuse access to certain medications;
- The ability to refuse access to medical treatments;
- The ability to prevent a person from engaging in certain forms of employment;
- The ability to limit where and how liquor is consumed;
- The power to stop and search people;
- The power to prevent someone from working;
- The power to seize liquor;
- The power to search someone without a warrant;
- The power to search a vehicle without a warrant;
- The power to use drug detection dogs on people;

- The power to give a move-on direction;
- The power to question (or not) a person;
- The power to detain a person;
- The power to take control of someone's affairs or someone's estate;
- The power to take disciplinary action;
- The power to issue a penalty in the form of a fine;
- The power to limit access to certain goods (e.g. weapons);
- The power to prevent entry to or access of certain spaces.

As this list reveals, powers are not just confined to those we might consider to be more obvious or highly visible, such as the power to arrest and jail offenders or 'move on powers'. As we shall explain in the next section, these decisions sometimes confer rights and protections, and sometimes inhibit rights.

What kinds of protections are offered?

As Corrigan et al. (2005) note, one way of establishing whether legislation is stigmatising and/or discriminatory (or, as we prefer, whether it has *stigmatising or discriminatory potential*), is to examine whether it affords protections to targeted individuals, practices, activities and behaviours. There are a range of ways in which laws may offer protections to targeted individuals, including via the use of review and appeal mechanisms. Where we speak about protections in this report, we mean (following Corrigan et al. 2005) specific initiatives or measures designed to prevent stigma or discrimination. Although most provisions (69.06%) offer protections of some kind to the target, a large proportion (30.94%) offer no protection to the target. Although there may be sound public policy grounds for this, provisions that offer no protection to target groups have a greater potential to be stigmatising and/or discriminatory.

It is also important to acknowledge that laws may not always offer protections to the targets of those laws, and that they may instead offer or seek to offer protections to others. Examples of the latter are laws that seek to protect public spaces and public amenity, to minimise the risks that might be associated with AOD consumption (including, for example, risks to oneself, to fellow workers, to children, users of public transport and to members of the public more broadly). As we noted earlier, protections for others might be deemed necessary and appropriate where the targeted activity or behaviour is of a kind that might pose a risk to the community or public safety. The question in part is how competing rights might be balanced in ways that minimise the potential for stigma or discrimination.

In some instances, laws might confer rights on targeted populations (and thus extend protections to targeted practices, activities or behaviours), while other laws may inhibit the rights of individuals who are targeted, while conferring rights and protections to others. An example of a provision that confers rights and protections can be found in section 423 of the *Police Powers and Responsibilities Act 2000*. That provision provides that the police must delay questioning of a person who is apparently under the influence of liquor or a drug. Here, at least one purpose of the legislation is to protect a person who is under the influence of AOD from speaking to police and potentially incriminating themselves. Importantly, this law simultaneously affords protections to others by protecting the integrity of the criminal justice system, ensuring due process and preventing miscarriages of justice. An example of a provision that confers rights and protections to others while inhibiting or reducing the rights or the targeted populations is section 34 of the *Aboriginal and Torres Strait Islander Communities (Justice, Land and Other Matters) Act 1984*. That provision makes it an offence to possess or consume alcohol in a designated 'dry place'.

This provision appears to be designed to provide protection to the wider community, by minimising the potential for alcohol-related harms, by impeding the right of community members to possess or consume alcohol.

Summary

In this section, we summarised findings from the legislative component of the study. We located a total of 222 provisions in Queensland that were relevant in some way to people who experience problematic AOD use. We analysed all 222 provisions with a view to assessing their stigmatising and/or discriminatory potential, which we defined for the purposes of this study as: the enabling conditions for the manifestation of stigma and/or discriminatory practices. We suggested that the stigmatising potential of law is increased wherever the law isolates certain individuals, practices, activities and behaviours associated with AOD, enabling key stakeholders to exercise power and authority over them (including in ways that are potentially arbitrary or insufficiently defined), without sufficient protections for the target. It is important to note that the stigmatising and/or discriminatory potential of each individual provision can only be established through a comprehensive/holistic reading of that provision using the aforementioned coding schedule. After undertaking such an analysis, we conclude that a proportion of provisions in Queensland law have the potential to stigmatise and/or discriminate against people experiencing problematic AOD use. Our analysis revealed that: relevant provisions appeared across 11 different areas of law, with provisions most often being found in the domains of: substantive criminal law, employment law and professional regulation, public health and public order. We also found that Queensland law targets a very wide range of practices, activities and behaviours, and uses a wide array of terms to describe the practices, activities and behaviours that are targeted. Only 33% of provisions define the targeted practice, activity or behaviour, with the remainder of provisions targeting practices, activities or behaviours that are not defined. The lack of definitional precision and clarity is a problem, because it may allow for highly subjective and variable assessments to be made. In other words, problems such as disproportionate, arbitrary or discriminatory policing may stem from insufficiently precise legislation, and these problems might be able to be alleviated or minimised through specific reforms that more precisely define targeted practices, activities and behaviours. We also found that the provisions convey decision-making powers and/or authority to a wide range of decision-makers, bodies and authorities. In some instances these decision-makers are familiar, highly trained and regulated (e.g. the police) but in others, powers are conferred upon private citizens and organisations who may be less familiar, well trained or well versed in the exercise of power (e.g. mining operators, employers, sellers of goods). We noted that the stigmatising and/or discriminatory potential of law was reduced when targets were offered protections in law. While most provisions provide some protections for the target, 30.94% do not. The stigmatising and/or discriminatory potential of law might be alleviated or reduced where the protections in individual provisions are included and strengthened, or where the strengthening of overarching legal protections for people who use AOD is embedded in other laws (e.g. anti-discrimination protections).

5. INTERVIEWS AND ANALYTICAL CASE STUDIES BASED ON INTERVIEWS

In total, 21 interviews were conducted at three sites in Queensland during September and October 2016. Interviews were conducted at a residential rehabilitation treatment service located in outer Brisbane (n=6), a residential rehabilitation treatment service located in northern regional Queensland (n=9), and a needle and syringe program and primary care clinic in inner city Brisbane (n=6).[4]

Fifteen men and six women were interviewed across the three sites. Participants were aged between 25 and 59 years (with a mean age of 38 years across the sample).

For the majority of participants, poly-drug use was common. Most participants reported having used alcohol, cannabis and methamphetamine, and five participants had also used heroin at some point in their lives. Three participants also mentioned non-medical use of pharmaceutical drugs including dexamphetamine, benzodiazepines and oxycodone, and two reported morphine use. Two participants primarily used alcohol. Fourteen participants had injected drugs in their lifetime.

The majority of participants had engaged with multiple drug and alcohol treatment services, at various times, including residential rehabilitation services, detoxification services, AA and NA, workplace employee assistance programs, counselling, psychologists, psychiatrists, opioid treatment programs (including methadone and suboxone), as well as seeking help through general practice and primary care.

Many participants had been employed in industries including hospitality, hairdressing, finance, fishing and trawling, building and construction, nursing, truck driving, and public service. None of the participants were working fulltime at the time of interview due to engagement in a residential treatment program, homelessness, issues related to their drug use, health or criminal history (some participants were planning to return to work after treatment, and had jobs held for them). Eleven participants said that they had children (at the time of interview, the majority of these participants did not have their children in their care).

Six participants said they were originally from Brisbane, and seven participants were originally from regional Queensland (including Mackay, Townsville and Charters Towers). Seven participants were born interstate (NSW, Victoria and Western Australia) and one participant was born overseas. All participants had been living in Queensland for a significant period prior to the time of interview. While we did not specifically ask about Aboriginal and Torres Strait Islander status, two participants identified as Aboriginal when introducing themselves to the interviewer.

Analysis of the interviews is presented in two sections. In this first section, we present a thematic analysis exploring experiences across the interview sample as a whole. In the second section, we build a series of illustrative analytic case examples.

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[4] The names of these services have been anonymised to protect the confidentiality and anonymity of the interview participants. We are grateful to QNADA for facilitating collaboration with the participating interview sites, and we thank the services for their assistance.

5.1 Experiences and effects of stigma

Experiences of stigma and discrimination were ubiquitous as participants told their stories. Every participant said that they had been stigmatised, judged, treated differently or discriminated against because of their alcohol or other drug use at multiple times in their lives, and could describe specific instances when this had occurred.

Participants experienced stigma across a range of settings including health care, policing, employment, child services, courts, welfare services, as well as in relationships with family and friends, and in the general community. Experiences ranged from social isolation and family exclusion, to verbal abuse, denigration and being called names, to looks of disgust, violence and being spat on in the street, as well as denial of service or dismissive or abusive treatment from professionals in positions of care, power or responsibility. These experiences created inequitable barriers in the most fundamental aspects of people's lives including health care, justice, family connection, employment opportunities, welfare, housing, and community belonging. Every participant could account for such experiences across multiple settings in their own lives, and described these experiences as being the norm.

First, we describe participants' experiences in broad terms, including participants' own descriptions of the impact of stigma in their lives. We then turn to examine participants' descriptions of how stigma and discrimination manifests in particular settings and sectors, and contrast these experiences with (comparatively rare) positive examples of instances where participants had not felt judged in these settings.

Stereotypes and assumptions

Participants described the ways in which they were labelled, stereotyped and had assumptions made about them because of their problematic AOD use:

> "Society has painted a certain picture that they see us to be. Unfortunately, it's not a nice picture. […] They assume that we're all low lives, dole bludgers, pretty much want everything given to us on a silver plate. We don't want to work for it, we'd rather sit at home and do drugs than actually work and make a living. That's not the case. Yes, there are a small group of people out there that do fit that lifestyle, but there's a large portion of us that don't do it for that particular reason. […] A lot of people in here, including myself, we're very switched on. We've done apprenticeships, we've got certificates and degrees and all that sort of stuff. It's just that we've been stuck at a certain point in our life that we've got nothing to look forward to. But we're not all street bums, and that's how I think we're looked at. But it's hard. Society has just blanketed a certain picture and everyone just goes with it, because they don't know any different." (Interview 6, Female 32 years)

The pervasiveness of this stereotypical "picture" of people with a lived experience of problematic AOD use meant that participants were treated differently in many aspects of their lives. Such assumptions and stereotypes led to status loss, discrimination and unfair treatment:

> "I've been treated differently now because I'm using drugs." (Interview 17, Female 42 years)

These experiences of stigma and discrimination had profound effects on participants' self-esteem, alcohol and other drug use, and produced barriers to seeking help, as detailed below.

Subjectivity, self-esteem and self-worth

When participants were asked how experiences of stigma and discrimination made them feel, they described feelings of degradation, shame and anger:

> "It made me feel like a piece of s**t, really. It made me feel like I was nothing better than the thing on the bottom of your shoe." (Interview 6, Female 32 years)

> "It doesn't do anything for my self-esteem or my confidence, that's for sure, and it gets me really angry." (Interview 10, Male 38 years)

Such experiences had adverse impacts on individuals' feelings of self-worth, mental health and sense of connection to community:

> "Puts you into a spiral, I suppose - it affects your mental health, your self-esteem and your self-worth, who you are as a person. If you're not - if you're being stigmatised as that and - you know, one thing that people in the world strive for is connection, and if no one wants to connect with you then you have nothing, and you're just going to a mental health spiral of darkness in the end. It leads down the roads to suicide and self-harm and things like that. I mean, we put ourselves there but that's where that stigma takes you, because no one wants to be around you so you're only with you and yourself and your mind." (Interview 3, Male 30 years)

Repeated experiences of stigma and discrimination shaped how participants saw themselves and their place in the world. Where certain stereotypical "junkie" attributes were assumed or expected, some participants talked about how they would end up performing that role out of sheer frustration:

> "Yeah, it's got a way of bringing out the worst in you. And the more you get pushed in the corner, the more you hate, because you're not fitting in, these people are doing this to you, so you're, in a roundabout way, giving them the ammunition that they need." (Interview 13, Male 38 years)

> "Having that put on you by people that don't even know you, don't know your story, if they don't know you from a bar of soap, they only know you through someone else, for them to judge you and class you as something that is worthless, it's hard to deal with. That just spins you into a further addiction because you're like, people already think less of me. I'm not a Class A citizen. I might as well just be a junkie. So it is hard." (Interview 6, female 32 years)

> "By the end of it, I suppose you're worse because you get that idea of, I don't give a f**k what you think. It's - I'm like, you want to portray me as a junkie? I'll show you what a junkie acts like. That's the way my mind - yeah. Not - just bung it on, I suppose, you know what I mean? Play up like a junkie."(Interview 1, Male 32 years)

As we discussed in the literature review, theorists have also described the notion of 'self-stigma' or 'internalised stigma'. In these interviews, it was evident that participants had internalised the shame associated with the "picture" of problematic AOD use presented by society. Given the frequent experiences of stigma and discrimination in their lives, some participants found it difficult to believe in their own worth or hold onto an identity outside of this stigmatised image:

> "When you've heard it for long enough, after a while people who treat you differently and say this, that and the other, you start to almost feel like that. You start to think

whether or not what they're saying is true. Sometimes I've second guessed myself." (Interview 19, Male 47 years)

"You feel a little bit of shame and guilt because of where - you know that you made your own bed. You feel a little bit untrustworthy, you feel dirty and you feel like you have to climb up a mountain to say, 'Hey, I'm actually a decent person when I'm straight'." (Interview 4, Male 27 years)

Effects on drug use

Stigma did not provide a discouragement to problematic AOD use and was not a motivator for getting help. Many participants talked about how stigma and discrimination made them feel worthless and hopeless, which in turn triggered them to use alcohol or other drugs or give up on seeking change in their lives:

"Being told that you're worthless, you're good for nothing, you're a low life, you'll never accomplish anything, makes you feel if I'm not good enough, why should I even bother? So for me personally, it made me want to go harder in my addiction, because I was always - I was already classified as nothing, a no-hoper, so why should I even bother trying?" (Interview 6, Female 32 years)

"Yeah it's like that's why you take drugs is to forget that s**t." (Interview 11, Male 44 years)

"Quite often it triggers me to just give up and go back to using drugs." (Interview 7, Male 51 years)

Stigma as a barrier to help-seeking

As such, experiences of stigma and discrimination created barriers to seeking help or getting treatment, even at times when participants had felt they really needed it. Experiences of stigma and discrimination at the moment of help-seeking (for example, from health care workers, doctors, psychologists, welfare services, or even AOD treatment providers) discouraged participants from seeking help again or finding other pathways into treatment:

"There's no good feeling from it, so as an addict, you take the bad from every - you take the worst from anything. F**k it, I'll just go and use. They don't help me, no one wants to help me. You'd think a doctor would if anyone's going to. And you go and use." (Interview 1, Male 32 years)

"The judgment does come in, when you really need that help. So you get knocked back a few times, and that's what makes you go back out using. Well, that's for me anyway. It makes me want to go back out and use and go to the black market to buy it. So it's a lot harder in so many ways." (Interview 15, Female 27 years)

Within group stigma

While experiences of stigma and discrimination were ubiquitous across the sample, participants also noted that different stigma attached to different kinds of drug use. Not all problematic AOD use was stigmatised in the same way. Some individuals felt that particular groups of people and behaviours were more stigmatised and marginalised than others, even amongst those with experience of problematic AOD use. This accords with what has been described as 'within group' stigma (as we noted earlier in the literature review). As one participant said:

> "The heroin addicts all look down on the speed addicts, and the speed addicts look down on the alcoholics and all three all look down on the petrol sniffers. There's always going to be judgement, even within the drug world." (Interview 8, Male 45 years)

Given the heightened public attention given to methamphetamine in recent years, participants felt that methamphetamine use carried a particular stigma, over and above the stigma associated with other kinds of drug use. Whereas some participants could be quite open about their cannabis use for example, they described hiding their methamphetamine use and being pushed away by family and friends due to the stigma associated with this particular drug:

> "When I say treated differently, it's almost like - with the ice, it was - ice was more of a hidden addiction. It's not something you run around and tell everyone that you're doing, whereas dope's quite a social and a commonly used drug, I find in Australia. You have a few cones or you have a joint. You find that there's a few people around that - yeah, I'll have a puff on that. It's like the next day, no one talks about it. It's a common thing." (Interview 3, Male 30 years)

> "My brothers they didn't talk to me. They pushed me away actually in the ice usage. Not because of the pot. Like they were cool for it because they both smoke it." (Interview 5, Female 31 years)

Many participants also described the particular shame and judgement associated with injecting drug use. The stigma of injecting was compounded by the co-stigma associated with blood borne viruses such as hepatitis C and HIV:

> "'You're a filthy disease-spreading' - I feel that's come into play a lot, there's an undercurrent of almost, 'Ice smoking is fine, but let's hotshot the IV users, because they're the real maggots who spread disease and cause all the trouble'." (Interview 8, Male 45 years)

5.2 Settings

As participants talked about their experiences of stigma and discrimination, they were encouraged to give accounts of specific times when stigma had occurred in particular settings. Participants were also asked to describe times when they had not felt stigmatised in particular settings, and talk about what had been different in those instances. In this next section of the thematic analysis, we present participants' accounts and experiences in each of these settings:

- Family/social;
- Health care;
- Employment;
- Police/public order;
- Child services/Legal issues/Courts;
- Other services;
- Society at large.

Family/social

Participants described the ways in which family, friends and others in their social worlds had distanced themselves because of the participant's problematic AOD use. Participants felt that the stigma associated with problematic AOD use led to separation and status loss. Many participants had suffered social exclusion, or had been treated as though they were an embarrassment to their

family and friends. This manifested in multiple ways, often by being excluded from important social gatherings (such as birthday celebrations or weddings):

> "I would not get invited to certain things because they didn't want their children or their friends to be around me. Even though I wasn't using at that point, I was still classed as a junkie and they still saw me to me that dirty person. If I did go to an event, there would always be talking or whispering behind your back, or pinpointing, and you could feel it, and you heard it. It made me feel like a piece of s**t, really." (Interview 6, Female 32 years)

> "Birthdays, gatherings, weddings, dinners and not - no invites being handed out, because you're an embarrassment. That's what it comes down to." (Interview 3, Male 30 years)

The stigma and discrimination associated with problematic AOD use led to many participants being estranged from their families, friends and communities:

> "Not very long ago my sister and my brother stopped talking to me because they found out that I used to inject. Well, they asked me about it because someone else told them and so I was honest with them and I told them and they just stopped talking to me, so they judged me pretty harshly on that." (Interview 18, Male 25 years)

Underlying these experiences of social exclusion, were stereotypical assumptions about drug use and the people who use them. Endorsement of the stereotypical 'junkie' image pervaded many interactions, leading to separation and isolation. Participants spoke about how friends and family members assumed that they were untrustworthy, violent, and erratic because they had a history of drug use, and would distance themselves often without discussion:

> "With one of my best mates, and he still doesn't talk to me now. Same thing. He has two kids. One's the same age as my daughter and because he knew what I was doing, using ice and that, he still hasn't talked to me since February this year. If that's not a little bit of - he doesn't know anything about drugs so he would've just researched and seen what's on TV, and gone, 'He's like that? He's not coming near my family.' I've tried to reach out just recently and I still haven't - I haven't heard anything back." (Interview 3, Male 30 years)

> "They look at me as I'm a junkie and I can't control or budget money, like they wanted to give me vouchers for my birthday instead of like I used to always get money to buy something. And I said, 'Look mum, like I'm a big boy, I can control what I spend my money on' and like even my kid's presents, she puts her money into a bank account now because my ex said one time when we were on the phone that I was spending all the money. My kids always got their birthday money and their present, like it's there. Like I can be a piece of s**t sometimes but I've never lowered myself that bad." (Interview 11, Male 44 years)

> "I'm more judged than anything. People are more worried about stuff being laying around because they think it's going to be stolen […] So that makes it a lot harder to build a friendship or have a friendship while you're on drugs." (Interview 15, Female 27 years)

Many participants talked about a lack of understanding about problematic AOD use, which meant that negative stereotypes dominated interactions with family and friends and led to social exclusion:

"instead of trying to understand why, they just put me in one big - you know, put me in that category and like don't want to know you sort of thing. Yeah. Same with my brother. We don't talk because of it. No one ever asked me, 'Why are you doing it?' They were just like, 'Oh, you're nothing but scum.' Put you in that one category." (Interview 16, Female 38 years)

Few participants could describe positive situations where they had not felt stigmatised or discriminated against by family or friends. Of those who did have positive experiences, two factors were important: (1) understanding; and (2) inclusion:

"Mum's particularly good. She's known about my problems for years and she still stands by me, you know. […] She used to do a bit of counselling so she understands, which is good, and, you know, I rarely see that really." (Interview 18, Male 25 years)

"They've tried to understand. They've tried to understand what was going on through their daughter's mind, but at least they tried." (Interview 16, Female 38 years)

"My immediate family don't judge me; my Mum and my Dad. So they're really good, they're really supportive.
Interviewer: What's different about that support?
Well, it's unconditional for starters. What's different is that it makes you feel included."
(Interview 19, Male 47 years)

Health care

Participants described experiences of stigma and discrimination in a range of health care settings including hospitals, GPs, psychologists, pharmacies, and dentists. Across the interviews, most participants could describe stigmatising experiences in these settings.

Of the many accounts, the most distressing instances were those when stigma and discrimination produced barriers to participants accessing appropriate treatment for health conditions. Many participants spoke about such experiences, especially in relation to hospital and emergency department settings:

"One time I went into hospital for something. One of the doctors said, 'She's a bloody drug user. No use keeping her in hospital for the night. May as well just treat her and let her go, because she won't stay in hospital.' I said, 'What?! Sorry?!' I said, 'I love hospital, I'll stay in here for the night if you want me to.' But saying that about me? I felt a little bit down." (Interview 9, Female 46 years)

Due to these kinds of experiences, some participants even reported using self-harm as a strategy to ensure they would be looked at and taken seriously when seeking medical attention in emergency departments:

"If I really need to get help, I will honestly do some real damage to actually get looked at." (Interview 14, Male 35 years)

For people experiencing homelessness, there were particular challenges. The co-stigmas of problematic AOD use and homelessness produced multiple barriers to accessing medical care:

"Well, if an ambulance comes and picks me up after I feel like I'm having a heart attack, because I've got a swag, I'm homeless, and I be honest, I tell them that I drink a lot, and I just had two cans of bourbon, so it's not withdrawal. And the first thing ambulance driver did was tell the doctors it's just alcohol withdrawal and I got told to leave. I had a temperature of 41.9 and they said there was nothing wrong with me. Now, there is

something wrong with you when you've got a temperature that high. Because I'm homeless and alcoholic, 'No thank you. We don't need you. We don't need to help you'." (Interview 7, Male 51 years)

"When it comes to a homeless person they just write them off as you're either on drugs or you're trying to get out of sleeping outside as well, because they're trying to get out of sleeping outside, but if they've got a problem, they've got a problem. Like last time I went to hospital, they were about to let me go and then they found out that I had a broken ankle and I had cellulitis on one of my legs and septicaemia on my arm and all the rest of it. No one really walked me out because they thought I was faking my limp and all the rest of it." (Interview 14, Male 35 years)

One particular source of stigma and discrimination was the assumption that participants were merely 'drug seeking' when they were seeking treatment for medical conditions:

"They just assumed that I was there for something, a big hit of bloody morphine or a big hit of Fentanyl or something" (Interview 12, Male 59 years)

"Look, I've always thought every time I go to a doctor, because it's on my record of being a drug user - like I go to a hospital and I've got a toothache, right? I go there and I'm like, I really need some painkillers. And I'm sure when they put in my name, it comes up colourful and says red flag, don't give him anything. So then I don't get anything for my pain that I'm having. So there has been times like that, where it's just like wow, because of the past, it alters where I'm at, you know what I mean?" (Interview 4, Male 27 years)

"There's been a couple of situations where I've been at the hospital because I've been really sick with a bad migraine, and what-not, and because it's on my file that I used to use, they won't treat me up there, they just put me down that I'm an ice junkie, you know, and I don't even use the stuff." (Interview 10, Male 38 years)

Such discriminatory treatment was not only a barrier to seeking diagnosis or appropriate pain management, but also in relation to psychiatric conditions. Even where participants had been assessed and diagnosed, continuity of treatment was often difficult when faced with new doctors or health workers:

"My shrink took off, he went to Tasmania and didn't tell any of his patients, took all their files, everything. And with dexamphetamines you can't really stop taking them, you've got to keep taking them. And the only way to get them is through a psychiatrist. So I've gone down to [a mental health service] and told them my situation and basically the security guard there has thought I'm a f***ing junkie, 'Oh you just want to get on to med – on dexamphetamines' and I'm like, 'Mate, I'm f***ing on them, I need to be on them, I've been told not to stop them because it can really f***ing affect me and you're putting me on a f***ing junkie you piece of s**t, come out here, I'll f***ing show you what junkies are all about c**t.' And anyway eventually I did get some help. But why did I have to be treated like that and why did I have to react like that for me to get help? Like I just wanted to know how I could get my medication." (Interview 11, Male 44 years)

These assumptions about drug-seeking behaviour also created barriers when participants had sought help with AOD problems and mental health. The assumption that as a 'drug user' all that they were interested in was a prescription often meant that other pathways and treatment options were not offered by health workers, at times when participants were seeking advice:

"I'm not here to get a prescription, I'm actually here to get some help or some counselling or some ideas on how the f**k can I get off this merry-go-round?" (Interview 11, Male 44 years)

While it might be assumed that doctors (particularly GPs) might be a first point of contact for many people needing help or advice about their problematic AOD use, the stigma associated with problematic AOD use meant that many participants said they had been reluctant to talk about alcohol and other drug issues with doctors. Participants were fearful of enacted stigma, were worried about disclosure and confidentiality (especially with local services or family doctors), and anticipated a lack of understanding:

"I went to my family - my always family doctor, from - which was a hard thing to do, because I didn't want to tell anyone I was an addict.
Interviewer: Why didn't you want to tell him that?
Just - it was still a hard thing. Mum's house had been raided and stuff before. She had - she knew, but your parents don't want to 'know'. She knew I was an addict, but she didn't - they don't want to think you're still using, you know what I mean? They just - yeah. So I didn't want to tell the family doctor, and I know he wouldn't have told her directly but it still would've - yeah." (Interview 1, Male 32 years)

"It's just like that with the doctors. Because they've never been a drug user or anything of the sort to know what you go through, they have no reason to sit there and judge you for the person you are or what life you've been through, what steps you've taken to try and help yourself. You're doing the right thing coming to a doctor, and then that happens, well, it doesn't make you want to go to the doctor and seek help, or go seek help anywhere because you think you're going to get judged everywhere else because of that one thing. So it makes it a lot harder." (Interview 15, Female 27 years)

"It was difficult going - because the local doctor looks at you like, "Well, just get off it." They don't understand. Well, from my experience, they don't understand that it is a disease. They just think, just stop using it. Well, it's not that easy." (Interview 1, Male 32 years)

Many participants also described times they had been discriminated against in pharmacy settings. These experiences often occurred when participants were taking care of their health by accessing methadone treatment or buying sterile injecting equipment to help prevent blood borne virus transmission. Such purchases in these settings were not looked upon positively, but rather 'marked' them as people who used drugs and therefore not worthy of the same service as other customers:

"The pharmacy assistants you could tell just thought of us as second class because, you know, you can just tell by people's body language and the way they served us and just spoke to us and stuff. They weren't willing, there was just like that sense of disgust, you know what I mean. You know when you can just tell, because people, they snatch things from you and they - it's hard to explain, like body language, you know, and they'd sort of talk in a different tone of voice. They weren't in any hurry to serve you when you were clearly the next one in line, they'd call other people, stuff like that. [...] it was like we were second class, just because we were on that [methadone] program, you could just tell that they knew, you know, they thought of us as junkies. Well that's how I felt anyway." (Interview 19, Male 47 years)

> "I remember there was a guy behind me in line at the counter and I said, 'Can I get a 1ml sharps kit, please?' And they're there on standby. When I said that, I noticed the man behind me kind of stood away a bit." (Interview 17, Female 42 years)

Some participants spoke positively about times when they had not felt stigmatised or discriminated against in health care settings. While the negative experiences certainly outweighed the positive experiences, some could describe occasional instances where they had received good care and had not felt judged. When participants spoke about these positive experiences in health care settings, they spoke of a sense of understanding and the provision of a different kind of 'care.' For people who so often experience marginalisation and exclusion, having health workers who understood their problems and engaged with them in a different way was important:

> "They're more sympathetic, more understanding. They know people have problems, and what-not."(Interview 10, Male 38 years)

> "She actually listened to what I had to say, she had positive things to say. Made me feel good about myself and said, 'Look, like you're just dealing with it the only way you know how, don't, stop kicking yourself'." (Interview 11, Male 44 years)

> "He was giving me a kick in the arse without putting me down." (Interview 11, Male 44 years)

> "She actually cared and she looked into alternative things like relaxation and even reiki, and just not that she did it, but she gave me the option, the opportunity to look into that sort of stuff. And she researched stuff for me whereas I was too lazy to do it and made an effort, you know what I mean? Like went past what she was supposed to do." (Interview 11, Male 44 years)

> "They were beautiful; both of them were beautiful, they had my best intentions at heart. […] They didn't see what the society saw, they had understanding, they could see me for me." (Interview 13, Male 38 years)

Being seen as a 'normal' patient in clinical settings, not as a 'just a drug user' or 'just an alcoholic' was particularly important. This sense of being seen as an individual often manifested in very simple, yet effective and powerful ways, through conversational style and listening:

> "They just want to talk to you like a normal person." (Interview 14, Male 35 years)

> "It was a nurse or a mental health worker in the detox, and he was going out of his way just to help me. Like he'd take me down to the little reading corner, the reading nook and we'd talk" (Interview 5, Female 31 years)

> "He actually sits there and has a conversation and doesn't judge you, has a yarn and, you know, asks how your days going and how can he help you. He's like, you know, there's other alternatives and this and that, this might work better. He just supports more in a way than tells you what you should and what you shouldn't. And that's what I think you need more when you're in a drug problem. You need that support behind you and it's hard to find because you're so judged by a lot of people, that they don't have no time for you because they see you as somebody else and rarely the person you are inside." (Interview 15, Female 27 years)

> "It's the little ways about how you speak to someone or what you say. And I would have gone into a rehab a long time ago if I was asked to, not told to." (Interview 7, Male 51 years)

"His demeanour, his attitude, I think. He asks questions, he just doesn't wait for you to talk, he asks questions, how we are, how we're going, how this is going, what's going on in your life, that sort of thing. He's a sympathetic ear. He'll listen to you. Everything, everything about him is different." (Interview 12, Male 59 years)

Employment

Most of the participants had worked throughout their lives, and were qualified and experienced in a range of different employment sectors including hospitality, hairdressing, finance, fishing and trawling, building and construction, nursing, truck driving, and public service. In some industries, alcohol and other drug use was common and acceptable (and sometimes even seen to be 'part of the job' when participants were required to work long hours or do extra shifts, or take part in work lunches):

"I've been in the trucking industry where sometimes you need to use drugs just to get through the day, like we were doing 24 hour days at some stages and it's just ridiculous. And people don't care about you, they just want the job done. When my truck broke down I sat on the side of the road for eight hours until another truck come along, I had to load that and then go and do all the drops anyway. And that ended up being like a 22 hour day. Which is against the law for one and two, they didn't care about my safety or anyone else's safety, they just wanted the job done." (Interview 11, Male 44 years)

"They used to take me to lunch, the bosses.
Interviewer: They used to take you to lunch?
Yeah, big Chinese banquet and a Crown lager. And then about seven Crown lagers and a meal later I'm back at my desk curled up sleeping. I get woken up and told to drive across Canberra, but because it's a red Z plate, I couldn't be done for drink driving. And it was just expected of you." (Interview 7, Male 51 years)

"Hospitality in pubs. So for my industry, it was always common. Management used and stuff. I've been in that - did that for about ten years. It was almost like if you did it, you were part of the crew, because that was a common thing working in that industry, is drugs. Even ice too. See, I wasn't - because I've always done that industry, it wasn't like I was pushed away because of it." (Interview 3, Male 30 years)

"[It is] kind of known for hairdressers to be involved with the drug scene." (Interview 6, Female 32 years)

Stigma and discrimination manifested in different ways in participants' work lives. For some participants, AOD-related stigma was a barrier to employment. In particular, stigma made it difficult for some participants to return to work after they had been in treatment. Sometimes this resulted in participants being held back from promotion, or being forced to take lower pay rates because their alcohol and other drug use history had become 'known' in their industry (this was particularly problematic for people living in smaller towns or regional centres, where job markets were tighter). While participants said they had come to expect stigma and discrimination in many areas of their lives, the ways in which it stymied their careers or prevented them from getting work was particularly distressing:

"You get stigma in society, you know what I mean, he's a f***ing nutter or he's a junky f***ing nutter, but they're just the haters. It's when it affects your career, that's the problem, you know what I mean?" (Interview 13, Male 38 years)

The intersection of past drug use with criminal histories was a particularly difficult barrier to overcome for some participants:

"It's stopped me from getting jobs, certain jobs in the past -
Interviewer: Tell me a bit about that?
Actually, not just my drug use, but my criminal history. They both go hand in hand because I wouldn't have had one without the other. I wouldn't have a criminal history if it wasn't for drugs, so I just use those terms interchangeably. But yeah, I've applied for jobs and I've been knocked back because of security purposes. I've applied for a job and gone through all of the other steps, you know, and then at the last hurdle when they've done a security check, I've been found not suitable." (Interview 19, Male 47 years)

When participants were repeatedly discriminated against by employers or unable to find work, this had profound effects. Where AOD-related stigma produced barriers to employment, participants felt discouraged from making change in their lives and felt worthless:

"I didn't feel worthy. I didn't feel as worthy because three people knocked me back because I had a criminal history. I almost thought - well, I did think, I should just chuck this in and just go back to - because I'd battled for a few years to get my clean time up to get into a routine of not being an addict and trying to work and stuff like that. So I'd put in the hard yards, only just to be kicked in the teeth three times. And then I sort of thought, well, stuff it. I'll just go back to stealing and robbing places. Because you start to think is it all worth it, you know. And when people treat you like this, it's not, or if employers treat you like this, what's the point. What am I doing all this for anyway when it doesn't make any difference? It's not making any difference - people are still marginalising me at work." (Interview 19, Male 47 years)

A few participants spoke about positive experiences in the workplace, where they felt they had been supported. These experiences and work environments were characterised by employers being supportive of participants' requests to take a leave of absence to seek help, pathways into support such as access to confidential counselling through employee assistance programs, and a sense that employers had their best interests at heart. Support, understanding and flexibility from employers while participants were engaged in treatment were particularly important, and helped to validate the choice to be in treatment:

"When I was on the methadone program - it was out there at this one place I worked, because I used to have to go and pick up my methadone after work had started. And I used to get support from them. They used to ask me about my story and how I came to be the way I was and stuff like that. They were all supportive, and if they could do anything for me, you know, they'd ask me, 'If we can help you in any way, let us know'." (Interview 19, Male 47 years)

Police/Public order

Contact with police was one setting in which many participants said they had experienced stigma and discrimination (and in some cases, even violence and degradation). Many participants felt they experienced stigma and discrimination by being 'targeted' as people who were known to have a history of problematic alcohol and other drug use. Being the constant subject of police attention was particularly difficult for people experiencing homelessness, as they did not have a private space to go to. Being 'known' to police due to past alcohol and other drug use history often resulted in being singled-out, regularly searched and questioned in the street:

"The police are always, they're just public enemy number one. They'll just harass you for any reason at all, like they'll just, they want to pat you down and strip you off. If you've got anything like of a criminal record or anything to do with a criminal record and say you had a drug conviction for a possession of a joint 20 years ago, they'll still want to pat

you down, they'll still want to do something, see what you, who you know, and they'll want to look at your phone and they'll want to say, 'Who's this?' and, 'Who's that?' Yeah that's discrimination I suppose." (Interview 12, Male 59 years)

Once 'known to police', participants felt they were targeted even when they were not using or when they were engaged in treatment. Such experiences were constant reminders to participants that shedding the stigmatised drug-using identity was incredibly difficult:

"I have had organisations like Queensland Police, even though they know that I've been rehabilitated, that I'm trying to change my life, they're still down on me like I'm a piece of scum. […] Well, I got spoken to a few months ago, and I hadn't had any drugs in my system, but they just spoke down to me just like I was scum, even when I'm trying to make an effort." (Interview 10, Male 38 years)

There were very few positive examples of non-discriminatory interactions with police across all of the participants' accounts. Only a few participants could describe a time they had not felt stigmatised in an interaction with police, and these all occurred after participants had engaged in treatment:

"We were in rehab in a car, but we got pulled over. And the police officer was like, 'How's your night been? Have you had anything to drink?' We're like, 'No, we're recovering addicts.' And they still went about their business and did the breathalyser, which is protocol. And it all came up fine. But his reaction to us was completely different. […] Previously in the past when I've been pulled up for drink driving, whether I'm high or coming down, either way, I was an addict, my reaction has been short and a little bit dismissive, with their reaction being very to the T, to the line, showing no respect back. But in this case, we were open about the fact that we were recovering addicts and it was like the response was good. He was smiling, saying 'That's really awesome, you guys are doing really well, good on you.' (Interview 4, Male 27 years)

When asked how this positive interaction with police made him feel, the participant said:

"Just encourages you to keep doing what you're doing. Encourages and reaffirms to you that you are the person who you were in the beginning. Reaffirms to you that you aren't your choices and you aren't your behaviours, that you are who you are. You have worth." (Interview 4, Male 27 years)

Child services/Legal issues/Courts

A number of participants in the sample had been involved in various legal processes, not necessarily related to alcohol or other drug offences. Sometimes these legal processes had been related to family court business and child custody battles, and in other cases participants had been involved in various criminal proceedings (ranging from small fines and charges of drinking in public, to driving under the influence and domestic violence). Participants said that previous history of drug use would come up in court proceedings, even long after participants had accessed treatment. In these settings, particular use of language devalued and discredited those individuals. Rather than being seen as a person who had successfully made change in their lives, recovery was sometimes referred to as an 'inactive period,' reinscribing the 'junkie' identity:

"I've shown 18 months of clean drug-testing and all the rest of it, but because I've had previous history on police records, and mental health records, it was all brought up that I'd suffered from induced psychosis and all the rest of it, it was basically dismissed as yeah, you're just having an inactive period.
Interviewer: Okay, so that was the terminology they used?

Yeah, it's kind of all you're being told is that you're still a junkie, you're just inactive." (Interview 14, Male 35 years)

These stereotypes meant that participants felt like they were often treated as a 'lost cause' during legal proceedings, given the assumptions being made about their likelihood of recidivism:

"'A lost cause,' you know, 'He's just going to reoffend anyway. He'll either end up in jail or dead like most junkies do.' Or alcoholics." (Interview 8, Male 45 years)

Several participants with children did not currently have their children in their care at the time of interview. These participants had engaged with a variety of legal processes around child services and access. Participants spoke about how stigma and discrimination were often present in these settings and interactions:

"Like every time, we'd be there for an hour and then your kids are ripped apart from you again. So that's more f***ing trauma you've got to go through on a weekly basis and your kids are asking you, 'Why can't I come home with you?' Oh because I smoke f***ing dope. That's the only thing they had on me. And then they wanted me to do urines in front of women to prove that I smoke f***ing dope when I told them straight out and then they say, 'Oh amphetamines are coming up,' I said, 'Look I'm f***ing prescribed this s**t, it's got my name on it. It comes from a psychiatrist who's diagnosed me with an illness for me to take this medication.' And then they want to do separate tests, I said, 'Well you go for it.' I said, 'But that's going to cost you thousands of dollars extra just to find out that he's actually on medication.' Because I did stop using drugs when I was around my kids, except dope, I refused to, I've smoked the s**t for 20 years, it doesn't stop me from being a good dad. You know what I mean? Like it never stopped me from functioning and I went to work, I've done everything on the s**t." (Interview 11, Male 44 years)

Given that evidence of any kind of drug use often triggered processes with child services, participants who had children were reluctant to disclose their need for help. Seeking support at difficult times created major barriers to having access to their children, even after successfully seeking treatment. One participant recounted a time when he had been struggling with problematic drug use, so he had sought support from services to help him take care of his children. By admitting that he needed help and support, he had thought that he was doing the right thing. However, this past admission had become an ongoing issue which constantly placed him at a disadvantage in current proceedings. He felt that his admission that he needed support was now being held as a 'blanket' charge against him; a comprehensive and unmitigated indication that he could never be a responsible parent, even though he had successfully sought treatment and was now in a position to take care of his family:

"I'd put my hand up and said, 'Hey, I've got a drug problem, that I can't look after - keep up myself, let alone look after my children.' Since that, for the last six years, now it's a nightmare because I've admitted that I have a problem.
Interviewer: Can you tell me more about that?
[…] They use that as a blanket […] as in 'Oh he openly admits he has a drug problem, they can't go there.' It just automatically put me 10 steps backwards when I was trying to go and do the right thing." (Interview 4, Male 27 years)

A few participants spoke positively about times they had felt supported and not discriminated against during legal processes. These experiences were the exception not the norm, and were characterised by lawyers providing assistance when it was needed, and recognition of an individual's circumstances:

"It was very good, it was very good, yeah. Like I have been seeking assistance to reduce my drinking and I have been doing it myself, so I explained that, I'm actually getting better, and this was just a mistake, I had just woke up and forgot where I was. To me it's my lounge room, not the street. So I only got an $80.00 fine. Even the prosecutor sort of helped me through it. […] Yeah, it was strange but they don't usually try to help you." (Interview 7, Male 51 years)

Other services

In addition to health care, police and courts, many participants also had contact with a range of other welfare services such as charities and NGOs, housing services and Centrelink. While these services have a mission to provide support to marginalised and low-income members of the community, and would often have contact with people who had experienced problems with alcohol and other drugs, these settings were often equally discriminatory and judgemental environments. Participants spoke of the way alcohol and other drug use was looked down upon and how they were made to feel like they were not worthy of the same kind of help or assistance as might be offered to others. Again, this judgement was often borne from stereotypical assumptions about problematic AOD use:

"The Salvation Army and some of the places you get food vouchers from.[…] Well you start to tell them about your bills and things like that and you can see in their face that they're like you're full of f***ing s**t you junkie dog f***ing piece of s**t. Like you can just see. I've been around a lot of people and I've read body language and you can tell when someone just despises you or doesn't even want to give you eye contact. You know what I mean? Like you're not worthy." (Interview 11, Male 44 years)

"In homeless shelters a lot, straight off the bat they just assume, well, especially when you talk to the HOT team, the homeless outreach team, and then they find out that you've also been on drugs and all the rest of it, they just assume that you're a piece of s**t and you're going to knock everything off, and so you get put in dodgier places. Like I've had a room in a place where there was just broken crack pipes on the ground, needles lying around, and I'm a relatively clean junkie when I'm using. Not being able to access a lot of homeless places, it sounds bad, but just because of the assumptions and all the rest of it, I just used to sleep under a bridge." (Interview 14, Male 35 years)

Society at large

Stigma and discrimination impacted on participants in different ways, as they went about their daily lives. Outside of the particular institutions and settings described above, participants' experiences of stigma were perhaps less concretely attached to particular people, circumstances and interactions, but nonetheless permeated their lives with real effects.

Many participants spoke of the ways in which they felt that media portrayals, and in particular government-funded advertising campaigns, shaped society's perception of problematic AOD use, and contributed to stigmatising stereotypes. Participants felt that such campaigns and portrayals were not reflective of their own experiences. The ice campaigns especially were seen to be stigmatising and produce harm in terms of how people who use drugs were seen by society:

"When you see the ads of some guy on meth in a hospital, smashing up stuff and punching - I don't think it's a good thing. No, people just go, 'Oh, rehabs going to be full of those people.' When I took it, I just went out dancing and played ping pong all night. […] I had a great time. I know it sounds - I shouldn't say that. No, no, but I didn't do

anything absolutely crazy. […] So, when you put ads out there saying that we're horrible people, yeah it's weird." (Interview 2, Male 38 years)

"If you look in the papers and social media, and you relate those sort of drugs, they've already created this image of a person that uses that; that you've never seen before in your life, you have no idea what they're like. You hear the word and they're using this drug, you've already got an image of what they're going to look like. A skeleton, frail. That's what I mean." (Interview 3, Male 30 years)

One participant spoke about the imbalance in these media portrayals and how he thought that different kinds of media portrayals (for example, positive stories of change) could potentially reduce stigma and discrimination and increase understanding in the community:

"I think that with the way that, say, things are portrayed on TV, that's putting a stigma on behaviours, but also what about the reverse side of it; the outcomes for those that have succeeded and changed their life. It's all about the negatives and this is what ice users do, this is what heroin - but we don't get to see any of the other opposite end of the scale; of people that are suffering and copping stigma from their friends and family and that. There's nothing out there that shows hey, this guy was in addiction for ten years and look at him now, look what he has. He's got everything, family back. He's got a job, a car. So it's good to - for stigma, it puts a big downer on things, but we need something more about both ends, not always the negative." (Interview 3, Male 30 years)

The most common issue participants identified when speaking about experiences of stigma and discrimination in the community at large was the pervasive impact of the stereotyped 'junkie' image:

"Say if I come to grab needles, or something, and I'm walking down the street, people just automatically judge. Like, too bad if I was getting them for medical reason, like if I'm diabetic or something. People just assume that you're coming out of there that you're automatically a junkie." (Interview 10, Male 38 years)

"They automatically stereotype you because they're unaware of what addiction is. They're very stereotypical to - you know, you're an addict, you're a junkie. They pin it to people that live on the street or that - it's like, we're not all like that. We're not all - we don't all fit into that one category. There's such a wide range of people, even in here [in rehab]. Everyone's story's different." (Interview 6, Female 32 years)

"They thought we're disease-spreading junkies." (Interview 8, Male 45 years)

For some participants, experiences of stigma and discrimination in public (in the street) was exacerbated by gentrification of inner city suburbs and the tensions this had created alongside issues of homelessness and access to existing services which had historically been set up in these locations:

"I'm experiencing a lot more outwardly, sort of - my eyes caught a father carrying a daughter down the street and they were both just, like, staring at me, and it's happened to me numerous times. And I try to be thinking, "I hope that man gets better" in their heads, but my head will go, "We've got to get rid of that filthy junkie out of our suburbs." It's the gentrification of Bowen Hills." (Interview 8, Male 45 years)

Experiences of stigma and discrimination in public places ranged from 'looks' to physical violence:

"I've been spat on in the street. Sitting down and sitting on a swag, nothing to do so I'm sitting opposite a pub where there's a band playing. And I was sitting down, I'm just smoking a few cigarettes, sneaky little bit of pot, and listening to the music, I like my live music. And I'm just sitting there minding my own business and then people have spat on me because I'm homeless." (Interview 7, Male 51 years)

"Outside the train station, a lot of drug users, they all stand around The Valley train station. I think a lot of people knows that. A lot of the drug users stand around and they sort of look - give us dirty looks, because they know we're on drugs." (Interview 9, Female 46 years)

For some participants, these experiences of public judgement and exclusion were a part of everyday life. Often this was based on how participants looked:

"Oh day-to-day like just meeting people, they judge you on the way you look or the way you talk and won't have nothing to do with you." (Interview 11, Male 44 years)

As a result, participants would engage in strategies to avoid being identified as a person with a drug use history:

"Yeah, I've got a scar on my arm from it. If you don't hide it, I've got concealer down in my room, if I don't hide it when I go out, it's a big problem.
Interviewer: So you put concealer on your track marks?
Yep. It sounds silly, but it's the only way you can hide it. People see it and sort of go [makes disgusted sound]." (Interview 14, Male 35 years)

Summary

Experiences of stigma and discrimination were a common occurrence in the everyday lives of participants. Every participant could describe, in detail, multiple specific times that they had been judged, treated badly, looked down upon or excluded because of their experience of problematic AOD use. The frequency and commonplace nature of these experiences did not make them any less distressing for participants. As can be seen from the interview data above (and as will be explored in the case examples below) these experiences had profound effects in participants' lives. These effects were not superficial and cannot be dismissed as insignificant. Constant experiences of exclusion, marginalisation, and discrimination impacted on participants' access to health care (including treatment) and other services, fair treatment in the justice system, employment opportunities, and impeded connection to family, friends and community. Importantly, these experiences shaped participants' sense of self-worth, and how they saw their place in the world.

However, participants could also identify interactions and experiences which were different to their usual experiences of stigma and discrimination; where stigma had not been present. We suggest that there is much to learn from these descriptions: what does a non-stigmatising encounter look like? And how can we foster conditions so as to ameliorate the stigma experienced in so many different settings? In the following section, we draw on the interview data and examine particular case examples so as to consider these questions, before moving to discuss recommendations arising from the project as a whole.

5.3 Analytic case examples

Case example – Accessing medical care

Belinda is in her late fifties and lives in Brisbane, having grown up in regional Queensland. Belinda's life-long partner died recently, and she's now living alone. When Belinda was younger she used to have a drink after work and use cannabis, but not to any great excess. She still enjoys a few drinks when she's watching TV sometimes. Belinda has also injected heroin throughout her life, and has been on the opioid substitution treatment program on and off. Belinda contracted hepatitis C when she was very young. She says this is because the pharmacists in her home town refused to sell sterile injecting equipment. At the moment, Belinda is in treatment and is prescribed Suboxone by a psychiatrist. Belinda has a great relationship with her psychiatrist who is "a lovely, caring individual." Belinda feels that he "honestly cares" and she's "never struck that in a doctor" before now.

A few weeks ago, Belinda was woken up at 10:30pm by a pain in her hip. She paced around the house for 2 hours, trying to relieve the pain with hot and cold packs. At almost 1am, Belinda became concerned that there might some something seriously wrong, so she decided to go to hospital. Assuming that she might need to be admitted, Belinda packed an overnight bag, including a photo of her partner. Belinda lives not far from the hospital, so decided to walk there. Belinda arrived at the emergency department and described her symptoms to the nurse at the front desk (by now she felt like someone was stabbing her in the hip with a hot iron, and was also numb in places). The nurse began the usual intake procedure, and asked if Belinda was on any medication. Belinda said she was on Nurolax, Spiriva and Symbicort, and then told the nurse that she was also on 14 mls of Suboxone. At this point, the nurse stopped, looked at Belinda, changed her tone and said "Oh, you're on Suboxone are you? Well you're a bit clammy." Belinda had just walked some distance from her home with a big jacket and a hat on. Belinda was passed over to another nurse, and again described her symptoms: "I've got this pain in here, it's burning me, it's hurting me and I don't know what's going on." The second nurse asked her if she was on any medication. Again, Belinda was given a "real hangdog look" when she mentioned Suboxone. The nurse said "Oh, you're on that are you? Okay, all right then, say no more" and alluded to pain relief, assuming that Belinda was just drug seeking and wanted opioids. Belinda had her week's supply of Suboxone with her in a locked box, packed along with her clothes and partner's photo in her overnight bag. She wasn't seeking pain relief or drugs; she wanted to see a doctor to find out what was wrong with her. Feeling judged, Belinda said "Don't worry, I'll be fine" and turned and walked out of the emergency department. Belinda walked away, in pain, feeling angry and wondering what it would take to see a doctor and get treated like a 'normal' patient. "Just that one look" was enough for Belinda to walk away because she could see that it was a waste of time, and that she wasn't going to be taken seriously.

Belinda was still in severe pain the next morning, and arrived at her local primary care clinic at opening time. Belinda had been to the clinic before, and knew many of the staff. After talking to the nurse at the clinic, she was able to see her GP straight away, who diagnosed her with shingles. Belinda's GP wrote her a prescription. Before she left, Belinda asked her GP whether this new shingles medication was compatible with Suboxone. It was a conversation she didn't want to have with her local pharmacist, even though she knew the pharmacist would ask her if she was on other medication when dispensing this prescription. Given the looks she gets when she tells people that she's on Suboxone, Belinda often avoids telling pharmacists that she's on Suboxone. She's sick of the stigma and the judgment.

Points arising:

- Stigmatising experiences are a barrier to people who use drugs accessing appropriate care not only for their drug use but for all medical conditions;

- In particular, assumptions about 'drug seeking' behaviour form a significant barrier to health care for this stigmatised population. How can structures in medical environments make sure that doctors are protecting against drug seeking behaviour whilst also ensuring that people are getting the care/treatment/pain management they need?;

- Whether or not a patient is known to staff, or a regular client of a service should not determine the quality of care received. All patients should be able to access non-stigmatising and non-discriminatory health care at all services;

- Discriminatory attitudes are borne from not only the stigma associated with drug use per se, but also medications and conditions associated with drug use e.g. methadone/buprenorphine, hepatitis C, HIV etc. In trying to find ways to ameliorate drug-related stigma, we must also be aware of the impact of these layered co-stigmas;

- Experiences of stigma can make people reluctant to see doctors, or indeed be honest with medical professionals/pharmacists. Obfuscation and avoidance are used by people experiencing problematic alcohol and other drug use as strategies to avoid being stigmatised and judged, but these protective strategies could lead to harm (e.g. if a client does not disclose that she is taking Suboxone to a pharmacist, it is possible that other medications may not being compatible or she may not receive the appropriate dosing advice);

- Care and empathy and being listened to are important (and often rare experiences for people with experience of problematic AOD use);

- For many people with experience of problematic AOD use, experiences of stigma and discrimination build up over a lifetime. The stigmatising "hound dog look" or discriminatory treatment experienced in one setting is unlikely to be a standalone experience. For changes to have an impact, they need to be implemented across systems, not only at the individual level.

Paul was diagnosed with hepatitis C in the 1990s. Soon after being diagnosed he went to the Dental Hospital for a routine dental appointment. Paul flagged his diagnosis with the staff at the hospital, so that they knew.

After some time waiting, Paul was taken through to the surgery area. All the objects and furniture in the surgery area had been crudely and hastily wrapped in glad-wrap, and the dental nurses were all wearing "blood spatter space suits."

Paul went ahead with the dental procedure but made a complaint afterwards. He called the dentist aside to have a conversation about the glad-wrap and how he had been treated by the dental staff. The dentist cut him down straight away and rudely said "We're protecting ourselves." Paul felt like he was being told to "Cop it sweet, mate" and "Stop being so sensitive."

Paul felt like *he* was the contagion; that he was the one contaminated and that they were very reluctantly treating him. While Paul's experience at the dentist was over twenty years ago, he thinks that attitudes towards people who inject drugs haven't changed in the community. He thinks that people who inject drugs are thought of as "the real maggots who spread disease and cause all the trouble" and a "scourge to be eradicated."

Points arising:

- Educating health professionals about blood borne virus prevention and precaution is important to avoid extreme behaviour where people are made to feel like they are a 'contagion'. Blood borne virus prevention procedures should apply to every patient, and should never been applied in a stigmatising or discriminatory way. Such procedures should follow best practice, not be driven by fear;
- There need to be clear and accessible information about the avenues for people to make complaints and be taken seriously. Such complaints mechanisms should take into account people's experiences of stigma (and often internalised stigma). Peer liaison officers in health care settings may assist individuals to navigate such systems;
- People should not be made to feel like second-rate patients being reluctantly treated. Everyone deserves quality health care;
- There is a consensus building that the criminal law is not the most appropriate avenue for dealing with issues around blood borne virus transmission, and that alternatives to prosecution such as public health management are preferable. We note that in other jurisdictions this area of law is being reformed (NSW). How Queensland might reform these laws is worthy of consideration, given their stigmatising effects.

Steve grew up in Brisbane and is now in his thirties. He was a good student at school and his first job was in his parents' small business. Steve's not really sure why he started taking drugs, but he started smoking cannabis when he was a teenager and found that dealing a bit made him very popular at school. He was engaged to a "beautiful" woman when he was 22 years old, and stopped selling cannabis when that relationship broke up. It was around this time that he started using speed. It was easy to do; Steve's best friend dealt speed and had the "ultimate life" partying every night.

Steve was trying to "get clean" but was still using a bit. He was working in property management cleaning properties, and looking after gardens. While the other guys he worked with would knock off at 3pm or so, Steve would just keep working. He wanted the money and because he was still using, he was highly productive. He'd often offer to stay back and take extra jobs. Steve's supervisor loved his work ethic and that Steve was prepared to work 15 or 16 hour days.

Steve would sometimes ask his supervisor whether he could get some of his pay in advance, rather than waiting for pay day. This made Steve's supervisor a bit suspicious and he pulled Steve aside one day to ask if he was ok. Steve told him he was alright, and sensing there was some kind of an issue, asked straight out if there'd been any complaints about his work. Steve's supervisor said "No, no, you do great work" but then said "I'm going to have to let you go, mate." Steve asked why, and his supervisor was a bit cagey. Without being direct he said: "I can't have what you promote around my business." Steve was a bit confused and offended by this because he was a hard worker, there hadn't been any complaints, and he worked longer hours than anyone. Steve asked "What is it that I promote?" and was just told "You know what I'm talking about, mate. We can't have this around."

Steve was taken aback by this. He had been using, but he'd never used around his work colleagues. As far as he knew, no one knew he was using drugs. The only issue was that Steve had asked for his pay in advance a few times, often only a few days after he'd been paid. A few weeks earlier he'd tried to explain his requests for advance pay by pretending that he had a gambling problem. At that stage his supervisor had been very understanding and asked if he needed help with his gambling. When it was about gambling, his supervisor was asking if there was anything they could do at work to help Steve out. But now, the tone was very different. Steve was pretty sure that his supervisor had worked it out, and that the gambling excuse was no longer convincing. Once Steve's supervisor worked out that Steve's money problems were drug related, there was no offer of help. He was fired from his job, without any discussion. It was "See you later. We can't have your type here."

Steve just walked away. Losing this job was hard because Steve had been trying to reduce his drug use and had been working to avoid dealing drugs. Losing the job at this time just made his situation worse.

Points arising:

- The stigma of problematic AOD use means it sometimes cannot be talked about openly. Employers should be provided with training and resources to have conversations with employees. The workplace should be an avenue for support and help;
- Where AOD problems are affecting an employee's work and issues have arisen, employers should be equipped to help provide employees with pathways into help and

support. There should be mechanisms for returning to work, or adjusting work hours to accommodate the employee's needs;

- Assumptions that alcohol and other drug use is always associated with poorer performance at work is not always the case (we found many examples across the interviews where drug use was compatible in the workplace due to workplace culture, or just the need to stay awake for long periods). Such case examples challenge assumptions that people experiencing problematic AOD use are unemployed 'junkies'. People experiencing problematic AOD use could be in any workplace and need access to support;

- It is important to note that many workplaces are not large organisations with access to employee assistance programs and enterprise agreements which allow for periods of leave etc. Many people work as casuals, or as contractors or in small businesses. These workplaces need government initiatives to ensure that staff members have equal access to support and help. Equally, employers need access to information and education to support their staff and contractors.

Debbie moved to Queensland a few years ago. She has a son, and a young grandson. Debbie is currently seeking help for her methamphetamine use and has committed to a three-month residential rehab program. Debbie knew it was time to get some help when she nearly lost her job this year.

Debbie works as a carer in nursing home. Debbie was beginning to have trouble turning up for work, and had been giving her supervisor excuse after excuse. After a while, Debbie told her supervisor that she was struggling with depression and she referred Debbie to a psychologist through the workplace employee assistance program. Debbie found it easier to tell her supervisor that she was struggling with depression than mention drug use. She was worried about what the response would be if she mentioned drugs, and didn't want to lose her job. Debbie had already experienced judgement from her family about her drug use, and felt as though she was an embarrassment to them. Debbie didn't have a good experience with the psychologist she was referred to through the employee assistance program, and didn't feel comfortable with her. Debbie felt like the psychologist didn't really care because Debbie wasn't paying for the session, and she felt judged and shamed when she mentioned her drug use problems.

Things did not improve and a month later matters came to a head at work. Debbie had a meeting with her supervisor but took a support person into the meeting with her. The support person was a really good friend at work. Debbie had been honest with this friend recently about her drug problems. Before the meeting, Debbie's friend had researched drug treatment and had looked into rehab service options. When the meeting began, Debbie could sense that her supervisor was building up to saying "We're going to have to let you go." At that point, Debbie was honest and said "Look, I've got an addiction." Her supervisor asked her "What kind?" and Debbie talked about her methamphetamine use. Debbie's supervisor "was really good about." When Debbie felt like she didn't know what to say her support person was there to jump in and say that she'd done some research, and looked into treatment options.

Within 24 hours, Debbie's supervisor at the nursing home had organised an interview for her at a local rehab service. Debbie knows that sometimes people wait for ages to get into treatment, but thinks that her supervisor must have made special arrangements or done some work behind the scenes to make sure she got help straight away. Debbie was in the rehab program within 4 days.

Debbie's workplace has given her extended leave and is holding her job for her for as long as she needs. Knowing that her job is being held for her gives Debbie an incentive "keep going." Debbie has a few people from work saying hi and sending her supportive messages via Facebook.

Had she known that this would be her workplace's response, Debbie thinks she would have talked about her drug problems a month earlier, when she'd talked to her supervisor about her depression.

Points arising:

- Debbie's story is a good news example, and there is much to learn from these processes for other workplaces. From this case example, we can see the ways in which workplaces can provide pathways for employees to seek treatment and help as part of workplace policies and procedures;

- The stigma of drug use is greater than the stigma associated with mental health problems. As such, seeking help with mental health can be a doorway into confidentially accessing help for drug problems, and may be easier to talk about with employers. Emphasising that support services provided through the workplace are confidential may increase employees' willingness to access them. Employee Assistance Programs should be equipped to manage both mental health and AOD issues;

- Employees should be told that help is available so they seek help early. If policies and procedures are made clear to all employees then individuals may be less worried about what the response might be, knowing that systems of support are in place. Friends and colleagues can also play a supporting role, if they too are aware of what support structures are in place. Policies should be transparent and employees should be aware that pathways are available should they need help (in ways that won't jeopardise their employment);

- Quick and easy access to treatment is important, so that people can get help when and where they need it;

- There is a need to review Queensland protocols for AOD in the workplace to ensure that the competing policy priorities of workplace safety, employee privacy and also avenues for help and treatment (not mere dismissal) are balanced effectively.

Joel is 44 years old. Joel moved to Queensland in the late 1990s when his ex-partner decided to move north with their daughter. Joel has two other children with his current partner, but the relationship has been a bit of a rollercoaster. Joel feels like he struggles to fit into the "normal world" and was diagnosed with adult ADHD when he was in his thirties. Joel uses cannabis regularly and methamphetamine occasionally. Joel will use for a few days and then go for weeks at a time without using, and feels that he has control over his use. Lately, Joel has had some good support from a GP who made him feel that he wasn't a hopeless case, and took the time to listen. It is rare for Joel to feel like someone is willing to help him.

Joel was very close to his grandfather who had brought him up for nine years when his Dad wasn't around. Joel's grandfather was dying, so Joel went to Centrelink to make an application to access a bereavement payment so he could travel to see him before he died. Joel's application was refused on the basis that his grandfather wasn't his immediate family. Joel was very distressed and felt like Centrelink wasn't taking his application seriously even though he was providing proof of his grandfather's illness. While the application was being discussed, the worker at Centrelink said "Where do you spend your money? You're putting it up your arm." Joel was already feeling very low and upset, knowing that his grandfather was so ill. He was angered by the worker's insinuation that he wanted the money for drugs and refused to leave the Centrelink office. Eventually they let Joel use the phone to call his grandfather at the hospital. They only spoke for a few minutes. That was the last time Joel got to speak to his grandfather, who died soon after.

Joel never made a formal complaint about the worker's comments. He was too distressed. He never went back to that particular Centrelink office, though.

Joel is angry about how he is treated at services that are meant to be providing support for people who need it: "They're supposed to be *helping* poor people that are in those circumstances. You know what I mean?"

Points arising:

- Stigma manifests in a range of settings, including welfare and support services. Anyone who works in a service capacity with people who may be experiencing problematic AOD use should be educated about non-stigmatising practices. Comments like "you're putting it up your arm" are completely unacceptable for any service provider, in any setting;
- Often people experiencing problematic AOD use will not make formal complaints, precisely because they feel judged and shamed. There need to be clear and accessible information about the avenues for people to make complaints and be taken seriously. Peer liaison officers may be helpful to provide assistance in welfare services;
- It is important to recognise that not everyone's drug use is 'out of control.' There is research in the AOD literature demonstrating controlled drug use. Even where people understand their drug use to be out of control or problematic in their lives, stigmatising and discriminatory behaviour (of the kind experienced in Joel's case) is never justified;
- Feeling listened to and supported is the exception not the norm for many people who use drugs.

Paul is 45 years old. He was born in Brisbane but spent 5 years living in Melbourne in the late 1990s. Paul has been in and out of rehab a few times, and has a history of methamphetamine and heroin use. Paul has experienced homelessness at a few points in his life and constantly feels like housing services are dragging their feet.

While Paul was in rehab, the new Housing Minister came to visit the service. He gave a presentation and mentioned a new approach to housing policy, which planned to combine private and public housing options. Given Paul's experiences of homelessness, drug dependence and seeking help with housing, he spoke up and shared what he thought about this proposal. Paul spoke to him "straight up" about what he thought was the failure of a similar scheme in Brisbane, which had become "centres for drug addiction, drug addicts and criminality." Paul really enjoyed being able to share his thoughts and speak authoritatively on a topic he cared about, to a person in a position to make decisions and implement change.

After the presentation, Paul sat down and spoke to the Minister more over lunch. The Housing Minister was "really cool" and Paul felt like he was "non-judgmental" and wasn't treating him "like an addict." Paul respected that the Housing Minister had to "stick to the party line" and thought that some of his arguments were "fair enough". He was genuine.

Paul is concerned about how the gentrification of inner city suburbs of Brisbane impacts on people like him.

Points arising:

- People who use drugs should have their voices heard in policy discussions about issues that directly affect their lives;
- Being heard can reduce experiences of stigma. Research in the public health domain about consumer participation in health policy and practice has demonstrated that participation can be destigmatising;
- It is important to recognise that people who use alcohol and other drugs have knowledge to share;
- Urban development and gentrification is an issue for accessing services which have historically been in these areas and has a day to day impact in people's lives. Services should be included in planning processes and partnerships developed to ensure that people accessing services are not increasingly marginalised;
- AOD-related stigma is not isolated in one particular setting. Stigma manifests in multiple ways in people's lives. Consideration must be given to the intersection of stigma across health, housing, social services, policing etc.

Steve went fishing every night for a while. It was something he could do which meant he wasn't at home bothering his parents or annoying anyone. He found it also calmed him down when he felt paranoid. Often he'd go fishing by himself, sometimes with a friend. He would never drive under the influence if he'd taken any drugs (Steve used cannabis and methamphetamine) and he would usually ride his pushbike or walk to a local fishing spot.

Steve has never been charged with any drug offences but felt like he was becoming a 'police target' at that time. For a while, the Police were pulling Steve up every single night and would search him. The Police would constantly stop him to ask what he was up to. Steve never had drugs on him and he never used drugs in public (it wasn't his thing to do that). Steve felt he was being targeted because he "looked like a junkie."

Constantly being pulled up and searched made Steve feel like a fugitive. Every night for six months he'd have to talk to the Police, sometimes for up to an hour. He was never charged with anything. But more than this, he was never offered any help. Things were hard for Steve, and he was using fishing to get away from the feelings of paranoia he'd often experience. Night after night the Police officers would establish that Steve didn't have any drugs on him, and he wasn't doing anything wrong. Steve thought that instead of repeatedly strip searching him on the side of the road at night, if they were concerned about him or his behaviour, perhaps they could have offered some other help or advice. Steve felt degraded by these experiences.

Points arising:

- Police are often the 'front line' workers in the community who come into contact with people experiencing problematic AOD use, but their role as 'law enforcers' is sometimes problematic if people are subject to constant police attention;

- For some people experiencing problematic AOD use, this level of police attention can become a form of harassment (this is especially problematic if people are experiencing psychological distress). It is important that clear and accessible systems be put in place to help people make complaints when this occurs, without retribution. Peer liaison officers may assist here, given that individuals may feel reluctant to make complaints;

- In any police encounter, individuals should be treated with dignity and not be made to feel degraded by police questioning;

- Consideration should be given to whether police might be an avenue for offers of help rather than just punitive actions, especially for people 'known' to police. How could such pathways we built into police protocols and operating procedures? Within particular local communities are there untapped opportunities for partnerships between police and other services better equipped to assist? This could take the form of a Memorandum of Agreement, for example. Police should be provided with resources to make referrals and direct people to appropriate services.

Gary doesn't like to admit that he's over the age of 50. Gary has been a binge drinker since he was a teenager but has only recently become alcohol dependent. Living on the streets for the last three years and a battle through the family courts became the triggers for Gary's alcohol problems. Drinking numbs the anger. But he's been doing well lately and has reduced his drinking substantially and he's not drinking at all two days a week.

Since Gary has been homeless, it has been too easy to drink because he doesn't have anything else to do. He tells people that 'he's in the park because he's drinking and he's drinking because he's in the park.' He feels that every time anyone sees the swag they decide that he's not worth helping; that there's no use in helping a 'homeless alcoholic.' Gary says his biggest problem is getting help.

The Police regularly harass Gary about his drinking. On the weekends, Gary will often find somewhere to sit outside a pub or a music venue, and will listen to the music and watch the world go by. He says, "It's like my television." If the Police saw him, they'd check if he had a bottle on him. Because they knew Gary had been caught for drinking in public before, and they saw him regularly in parks and public spaces, they'd look for a bottle and tip it out or slash the cask.

One time, Gary had just woken up. Gary had a bottle tucked in behind his swag while he slept. There was a Police officer sitting across the road, watching and waiting for Gary to take a swig after he woke up. Gary was charged with drinking in public. He admits he was doing the wrong thing, and knows it's against the law to drink in public. But when you're homeless, as he says, "Hey, I'm drinking in my lounge room. But that doesn't mean a thing to them."

The court date coincided with Gary's birthday that year. Gary represented himself in court and explained to the Magistrate that he'd been reducing his alcohol use and had been getting better, and this incident had been a mistake. He thought of the park as his lounge room, not the street. The Prosecutor helped him through the legal process too, offering to guide him through and get it over and done with so he didn't have to come back. Even though she was helpful, Gary assumes she was thinking that he wanted it over with just so that he could "piss off and get drunk." On this occasion, Gary got an $80 fine. He felt like it was all very petty.

Points arising:

- As noted earlier, police are often the 'front line' workers in the community who come into contact with people experiencing problematic AOD use;
- Increased police attention is a particularly significant issue for people experiencing homelessness, as they do not have access to private spaces and are often in the eye of the public and the police;
- Homelessness is another issue where police (as 'front line workers') could be a vehicle for offers of help rather than just enforcement actions, especially in cases where individuals are 'known' to police;
- It is important to consider how people experiencing problematic AOD use, or other vulnerable people, might be better supported in legal processes and court environments. Peer liaison officers in courts could be appointed to work with this population, to ease the process and reduce stigma and discrimination in legal settings.

6. RECOMMENDATIONS

We have developed these recommendations from a synthesis across the three primary data sources: the literature review, the legislation review and the participant interviews. Given the extensive mechanisms which produce discriminatory outcomes, approaches put in place to reduce stigma must also be broad ranging (Link & Phelan, 2001). In making these recommendations, we are mindful that approaches must be *multifaceted* to address these many mechanisms, but also *multilevel* to address issues of both individual and structural discrimination. Circumscribed interventions that target only one mechanism at a time are unlikely to bring about change because they fail to address broader contextual factors (Link & Phelan, 2001).

There are 34 recommendations in total, as listed in the below table.

Table 5: List of all Recommendations

Overarching recommendations:
Recommendation 01: Implement a Queensland Human Rights Charter
Recommendation 02: Conduct anti-stigma awareness training across all relevant workforces
Recommendation 03: Ensure consumer participation in policy and actions designed to reduce stigma and discrimination
Recommendation 04: Increase the access and availability of AOD treatment
Recommendation 05: Improve the marketing of AOD treatment
Recommendation 06: Better support family members of those in AOD treatment, through education and information resources
Recommendation 07: Invest in improvements in the physical facilities within AOD treatment services
Recommendation 08: Employ peer workers/liaison officers in health care settings
Recommendation 09: Audit complaints mechanisms in health care settings
Recommendation 10: Conduct consumer rights 'training'
Recommendation 11: Develop and disseminate clear clinical advice about pain management in people with opioid dependence for emergency departments and primary health care settings
Recommendation 12: Develop and disseminate clear clinical advice about access to medications for those with concurrent physical and mental health disorders and AOD use
Recommendation 13: Ensure consumer participation mechanisms are not just part of health care service provider's accreditation, but are implemented
Recommendation 14: Review reporting and monitoring systems to ensure anti-stigma actions are

part of organisational Key Performance Indicators

Recommendation 15: Develop and implement programs aimed at resilience to internalised stigma for people experiencing problematic AOD use and AOD treatment clients

Recommendation 16: Consider introducing a supervised injecting facility

Recommendation 17: Consider reform of the 'notifiable conditions' sections of public health law

Recommendation 18: Amend legislation pertaining to HIV/hepatitis C

Recommendation 19: Apply the recommendations from health care to welfare and support services

Recommendation 20: Encourage police to be aware of and where possible facilitate access to services

Recommendation 21: Consider a pilot of tracking police encounters

Recommendation 22: Ensure Memoranda of Understanding are in operation between police and health care and harm reduction service providers

Recommendation 23: Reform areas of criminal law where the definition of the behaviour has the potential to be stigmatising or applied in discriminatory ways

Recommendation 24: Decriminalise the personal use/possession of drugs

Recommendation 25: Amend laws regarding peer distribution of injecting equipment

Recommendation 26: Review policies regarding criminal history checks at pre-employment

Recommendation 27: Encourage uptake of clear employer guidelines regarding AOD use in the workplace and how to best respond

Recommendation 28: Improve access to Employee Assistance Programs

Recommendation 29: Develop and support pathways into employment for people completing AOD treatment

Recommendation 30: Encourage and support flexible work hours policies

Recommendation 31: Exercise extreme caution in mass media campaigns for drug use prevention

Recommendation 32: Explore running a mass media campaign to reduce stigma

Recommendation 33: Improve Queensland media reporting of AOD issues

Recommendation 34: Implement guidelines for government department communication about AOD issues

Recommendations are discussed in sub-groups pertaining to the five settings where stigma and discrimination were found to most commonly and pervasively occur:
1. Health care/public health
2. Welfare and support services, including housing
3. Police, public order and criminal law
4. Employment
5. Society at large

There are three overarching recommendations, which apply across all of the above. We discuss these three overarching recommendations first, before addressing each of the five settings.

6.1 Overarching recommendations

Recommendation 1: Implement a Queensland Human Rights Charter

Throughout the data collection for this project, we were made aware of and identified the importance of human rights, and in particular the rights of people who are stigmatised and marginalised. A Human Rights Charter would provide protection for all members of Queensland society, not only people with experience of problematic AOD use. As noted in the literature review, in order to bring about meaningful change, it is essential to address structural factors (and not only individual attitudinal and behavioural factors). A Human Rights Charter is one mechanism through which widespread structural stigma and discrimination can be alleviated. A Human Rights Charter would seek to provide broad, overarching human rights protections to individuals in certain circumstances, including, in particular, where 'public authorities' make decisions that impact upon them. In this sense, human rights laws are intended to act as a 'backstop' – or a check and balance – against infringements of certain basic rights and the use of excessive power by public authorities.

Two jurisdictions in Australia (Australian Capital Territory and Victoria) have human rights charters. The relevant Acts are the *Human Rights Act 2004* (ACT) and the *Charter of Human Rights and Responsibilities Act 2006* (Vic). In a recent statutory review of the Victorian Charter, Michael Brett Young noted that "The Charter is designed to improve the lives of individuals and the life of the community as a whole. It performs an integral role in our democratic society by protecting fundamental rights and freedoms" (Brett Young, 2015, p.iii). In imposing obligations on public authorities to consider human rights in the carrying out of their statutory duties, human rights charters can help to foster and encourage a culture of human rights and respect, particularly for marginalised populations. In both Victoria and the ACT, human rights charters have been used to successfully challenge and/or prompt revisions to discriminatory health care practices and policies and to disrupt entrenched perspectives on particular cohorts (for examples, see Brett Young, 2015). In Victoria, for instance, the Charter has been utilised to prompt changes to hospital policies and processes to better accommodate the needs of patients from Muslim, Jewish and Aboriginal backgrounds who require same-gender medical care for religious or cultural reasons. In practical terms, this might mean that a pregnant Jewish woman will now have access to a female obstetrician for maternity care if that is her preference and the hospital can accommodate it. Were human rights legislation to be introduced in Queensland, we think it highly likely that similar systemic and culture change could be effected.

We understand that discussions regarding a Human Rights Charter have been underway in Queensland for some time and that a Legal Affairs and Community Safety Committee Inquiry in 2016 was unable to agree on whether a Charter was necessary and appropriate (Queensland Parliament, 2016). The Queensland Mental Health Commission (2016) expressed support for a

Charter based in part on its potential to provide much-needed support to people who experience AOD problems. Calls for a Human Rights Charter in Queensland are ongoing, and include a campaign which is generating public support (http://www.humanrights4qld.com.au/). The findings of our report provide further evidence of the likely benefit of the introduction of a Human Rights Charter in Queensland, should parliament revisit the issue in future.

Recommendation 2: Conduct anti-stigma awareness training across all relevant workforces

Within Recommendation 2 we specifically recommend the following:
- Evaluate the 'Putting the puzzle together' program;
- Subject to evaluation findings, provide resources to roll out the 'Putting the puzzle together' program across services in Queensland and develop different modalities of delivery;
- Develop and evaluate a similar program focussed on alcohol;
- Identify opportunities to provide awareness training, beginning with a needs assessment within the priority targets of health practitioners (as well as the Health Ombudsman's office and Department of Health employees), law enforcement officials (including police and Corrections employees), and employers.

The lived experience of the participants as reported in the interviews has shown the impact that health care providers, police and welfare staff attitudes (both positive and negative) can have on how they feel about themselves, and access to and provision of services. Awareness training broadly refers to behavioural, educational and social intervention programs that address actionable causes of stigma, by creating an awareness of what stigma is, how it is produced and its implications. We note the findings of the literature review, that information-based approaches along with skills building is more effective for increasing knowledge and reducing stigmatising attitudes, compared to simply providing information alone (Brown, et al., 2003). The literature review identified a number of successful awareness programs from the AOD, HIV and mental health fields, particularly education and awareness programs aimed at health care workers and other professionals (e.g. Brown, et al., 2003; Hayes, et al., 2004; Li, et al., 2014; Lohiniva, et al., 2016; Sengupta, et al., 2011; Shah, et al., 2014; Varas-Díaz, et al., 2013; Varas-Díaz, et al., 2016; Wu, et al., 2008).

We note that QuIHN (Queensland's peer-based drug user organisation) is already equipped to deliver an awareness program which has been developed by the Australian Injecting & Illicit Drug Users League (AIVL). It is called the 'Putting together the Puzzle' program. As noted in the literature review, QuIHN has adapted this national program to be suitable for delivery across a variety of settings in Queensland. This program focuses on reducing stigma and discrimination experienced by people who inject drugs, people on opioid pharmacotherapies and people affected by HCV and other BBVs. Delivered over five sessions, the objectives of the workshop-based program are to: develop deeper understandings and awareness on how stigma and discrimination occurs; develop a comprehensive understanding of the impact of stigma and discrimination; develop a comprehensive working knowledge of strategies and initiatives to prevent and challenge stigma and discrimination directed at people who inject drugs from an individual, organisational and community perspective; and help participants to identify at least one personal or individual strategy to reduce barriers to access and services that they can implement within their personal and/or professional lives. A particular strength of this QuIHN/AIVL program is that it has been developed by people with lived experience of drug use, and is delivered by people with lived experience of drug use. The engagement of people with lived experience in the development, planning and delivery of awareness training is essential.

Since 2014, the 'Putting together the Puzzle' program has been delivered in a variety of settings in Queensland including the Australian Winter School Conference, different pharmacy groups, Probation and Parole, Department of Child Safety, as well as youth workers, nurses, GPs, community workers and with staff and volunteers at QuIHN and QuIVAA. An abridged version of the program has also been delivered to the Queensland Police Force as part of a more generalist AOD training session. There are also plans underway to deliver the training to the Pharmacy Guild and for NSP/OST pharmacists and pharmacy staff. This program is designed to be delivered by people with lived experience of drug use (see AIVL, 2016). To our knowledge, QuIHN has not received dedicated funding to ensure the ongoing delivery of this program, nor expand its remit. This is currently an untapped resource which could be rolled out across Queensland. In the first instance, an evaluation of the QuIHN program would provide the necessary evidence-base to either adjust or expand their program to these other target groups, and tailor it to a variety of settings, professional groups and workforces in Queensland. Expansion and tailoring to cover alcohol is also required.

As identified in the legislation review, there are many decision makers and professionals beyond health, welfare and police who exercise power and discretion in relation to people experiencing problematic AOD use. These are listed on page 63, and repeated here:

- Law enforcement officials;
- Judiciary;
- Corrections staff;
- Education providers;
- Certain regulatory boards (e.g. Veterinary Surgeons Board);
- Staff from the Department of Health;
- Health practitioners;
- The Health Ombudsman;
- Proprietors of licensed premises;
- Venue operators;
- Mining operators;
- Employers;
- Sellers of goods;
- Second-hand brokers;
- Rail safety officers;
- Environmental health officers;
- Licensees; and
- Firing range operators.

Awareness training for these workforces is also required. Given the evidence provided in participants' interview accounts, we suggest that health practitioners (as well as the Health Ombudsman's office and Department of Health employees), law enforcement officials (including police and Corrections employees), and employers should be priority targets within this list. As noted in the literature review, stigma-reducing programs tend only to be effective when based on context-specific needs assessment and collaborative planning (Bos, et al., 2008). We suggest that needs assessment and collaborative planning be undertaken as a priority in the settings identified as of primary concern.

We recognise that a face-to-face multi-session training program may not be feasible in all workplaces and with all workforces. While QuIHN's 'Putting together the Puzzle' program is currently designed to be delivered in a particular way, there may well be scope to adapt this program to be delivered through different modalities (e.g. face-to-face programs of various duration, online, self-completion etc). Where different modalities are developed, we again emphasise that the engagement of people with lived experience of problematic AOD use in the development, planning and delivery of awareness training is nonetheless essential for a variety of reasons. One obvious example is the choice of language and imagery used in such programs; the involvement of people with lived experience can help ensure that language and representations of alcohol or drug use are non-stigmatising.

There are a number of ways in which the uptake of awareness training might be enhanced across a variety of workplaces and industries. AOD awareness training might be incentivised for example through the award of continuing professional development points for various professions including health care, psychology and law, where such professional accreditation systems are already in place. It would also be possible to use regulation to enhance uptake by making AOD awareness training a requirement of accreditation for particular organisations or services, or when in receipt of Queensland government funding.

As noted in the literature review, individual attitudinal awareness is not enough on its own, and should be regarded as just one aspect of a *multifaceted* and *multilevel* approach. It is essential to consider how sustained change in practices might be introduced.

Recommendation 3: Ensure consumer participation in policy and actions designed to reduce stigma and discrimination

As noted in the literature review, including marginalised individuals in policy processes (consumer participation) is one way of reducing stigma and discrimination, and an important ethical consideration. Consumer participation may be understood broadly along a scale ranging from information, to consultation, partnership, delegation and control (Duckett & Willcox, 2011).

Consumer participation should be implemented and integrated at all levels: planning, design, delivery, monitoring and evaluation. Consumer participation should be resourced and implemented across all areas of health care, welfare and housing, and whenever AOD-specific resources are being developed to ensure that such resources are not stigmatising and discriminatory. This is an especially important consideration in designing and implementing strategies aimed at preventing stigma and discrimination, and should be resourced accordingly.

6.2 Health care/public health

Recommendation 4: Increase the access and availability of AOD treatment

AOD treatment reduces stigma through a number of mechanisms. Provision of treatment shows care and concern for the welfare and wellbeing of people who experience problematic AOD use, and treats with respect and dignity the problem of AOD use. It emphasises that problematic AOD use is a health and social issue, to be addressed as such. Of course, treatment provision also has many other substantial benefits simply in terms of recovery. AOD treatment has been shown to reduce consumption of alcohol and other drugs, improve health status, reduce criminal behaviour, improve psychological wellbeing, and improve participation in community (Ritter, et al., 2014).

Increasing the availability of AOD treatment was seen by interview participants are an essential part of reducing stigma. When explicitly asked what they would like to see changed to reduce stigma, many participants said that they would like to see more treatment available and more avenues for seeking help. As one participant said:

> "More rehabs, so there's not big waiting lists so guys aren't waiting for a month. I mean, they could be dead in a month, more rehabs." (Interview 13, Male 38 years)

The increase in availability of AOD treatment in Queensland should also consider the settings of treatment. As noted in the literature review, increased provision of treatment through primary care settings may help reduce stigma and increase access (Lloyd, 2013), provided that practitioners have received awareness training (see Recommendation 2).

Recommendation 5: Improve the marketing of AOD treatment

Improving AOD treatment marketing reduces stigma associated with treatment seeking, and increases the uptake of AOD treatment. Marketing materials (whether generated by the Queensland government or by NGO treatment services) should redress stigma by normalising AOD treatment, providing accurate information about access paths and outcomes (and self-evidently not use images or language that may increase stigma). The involvement of consumer and family representatives in the development of such materials is essential.

AOD treatment marketing and information materials have dual audiences: (1) people experiencing problematic AOD use who may wish to access treatment; and (2) concerned family and friends who may need information and support. Carefully designing AOD treatment marketing to reduce stigma associated with AOD and treatment itself will also help to inform the community, increase awareness among family members and friends, and ultimately enhance social reintegration and connection. As many participants noted in the interviews, isolation and family rejection even when seeking treatment was a great concern, largely due to lack of information and awareness.

Recommendation 6: Better support family members of those in AOD treatment, through education and information resources

Within Recommendation 6 we specifically recommend the following:
- The development of resources especially for family members of those in AOD treatment;
- Partnering with Family Drug Support Australia to expand their support services to Queensland families and develop resources aims at reducing stigma.

In both the literature review and participant interviews, we found the impact of the families, friends and loved ones was a significant part of how people who experience problems with AOD use view themselves.

> "Birthdays, gatherings, weddings, dinners and what not - no invites being handed out, because you're an embarrassment. That's what it comes down to." (Interview 3, Male 30 years)

Families have powerful influences on people. By educating family members and increasing education and awareness through the provision of non-stigmatising resources, it is possible to reduce stigma for family members (and for the person in treatment) and encourage them to be able to better support their loved one. Tangible resources in the form of information brochures, as well as online resources (for example information pages, adapted awareness training modules,

or mobile-based apps) should be developed. Such resources could be developed through an integrated approach alongside design and development of AOD treatment marketing (see Recommendation 5). Related to Recommendation 2, an awareness training program or module could be developed, targeted specifically at families.

People with lived experience of problematic AOD use should be involved in the design, development and delivery of such education and information resources, for example partnering with Family Drug Support Australia (http://www.fds.org.au/). Family Drug Support's mission is to assist families throughout Australia to deal with alcohol and drug issues in a way that strengthens relationships and achieves positive outcomes. We understand that Family Drug Support are in the process of expanding their support services to Queensland families and significant others with new funding from the Queensland Government through Queensland Health. The funding will support more Queensland callers to the Telephone Support Line, establish additional Family Support Meetings and help deliver the Stepping Stones Program and Stepping Forward Sessions in targeted locations across the State. Extending this support to include partnering to develop tangible resources, by families for families, aimed at reducing stigma and discrimination would be beneficial.

Recommendation 7: Invest in improvements in the physical facilities within AOD treatment services

As noted in the literature review, the ways in which drug treatment services are stigmatised and 'marked' as services 'for junkies' means that would-be help seekers seek to distance themselves from such settings (Radcliffe & Stevens, 2008). Negative connotations with treatment settings have practical implications and are a barrier to early intervention. As noted above, one option is to provide AOD treatment through both specialised as well as primary care settings (Lloyd, 2013). Another approach is to actively improve the physical environment of AOD treatment settings to reduce the stigma associated with these spaces. The physical environment of treatment services is often not prioritised due to tight funding environments, however investing in the physical space can decrease the sense of shame felt by AOD treatment clients, show respect (by providing physical settings of an equivalent standard to those provided in other specialist health care settings) and help reduce discriminatory attitudes from the wider community. As per Recommendation 3, people who have experienced problematic AOD use as well as current- and ex-clients should have input into design.

One option would be to partner with art rental services such as the Commonwealth-funded Art Bank program (http://artbank.gov.au/). Another avenue would be to partner with local Queensland arts institutions and galleries such as the Queensland Art Gallery and Gallery of Modern Art, or other local community-based galleries and organisations. We note that similar work has recently been undertaken in Queensland, in the Lady Cilento Children's Hospital. Such partnerships may also feed into art programs in which AOD treatment clients may also participate.

Recommendation 8: Employ peer workers/liaison officers in health care settings

Many people with experience of problematic AOD use have repeatedly suffered discrimination in health care settings (as seen in the participant interviews). Given internalised stigma, people with experience of problematic AOD use may not be assertive in health care settings when feeling unwell, vulnerable and disempowered. Having peer workers and/or liaison officers on hand to advocate for this population group is one crucial way of addressing systemic discriminatory cultures and practices, as well as providing direct support for individuals.

It is important for people with experience of problematic AOD use to have easy access to mechanisms for support in health care settings, to help overcome structural stigma and

discriminatory attitudes of individual health care workers, and gain access to the health care they need. The employment of peer workers and/or liaison officers is one such mechanism.

While ideally resources would be provided to employ peer workers or liaison officers in all health care settings in Queensland, as an initial step we suggest that an audit take place to establish sites of particular concern (for example hospitals or emergency department settings which regularly see people with experience of problematic AOD use such as Royal Brisbane Hospital).

As such, within Recommendation 8 we specifically recommend the following:

- Undertake an audit of existing peer worker/liaison officers across all health care settings in Queensland to establish key settings of need, and map systems already in place;
- Provide resources to sites of particular concern where liaison officers are note currently engaged.

Recommendation 9: Audit complaints mechanisms in health care settings

Complaints mechanisms are one way in which the ongoing issue of stigma and discrimination leading to poor treatment being received can be addressed, and so they play a vital role in empowering clients as well as ensuring continuous improvements to health care services. Formal complaints mechanisms are available in Queensland, through for example the Office of the Health Ombudsman. There may also be local systems in place, within particular services, settings or districts.

A full audit of complaints mechanisms in health care settings is required, given the findings of this report, particularly the accounts provided by interview participants. This audit should cover emergency departments, primary care, pharmacies, AOD treatment services, as well as other health care settings (including community health).

The focus of this audit should not be limited to mere availability of complaints mechanisms. Complaints mechanisms must be: (1) available; (2) easy to access (even for people with low literacy, or internalised stigma); (3) publically and openly advertised; and (4) non-stigmatising (e.g. the potential for anonymity when making a complaint is especially important for individuals who use illicit drugs, or for those who are in precarious living conditions and for whom health care access is essential). (Operationally there is overlap between this recommendation and Recommendation 8 above – peer workers or liaison officers may be one important way of facilitating access to complaints mechanisms). Another key aspect of such an audit would be mapping barriers in cases that do not proceed to finalisation by complaint agencies or Tribunals (Legal and Discrimination Working Party of MACBBVS, 2013).

As such, within Recommendation 9 we specifically recommend the following:

- Undertake an audit of complaints mechanisms available in health care settings (emergency departments, primary care, pharmacies, AOD treatment services, community health) across Queensland to establish gaps, and map systems already in place.
- Conduct an analysis of mapping of cases that do not proceed to finalisation by complaint agencies or Tribunals to understand barriers.

Recommendation 10: Conduct consumer rights 'training'

As noted in the literature review, and demonstrated in participants' accounts, self-stigma or internalised stigma can impact on people with problematic AOD use in multiple ways. This may include being reluctant to make complaints; people who have internalised the stigma associated with problematic AOD use may not believe that they are entitled to appropriate care and treatment or see themselves as full citizens. Educating and empowering people through consumer rights 'training' is another mechanism by which discrimination in health care settings can be addressed. This can be implemented by increasing funding for community groups, legal centres and human rights agencies to engage in outreach, community education and rights awareness for priority populations (Legal and Discrimination Working Party of MACBBVS, 2013).

Recommendation 11: Develop and disseminate clear clinical advice about pain management in people with opioid dependence for emergency departments and primary health care settings

Through the participant interviews and case examples, we identified a problem related to denial of appropriate pain management. Denial of pain management may be due to suspicions about drug seeking behaviour and/or lack of clinical understanding of pain management issues for people with opioid dependence. It is essential that people who experience problematic AOD use have access to appropriate health care (including appropriate pain management) and that stigmatising stereotypes about people with a history of drug use do not guide interactions with clients. This is especially important for people currently engaged in opioid substitution treatment programs. Clear clinical guidance (in the form of best practice guidelines and awareness training) especially in relation to pain management amongst this population is required across all health care settings ranging from hospital emergency departments to local general practice and primary care.

Recommendation 12: Develop and disseminate clear clinical advice about access to medications for those with concurrent physical and mental health disorders and AOD use

Relatedly, through the participant interviews and case examples we also identified a problem regarding access to medications for people with concurrent physical and mental health disorders and AOD use. In particular, accessing continual care and consistent prescribing of medications for psychiatric disorders and conditions such as ADHD was difficult for some participants. People with experience of problematic AOD use are stigmatised by medical professionals and in some cases denied medications for physical and mental health conditions with which they have been diagnosed. Clear clinical advice (in the form of best practice guidelines and awareness training) is required along with effective dissemination to clinicians treating patients with concurrent physical and mental health disorders and problematic AOD use. As noted in Recommendation 11, stigmatising stereotypes about people with a history of drug use should not guide interactions with clients nor prescribing decisions.

Recommendation 13: Ensure consumer participation mechanisms are not just part of health care service provider's accreditation, but are implemented

Consumer participation mechanisms need not only to be present, but *implemented comprehensively* in all Queensland health services and AOD treatment settings. Often such mechanisms form part of a health care provider's accreditation, but we suggest that there might be additional ways of ensuring comprehensive implementation, for example through reporting and data collection related to government funding of services. Consumer participation should be a reportable key performance indicator.

Moreover, organisations such as Health Consumers Queensland (http://www.hcq.org.au/) should be properly trained and equipped to manage issues relating to alcohol and other drug treatment, and understand the stigma experienced by people with experience of problematic AOD use across all health services. We suggest that a strategic partnership between Health Consumers Queensland and QuIHN would be beneficial.

Recommendation 14: Review reporting and monitoring systems to ensure anti-stigma actions are part of organisational Key Performance Indicators

One issue identified in the conduct of this project is that while many anti-stigma initiatives appear to be in place, there are often insufficient formal levers for their continuation or maintenance. To achieve multifaceted and multilevel stigma reduction, organisations and governments need to be held to account. One way of increasing the accountability, ensuring maintenance of anti-stigma initiatives and potentially incentivising them is to make sure that the initiatives form part of ongoing monitoring systems (such as key performance indicators).

Reporting systems can be reviewed with an eye to ensure that reporting becomes one way that stigma and potentially stigmatising practices might be (1) documented and (2) reduced. What is counted in performance measures and compulsory reporting is what matters in practice; activities inevitably focus on these reportable requirements. For example reporting in relation to referral rates (e.g. to housing services, AOD treatment) might help foster the provision of holistic, person-centred care and reduce discrimination for people experiencing problematic AOD use and homelessness.

Recommendation 15: Develop and implement programs aimed at resilience to internalised stigma for people experiencing problematic AOD use and AOD treatment clients

As noted in the literature review, there are a small number of interventions which are aimed at addressing internalised stigma (that is, when individuals take on and endorse public stigma within themselves) (Harper, et al., 2014; Luoma, et al., 2007; Rao, et al., 2012).

The programs developed in relation to HIV (e.g. Fuster-Ruizdeapodaca, et al., 2016; Harper, et al., 2014; Rao, et al., 2012) can be adapted for people with experience of problematic AOD use, to help functioning and quality of life, enable coping mechanisms and increase self-esteem. This program should be adapted in collaboration with consumer representatives to ensure consumer input and program acceptability. This program could be adapted for people currently experiencing problematic AOD use, as well as those in AOD treatment. It could be delivered through peer-based organisations (such as QuIHN), through needle and syringe programs, as well as through all AOD treatment services.

Recommendation 16: Consider introducing a supervised injecting facility

A publically endorsed space to inject more safely, under supervised conditions, reduces stigma in a number of ways. Most fundamentally it denotes that society cares for these people, and in practical terms it provides a secure space, not under scrutiny from police nor the general public. There are a number of well-documented public health reasons to implement these services, as demonstrated in the existing efficacy and cost-effectiveness literature (as outlined in the Drug Policy Modelling Program's annotated bibliography: https://dpmp.unsw.edu.au/resource/supervised-injecting-facilities). Since opening in 2001, the Sydney Medically Supervised Injecting Centre has supervised more than 1 million injections, and now managed more than 6000 overdoses without a single death.

Introducing a supervised injecting facility is one way to provide a compassionate and practical health service that connects with people who inject drugs in a non-discriminatory way. These

services also provide an opportunity for brief interventions and provide links to treatment, support and other social support services. A number of our interview participants recognised the need for such a service, and mentioned this as a key stigma-reducing intervention:

> "make a little area for drug users to go to and feel safe, that they can use their drugs, like they've got in Sydney." (Interview 12, Male 59 years)

We recognise that the introduction of such a service requires considerable discussion, and notably must be implemented in an area with an existing high rate of public street-based injecting.

Recommendation 17: Consider reform of the 'notifiable conditions' sections of public health law

In the analysis of legislation we identified a range of provisions with stigmatising potential, one of which is the public health laws related to notifiable conditions. The key issue here is whether the name of the person who has acquired a notifiable condition such as hepatitis C must be provided and also whether the likely source or origin of that acquisition must also be declared (it would appear that this is required by the current Queensland Health Notifiable Conditions form: https://www.health.qld.gov.au/__data/assets/pdf_file/0023/444245/notif-conditions-rpt.pdf). If the likely source is noted as 'injecting drug use' for example, and the notification is identifiable (i.e. the person is named), the possibility of stigma and/or discrimination increases. The public health implications for making such notifications non-identifiable need to be carefully considered. Questions of how these data are used, stored, and shared is crucial. The key issue for people with experience of problematic AOD use is whether their history of alcohol or drug use is somehow made 'known' through this system. This is important for stigma and discrimination not only for people currently using alcohol or drugs, but also for those who may have ceased some years ago (and, for example may have undergone hepatitis C treatment and been cured) but still have 'drug use status' attached to their records within health systems.

Recommendation 18: Amend legislation pertaining to HIV/hepatitis C

There is a consensus building that the criminal law is not the most appropriate avenue for dealing with issues around blood borne virus transmission, and that alternatives to prosecution such as public health management are preferable. We note that in other jurisdictions this area of law is being reformed (NSW). In their report on the criminal transmission of HIV in New South Wales, the HIV/Aids Legal Centre and Phillips Fox (Mitchell, 2009, p.16) noted that:

> No studies to date have shown that applying the criminal law to HIV transmission has prevented HIV transmission. There is a serious risk that harsh punitive justice will reinforce the HIV/AIDS related stigma, spread misinformation about HIV/AIDS and create a disincentive to HIV testing, as people fear a threat of incurring criminal liability. Furthermore, application of criminal sanctions may in fact hinder access to counselling and support, by discouraging honest disclosure to medical staff and creating a false sense of security that the criminal law can protect a person from contracting HIV.

Section 143 of the *Public Health Act 2005* provides for an offence for recklessly putting someone at risk of contracting a controlled notifiable condition. Also, under the *Criminal Code*, s 317(b) states: "Any person who, with intent to do some grievous bodily harm or transmit a serious disease to any person; is guilty of a crime, and is liable to imprisonment for life", and s 320 states: "any person who unlawfully does grievous bodily harm to another is guilty of a crime, and is liable to imprisonment for 14 years". We understand that these provisions are rarely used to prosecute individuals who transmit conditions such as HIV and hepatitis C to others (although see, for example, *R v Reid* [2006] QCA 202). Nevertheless, the use (and possible use) of these

provisions has the potential, as noted above, to reinforce stigma associated with HIV/AIDS and other blood borne viruses.

How Queensland might reform these sections is worthy of consideration, given their stigmatising effects/potential. Such reform will reduce stigma for those who are either HIV/hepatitis C positive – regardless of the mode of acquisition – and for people with experience of problematic AOD use (due to the co-stigmas associated with this condition, as discussed in the literature review).

6.3 Welfare and support services, including housing

Recommendation 19: Apply the recommendations from health care to welfare and support services

The recommendations relating to health care outlined above also apply to welfare and support services, including housing and legal aid. We reiterate the following Recommendations and suggest that the recommendations outlined in relation to health services be adapted in relation to welfare and support services as follows:

Recommendation 4:
Increase the availability of welfare and support services –

Provision of welfare and support services shows care and concern for the welfare and wellbeing of people who experience problematic AOD use, and treats with respect and dignity the problem of AOD use and people who use AOD. The provision of services emphasises that problematic AOD use is a health and social issue, to be addressed as such.

Recommendation 5:
Improve welfare services marketing (public service announcements) –

Improving welfare services marketing reduces stigma associated with seeking help through these services, and with AOD issues specifically. Marketing materials (whether generated by the Queensland government or by NGO services) should redress stigma by providing accurate information about access to services, and self-evidently not use images or language that may increase stigma associated with problematic AOD use. The involvement of consumer and family representatives in the development of such materials is essential.

Recommendation 7:
Invest in improvements in the physical facilities within welfare and support services –

Actively improve the physical environment of welfare and support services can reduce the stigma associated with these spaces. The physical environment of services is often not prioritised due to tight funding environments, however investing in the physical space can decrease the sense of shame felt by clients, show respect and help reduce discriminatory attitudes from the wider community.

Recommendation 8:
Employ peer workers/liaison officers in welfare and support service settings –

As has been noted in relation to AOD treatment and health care settings, it is important for people with experience of problematic AOD use to have easy access to mechanisms for support in welfare and support service settings, to help overcome structural stigma and discriminatory attitudes of individual workers, and gain access to the services they need. The employment of AOD peer workers and/or liaison officers in welfare and support services (similar to health care settings) is one such mechanism.

While ideally resources would be provided to employ peer workers or liaison officers in all welfare and support services settings in Queensland, as an initial step we suggest that an audit take place to establish sites of particular concern (for example inner-city services which regularly see a high volume of people with experience of problematic AOD use).

Recommendation 9:
Audit complaints mechanisms in welfare and support service settings –

Complaints mechanisms are one way in which the ongoing issue of stigma and discrimination leading to poor treatment being received can be addressed, and so they play a vital role in empowering clients as well as ensuring continuous improvements to services.

While these systems are more established in health care systems, we suggest a full audit of complaints mechanisms in welfare and support service settings, given the findings of this report, particularly given the accounts provided by interview participants.

Recommendation 10:
Implement consumer rights 'training' in relation to welfare and support services –

Educating and empowering people through consumer rights 'training' is another mechanism by which discrimination in welfare and support services settings can be addressed. As with health care settings, this can be implemented by increasing funding for community groups, legal centres and human rights agencies to engage in outreach, community education and rights awareness for priority populations (Legal and Discrimination Working Party of MACBBVS, 2013).

Recommendation 13:
Ensure consumer participation mechanisms are a part of welfare and support services' accreditation, and are implemented –

We recommend that consumer participation mechanisms are not only present, but *implemented comprehensively* in all Queensland welfare and support services. Such mechanisms could form part of welfare and support services' accreditation, but we suggest that there might be additional ways of ensuring comprehensive implementation, for example through reporting and data collection related to government funding of services. Consumer participation should be a reportable key performance indicator.

Recommendation 14:
Review reporting and monitoring systems –

We recommend that reporting systems be reviewed with an eye to ensure that reporting becomes one way that stigma and potentially stigmatising practices might be (1) documented and (2) reduced. What is counted in performance measures and compulsory reporting is what matters in practice; activities inevitably focus on these reportable requirements.

Recommendation 15:
Develop and implement programs aimed at resilience to internalised stigma, delivered through welfare and support service settings –

We recommend that programs developed in relation to HIV (e.g. Fuster-Ruizdeapodaca, et al., 2016; Harper, et al., 2014; Rao, et al., 2012) be adapted for people with experience of problematic AOD use, to help functioning and quality of life, enable coping mechanisms and increase self-esteem. Such programs should be delivered in welfare and support service settings. This program should be adapted in collaboration with consumer representatives to ensure consumer input and program acceptability.

6.4 Police, public order and criminal law

Recommendation 20: Encourage police to be aware of and where possible facilitate access to services

Through the participants' accounts, it is clear that many people who experience problematic AOD use come into regular contact with the police. Police are often the 'front line workers' in dealing with people who may require help, and as such this presents an opportunity to intervene in ways that will reduce harm and increase the likelihood that the person will change their behaviour. We also note in the interviews and the literature review that police encounters can be stigmatising and discriminatory. One potential way to reduce this perception is to provide police with resources to be able to offer access to services.

While the role of police is to enforce the law, if they had resources to facilitate access to services, especially housing, welfare and AOD treatment services for those in need, a less stigmatising experience may result. As noted by participants, changing the quality of police encounters can reduce stigma. Partnerships will need to be put in place between local police and services in the area, and in some cases memoranda of understanding established. Such facilitation activities should also be formally recognised in reporting mechanisms (accounted for as part of the work of police, rather than seen as an "added extra").

Recommendation 21: Consider a pilot of tracking police encounters

Participants reported experiences of police harassment, and this has also been raised in the international literature. Consideration of a pilot of tracking police encounters would increase accountability for police. One such trial has been conducted in Victoria, focussed on issues of equality in police encounters. The 'Receipting Proof of Concept' was developed to test receipting of police encounters, and collect data relating to individual police members, work locations and the contact person's race and ethnicity (as the project was focussed on issues of discrimination related to racial profiling) (Victoria Police, n.d.). The system was not adopted following evaluation in Victoria, in part due to design issues, but approaches to increase police accountability have been documented and adopted in the UK (http://www.policeaccountability.org.au/research_resources/). Queensland should consider whether such a pilot would support police transparency and accountability in relation to encounters with marginalised people, so as to reduce perceptions of harassment, stigma and discrimination.

Recommendation 22: Ensure Memoranda of Understanding are in operation between police and health care and harm reduction service providers

It is essential that people experiencing problematic AOD use can access treatment services, harm reduction services (such as needle and syringe programs) and other health care services without fear of police attention or surveillance of these services. This was raised as an issue by interview participants, and highlighted in the literature review.

Memoranda of understanding (MOUs) should be standard practice between all health care and harm reduction services, and local police. In some cases, such MOUs are in place as part of local community arrangements, but efforts should be made to standardise these practices across Queensland. Moreover, clients of services should be fully informed as to the kind of MOUs that are in place, to help reduce fear and encourage service access.

Recommendation 23: Reform areas of criminal law where the definition of the behaviour has the potential to be stigmatising or applied in discriminatory ways

As highlighted in the legislation analysis, provisions in criminal law where the definition of the targeted behaviour is not clearly defined in the legislation provides the potential for that legislation to be stigmatising and applied in discriminatory ways. Reforms to ensure clear and adequate definitions within legislation protect both the target of the law and the police when exercising the law.

In particular, we identified the following provisions:

Section 18(3) of the *Major Events Act* makes it an offence for a person to enter a major event if that person "appears to be drunk or adversely affected by a drug". Similarly, Section 26 of the *Major Events Act* allows for an authorised person to direct a person who "appears to be drunk or adversely affected by a drug" to leave the arena of a major event. Both of these are examples of provisions that inadequately define the behaviour and could result in stigmatisation and discriminatory practices in relation to people with AOD problems, as well as people on opioid pharmacotherapies or other medications which may impair speech or movement. The test for drunkenness/adverse effect should be reviewed and more clearly defined and/or that any guidelines pertaining to the exercise of discretion under these section be reviewed.

Section 390E of the *Police Powers and Responsibilities Act 2000* authorises police to detain and transport an intoxicated person to a sober safe centre if:

1. (a) a police officer reasonably suspects a person is intoxicated; and
2. (b) the person is behaving in a way the police officer reasonably suspects—
   (i) constitutes a nuisance offence; or
   (ii) poses a risk of physical harm to the person, or another person; and
   (c) the behaviour mentioned in paragraph (b) is in a public place located in a prescribed safe night precinct for a sober safe centre.

The meaning of 'intoxicated person' is not defined. While we acknowledge that the rationale for this provision is sound (i.e. it is ostensibly designed to protect the intoxicated person), the Act does not define 'intoxicated person' and thus might be open to misinterpretation and misapplication (Quilter, et al., 2016b).

Section 10 of the *Summary Offences Act* states that a person must not be intoxicated in a public place. For the purposes of this provision, "intoxicated means drunk or otherwise adversely affected by drugs or another intoxicating substance" (section 10(2) *Summary Offences Act*). The test for intoxication should be reviewed and more clearly defined, and/or that any guidelines pertaining to the exercise of discretion under this section be subject to review (Quilter, et al., 2016b).

Section 328A of the *Criminal Code* makes it an offence to dangerously operate a vehicle whilst "adversely affected by an intoxicating substance". Section 365(C) of the *Criminal Code* states that: (1) A person is taken to be adversely affected by an intoxicating substance if— (a) the concentration of alcohol in the person's blood is at least 150mg of alcohol in 100mL of blood; or (b) the concentration of alcohol in the person's breath is at least 0.150g of alcohol in 210L of breath; or (c) any amount of a drug prescribed by regulation is present in the person's saliva; or (d) the person fails to provide a specimen as required under the *Transport Operations (Road Use Management) Act 1995*, section 80 as applied under the *Police Powers and Responsibilities Act 2000*, chapter 18A. Although section 365(C)(1)(c) may legitimately capture people who are driving

while under the influence of (or intoxicated by) drugs, the provision, as it is presently drafted, also risks criminalising past use, where a person is not presently intoxicated or adversely effected but does retain traces of a drug in their saliva. Where such a provision criminalises past use it is akin to a minor drug possession charge (see Recommendation 24) and risks increasing stigma and discrimination. The test for being "adversely affected" should be reviewed and more clearly defined.

(These issues of definition should also be taken into account when reviewing other areas of law, as we have highlighted throughout the legislation review, including laws related to public health.)

Recommendation 24: Decriminalise the personal use/possession of drugs

Much of the stigma and discrimination we documented through this project comes from the fact that the personal consumption of drugs is a criminal offence. The decriminalisation of personal use/possession offences (with threshold limits) provides the opportunity for a health response, rather than criminal justice response, and facilitates greater treatment seeking and opportunities for recovery. A past criminal record for drug use/possession reduces the chances of reintegration into society (by limiting opportunities for work and sometimes even the ability to care for or spend time with one's children) and increases stigma. The stigma of a criminal record carries through life, even long after someone has sought treatment and stopped drug use. As participants noted in their interviews, reconnection to work and family is often a motivator in treatment, and such motivation is thwarted when the legacy of a criminal history remains. Participants noted that decriminalisation would make a difference to the stigma and discrimination experienced in their lives:

> "Decriminalisation. […] [It's] the main stigma - because it's against the law. It's okay to be an alcoholic because you can buy it over the counter but you can't be a drug addict because it's against the law. That's my main argument for it. Straight out. Not just that, our jails are full of drug users […] once they're in that system they usually end up staying in that system. They end up back in that system because that's the only system they know, it's the only place they can get a feed or a roof over their head or some support. Which is sad." (Interview 11, Male 44 years)

As has been noted in research, there is strong public support in Australia for decriminalisation approaches. The research evidence indicates that decriminalisation of drug use: (1) Reduces the costs to society, especially the criminal justice system costs; (2) Reduces social costs to individuals, including improving employment prospects; (3) Does not increase drug use; (4) Does not increase other crime; (5) May, in some forms, increase the numbers of people who have contact with the criminal justice system (net widening). Many countries around the world have decriminalised drug use and possession in various ways (the full Drug Policy Modelling Program decriminalisation briefing note is available here: https://dpmp.unsw.edu.au/sites/default/files/dpmp/resources/Decriminalisation%20briefing%20note%20Feb%202016%20FINAL.pdf).

Recommendation 25: Amend laws regarding peer distribution of injecting equipment

Amending section 10(3) of the *Drugs Misuse Act 1986* to remove prohibitions related to distribution of injecting equipment would reduce stigma. Previous research (Lancaster, Seear, & Treloar, 2015) has demonstrated the stigmatising potential of the prohibition on peer distribution of injecting equipment in Australia; a point echoed in the legislative component of our analysis. In this research, the authors argued that the prohibition on peer distribution of injecting equipment increased the risk of stigma, and that: "it is important that this highly stigmatised and marginalised group be able to participate in practices that challenge dominant

conceptualisations of them and remake the stereotype of the irresponsible 'addict'" (Lancaster, Seear, et al., 2015, p.1204). This law significantly curtails public health strategies in relation to blood borne virus prevention (including the operations of needle and syringe programs), and pre-dates the discovery of the hepatitis C virus and understandings of the links between sharing injecting equipment and transmission. Given that it is relatively common practice for peers to collect and distribute sterile injecting equipment within their community, and that these practices likely play an essential role in preventing the transmission of BBVs, there is a strong argument against criminalising the conduct of a person who gives a clean syringe to another (Lancaster, Seear, et al., 2015). Similar recommendations have been made over a number of years by a number of other organisations and bodies, including the Australian Injecting and Illicit Drug Users League (AIVL) (2010), the Australian National Council on Drugs (ANCD) (2013) and the Legal and Discrimination Working Party of the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections (MACBBVS) (2013). Following the recommendations of this research, the ACT, NT and Tasmania have reformed equivalent provisions, removing criminal offences associated with distribution of injecting equipment.

6.5 Employment

Recommendation 26: Review policies regarding criminal history checks at pre-employment

As noted in Recommendation 24, a criminal history pertaining to drug use can be highly stigmatising and can cause major barriers to employment for people with a history of problematic AOD use. As the interviews demonstrated, this is not only limited to drug use/possess offences per se, but also criminal history related to acquisitive crime during periods of drug dependence. The barrier a criminal history poses to employment in some sectors is significant. This limits opportunities for employment and reconnection with the community even after people have been through AOD treatment.

As well as our recommendation to decriminalise minor drug use/possession offences, we suggest that a review of the ways in which criminal history checks are used as pre-employment screening be conducted across industries. Self-stigma and lack of formal mechanisms of review often prevent individuals from accounting for such criminal pasts. We acknowledge that there are situations where particular criminal offences should preclude certain types of employment or employment that involves contact with vulnerable populations (e.g. working with children if the individual has been found guilty of child sex offences). However, where criminal checks encompass minor use or possession offences and/or low-level acquisitive crime, and such criminal history is not materially relevant to that employment, these policies should be revised.

Recommendation 27: Encourage uptake of clear employer guidelines regarding AOD use in the workplace and how to best respond

Workplace dismissals for AOD use can result in both stigmatising and highly negative outcomes for the person. As was shown in the interviews and case examples, it is far better to try and engage the employee in some form of assistance rather than simply dismissing them from the role. Mechanisms for seeking help (as noted below in Recommendation 28) should be easily accessible, and rather than dismissing employees, systems should be put in place to allow employees to seek help then return to work after a suitable period of time. The focus should be on how to reduce problematic alcohol and other drug use, wherever possible, using the least restrictive or punitive means available.

We note that good guidelines are in place governing public service employees in the Queensland government, in relation to AOD use in the workplace. We suggest that systems be put in place to encourage uptake of these guidelines by private employers. In so far as is possible for

Queensland government to incentivise such mechanisms in private workplaces (for example, as a condition of accreditation or for organisations in receipt of government funding or contracts) this should be implemented. WorkCover Queensland may be a key partner and facilitator across industries.

Recommendation 28: Improve access to Employee Assistance Programs

Employee Assistance Programs (EAPs) play a vital role in ensuring that people gain access to appropriate AOD interventions, in a confidential, non-stigmatising situation. The case examples clearly show how such systems are to the benefit of both employees and employers. If employers support the person, and help them to make the treatment connection, there are better health outcomes.

There should be clear, accessible and well-documented systems in place to facilitate access to EAPs for people who may be experiencing AOD problems. Early intervention is important, and EAPs should be low-threshold services to minimise stigma. Confidentiality is essential to ensure that employees do not fear discrimination in the workplace, as a result of seeking help.

Such programs should include strategies for facilitating returning to work after a period of treatment or rehabilitation, and should encompass AOD along with mental health or other disabilities. All EAP systems should include in-built opportunities for referral and interventions, where required (not simply be limited to phone counselling etc). The Queensland Government can play a role in developing best-practice guidelines to help employers put systems in place. WorkCover Queensland may be a key partner and facilitator across industries.

Recommendation 29: Develop and support pathways into employment for people completing AOD treatment

Employment is a very important signal to an individual that they are worthwhile, respected and able to contribute. However stigma prevents people from gaining employment post-AOD treatment.

As one participant noted:

> "I think there needs to be opportunities to help people grow […] especially with work. Give people the opportunity to prove themselves. I can't speak for each individual, but if I could go and get an apprenticeship tomorrow, […] if there was a system there for recovering addicts to stay clean, a program or whatever, to go and do a traineeship, that'd be great. Everyone knows where I'm at, everyone knows where I'm heading forward. It doesn't become a surprise to anybody and no one has to make any judgment." (Interview 4, Male 27 years)

There is a need for specific programs that provide incentives for employers to help people get into employment quickly upon leaving treatment. Such programs are in place in relation to disability for example, and such models could be extended to AOD treatment. At present, based on the interviews conducted, relationships between employers and treatment services are ad hoc and largely driven by particular treatment services. A more systemic and comprehensive approach is required.

Recommendation 30: Encourage and support flexible work hours policies

There is a need for flexibility within the workplace to access ongoing support as required (or, as noted in the interviews, attend appointments or to pick up pharmacotherapy medication). Research undertaken by our team (KS) that has not yet been published suggests that flexibility is a common practice in other countries, such as Canada. In Canada, many employers attempt to

accommodate the needs of people who are experiencing problematic alcohol and other drug use, and this may include offering flexible work hours (such as later start and finish times) for those who need it.

As an employer, the Queensland Government could introduce a state-wide policy allowing for flexibility for issues related to AOD problems and treatment-seeking and encourage other non-government workplaces to make similar opportunities available. Incentives could be provided to non-government and private employers. At a more basic level, a resource or best practice guide could be developed for advising employers on how to manage these issues where employees request it, to help reduce stigma and discrimination in the workplace.

6.6 Society at large

Recommendation 31: Exercise extreme caution in mass media campaigns for drug use prevention

The images used in mass marketing campaigns that aim to prevent drug use are often stigmatising and perpetuate stereotypical images of people who use drugs. Such images do not help people to access treatment and, as participants have noted, often end up alienating individuals from their friends and family out of fear. Research evidence shows that some mass media drug prevention campaigns can further compound and contribute to experiences of stigma and marginalisation.

In addition, there is not a clear evidence base that mass media campaigns for drug prevention actually work as intended. A large body of international research shows that mass media campaigns have no effect on drug use behaviour, and moreover, negative effects have been shown in some studies. Hence they are by no means cost effective. A systematic review of the effectiveness of mass media campaigns (in this review termed 'anti-illicit drug public service announcements') by Werb et al. (2011) identified and examined seven randomised trials and four observational studies from Australia and internationally. Their analyses of these evaluations concluded that there was limited evidence to support the use of mass media campaigns for illicit drug prevention. Specifically:

- No trial demonstrated any significant benefits;
- No studies reported any long term effectiveness of mass media campaigns;
- Overall mass media campaigns had a limited impact on the intention to use illicit drugs or on illicit drug use amongst the target population. In one example of the more common negative findings, evaluation of the 'Montana Meth Project' found that the graphic advertising campaign to deter methamphetamine use amongst young people was ineffective (compared to an unexposed control comparison (Anderson, 2010);
- Importantly, two randomised controlled trials in the systematic review found evidence that public service announcements actually increased intention to use drugs. Werb et al. (2011) argued that this is because mass media campaigns increase the perception that drug use is widespread, which may lead to a greater likelihood of initiation of drug use.

Given that mass media campaigns have been demonstrated to be ineffective for drug use prevention and may carry the risk of negative effects (such as increased stigma and discrimination, increased initiation to drug use, and changing perceptions about the social norms of using a particular drug) we suggest that the Queensland Government approach the use of drug prevention mass media campaigns with extreme caution.

Recommendation 32: Explore running a mass media campaign to reduce stigma

While there seems an obvious opportunity to develop and run a different kind of mass media campaign – that is, an anti-stigma campaign around drug use - in Queensland, the research evidence remains somewhat equivocal. As noted in the literature review, a systematic review has shown mixed findings as to the effectiveness of anti-stigma campaigns (Clement, et al., 2013). The authors found that anti-stigma mass media campaigns may reduce prejudice, but there was insufficient evidence to determine if the campaigns reduced discrimination. Nor were any of the interventions assessed for cost-effectiveness.

We suggest that the Queensland Government explore the option of an anti-stigma mass media campaign, but proceed with caution to ensure that the campaign is evidence-based and developed in consultation with drug user organisations. AIVL has done market research work exploring viable mass media campaign options, and this work should be taken into account: e.g. http://www.aivl.org.au/stories/afternoons-with-max-marshall/. A Melbourne based project, Lives of Substance, may also be informative and provide partnership in content development: http://www.livesofsubstance.org/.

Recommendation 33: Improve Queensland media reporting of AOD issues

As has been noted in the literature review and through participants' accounts, the 'junkie stereotype' perpetuated in some media reporting can be highly stigmatising. A range of recommendations in relation to media reporting of illicit drugs has been developed in previous research (see for example, page 110: https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/19%20Media%20reporting%20on%20illicit%20drugs%20in%20Australia.pdf)(see also: Lloyd, 2010). A new website (launched in February 2017) also provides guidance to journalists, and highlights case examples of problematic media reporting (http://aodmediawatch.com.au/).

Improving Queensland media reporting on AOD issues is an important component to an effective, systemic response to stigma and discrimination. Guidelines ensuring that AOD use is not presented in a stigmatising or discriminatory light could be developed and implemented in relation to all Queensland media outlets. Review of journalistic and broadcast Codes of Practice to ensure that any clauses relating to discrimination within these codes relate to problematic AOD use as well is also recommended. A monitoring and support role (noting where breaches may occur, supporting journalists with access to reference material, as noted above) is also recommended.

Recommendation 34: Implement guidelines for government department communication about AOD issues

Related to Recommendation 33, the development of clear guidelines for all government department communications (press releases, online media, resources, reports etc) should ensure that no language or portrayals of people who use alcohol and other drugs which could be stigmatising occur. These could be developed from the resources listed above. As noted in the literature review, one aspect to be addressed would be ensuring the use of person-centred language in government department communication about AOD issues (Office of National Drug Control Policy, 2017).

6.7 Consideration of priorities

In light of more than 30 recommendations, and the fact that some are relatively straightforward to implement and others would require substantial thought and resources, we have undertaken to provide some sense of prioritisation, based on the research we have conducted and our own understanding of some of the critical issues in moving towards implementation.

Some of the recommendations focus on making change at the individual or interpersonal level (for example interventions aimed at health practitioners or workers in services) and some focus on structural arrangements (such as organisational policies). For success, interventions aimed at ameliorating individuals' discriminatory attitudes and behaviour need to be implemented *alongside* structural and systemic reforms aimed at addressing stigma and discrimination. For example, conducting anti-stigma awareness training for health practitioners (i.e. implementing Recommendation 2 in health care settings) should be done in conjunction with the kind of structural and organisational change contained in Recommendation 14 (i.e. reviewing reporting and monitoring systems to ensure anti-stigma actions are part of organisational Key Performance Indicators). Making sure both individual level reforms are implemented together with structural reforms is important to maximise impact.

We use two categories in considering prioritisation:

1. Resources: whether the recommendation requires a relatively small amount of resource versus whether the recommendation has significant resource implications. This did not take into account the cost savings associated with some of the measures. For example while creating new treatment places is costly, the health, economic and social benefits outweigh the costs: as per the famous quote from the Californian study "for every dollar spent on treatment, society saves $7.00" (Ettner, et al., 2006).

2. Time frames: whether the recommendation could be implemented relatively quickly (using in the next 12 months or so as the metric here) or whether the recommendation reflects a long-term effort requiring substantial engagement with multiple parties.

Based on this two-way categorisation, and a 'first pass' assessment by us, without detailed costing or implementation analysis, the 34 recommendations fall as such:

Table 6: Consideration of priorities

	Low resource requirements	**High resource requirements**
Relatively fast timeframe for implementation	Recommendation 03: Ensure consumer participation in policy and actions designed to reduce stigma and discrimination	Recommendation 02: Conduct anti-stigma awareness training across all relevant workforces
	Recommendation 05: Improve the marketing of AOD treatment	Recommendation 32: Explore running a mass media campaign to reduce stigma
	Recommendation 06: Better support family members of those in AOD treatment, through education and information resources	
	Recommendation 09: Audit complaints mechanisms in health care settings	
	Recommendation 13: Ensure consumer participation mechanisms	

	Low resource requirements	**High resource requirements**
	are not just part of health care service provider's accreditation, but are implemented Recommendation 18: Amend legislation pertaining to HIV/hepatitis C Recommendation 22: Ensure Memoranda of Understanding are in operation between police and health care and harm reduction service providers Recommendation 25: Amend laws regarding peer distribution of injecting equipment Recommendation 31: Exercise extreme caution in mass media campaigns for drug use prevention Recommendation 34: Implement guidelines for government department communication about AOD issues	
Relatively long timeframe for implementation	Recommendation 01: Implement a Queensland Human Rights Charter Recommendation 13: Review reporting and monitoring systems to ensure anti-stigma actions are part of KPIs Recommendation 17: Consider reform of the 'notifiable conditions' sections of public health law Recommendation 20: Encourage police to be aware of and where possible facilitate access to services Recommendation 21: Consider a pilot of tracking police encounters Recommendation 23: Reform areas	Recommendation 04: Increase the access and availability of AOD treatment Recommendation 07: Invest in improvements in the physical facilities within AOD treatment services Recommendation 08: Employ peer workers/liaison officers in health care settings Recommendation 10: Conduct consumer rights 'training Recommendation 11: Develop and disseminate clear clinical advice about pain management in people

	Low resource requirements	High resource requirements
	of criminal law where the definition of the behaviour has the potential to be stigmatising or applied in discriminatory ways Recommendation 24: Decriminalise the personal use/possession of drugs Recommendation 26: Review policies regarding criminal history checks at pre-employment Recommendation 27: Encourage uptake of clear employer guidelines regarding AOD use in the workplace and how to best respond Recommendation 33: Improve Queensland media reporting of AOD issues	with opioid dependence for emergency departments and primary health care settings Recommendation 12: Develop and disseminate clear clinical advice about access to medications for those with concurrent physical and mental health disorders and AOD use Recommendation 15: Develop and implement programs aimed at resilience to internalised stigma for people experiencing problematic AOD use and AOD treatment clients Recommendation 16: Consider introducing a supervised injecting facility Recommendation 19: Apply the recommendations from health care to welfare and support services Recommendation 28: Improve access to Employee Assistance Programs Recommendation 29: Develop and support pathways into employment for people completing AOD treatment

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APPENDIX A – LAW CODING SYSTEM

1. How are people who use, possess, consume (etc.) AOD described as a target of the law?

2. Is there a definition of the person, activity or targeted AOD behaviour?

3. Who is the decision-maker or authority?

4. What is the decision-maker/authority able to do?

5. In what ways does the law offer protections to the targeted person?

6. In what ways does the law offer protections to others?

APPENDIX B – SEMI-STRUCTURED INTERVIEW GUIDE

1. Tell me a bit about yourself?
2. Tell me about your experiences of alcohol and other drug use?
   - Different drugs / routes of administration – contexts / turning points
3. Have you ever sought help with your alcohol and other drug use?
   - Can you tell me about that experience?
   - What was positive about that experience?
   - What was negative about that experience?
4. Do you think you have ever been treated differently as a result of your alcohol or other drug use?
   - In what ways?
   - Can you describe a specific time when you think you were treated differently?
   - Why do you think you were treated like that?
5. Do you think you have ever experienced stigma or discrimination as a result of your alcohol or other drug use?
   - Can you tell me about a specific time when you think that occurred? What happened?
   - What were the consequences of that?
   - How did that make you feel? How significant was that experience for you?
6. When you think about the times you think you've been treated differently, or experienced stigma or discrimination, where have those interactions taken place?
   - Who have you been speaking to?
   - What are the settings where this has occurred? Prompt with: treatment services, health settings, interactions with police or law enforcement, or the legal system, housing etc.
7. Have you had different or really positive experiences where you have not experienced stigma and discrimination?
   - Can you tell me about a specific time when that occurred? What happened?
   - What was different about those times?
8. How have these different experiences impacted on your alcohol and other drug use, or your treatment journey, or your life experiences more generally?
9. Participant's additional thoughts
   - Based on your experiences, what would you like to see changed?
   - Anything you would like to add or reflect on before finishing?
   - Anything that you think would be helpful for us to think about?