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Demystifying the enduring legacy of stigma on Indigenous Australians access for treatment and services for alcohol and other drug problems: A Western Australian case study

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Abstract

The following research describes an exploratory study that identified and provides a contextual history about stigma and its impact on managing the problematic use of alcohol and other drugs, in particular relating to treatment for alcohol use and other substance use disorders involving Australia's First Nation Peoples.

The article includes an overview of the historical arrangements within the jurisdiction of Western Australia which created and institutionalised pervasive stigma-informed policies and measures which continue to shape access to, and use of, alcohol involving Indigenous peoples in that State.

The research maintains stigma is a deeply entrenched and long-standing concept. Until recently this has not been sufficiently well recognised for its corrosive impact on the engagement, recognition and provision of treatment services to Indigenous Australians experiencing problematic use of alcohol.

Introduction

This paper describes research that considers the damaging and pervasive consequences of the stigma experienced by Aboriginal and Torres Strait Islander (ATSI) people who use alcohol and other drugs (AOD), or who may have either an alcohol use disorder (AUD) or substance use disorders (SUDs). In particular, we explored how this stigma not only impacts accessing treatment for the individual/s but also extends to the broader population of First Nations Peoples.

We introduce and review the concept of stigma to support our understanding that stigma is an integral part of usage of AOD by First Nations Peoples and those who are problematic users of alcohol or other substances or have a SUD. This review also discusses the significance of stigma involving use of AOD, drawing upon some of its historical antecedents, to explain the profound harms that the use of alcohol as well as other drugs has had on ATSI people.

Discussion

What is stigma?

Although the concept of stigma has been criticised as being vague and overly concerned with the individual, this has been rebutted by Link and Phelan (2001), who posit it is properly understood as 'the co-occurrence of its components – labelling, stereotyping, separation, status loss, and discrimination – [which] to occur, power must be exercised' (p. 363). In other words, stigma is the labelling, categorising, and stereotyping of difference, both on a personal and a structural societal level, which results in exclusion, rejection, and discrimination. For example, a person with mental illness can be stereotyped as less intelligent rather than if they were considered to have an illness.

This can lead to facilitation, adoption and application of inaccurate, unpleasant and mostly negative stereotypes resulting in discrimination.

Why do some people experience stigma?

Stigma is closely linked to the social selection of human differences, some of which are perceived harmless while others are viewed as relevant and accordingly are labelled. For example, the labelling of a human difference such as obesity means a person is labelled as "being lazy and having a lack of willpower" (Andersen et al, 2022, p. 850). Consequently, the label is upheld and can be extended by stereotyping all of those who may be obese.

An example of how differential social and individual characteristics can be determinative of stigma, identified as a 'courtesy stigma', can occur in families of a member who uses drugs, a family may "often experience a lack of social support from peers and other family members following their loved one's death" (Stout & Fleury-Steiner, 2023, p. 2). Or consider the example of a group of homeless men drinking alcohol, who may be labelled as being AOD dependent through a stereotypical association conflating homelessness to alcohol misuse, as "what is important is the effect on the homeless if we automatically associate them with alcohol abuse" (Andersen et al., 2022, p. 848).

Stigma and AOD

The previous examples involves the concept of 'othering' which creates stigma, as AOD use is perceived as a conscious choice, such that problematic users will be stigmatised and "judged, treated badly, looked down upon or excluded" (Lancaster et al., 2017, p. 74). This means that those with SUDs can be judged, punished, disrespected and mistrusted as they are perceived as being "weak and deserving of lower status" (Douglass et al., 2023, p. 5). Furthermore, within the concept of stigmatisation there are further forms of discrimination and stereotyping, such as people who consume alcohol (which is a licit drug), can be viewed as more capable compared to others who used illicit drugs like heroin. Or there may also be gender-based forms of discrimination involving women who use drugs as they have "defied womanhood and stereotyped as sexually deviant, unmarriageable and unfit mothers" (Douglass et al., 2023, p. 14).

According to Pickard (2017, p. 169) people who use drugs can be stereotyped as being "dirty". This occurs when referring to those who inject drugs as "junkies"; that mothers who use

cocaine are “crack moms”; and even recovery from dependence is tainted by referring to recovery as “getting clean”. This feature of the process of stigmatisation has been described as serving to separate the stigmatised (“them”) from others (ie “us”). This process treats those who use drugs as being inseparable from their behaviour, which can be compared to other types of illness, such as a “person who has cancer, heart disease, or the flu” (Link & Phelan, 2001, p. 370), serving the purpose of determining if a person is being ‘one of us’ as who happens to be beset by a serious illness - contrasted to a person labelled an ‘addict’. This can (and often does) result in social distancing and being viewed as unworthy of empathy, trust, or our assistance, as well as being perceived as “more dangerous and more responsible for their condition” (Kilian et al., 2021, p. 908).

History of stigma in relation to people with AOD use

The reason for the stigmatisation of people with SUD can be traced back to the Temperance Movement in the US in the early nineteenth century, which then spread to Australia (Room, 2010). In Australia the movement was led by the non-Anglican Protestant churches who were involved in a cultural struggle which rested on the “negative symbolism of the drunkard as wastrel and because of the real costs of drinking to the drinker’s family’s fortunes” (Room, 2010, p. 153). This meant drinking was considered immoral and was condemned, resulting in harsh bodily and social consequences such as whipping, banishments, use of fines, prohibiting taverns from serving Indigenous peoples, debtors, and habitual drinkers, and restricted opening hours of taverns (Smith, 2006).

Temperance supported the criminalisation and condemnation of public drunkenness in colonial New South Wales (NSW) and later by other colonies, through so-called inebriates laws. In NSW this was the *Inebriates Act 1912*, which has been found targeted poor people and in particular "was used disproportionately against Aboriginal people” (Standing Committee on Social Issues, 2004, p. 33). By the 1860s NSW had more than 40% of arrests related to alcohol consumption, of whom three out ten (29%) were Indigenous Australians - demonstrating how the problem of stigmatisation and discrimination towards the minority (ie First Nations Peoples) has existed in Australia for a long period of time, arguably reflecting the entrenched nature of stigma regarding the use of alcohol Smith (2006).

Stigma, AOD, and Indigenous Australians

Indigenous Australians continue to experience structural, psychological, and physical disadvantages due to colonisation and the impacts of policies, including assimilation and protection. These were, according to Warin and colleagues based on supposed “scientific claims of inferiority, the ‘doomed race’ theory, and, later, policies of assimilation that removed children of ‘mixed’ ancestry from their families” (Warin et al., 2020, p. 88). We contend this has resulted in damaging inter-generational trauma affecting Indigenous Australians across generations, as described in *Bringing them home: National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*) report. This seminal work included identifying total separation of children of “mixed descent” and forcibly placing them into “segregated ‘training’ institutions before being sent out to work” (Human Rights and Equal Opportunity Commission, 1997, p. 25).

Recently a major paradigm shift has occurred in identifying and connecting the social past and the biological present to provide a culturally relevant method of comprehending the

intergenerational effects of historical trauma, through the concept of environmental epigenetics[1] (Yehuda & Lehrner, 2018). Research has confirmed that past injustices among First Nations Peoples are passed on "at the cellular level [which demonstrates] that powerful stressful environmental conditions can leave an imprint or 'mark' on the epigenome (cellular genetic material) at key developmental periods" (Warin et al., 2020, p. 94). In addition, the stigmatisation of users of AOD is magnified when an individual is an Indigenous Australian, identified in research by Queensland Mental Health Commission (Lancaster et al, 2017) and in the *Don't Judge and Listen: Experiences of stigma and discrimination related to problematic alcohol and other drug use* report (ACIL Allen, 2020).

As an illustration, when buying alcohol an Indigenous person could be judged as alcohol dependent (i.e., 'alcoholic') if they purchase a cask instead of a bottle of wine, as they are buying the cheapest and largest packaged volume of alcohol in the four-litre cask (ACIL Allen, 2020, p. 5). Or, while non-Indigenous individuals are given preferential treatment in bars and bottle shops, Indigenous Australians are frequently required to show additional identification, while having limited access to hotels and other venues serving alcohol (Krien, 2011; Puddy, 2012). These instances highlight the extent to which Indigenous Australians are stigmatised.

In Western Australia (WA) being intoxicated (drunk) in a public place was considered an offence until public drunkenness was decriminalised in May 1990. This was a result of law reform through the *Acts Amendment (Detention of Drunken Persons) Act 1989*, (Swensen, 2017). Before May 1990 a provision in Section 53 of the *Police Act 1892* meant police had the right to detain and take someone before a Magistrate, where they could be fined $10 or imprisoned for up to seven days - if a first offender. With subsequent convictions there were often harsh escalated penalties for repeat offenders. Initially the fine had remained unchanged at $2, the same when it was set as £1 in 1892 for some 80 years, until increased to $10 in November 1975.

Section 4(1) of the *Convicted Inebriates Rehabilitation Act 1963* was deployed to force the treatment of 'convicted inebriates', when a person was convicted summarily, or on indictment, of an offence and when drunkenness was an element, or contributory cause, of the offence. They could then be ordered to be placed in an institution, for a period not exceeding twelve months, gazetted as being located within Karnet Prison[2]. Even though these laws sought to criminalise public drunkenness, they were applied selectively with those most penalised being Indigenous Australians (Swensen, 2017).

WA had further controls on Indigenous peoples' access to alcohol, beyond the use of the *Police Act 1892,* through provisions in so-called 'native welfare' and 'native citizenship' laws and restrictions in liquor licensing legislation involving the serving and sale of alcohol, as well as entry to hotels (Brady, 2010). One consequence of liquor licensing controls was Indigenous people were forced to drink in parks and areas outside of town boundaries, resulting in further stigmatisation (Swensen (2017).

The extent to which Indigenous-specific controls were utilised to criminalise access to alcohol between the 1920s and the mid 1960s was achieved via proclamations that excluded

[1] Epigenetics: Involve bridging Nature and Nurture by including how external environments – ie cultural rituals, shared traumas or social structures – all become part of an individual's and/or their descendants' functioning.

[2] Karnet Prison – a minimum-security facility with male prisoners - located on Whadjuk Noongar land, 78 kilometres south of Perth, WA.

Indigenous people from country towns and other localities, as well as gazetted areas in the Perth's central metropolitan area (Carmody, 2019)

The cumulative effect of this exclusion and its powerful stigmatisation was starkly revealed in research conducted by the Royal Commission into *Aboriginal Deaths in Custody* (RCIADIC) covering 1987 to 1991. The Interim Report of the RCIADIC, the 'Dodson[3]' report, identified higher imprisonment, detention, and death rates of Indigenous peoples in custody compared to non-Indigenous Australians. However, as noted in Dodson's report, the courts started to scrutinise the s.53 section's regime of punishment of public drunkenness within the *Police Act 1892*. For example, in the 1984 the Supreme Court of WA's (SCWA) decision, in *Brown v Nunn*, found that "it was inappropriate for an accused convicted of habitual drunkenness to be sentenced to imprisonment, where the offender is addicted to alcohol" (Royal Commission Into Aboriginal Deaths in Custody, 2019, p. 63).

The decriminalisation of public drunkenness in 1990 led to the development of a network of sobering up centres (SUCs) in WA, largely located in regional towns in the North-West of the State. The power for police to apprehend and take intoxicated persons to a SUC was initially set out in the *Police Act 1892* (Part VA: Apprehension and detention without arrest), which was superseded by the *Protective Custody Act 2000* (PCA). The PCA established a framework that not only covers police responses to managing both adults and juveniles affected by either alcohol, a drug or a volatile substance, but also the seizure of intoxicants in WA. A key part of these reforms included adoption of new protocols and training to support changes in attitudes by police, health care providers and others to understand that those who had problematic alcohol issues, especially Indigenous people, had complex social and other problems (Daly & Maisey, 1993).

Similarly, there were reforms in other Australian jurisdictions to decriminalise public drunkenness, including the Northern Territory in 1974, NSW in 1979, the Australian Capital Territory in 1983, in South Australia in 2016 and in Victoria in 2023. The decriminalisation of public drunkenness in Queensland did not happen until September 2024. However, in June 2025 the Liberal-National Party government announced it would re-criminalise public intoxication (Maxwell & Rennie, 2025). There has also been research that identified the importance of those reforms needs to include the adoption and implementation of reforms by police (Commonwealth Ombudsman, 1998; New South Wales Ombudsman 2014; Nicholas, 2008).

In summary, the establishment of SUCs in WA should be understood within a broader suite of community safety measures and supports such as night patrols. It has been suggested the combined law enforcement and community-based measures have arguably facilitated, to some extent, destigmatising perceptions about Indigenous people's use of alcohol and growing acceptance of potentially being a treatable illness by understanding the existence of AUDs. (Community Development and Justice Committee, (2013).

Impacts of stigma

The extent to which AOD-related stigma can have serious detrimental effects on people and negatively affect all facets of their lives, including work, relationships, housing, social and

[3] Patrick (Pat) Dobson, strong long-term Western Australian Indigenous rights activist ,who later (2016-2024) became a Senator for WA in Australia's Commonwealth Government.

personal life should not be understated (Douglass et al., 2023). Because Indigenous communities have unique and profound connections to Country, extended family and kinship networks, stigmatising one individual can negatively impact their entire family network and kindle a feeling of shame. This type of stigma, where people close to a stigmatised individual experience stigma, is known as secondary stigma.

Overall, secondary stigma may not only affect the individual but the entire community's social relationships with concomitant consequences that are "diverse and far reaching, affecting both individuals and the broader community" (Standing Committee on Indigenous Affairs, 2015, p. 27). Thus, secondary stigma and the resultant discrimination may amplify, and have corrosive consequences, by affecting the mental and physical wellbeing of people around the person with the substance use issue (Standing Committee on Indigenous Affairs, 2015).

The historical oppression and stigmatisation that First Nations People have experienced means social determinants of health such as education and employment are seriously affected, resulting in fewer employment prospects and educational opportunities. In addition, it has been argued that these social and economic determinants are causal factors in "a person's choice to consume alcohol at levels that causes harm to themselves and others" (Standing Committee on Indigenous Affairs, 2015, p. 19).

Furthermore, there is a substantial body of research that shows how these consequences fuel the risk of also developing significant and difficult-to-treat mental disorders, such as depression, anxiety, SUD, and suicide attempts (Dudgeon et al., 2021). For this reason, the adoption of approaches such as the Dahlgren-Whitehead Model[4] are necessary "to bring about new intervention policies to tackle alcohol abuse [which] need to be a multi-dimensional approach that not only targets environmental factors but also promotes individual making healthy choices" (Aleem et al., 2019, p. 66)

Accessing treatment

Barriers resulting from the stigma felt by First Nations people, who use AOD and develop dependence disorders needing access treatment, arise in social circles, healthcare, media, and legal systems (Douglass et al., 2023). This means that instead of being considered a health issue, SUDs are often viewed as moral and legal issues which undermine participation in treatment systems. Important research has been undertaken which has identified historical barriers showing some approaches towards treatment can play a key part in participation involving First Nations Peoples:

> Indigenous service providers were resistant to and suspicious of harm minimisation policies, which were perceived to provide subtle permission for continued misuse or even to encourage non-drinkers to drink [because] problems of alcohol abuse and dependence continued to be typified as 'alcoholism' (Brady, 2007, p. 761).

[4] A 'rainbows' diagram model that illustrates multiple, interacting layers of determinants influencing population health, placing the individual at the centre, surrounded by lifestyle, social networks, along with living and working conditions.

This also reflects in other conduct in victim blaming discourses, such as depleting system resources, not investing in their own health, abusing the system through drug-seeking, and often failing to adhere to the prescribed treatment (Livingston et al., 2012).

An illustration of the deep harm from, and pervasive nature of, stigma is recognised through the concept of internalised stigma, whereby "individuals with substance use disorders may choose to conceal their substance use problems to avoid stigma, which may result in care provision that does not attend to substance use-related needs (e.g. while pregnant)" (Livingston et al., 2012, p. 41). In summary, those negative perceptions and forms of stigma contribute to limited treatment access, poor quality healthcare, and obstruction of evidence-based responses.

Public perception of AOD-using Indigenous peoples

A consequence of the long-standing and deeply entrenched nature of stigma towards Indigenous people portrays them as being unable to use alcohol like non-Indigenous Australians. This has involved the negative labelling of the "drunken Aborigine [as] a colonial construct which predated the ready availability of alcohol to Aboriginal people" (Langton, 1993, p. 196). For instance, non-Indigenous Australians have long had a misconception that fights and aggression are common among the Aboriginal people. This is a stigmatised understanding which bears emphasising:

> These misconceptions are significant in that they predetermine the nature of interactions ... between Aborigines and non-Aborigines [because] people who view Aborigines as 'culturally and morally destroyed alcoholics' [also] tend to approach their inter-racial relations with a negative attitude" (Harrison, 1995, p. 39).

It is argued that this continues to be significant in the minds of many non-Aboriginal Australians, which clearly demonstrates how pervasive this can remain, including medical staff, public service officers, teachers, and other professionals (Skinner et al., 2007; Cooper et al., 2018; Cheetham et al., 2022).

Responding to AOD-related stigma

Connections to Country, family, and kinships are integral to Indigenous Australians' lives. Therefore, treatment plans should emphasise this tend to enable less stigmatising and more effective change approaches for Indigenous communities (Standing Committee on Indigenous Affairs, 2015).

Importantly, there is a body of research that affirms how community-led approaches to treatment and rehabilitation explore consequences of the use of AOD being a key component towards reducing AOD-related stigma (Blignault et al., 2016; Colmar Brunton Social Research, 2014). We contend the lessons from the community-led responses to other health issues should be carefully considered as exemplars for informing strategies to address AOD-related stigma, which was recently been affirmed based on First Nations COVID-19 responses (Sullivan et al., 2023).

This has also been encapsulated within the community-controlled health organisation model, which demonstrated First Nations Peoples were "capable of leading this response, were given

the power to act and they established effective partnerships with government and non-government services" (Stanley et al., 2021, p. 1854).

One example involves the community-led approach of 'Bushmob' in Alice Springs, which offers a model residential program for young people aged 12 to 24. This involves a range of serious health and social consequences from the use of drugs, alcohol or petrol/solvent sniffing and focusses on relationship building and getting back to/on Country. (Standing Committee on Indigenous Affairs, 2015, p. 5). Similarly, participants in the Indigenous Rangers Working on Country Program reported "better outcomes across a number of social determinants, including reduced contact with the justice system, better family relationships, and reduced consumption of alcohol" (Department of Health, 2017, p. 21), within their programs.

We proffer the hallmark of these examples as one approach for SUD which involves ATSI people in community-led programs. Further, this could be developed as a template for strategies to reduce AOD related stigma in the wider community (Van der Beeke, 2014, p. 5).

Strategies to reduce AOD-related stigma

It has been argued there are three strategies in exploring this theme: namely advocacy, community-based education, and place-based interventions; that could be particularly important in reducing AOD-related stigma experienced by Indigenous Australians in WA (Van de Beeke, 2014). The National Agreement on Closing the Gap (NACG) which commenced on 30 July 2020, superseded the targets that had been set out in the framework in the National Indigenous Reform Agreement (NIRA) established in 2008 through the Council of Australian Governments (COAG) process (McNicol, 2022).

We maintain that, within the four areas of priority reform identified in the 2020 NACG priority area 2, building the community-controlled sector, means that advocacy is still relevant strategy to address AOD-related stigma. The importance of building a community-controlled approach is strongly supported by a report from a special consultative meeting in February 2018. This meets the requirements of ensuring a greater role for the Indigenous community in program design and implementation (Dillon, 2021, p. 2).

Advocacy, the first strategy, has been described as "a process to bring about change in the policies, laws and practices of influential individuals, groups and institutions" (Van der Beeke, 2014, p. 7). While it is potentially a powerful method to counter stigma involving AOD-related strategies to change community attitudes and behaviours, advocacy also has another purpose "to change upstream determinants … such as policy design and implementation, legislation, organisational practices etc" (Van der Beeke, 2014, p. 7).

There are three limbs for bringing about change through advocacy to transform stigmatising views discussed here. The first limb is education, where facts about AOD use and dependence replace myths and misconceptions. The second involves direct interaction with the stigmatised group to change public attitudes, while the final limb is to challenge the negative perceptions portrayed through media (Van der Beeke, 2014).

The second strategy of community-based education and communication is an extension of advocacy and holds that anti-stigma campaigns could be effective only if they are adequately funded, use a variety of methods and channels that need to possess considerable intensity, and extend over periods of time (Van der Beeke, 2014, p. 8).

The third strategy involves place-based behaviour change interventions. This recognises that as Indigenous Australians face barriers when attempting to access high-quality services due to AOD related stigma, recognising place-based behaviour change intervention strategies through targeted behaviour change programs could be executed to increase consumer access to services and improve their service experiences (Van der Beeke, 2014).

For example, the implementation of intervention frameworks, such as the Behaviour Change Wheel[5] (BCW) means organisations can tackle stigmatising attitudes to service users by enabling more people to access services without being negatively stereotyped. The BCW strategy should involve evidence- based tools to enable a range of users to design and select interventions and policies according to analyses of the nature of the behaviour. This also identifies the mechanisms needed to be changed to trigger behaviour change and develops interventions and policies required to change those mechanisms (Michie et al, 2011, p. 50).

Conclusion

As authors of this research, we have outlined advantages of utilising broad-approaches to address stigma by detailing AOD-related stigma and drawing on history to identify how this has impacted Indigenous Australians. It is our conclusion there needs to be clearer understanding of damaging inter-generational trauma and how it has detrimentally impacted on the lives of ATSI people. In relation AOD services this means an expanded framework should be adopted by those providing services and treatment which recognises its impact on access to services, participation in treatment and attitudes towards Indigenous peoples' use of AOD.

Additional research is necessary to confirm the importance of strategies of advocacy, community-based education, and place-based behaviour change interventions, to reduce AOD-related stigma. A requirement to determine potential for these strategies to undertake bridge-building between the development of community-led programs and broader strategies for achieving broader community social and wellbeing change is also desired.

Finally, further research should be undertaken to incorporate stigma as part of the architecture of relevant National Agreements to address the entrenched nature of stigma, as it is a necessary pre-condition to support change and develop a greater understanding and awareness by all Australians about the stigma associated with Indigenous Australians in relation to the use of AOD.

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[5] BCW – A method of characterising and designing behaviour change interventions, recognising behaviour is part of an interacting system involving related components.

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