Theme 3: Overcoming stigma and discrimination

The stigma that is associated with gambling and substance use—and the discrimination that individuals are exposed to—can be a significant contributor to the experience of harm. Gambling and substance use carry overlapping burdens of stigma and discrimination that can be magnified where there is co-occurrence. As practitioners, it is important that we understand the mechanisms of stigma and discrimination as they can profoundly impact whether, when and how an individual discloses co-occurring harms. Recognising and challenging our own biases and assumptions can help to create a safer and more welcoming environment for service users to talk about the range of complexities that may be impacting their life and affecting treatment or harm reduction outcomes.

STIGMA

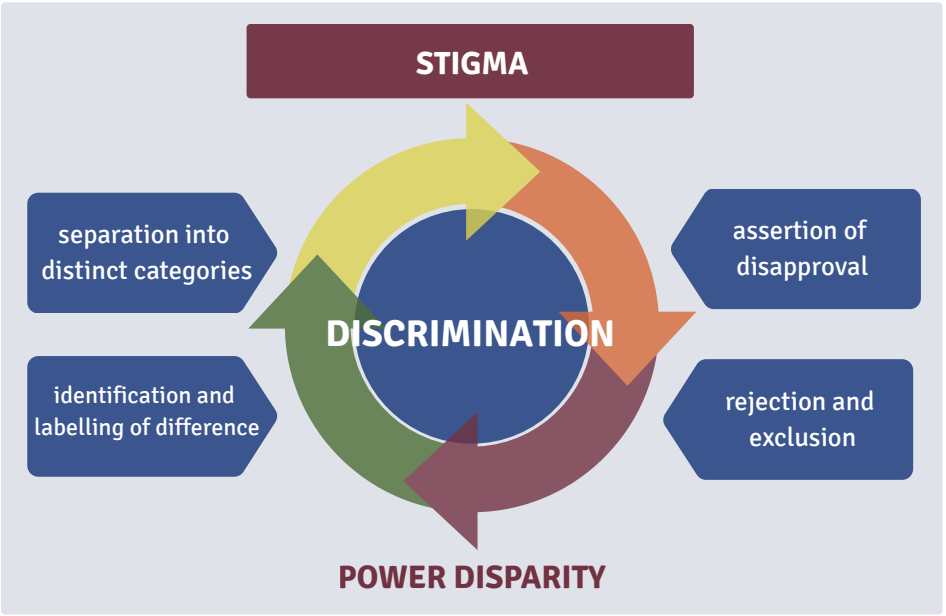
Stigma occurs in the context of uneven relations of power, where there is identification and labelling of difference, construction of (negative) stereotypes, separation of the labelled person/s into distinct categories, and assertion of disapproval, rejection and exclusion, leading to discrimination (see Figure 3.1).[1] Stigma is felt and enacted at both the individual level, and through institutions and structures.

SELF-STIGMA

The concept of 'self-stigma' or 'internalised stigma' is important in the context of gambling and substance use harms. Self-stigma can powerfully shape an individual's subjectivity (how they see themselves and their place in the world). Self-stigma may be enacted through changed behaviour and changed ways of thinking and being.

SELF-STIGMA IS THE NEGATIVE THOUGHTS AND FEELINGS (E.G. SHAME, EMBARRASSMENT, FEAR) THAT EMERGE FROM IDENTIFICATION WITH A STIGMATISED GROUP

Figure 3.1 Stigma



Certain types of drug use are more stigmatised. Injecting drug use is amongst the most stigmatised conditions globally. People are more likely to distance themselves from people who use drugs and more likely to perceive them as dangerous, than for example, people experiencing mental illness.[2, 3]

STIGMA BY ASSOCIATION

Stigma can be felt by others who are associated with the individual experiencing direct harm from gambling and / or substance use.[4, 5] The association may be a genuine association—for example family members—or a perceived association—for example, having a shared cultural background.

STIGMA BY ASSOCIATION HAS BEEN REPORTED IN PEOPLE WHO WORK WITH STIGMATISED INDIVIDUALS AND COMMUNITIES, SUCH AS THOSE WORKING IN THE ALCOHOL AND OTHER DRUGS SECTOR OR IN GAMBLING SUPPORT.

ACT Spotlight: On a measure of stigma by association, workers in the alcohol, tobacco and other drugs sector in the ACT scored a moderate 2.27 out of 5.[6]

DISCRIMINATION

Discrimination follows from stigma. It is defined as actions from members of a dominant group that aim to harm individuals that are part of a less dominant group.[7]

The more narrow, legal definition of discrimination refers to unfavourable treatment or unfair effect because of a protected attribute such as race, gender identity or religious belief.[8] Experience of gambling and / or substance use harms or experience of accessing treatment or other services for gambling and / or substance use harms are not protected attributes under ACT or Commonwealth law. Nor do people within these categories comprise priority populations in any current ACT strategy or policy document.[9]

STIGMA AND THE PERSONAL RESPONSIBILITY NARRATIVE

Where products or behaviours are not only legal but have broad cultural acceptance—as is the case for alcohol and gambling—it is the harms rather than the products or behaviours per se that are stigmatised.[8] Both the gambling and alcohol industries have invested large sums of money in developing and perpetuating a narrative of personal responsibility. This narrative has subsequently been perpetuated through policy, research and service provision. It blames the extensive harms caused by the products and practices of industry on a few 'flawed' individuals who gamble or drink 'irresponsibly'. Research has shown that responsibility discourses play a significant role in the perpetuation of stigma and that this extends to stigma and discrimination in the healthcare context, where professionals may feel that people harmed by alcohol or gambling are not as deserving of help as their 'problems' are 'self-inflicted' and that they are, or should be, capable of taking rational actions to reduce their harms.[10] In other words, harms come to be seen not as indicative of harmful products (harm by design) but as evidence of weakness, lack of self-control, or even moral failure on the part of the individual.[11]

ACT Spotlight: Over 52% of adults in the ACT agree with the statement that 'people are completely responsible for the negative consequences of their gambling.'[12]

STIGMA AND CRIMINALISATION

The stigma and discrimination associated with drug use (and particularly with injecting drug use) is magnified by criminalisation.[13] The historic criminalisation of drug use has made socially acceptable and permissible the forms of stigma and discrimination that people who use drugs in the ACT report as routine. Recent changes to legislation that have resulted in the removal of criminal penalties for carrying small quantities of some drugs may not necessarily have brought about reductions in public stigma (already falling in the ACT) or in self-stigmatisation of people who use drugs.

ACT Spotlight: Approximately 40% of service user respondents in the *2023 Service Users' Survey of Outcomes, Satisfaction and Experience (SUSOSE)* said that they often or always experience stigma or discrimination in relation to their alcohol or other drug use.[14]

STIGMA, DISCRIMINATION AND CO-OCCURRING HARMS

Where there are co-occurring gambling and substance use harms, a person may experience stigma and discrimination in relation to one or both, and either independently or in ways that are overlapping or deeply intertwined. The experience of stigma and discrimination in the context of co-occurring harms can create additional barriers to accessing support and lead to further complex harms. Much of the research on stigma and discrimination in co-occurring conditions has focused on the intersection of mental health and substance use.[15-17] These studies show that stigmatising attitudes held by clinicians tend to be higher and worsen over time where there are co-occurring conditions.[18] Where a worker lacks experience or knowledge in relation to a co-occurring condition, they may hold certain biases (including unconscious biases) that impact the development of the therapeutic relationship.

STIGMA AND DISCRIMINATION AS A BARRIER TO TREATMENT

Stigma has been identified as a significant barrier to treatment for people experiencing gambling or substance use harms.[19, 20] Those who have experienced stigma or discrimination, or perceive that stigma exists, are less likely to access treatment services or seek help. Stigma experienced in a specialist health setting (such as an alcohol and other drugs treatment service) may influence an individual to cease treatment before its conclusion.[21] For those experiencing co-occurring harms, there are heightened risks of stigma and discrimination where treatment and/or expertise is siloed, such that the primary treating service or clinician is (or feels themselves to be) inadequately educated, informed or resourced about best practice responses to the co-occurring issue. The burden of self-stigmatisation can make an individual reluctant to disclose co-occurring harms, particularly in a setting where they feel these harms may not be understood or where disclosure may result in the experience of discrimination.

STIGMA, DISCRIMINATION, AND GENDER

Women face multiple barriers to accessing treatment for substance use harms, and are less likely to seek treatment at a specialised service.[22] However, they are also less likely to cite shame or stigma as inhibiting factors in treatment-seeking.[23]

For women, where stigmatisation occurs in the context of gambling and substance use, it is closely linked to social norms around femininity and motherhood.[24] Intersecting dynamics of gender, race, class and other forms of inequality and the effects of living in societies that do not fully value women's participation, viewpoints, and healthcare concerns shape gendered experiences of stigma and discrimination.[23] Intersectional stigma exposes women to higher rates of harm, including increased risk of blood borne diseases and higher rates of violence from intimate partners, acquaintances and strangers.[25]

STIGMA AND DISCRIMINATION AS RISK FACTORS IN CO-OCCURRING HARMS

People come to treatment with a range of backgrounds and life experiences that may make them more or less likely to experience harms. Being part of a stigmatised group or experiencing discrimination in other areas of life, may increase an individual's risk of experiencing gambling and substance use harms. Stigmatised groups that experience higher rates of gambling and substance use harms include people who identify as Aboriginal and / or Torres Strait Islander,[26, 27] people who come from culturally and linguistically diverse backgrounds,[28, 29] and people who are part of the LGBTIQA+ community.[29]

PEER WORKERS AND LIVED EXPERIENCE WORKERS

In the ATOD sector in the ACT, the term **peer worker** refers to workers who are in roles in which they are identified as peers and in which they use general and peer-specific skills acquired through a combination of training and lived / living experience of alcohol and drug use to support service users, undertake individual and systemic advocacy, and offer training and education in harm reduction.

The term **lived experience worker** is heard more often than 'peer worker' in the gambling support sector and can refer to individuals who utilise their lived experience of gambling in counselling, education or advocacy roles.

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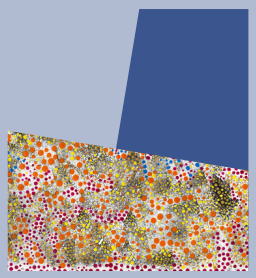
Peer workers and lived experience workers play a critical role in addressing stigma and discrimination.[30] The availability of such roles in alcohol, tobacco and other drugs (ATOD) treatment services and in gambling support services, addresses barriers to employment that people with lived experience of gambling or substance use can face as a result of stigma and discrimination. Furthermore, peer and lived experience workers model hope and can lower the barrier to accessing treatment that self-stigmatisation imposes. Importantly, peer and lived experience workers can facilitate cross-sectoral links through education and by supporting warm referrals between ATOD and gambling support services.

There are a range of stigma-reducing interventions that can support the community sector to better address the issue of stigma and discrimination. These range from training that aims to shift attitudes and behaviours of individual healthcare professionals, through to effecting policy change and shifting cultural constructions of gambling and substance use.[7] Across all such interventions people with lived and living experience (including peer workers) should be empowered to drive the process.

ORGANISATIONAL OR STRUCTURAL INTERVENTIONS ARE IMPORTANT IN CREATING SERVICES AND PROGRAMS THAT REDUCE STIGMA AND AVOID THE PERPETUATION OF DISCRIMINATORY PRACTICES THAT PLACE BARRIERS TO SERVICE ACCESS FOR THOSE EXPERIENCING CO-OCCURRING HARMS.[31]



Knowledge point: People who are experiencing co-occurring gambling and substance use harms can face barriers to accessing or remaining engaged with treatment as a result of stigma (including self-stigmatisation) and discrimination, in relation to one or both of these issues.

Practice point: Be prepared to challenge your own biases and assumptions, so you can support service users in ways that are non-judgemental and empathetic. Consider interventions to reduce stigma at an individual and / or organisational or broader structural level.