Why wouldn’t I DISCRIMINATE AGAINST ALL OF THEM?

A Report on Stigma and Discrimination towards the Injecting Drug User Community
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A Report on Stigma and Discrimination towards the Injecting Drug User Community
The Australian Injecting and Illicit Drug Users League (AIVL) is the national peak organisation for state and territory peer based drug user organisations and represents issues of national significance for people who use or have used illicit drugs. Its mission is 'to promote and protect the health and human rights of people who use or have used illicit drugs'.

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Any enquiries or comments about this publication should be directed to:

Australian Injecting and Illicit Drug Users League [AIVL]
GPO Box 1552
Canberra ACT 2601

Telephone: (02) 6279 1600
Facsimile: (02) 6279 1610
Email: info@aivl.org.au
Website: www.aivl.org.au

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We thank, too, Ms Annie Madden, who offered a level of insight and thoughtfulness that allowed for wide-ranging and thought-provoking discussions as we tried to ‘tease out’ what was pivotal to ensuring that the document reflected our voice—the voice of the injecting drug user community.
In 2009 AIVL received funding to commission market research with a view to determining the feasibility of developing a national campaign to redress the stigma and discrimination routinely faced by people who inject drugs. The primary objectives were to learn more about the perceptions of the general community—and some subsections of it, such as the medical profession—towards our community. This new information could then be used in determining how the community might respond to messages aimed at countering the misconceptions and prejudices associated with people who inject drugs. The market research report, published in 2010, was the catalyst for production of this document.

The researchers found that stigma and discrimination associated with people who inject drugs are both institutionalised and pervasive. One of the most important findings was that the focus group participants—particularly the members of the general public—saw this stigma and discrimination as ‘good’ for the community as a whole. Further, participants believed stigmatising and discriminatory attitudes and actions would discourage people from taking up the practice of injecting drug use. These views were widely and strongly held, despite the wealth of research evidence highlighting the extremely harmful effects of stigma and discrimination on people who inject drugs and the lack of evidence to support discrimination as an effective deterrent to illicit drug use.

The concerns raised by the market research prompted AIVL to seek further resources in order to investigate in greater depth some of the main findings before embarking on any public education campaign. In particular, we wanted to explore a range of questions from the perspective of people who inject drugs, to ask how current attitudes towards our community have developed over time and left us in a situation where we are almost universally categorised as social pariahs whose lives are of no value. We felt we needed to ‘look back’ and try to pinpoint the origins of many of these views before we could make any meaningful effort to ‘look forward’ and begin the process of challenging and changing the tired narratives that dominate injecting drug users’ lives.

As a result, Chapter 2 of this document reviews the historical determinants of stigma and discrimination among people who inject drugs. It traces the history or ‘key points in time’ when attitudes towards the use of illicit drugs, the people who use them, or both, can be seen to emerge or change. As this theme develops, we increasingly focus on the question of injecting drug use, rather than broader developments in relation to all illicit drug use. Such an approach ensures that the document remains focused on the primary aim of reducing stigma and discrimination as they relate to blood-borne viruses such as hepatitis C by tackling what we believe is the main ‘driver’ of that discrimination—community attitudes towards injecting drug use and people who engage in this practice.

It is difficult to single out one process or action, one definitive point in time, that can be characterised as ‘when the demonisation of people who inject drugs began’. What we have identified, however, is that the Industrial Revolution of the 19th century—a period of enormous social, cultural and economic upheaval—is one of those key points in time for tracing the development of contemporary attitudes
towards people who inject drugs. As part of understanding the impact of the Industrial Revolution, we look at a range of interrelated factors that, we argue, both directly and indirectly laid the foundations for the systematic marginalisation of people who injected drugs in the 20th century and those who do so now. Among those factors are the following:

- the rapid growth of cities
- the beginning of urban planning
- the proliferation of factories
- the development of statistics gathering and the process of ‘othering’
- the impact of immigration and the blending of new cultures, habits and practices
- the rise of the medical profession and the changing status of doctors and apothecaries.

This brief history of the significance of industrialism to current attitudes is further developed through an exploration of the roles of religion, trade, policy and law in shaping a deliberate process of pathologising and ‘diseasing’ people who inject drugs.

Chapter 3 examines the emergence and growth of the temperance movement, the rise of organised religion and the Protestant ‘work ethic’, the Opium Wars, and the development of policy and legislation as a way to both ‘problematising’ and control the use of licit and illicit drugs. The rise of the counterculture revolution, the impact of the Vietnam War and the invention of the ‘war on drugs’ analogy by President Nixon in the 1960s and 1970s are also explored for their role in building a growing sense of fear and dislike of people who inject drugs. The chapter concludes with an analysis of several themes that feature strongly in narratives relating to people who inject drugs—the fear of contagion, needles and syringes as symbolic weapons, and the impact of mass communications on social attitudes.

The final chapter offers an overview of stigma and discrimination as they are played out in contemporary society, including what it means to experience entrenched and widespread stigma and discrimination from the drug user’s perspective. A range of important social theories dealing with stigma and discrimination and injecting drug use are explored in order to link the findings arising from the AIVL-commissioned market research project with the available research and literature on this topic. In particular, the negative impact of illegality and criminalisation on both the lives and the actions of people who inject drugs is examined. Finally, the theory and practice of stigma and discrimination as they relate to people who inject drugs are explored in a range of specific contexts—the media, the general community, and the medical profession—to provide examples of stigma and discrimination ‘in action’.

The magnitude and complexity of the exercise we embarked on meant this document was always going to have limitations. Our resources did not allow us to explore all the social, economic and political factors that have affected the development of the current discourse in relation to people who inject drugs. Some might even disagree with the key points in time we chose or the conclusions we draw from the factors examined. We are not historians: we are people living with the outcome of over two centuries of highly repressive and unjust social and legal responses to injecting drug use.

What we want to do is to begin, rather than conclude, a dialogue on how the community has arrived at the current harmful and inhumane attitudes to and practices affecting people who inject drugs. We hope that those of you who pause to read this document will at least think about your own role in perpetuating current attitudes towards people who inject drugs and how you might begin the process of breaking this cycle of social violence.

The recommendations that follow should act as a guide to action for all who seek to make a difference by encouraging genuine change.
Recommendations

The recommendations arising from this document lend themselves to both ambitious and modest projects involving many aspects of the community. They are directed not only at AIVL and people who inject drugs; the plethora of agencies, both government and non-government, that are responsible for the health and human rights of people who inject drugs must also be involved. Beyond these individuals and agencies, however, AIVL aims to define responsibility for action to reduce stigma and discrimination as something that needs to be shared by the entire community.

In view of this, the recommendations are directed at all of us and how, in our everyday lives, we can grasp opportunities to influence and change what is an unjust situation. A throw-away remark at the family BBQ—“It’ll be those filthy junkies”—must be challenged. A view expressed in the workplace—‘Don’t use that cup: you’ll get AIDS or hepatitis. She’s a smacko’—must not be tolerated. When a newspaper, a magazine or a television program portrays people who inject drugs as the scapegoat for a community or social ill, we should let the journalist or the proprietor know through our phone calls and letters that we do not agree with them and that, more importantly, it is unacceptable to victimise any community group.

AIVL and other organisations that fight for human rights, at every level and for every person, will take their beliefs to the community in a determined, unswerving way, a way that clearly and thoughtfully describes for people exactly what it is we are living with and the cost of it for all in the community. Every family is touched by drug use in some way, and we need to work together to forge a new paradigm that helps prevent the loss of loved ones.

The recommendations that follow are divided into three layers under four broader topic areas. The topic areas are legislation and policy, community education, peer empowerment, and professional societies and workforce development. The layers deal with matters that need to be challenged or dealt with at the international, national, and state and territory levels. Responsibility is allocated with each recommendation.

Legislation and policy

The legislative and policy framework that defines community norms and the legal sanctions that support those norms and expectations have developed over centuries. They are so deeply a part of the fabric of our society that most people do not think about how or why particular customs and laws exist: they simply understand the reality of them.
Untangling the various components in order to develop a humane and just approach to illicit drugs and people who use those drugs is beyond the scope of any single group. If we look to other stigmatised groups—people with mental illness, the gay community, single mothers, for example—we can see that genuine social and legal change must involve the cooperation of diverse groups in society, among them governments, religious groups and broad-based community movements. It is AIVL's belief that without a whole-of-society response it will be impossible to achieve what is required to support the 're-humanisation' and re-integration of people who inject drugs.

**International**

AIVL recommends as follows:

- that the Commission on Narcotic Drugs and the UN Office of Drugs and Crime be called on to ensure that all international drug control laws and policies are consistent with accepted international standards in relation to human rights and the right to health for all
- that UN agencies be encouraged to review all relevant UN policies and programs to ensure they actively support and implement the principles of the meaningful involvement of people who use drugs
- that the International Network of People Who Use Drugs and regional drug user networks work together to highlight the impacts of illegality and criminalisation and of stigma and discrimination on the health and human rights of people who use drugs, with a view to encouraging legislative and policy reform to redress these impacts
- that AIVL work with the International Network of People Who Use Drugs in its efforts to encourage the meaningful representation of people who use drugs on all relevant UN bodies—such as the Technical Advisory Group for the Global Commission on HIV and the Law—dealing with questions of legal and policy significance to our community.

**National**

AIVL recommends as follows:

- that the Australian Government identify, review and, as appropriate, repeal federal laws and policies that contribute to the continuing criminalisation and marginalisation of people who inject illicit drugs
- that the Australian Government support investment in peer-led social research initiatives aimed at documenting and improving our understanding of the impact of laws and policies that stigmatise and discriminate against people who inject illicit drugs
- that Australian Government agencies responsible for curriculum development in Australian universities institute a policy mandating that all university-level courses in medicine, nursing, pharmacy and dentistry include content on reducing stigma and discrimination against people who inject illicit drugs.
The states and territories

AIVL recommends as follows:

- that state and territory governments be called on to identify, review and, as appropriate, repeal laws and policies in their jurisdiction that contribute to the continuing criminalisation and marginalisation of people who inject illicit drugs
- that each jurisdiction carry out a jurisdiction-wide review of the policies and practices associated with needle and syringe programs, opioid pharmacotherapy programs and other major health services used by people who inject illicit drugs, with the aim of reducing stigma and discrimination and improving health service access for this group.

Community education

Community members’ acceptance of and adherence to the law allow the system to work. Community mores, the community’s tolerance of certain behaviours and intolerance of others, and making those attitudes obvious, can lead to stigma and discrimination. We must take the community with us. We must ensure that community members are made aware of the paradoxes inherent in the current legal situation while ensuring that they have access to honest, non-exploitative information about the injecting drug user community. We need to educate them so that they no longer accept mainstream views without question.

International

AIVL recommends as follows:

- that it work with the International Network of People Who Use Drugs, at the global, regional and national levels, to take advantage of relevant international forums and events to raise awareness of stigma and discrimination associated with people who inject drugs
- that it work with the International Network of People Who Use Drugs to develop for the World Health Organization, UNAIDS and other global agencies a media guide on how to refer to people who inject drugs in their communiqués and other online and print-based publications
- that it work with the International Network of People Who Use Drugs and Harm Reduction International to develop an international media awareness and awards program that celebrates appropriate media behaviour. Award recipients could be announced at the International Conference on the Reduction of Drug Related Harm or another suitable international forum
- that media complaints units around the world take a firmer stance on the stigmatisation in the media of people who use drugs
- that the International Network of People Who Use Drugs and other international drug user organisations work together to more effectively use current media—such as Facebook, Twitter, current affairs programs and newspaper articles—to give a more balanced account of drug-related matters.
National

AIVL recommends as follows:

• that the findings from this document and the AIVL anti-discrimination market research report be used to develop a multi-stage general community education campaign beginning in July 2011 to start the process of responding to the causes of stigma and discrimination associated with people who inject drugs
• that social research be carried out in order to develop a better understanding of other highly marginalised groups and the strategies they have developed for dealing with and overcoming stigma and discrimination in their community
• that AIVL seize opportunities to present papers or research results at relevant national forums and other events in order to raise awareness of stigma and discrimination against people who inject drugs
• that AIVL develop a national media guide to improve the quality of reporting in relation to illicit drugs and to reduce the stigma and discrimination associated with people who inject drugs
• that the National Drug and Alcohol Awards include a media awareness and award program that salutes appropriate media behaviour in relation to reporting on illicit drug use and people who inject such drugs
• that federal parliamentarians receive education about the health and human rights of people who inject drugs and how current approaches to drug control adversely affect the health and wellbeing of people who inject drugs on a daily basis
• that the Australian Communications and Media Authority be encouraged to take a firmer stand on the reporting of matters that reinforce negative attitudes and perpetuate stigma and discrimination associated with people who inject drugs
• that the importance of the concerns identified in this document be emphasised through further development of AIVL’s mass media communication approaches— for example, the website and Facebook and Twitter.

The states and territories

AIVL recommends as follows:

• that its state and territory member organisations take advantage of relevant local forums and events to raise awareness of stigma and discrimination associated with people who inject drugs
• that it assist state and territory member organisations in the dissemination of a national media guide, with the aim of improving the quality of reporting in relation to illicit drugs and reducing stigma and discrimination associated with people who inject drugs
• that its state and territory member organisations lobby jurisdiction-based communications and media authorities to take a firmer stand on the stigmatisation of people who inject drugs
• that its state and territory member organisations educate their members of parliament in how the current jurisdiction-based drug control laws negatively affect the health and wellbeing of people who inject drugs on a daily basis.
Peer empowerment

Empowering people who inject drugs is a crucial part of any campaign aimed at reducing the stigma and discrimination associated with our community. Research is needed in order to determine the most effective way of providing to people who inject drugs strategies for developing and maintaining resilience and for rebuilding their social capital. Social change takes time, and in the interim people who inject drugs need strategies that will allow them to function more effectively in a hostile environment.

International

AIVL recommends as follows:

- that it work with the International Network of People Who Use Drugs to ensure that people who inject drugs globally are informed of their rights and come to recognise stigma and discrimination for what they are—ways of diminishing and punishing us
- that it work with the International Network of People Who Use Drugs’ global programs to develop tools that empower people who inject drugs to fight stigma and discrimination.

National

AIVL recommends as follows:

- that it help its member organisations in individualising existing peer-run self-empowerment tools and programs so these tools and programs more clearly relate to the local situation
- that at AIVL general meetings and other events attended by people who inject drugs national training sessions be conducted in order to promote the findings and recommendations of this document and AIVL’s national anti-discrimination market research report
- that AIVL’s range of policy initiatives and publications (including this document) on stigma and discrimination among people who inject drugs be promoted on the AIVL website and through links with other online forums
- that AIVL continually promote and update its new online anti-discrimination reporting site as a central aspect of recording people who inject drugs experiences of stigma and discrimination and informing AIVL and its members in developing effective responses.

The states and territories

AIVL recommends as follows:

- that state and territory peer-based drug user organisations be supported to develop and run self-empowerment groups within their local community of drug users
- that AIVL work with its state and territory member organisations and their clients to use and promote the new AIVL online anti-discrimination reporting site in order to reduce stigma and discrimination associated with people who inject drugs.
Professional societies and workforce development

Professional societies and workplaces potentially have a major role to play in reducing stigma and discrimination associated with people who inject drugs. Elimination of differential treatment in health and social services would give people who inject drugs the freedom to attend those services and take control of their health.

International

AIVL recommends as follows:

- that members of all relevant professional societies and staff of government agencies be encouraged to read the international version of Nothing about Us Without Us to improve their understanding of the importance of the meaningful involvement of people who use drugs
- that AIVL support the International Network of People Who Use Drugs in international workplace development projects aimed at reducing hepatitis- and HIV-related stigma and discrimination against people who inject drugs.

National

AIVL recommends as follows:

- that the Australian Government Department of Health and Ageing take a leadership role in ensuring the implementation of the current national blood-borne virus and sexually transmissible infection strategies in relation to reducing stigma and discrimination and improving the health and human rights of people who inject drugs
- that there be an audit of workforce practices in relation to stigma and discrimination in organisations that provide services for people with a history of injecting drug use—including government agencies, hospitals, and other important health and social services
- that the recommendations of the C-Change report into hepatitis C–related stigma and discrimination be implemented as a matter of urgency
- that AIVL, in consultation with its member organisations, develop a national training module dealing with stigma and discrimination against people who inject drugs for inclusion in university courses in the areas of medicine, nursing, pharmacy and dentistry and in police training
- that AIVL support and, where possible, collaborate with the Australasian Society for HIV Medicine in any healthcare-related workplace development projects the society undertakes targeting stigma and discrimination against people who inject drugs
- that social research be conducted into the most effective ways of helping healthcare workers recognise and deal with institutional and individual discrimination against people who inject drugs
- that the findings and recommendations of other AIVL publications that specifically deal with stigma and discrimination among people who inject drugs be promoted to a range of relevant workforces. Among these publications and their proposed targets are the following:
- Hepatitis C Models of Access and Service Delivery for People with a History of Injecting Drug Use—for promotion to hepatitis C service providers such as tertiary liver clinics, general practitioners and other relevant health services
- Legislative and Policy Barriers to NSP for People Who Inject Drugs—for promotion to all needle and syringe programs, alcohol and other drugs organisations, police services, relevant government departments, and federal and state and territory parliamentarians
- Treatment Service Users (TSU) Research Project (Phases 1 and 2)—for promotion to drug treatment services such as opioid pharmacotherapy, residential rehabilitation, detoxification and counselling services
- the Older Injecting Opioid Users discussion paper—for promotion to all relevant health and social services
- the National Statement on Ethical Issues in Research Involving Injecting/Illlicit Drug Users—for promotion to all relevant national research organisations and relevant individual researchers.

The states and territories

AIVL recommends as follows:

- that its state and territory member organisations be supported in tailoring the AIVL national training module on stigma and discrimination associated with people who inject drugs to suit specific local workforce development needs and circumstances
- that it work with its state and territory member organisations to ensure the implementation of the national and state- and territory-based blood-borne virus and sexually transmissible infection strategies in seeking to reduce stigma and discrimination and improve the health and human rights of people who inject drugs
- that it ensure that all state and territory member organisations receive multiple copies of all AIVL publications dealing with stigma and discrimination associated with people who inject drugs for dissemination and promotion at the local level.
There is an inextricable link between the stigma and discrimination associated with injecting drug use and the stigma and discrimination associated with hepatitis C. Both the New South Wales Anti-Discrimination Board Inquiry into Hepatitis C Related Discrimination\(^1\) and the Senate Community Affairs Reference Committee on Hepatitis C and the Blood Supply in Australia\(^2\) found that hepatitis C is a highly stigmatised condition, that hepatitis C–related discrimination is rife, and that discrimination in relation to injecting drug use lies at the heart of both these circumstances. Indeed, the Anti-Discrimination Board concluded that strategies designed to redress discrimination against people on the basis of their past, current or assumed drug use must be an integral part of responding to hepatitis C–related discrimination.

The New South Wales Anti-Discrimination Board’s 2001 *C-Change* report was, and remains, the most comprehensive examination of stigma and discrimination among those affected by hepatitis C in Australia. Considering that more than 90 per cent of all new infections and about 80 per cent of all current infections are among people who inject drugs or who have injected drugs\(^3\), there is overwhelming evidence for supporting action against discrimination affecting this group.

Since the *C-Change* report was published there has been little specific work done to respond to the problems identified and the recommendations made. This is of concern because the report highlighted the systemic and entrenched nature of the situation at all levels of society—particularly in healthcare settings, employment, the criminal justice system and the general community (including the media).\(^4\) It is in these areas that much work needs to be done to remove the inequities. This present document tackles these concerns in detail and provides specific recommendations.

In the Barriers and Incentives to Drug Treatment for Illicit Drug Users National Research Project more than half the participants reported that they had been discriminated against by family (63 per cent), staff at pharmacies (63 per cent), friends (62 per cent), and doctors and nurses (54 per cent); a significant number mentioned discrimination by partners (37 per cent), health workers other than doctors, nurses and pharmacy personnel (36 per cent), landlords (36 per cent) and workmates (34 per cent).\(^5\) Such is drug use–related stigma and discrimination that AIVL and its member organisations are aware of many individual drug users who live with painful, debilitating and even life-threatening conditions rather than seek treatment from health services, including blood-borne virus prevention and treatment services.

Indigenous drug users, drug users from culturally and linguistically diverse backgrounds and drug users with mental health difficulties are among the groups that live with multiple layers of stigma and discrimination and violations of their human rights. Poor attitudes towards these groups on the part of service providers, the media and the community at large result in increased vulnerability and levels of social exclusion—including much higher rates of homelessness, incarceration, unemployment, poverty, social isolation and chronic health problems such as hepatitis C, hepatitis B and HIV infection\(^6\)—compared with the general population.
The National Hepatitis C Strategy 2010–2013 nominates ‘minimising the personal and social impact of hepatitis C’ as one of three primary goals for the term of the strategy. The main objective associated with this goal is to ‘reduce hepatitis C–related stigma and discrimination in health care settings’. The strategy also acknowledges that the social ramifications of hepatitis C infection—particularly the stigma and discrimination that come with the condition and the barriers it creates for individuals seeking access to prevention education, care, support and treatment—are at the base of all activities within the strategy.

In addition, the strategy highlights the need for a human rights framework for dealing with stigma and discrimination as a priority action area. It notes that people with or at risk of hepatitis C experience discrimination in a range of settings, such as the health system, employment and social networks. This is consistent with the findings of the C Change report and a range of research projects dealing with discrimination, injecting drug use and hepatitis C. Such reports also point to discrimination as a barrier to gaining access to information, prevention measures, support, testing, treatment and care for those most affected.

There is an urgent need to deal with the systemic problems identified in the C Change report, given priority in the National Hepatitis C Strategy and documented in AIVL’s commissioned market research report. The market researchers found the following:

- Discrimination against people who inject drugs is pervasive and overwhelmingly negative.
- Discriminatory attitudes are generally based on stereotypes, myths and misconceptions about injecting drug use and injecting drug users.
- People who inject drugs feel misrepresented, misunderstood and unfairly judged.
- Members of the general community and health professionals fear injecting drug users, seeing them as unpredictable and volatile and posing a threat of transmission of blood-borne viruses through publicly discarded injecting equipment.
- Members of the general community are concerned that injecting drug use is ‘contagious’ and that mere association with injecting drug users will ensure being ‘tarred with the same brush’.
- People on pharmacotherapies elicited some sympathy for trying to ‘help themselves’ but were also seen as simply seeking a cheap source of drugs rather than as making use of treatment or harm-reduction services.
- Members of the general community readily admitted to discriminatory attitudes and behaviour towards injectors because they thought this would discourage people from taking up injecting drug use.
- Health professionals were concerned about the impact on their professional status or about losing other patients if they allowed injecting drug users in their practice or clinic.
- Discrimination was on the basis of both actual and presumed injecting drug use.
- Members of the general community admitted having little or no actual contact with people who inject drugs.

AIVL is not naïve about the challenges we need to confront in tackling the problems revealed through the market research, yet at the same time we feel we have no choice but to take the necessary next steps. From the perspective of limiting the transmission of hepatitis C and other blood-borne viruses and reducing barriers to access to treatment, to do nothing is not an option, either for those most affected by hepatitis C or for the community as a whole.
It is now clear that until we effectively respond to the impacts stigma and discrimination have on the lives of those most at risk of and living with blood-borne viruses we will not be able to reduce infection or improve access to treatment and care.

As is highlighted by the market research, actual and assumed injecting drug use underpins the vast majority of hepatitis C–related stigma and discrimination. It is also clear that most of the discrimination towards people who inject drugs (and thus those most affected by hepatitis C) is the product of stereotypes, misinformation and a dehumanising of drug users, particularly in the media. For this reason AIVL developed a broad-based human rights and anti-discrimination theme for this document, rather than focusing on hepatitis C–related discrimination alone. Although it is important to include an emphasis on hepatitis C–related concerns in the document—particularly the fear of transmission of blood-borne viruses through discarded injecting equipment and how this can lead to discriminatory attitudes—it is also important to ensure that the document does not shy away from talking about the main cause of hepatitis C– and other blood-borne virus related discrimination—injecting drug use.

In this context AIVL is engaged in a national anti-discrimination project to reduce stigma, discrimination and social exclusion among people who inject drugs and people on pharmacotherapy programs. It is these people who are at greatest risk of or are living with hepatitis C. This is a three-stage campaign, and this document builds on the market research AIVL commissioned. The purpose of this document is to form the basis for a national campaign—with a multi-faceted approach, targeting the general community, the media, researchers and government—and to provide for AIVL members and other interested parties a theoretical and historical understanding of how and why drug users have come to be where we are in society today.

Why AIVL?

AIVL is the national organisation representing the state and territory peer-based drug user organisations and those most affected by hepatitis C in Australia—that is, people who inject or have injected illicit drugs and people on opioid pharmacotherapy. AIVL and its member organisations have a peer-based, user-centred philosophy: we provide support to people who use or have used illicit drugs or are on opioid pharmacotherapy, so that they can speak on their own behalf and participate directly at all levels of the representative organisations. For this reason AIVL is uniquely positioned to develop a document dealing with the history and theory behind stigma and discrimination, in addition to pointing out and seeking solutions for a situation that affects all aspects of our community’s everyday lives.

Terminology: ‘our community’

Throughout this document people with a history of injecting drug use and people on opioid pharmacotherapy are referred to as ‘our community’, ‘us’ or ‘we’. As far as we are aware, this is the only document dealing with the history and complexity of stigma and discrimination as they relate to injecting drug use and users that has been developed by current injecting drug users. AIVL also considers that to write in the third person, or in a ‘removed’ manner, would be to insult people with a history of drug use and would not fully acknowledge our philosophy of ‘doing it for ourselves’ (that is, drug user self-determination).

Stigma and discrimination affect all people with a history of injecting drug use in such a fundamental way that they cannot be divorced from our everyday experience. Although people move in and out of drug use—to stop or suspend injecting for long or short periods, to obtain pharmacotherapy treatment, and so on—the stigma and discrimination do not go away.
The Industrial Revolution

The end of the 18th century and the beginning of the 19th was a period of unparalleled change in all areas of human endeavour. For countries in the midst of what is now called the Industrial Revolution, life as it had been known virtually vanished. Centuries of accepted customs and lifestyles seemed meaningless in this new, fast-paced capitalist society. Large, previously unconnected populations were now living in environments that were cramped and unhealthy, and much of the social ‘glue’ that had supported them in their rural or semi-rural lifestyles (such as close family members) was gone. Emile Durkheim would probably have described this period as edging toward the ‘anomic’—‘when a society is without dominant values and social cohesion’. So many of the changes that were occurring were beyond people’s experience, and they had to seek a new path.

People struggled to find a way of life that allowed them to work reasonable hours, look after their families, maintain some semblance of health, and have a say in how this new era was unfolding. Conditions in the United States were described thus (and the same might be said of any industrialised Western nation at the time):

> In the early 19th century, industrialisation and its attendant mobility were transforming US society—straining family ties and traditional community support networks such that the economic fates of families increasingly depended on self control.14

After about 1830 literacy levels started to increase. Brown notes, however, that this development was not necessarily all positive: ‘Literacy has always been a two-edged sword, providing the means to expand experience but also leading to control over what people read’.15

The result was an ability to communicate ideas and practices rapidly to large numbers of people, enabling very efficient dissemination of attitudes and ideas—good ones and bad.

The invention of the steam engine led to the development of machinery that necessitated the building of factories, which in turn required workers. Country folk who had previously worked in agriculture poured into these new factories. They brought with them their families, and so was born the modern city, with all its pleasures and problems.

As Lambert notes, ‘In 1801 at the time of the first census only about 20% of the population lived in towns. By 1851 the figure had risen to over 50%. By 1881 about two thirds of the population lived in
towns’. With the rapid growth of cities came many challenges—for the city councils that developed to take care of the needs of the cities and for the city dwellers themselves. The cities were dirty, unhealthy places, and diseases such as tuberculosis, typhoid, scarlet fever and whooping cough were common.

Established methods of controlling small populations were not suited to managing large urban populations, so police and other law enforcement mechanisms were developed. According to Lea, ‘The ruling classes in the early nineteenth, as in the later part of the eighteenth century, feared the new urban working class as a potentially rebellious mob …’

Gattrell writes:

... it was not only the motley, vast and hitherto little regarded populace of paupers and pimps, vagrants and sharp practisers, pickpockets and beggars, unemployed and derelict, thieves and robbers, who were now transformed into that … which Frenchmen in the 1840s were to term the ‘dangerous classes’. The whole world of the poor tended to be accommodated within a system of criminal labelling not only to express the social fear of the respectable, but also to justify a broader strategy of control to cope with that fear.

The dramatic social changes, different work practices and developing financial institutions combined to create a situation in which new laws and social structures were being developed hastily in response to the needs and challenges of the new environment. Often this would happen with little or no thought to the new laws’ and structures’ implications for the present or the future. Campbell describes the situation:

In the wake of industrialisation processes, newly urbanised people in their new socio-spatial arrangements were met by new governmental regimes, seeking to create new practises of sanitary, hygienic and moral ‘conduct’. The mob or the ‘dangerous classes’—and everyone else—had to be governed ... Temperance, sobriety and drunkenness were now subjected to the requirements of ‘healthy’ (and sober) workplaces and workforces and ‘social’ projects actively inculcated moral character in the new subjects.

The impact of statistics and the process of ‘othering’

The further development of statistics collection and analysis and the classification of people was an innovation that has had negative consequences in that it has allowed some people to be labelled and then perhaps stigmatised. While there had been surveys of numbers of people and people in trades prior to this period there had been no classification of people by “labelling” them by a personal behaviour.

In small hamlets one or two people who drank alcohol or took other intoxicants to excess did not really disturb the functioning of the community. But in the city, where thousands upon thousands of people were packed into inadequate space, intoxication became a problem. People were now seen as units of labour, and intoxication was counterproductive and frowned on. It led to workers not coming to work or arriving when they were unfit to do their jobs, resulting in, among other things, work-related accidents. Steven Kreis writes, ‘Man no longer treated men as men but as a commodity which could be bought and sold on the open market. This commodification of man is what bothered Karl Marx’.
In less than 80 years the change in circumstances for the majority of people was dramatic—from clean air, hard labour, cottages and home-grown food to rancid living conditions, harsh landlords, and poverty and dislocation. The working class, who were needed to keep the factories running, somehow became the scapegoat in the scramble for wealth and a place in the new order. Lea describes the general attitude to the poor:

*The English reformers in the early years of the nineteenth century [such as] Jeremy Bentham and Edwin Chadwick ... saw the main problem as that of regulating the tumultuous and unstable life of the growing city populations. More specifically there was the problem of how to ensure an orderly and stable working class that would get up and go to work each morning.*

People became bewildered by the changes that were happening both to them and around them. They had no experience of such upheaval.

Theorists such as Foucault put forward the idea of a major change in Western cultural practices, from ‘sovereign power’ to ‘disciplinary power’. Foucault describes the transition from a top-down form of social control, in the form of physical coercion meted out by the sovereign, to a more insidious form of social control—surveillance and a process of ‘normalisation’.

This idea of transitions of power fits well with the idea that the changes that occurred in this period benefited the new industrialists, the upper classes, a growing middle class and the capitalist economy. The transition to ‘disciplinary power’ led to the development of a range of institutions that had not
existed before—prisons, mental hospitals, and so on—that developed their own moral codes, language and practices designed to categorise, label and control.

Campbell writes:

*The idea of classifying people is old, but the formal development of a classificatory scheme became possible through the invention of statistics, imbuing a whole new quality into the activities of naming and counting people.*

Campbell goes on to cite Hacking, who traced the ‘statistics of deviance’ back to about 1820, defining it as ‘the numerical analysis of suicide, prostitution, drunkenness, vagrancy, madness, crime …’ Although people might previously have thought of other people as ‘different’ because of their alcohol drinking or drug using, the statistics of deviance allowed for the possibility of thinking of them as ‘other’.

Then, as now, statistics were used and manipulated in order to reflect and promote practices and behaviours that suited the economy and the status quo or, conversely, to assist in encouraging social or legislative change required by those with power.

*No methodological foundation existed for research, that is representative sampling was not part of the process … The state investigators, and later the advocates for the movement to improve public health, were quite happy to select relevant facts from the avalanche of information only then becoming available to create the knowledge they wanted.*

So the developing capitalist economy, bolstered by the ability of statistics to anticipate things such as urban growth, provides a framework for the concept of drug users being seen as ‘other’ and not contributing to the system. Added to this situation was the growth in the professions, with doctors and pharmacists (apothecaries) jockeying for prestige in the new social order.

*In the late 1830s statistical inquiry was acknowledged as a valuable tool for the advancement of medicine.*

**The development of professional societies**

*In the early part of the nineteenth century the medical profession—along with a number of others, for example, the legal profession and even the clergy—began to assume its modern form.*

It can be argued that professional societies were introduced in order to advance the interests of certain sections of the community rather than the community as a whole. Doctors and pharmacists managed to wrest control of health from traditional healers such as herbalists, and the result was that people with few resources had to visit the doctors and pharmacists in order to obtain products that had previously been available in their local stores.

Opiates, in particular, had been readily available: they were, in Bull’s words, ‘freely available, and relied on in most homes as a valuable remedy’. Bull adds:

*In this context, the movement for the improvement of public health was never an autonomous entity; it was annexed by the profession and shaped by an interest in self-regulation. It was used by pharmacists and doctors as a vehicle to express concern about opium and other drug related deaths, and in doing so strengthen professional self-definition and validate their expert status …*
As a result of the keen interest in the condition and size of the population at that time, deaths from poisoning were widely reported in the medical journals of the day. It is arguable, however, that the perceived increase in poisoning was quite possibly an artefact of the then new reporting strategies or that many of these fatalities were largely a function of the lack of health care.30

Professional journals were used to note matters of concern in public health and to discuss trends. In this way doctors and pharmacists had enormous power to set the agenda in public policy. As their power and influence increased they sought to monopolise the control of medicines and drugs:

They sought to restrict trade in the interests of their members, by establishing a professional monopoly on the sale of opium and other poisons. By accentuating the problems that could be attributed to opiate use rather than looking at health in a systemic way, their monopoly was assured ... This was realised in a number of medical and pharmaceutical Acts ... Opium came under the Sale of Poisons Bill and after 1857 it was to be kept under lock and key; in 1869 it was included in the Pharmacy Act, [which] limited availability to professional practitioners.31

During this period accidental drug overdosing occurred for much the same reason as it does today—misjudging doses, inconsistent quality, and so on. Opiates were, however, widespread and most people knew how to respond to an overdose. It was not something that was thought to warrant medical attention.

The medical profession’s involvement in the public health discussion on opiate poisoning and regulation marked the beginning of sustained medical intervention in this area.32

This success paved the way for doctors to become increasingly involved in the prescribing of all drugs.
Addiction came to be labelled a disease in the last quarter of the 19th century as doctors became more involved in the way opiates were administered. According to Bull, the concept of inebriety was central to this. Previously, ‘inebriety’ had been used to describe undesirable patterns of alcohol use:

In 1877, Norman Kerr, the chairman of the Society for the Study of Inebriety, explained: inebriety is ‘undoubtedly a disease, a functional neurosis that could be classified with reference to the intoxicating agent’. We thus have alcohol, opium, chloral, chloroform, ether, chlorodyne and other forms of the disease ... As a concept it was a vehicle for the application of medical criteria to behaviours formerly regarded as much as a social problem as a vice.33

Members of the medical profession have been involved in the development of the perception of drug users as ‘sick’ people ever since. Their intervention has in many ways been problematic. Doctors like to ’cure’; drug users are not readily ‘cured’. Although the doctors wanted to have control over the drugs we used in order to increase their professional societies’ influence, they did not really want to deal with drug users as patients. They did not know, and still do not know, how to treat us.

The tension between the ascetics and the imbibers has been played out for a long time as ideas of inebriation have become more entrenched. This is beautifully explored by Reinman, citing Room: ‘addiction is a “set of ideas which have a history and a cultural location”’. In his famous painting of 1559, ‘Fight between Carnival and Lent’, Peter Breugel depicts an agrarian village in pre-industrial Europe in full celebration. Feasting, drinking and even drunkenness are seen everywhere: numerous peasant holidays were traditionally passed in varying degrees of intoxicated revelry. Drinking was part of everyday life, engaged in by most people, with the exception of a few monk-like figures from protestant sects, who in the painting can be seen in dark robes solemnly stepping toward the church while their fellow villagers frolic with abandon. Breugel gives us a glimpse of a historical shift—the beginning of the ‘problematisation of intoxication at the dawn of Western modernity’.34

Through the rise of the scientific medical discourse opiate consumption became a disease; somewhat paradoxically, the cure for this disease remained the responsibility of the individual patient, not medical science.35

The obvious and ongoing dilemma of where this ‘new’ disease belonged has been with society ever since and, as Campbell points out:

Many professions have attempted to establish—especially in their literatures—why they have the ‘right’ knowledge to be involved in decision making about the surveillance of drug problems or ... at least ... to play a major part in it, from the policy ‘bureaucrat’ and auditors to psychiatrists, clinicians and social workers ...36
Cohen argues that addiction as a disease is essentially a religious notion in that its function is to manage our fears about how firmly we are in control of our behaviours and destinies—a myth-like social construction of no greater scientific validity than the pre-Galilean cosmology of flat-earthers. Once the protestant reformation and market capitalism gave rise to the ‘autonomous individual’ in the ‘west’ somewhere around the 17th century, Cohen suggests we began to see the development of its opposite—a modern sort of devil which takes the form of people who are thought to have lost the capacity for self-regulation, independence and entrepreneurial activity, [capacities that] were considered the essence of the autonomous individual.36

The temperance movement and the Protestant work ethic

The temperance movement and the burgeoning ‘Protestant work ethic’ had an insidious effect on the development of social customs and personal attributes. Both ‘belief systems’ played into the hands of an evolving capitalist economy since they both upheld the duty to work hard and abstain from indulgences. Together they became a powerful force. A person who did not conform to this depiction of a hard-working, God-fearing individual was looked on with growing contempt:

In a few decades in the early 19th century the growing temperance movement transformed alcohol from what even leading Puritan preachers had called ‘the good creature of God’ into a ‘demon destroyer’.38

The temperance movement epitomised the values of middle class self-control and self-denial. Hard work was the sign of a ‘true Man’; needless to say, this coincided with the rise of industrialism, where working hours became more regulated and factory owners demanded punctual, alert workers. Previously many working class men had missed days due to intoxication, but this behaviour was no longer tolerated. ‘Saint Monday’, an accepted day in agricultural society for men to recover from their hangovers, became an impediment to the new industrial factories.39

According to German socialist Max Weber, capitalism evolved around the Protestant work ethic, which urged large numbers of people to engage in the secular world, developing enterprises in trade and accumulating wealth for investment.40

There is also another notion that could account for the strong influence of Protestants in the development of a society fuelled by capitalism. Many Protestants were literate: being able to read was essential to their obligation to read the scriptures. For Catholics, on the other hand, this was not only unnecessary; it was prohibited for some time to even possess copies of the Bible. So the Protestant groups were often much more literate and educated than the Catholic sections of communities.41

Literate people were able to take jobs with potential for influence, such as clerks and journalists, whereas many Catholics worked in factories. In addition:

The Catholic approach to serving the poor was manifestly different to that of the Protestants, who saw asking for help as a way of further begging and providing for a life of indolence. This had a huge impact on the development of social policy and practice and brought about the development of the concept of ‘the deserving poor’. Catholic moralism tended to be aroused by sexuality; Protestantism by idleness and drinking ...42
Although drunkenness was a major concern for Protestants, other substances began to loom into view as progress with alcohol control did not meet expectations. People moved on to other intoxicants, such as opiates.

The early temperance movement was not inclined to abstain from drinking completely, rather to moderate it. Many working class men were insulted by the movement and felt it implied the problems of drunkenness only lay with the working class and the movement diverted attention away from the real problems of overcrowding, lack of adequate sanitation and appalling working conditions.43

The notion that an intoxicating substance could cripple self-control and thus cause bad behaviour that would not otherwise occur is a culturally specific attribution ... It is a notion that made sense and took hold at a point in history and in those societies in which social life was organised such that individualism had become the taken-for-granted frame of reference. The notion that drinking or drug use can cause the neglect of other activities makes sense in 'the context of a culture attuned to the clock, a culture in which time is viewed as a commodity which is used or spent rather than simply experienced' ...44

The temperance movement was becoming more involved in the distribution of public largesse and the development of public policy when it came to providing relief to the poor. This had the effect of giving rise to the notion of the so-called deserving poor, and people who used drugs were not in that category. As Campbell notes, 'In the late 1800s craft and benefit societies [later called unions] refused to provide assistance and benefits to people whose illness “was occasioned by drunkenness or fighting or any disease improperly contracted”'.45
The Opium Wars

Drugs have been used as an instrument of government and the capitalist agenda in various ways. One of the most interesting cases concerns the Opium Wars and the British and US pursuit of opium. The Chinese authorities banned the substance and fought wars to keep it out of their country. [Paradoxically, during the Cold War one of the oft-quoted refrains was to the effect that the Communists—the Chinese—were flooding the United States with opium in order to destroy young Americans.]

British, French and American merchants felt there was an imbalance in the trade deals with China—an imbalance that did not favour them. The Chinese had followed an isolationist trade policy with the West: they were anxious to minimise the influence of unwanted ideas and customs permeating their society. The only commodity the Chinese would accept in exchange for the exotic produce the Western world craved was silver. The Chinese had prohibited the use of opium for anything other than medicinal purposes, yet the drug was being imported by French and British merchants and was becoming more and more popular.46

In 1757 British forces led by Robert Clive won the Battle of Plassey, gaining ascendancy over the French, who had been the predominant power in Bengal beforehand. This allowed Britain to gain control of Bengali opium production, which in turn led to the British East India Company gaining a monopoly over the opium trade.

For the next 50 years the British East India Company pursued a culturally devastating one-sided trade with the Chinese people. It established elaborate schemes partially relying on legal markets and partially leveraging illicit ones. The moral dilemma was clear:

This war with China ... really seems to me so wicked as to be a national sin of the greatest possible magnitude, and it distresses me very deeply. Cannot anything be done by petition or otherwise to awaken men’s minds to the dreadful guilt we are incurring? I really do not remember, in any history, a war undertaken with such combined injustice and baseness. Ordinary wars of conquest are to me far less wicked than to go to war in order to maintain smuggling, and that smuggling consisting in the introduction of a demoralising drug, which the Government of China wishes to keep out, and which we, for the lure of gain, want to introduce by force, and in this quarrel are going to burn and slay in the pride of our supposed superiority.47

"Why wouldn’t I discriminate against all of them?"
A report on stigma and discrimination towards the injecting drug user community
The ‘problematisation’ of opiates and other drugs

Drug laws in the 19th century reflected a society in which drug use and abuse were seen as a continuum, and as a matter of individual choice which required neither legal nor medical legitimating. As discussed, opiates became an item of interest in industrialised countries for many reasons. The dosing of babies and young children with over-the-counter patent medicines that contained unknown quantities of opium was coming to the attention of authorities. Women were often forced to work and leave their babies with other women, who would take in several children at a time and use the medications to soothe and quieten fractious babies. Because death certificates and other documentation were enabling the collection of information that would allow tracking of these previously unknown statistics, a public health campaign was mounted. As Lea notes, however:

While opium use was the object of concern, the campaign against it criticised particular patterns of child rearing as well. The structural imperatives that lay behind these practices went apparently unnoticed. Attention was focused on the individual failings of working parents or absent mothers rather than the difficulties that arose in a social and economic milieu that often required both parents to work for a wage in order for their family to survive.

This concern resulted in the passing in 1876 in New South Wales and Victoria of legislation that listed a range of drugs that could be sold only by a medical practitioner or chemist. The only limit on such sales was that the word ‘Poison’ be marked on the label along with the name of the product and of the seller.

Use of opiates by Chinese people was also becoming a problem, both in the United States and in Australia, where Chinese emigrants had come to work in the goldfields. Europeans took their opiates as a tincture, whereas the Chinese smoked their opium. The sight of people lying on couches enjoying their pipe of opium was very different from seeing someone taking a tablespoon or so of a tincture. This different approach to opiate use began to be used as a rationale for stopping any behaviour on the part of the Chinese that might interfere with European needs or offend European sensibilities.

It was becoming evident that the Indigenous community in Australia preferred working with Chinese rather than European bosses, possibly because Chinese bosses treated them a little better. White people wanting Indigenous workers fastened on the idea that opium was the reason for the lack of willing workers: opium was seen as the only possible explanation for what seemed a perverse choice. As a consequence, in Australia the first laws pertaining to opium were aimed at reducing opium use by the Indigenous population. In 1891 the Queensland Sale and Use of Poisons Act was promulgated. Under it, ‘any person who supplies or permits to be supplied any opium to any aboriginal native of Australia or half-caste of that race ... except for medicinal purposes would be penalised.

White Australians’ attitude towards the Chinese community was characterised by enmity and fear. The Chinese worked long and hard for low wages and were seen as a threat to white labourers. This attitude became mixed up with a fear of Chinese men luring white women into opium dens. One way of managing the fear was to legislate against the Chinese method of drug use.
Victoria and New South Wales passed legislation banning opium smoking in 1905 and 1908 respectively. It was not until 1914 that the Commonwealth prohibited the importation of opium for smoking. This was to become a pattern in Australia’s social and legal history—using drug laws to manage races that were feared and classes that were despised.

**Laws and treaties**

Various Australian and international treaties connected with drugs were adopted in the period following industrialisation. Australia appears to have modelled its treaties and laws more on the British legislation until the Single Convention of 1961, to which Britain has never been a signatory, allowing it to prescribe opiates to the population. Bull states:

> ... in the process of colonisation, early Australian experiences of public policy, legislative and medical developments in relation to the regulation of opiate use evolved directly from, and as an extension of, the British experience. American developments did not become influential until the early part of the twentieth century; they did not begin to shape policy or public perceptions in Australia until after World War II.

The table that follows summarises the laws and treaties that have influenced Australia’s domestic and international stance in connection with drugs. For the most part, none of these laws or treaties had any impact on Australians’ ability to obtain opiates from a chemist or their doctor.

By the end of the 19th century Australia had the highest per capita consumption of proprietary medicines in the world. Despite this, the only attempts to regulate opiate use were directed solely at the Chinese community.

**Australia from 1900 to the 1960s**

From 1900 to the 1960s in Australia medical use of heroin for a variety of ailments flourished. This period was not one of profound social change: two world wars and a depression did not provide an environment conducive to social change; people were busy just trying to survive or were concerned about their loved ones surviving. Most people who went to doctors seeking opiates were middle class and of little interest to authorities.

The Commonwealth’s annual report for 1957 noted that only 33 people had been charged with illegal possession of drugs and nine with trafficking. The maintenance of normal so-called therapeutic addicts was not challenged seriously during the 1950s.

**The introduction of specific policies on drug use**

By the beginning of the 20th century new social structures, religious influences and economic paradigms in Western civilisation were all aligning to facilitate the ‘scapegoating’ of an entire section of the community through the development and implementation of drug laws in the ensuing decades. Unsurprisingly, those most affected were the poor, the dispossessed, and people already marginalised as a result of race or ethnicity.
Anti-opiate propaganda: Propaganda – a world-wide phenomena

Top left: Netherlands Indies, 1930s (from Indie en bet Opium, Batavia, 1931)
Top right: Sichuan, China, 1930s (from H. Forman. “Horizon Hunter”, National Travel Club, New York, 1940)
Bottom left: Singapore, 1910s (from W.G. Sterling, “Opium Smoking Among the Chinese”, Ipoh, 1913)
Bottom right: China, 1910s (from G. Thibout “La Question de l’Opium”, G. Steinbeil, Paris 1912, p. 313)
## Laws and treaties that have influenced Australia’s stance on drugs, 1800 to 2006

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<td>1800</td>
<td>France</td>
<td>Napoleon bans cannabis usage among his occupying troops.</td>
<td>Worried about the widespread habit, Napoleon stated: ‘It is forbidden in all of Egypt to use certain Moslem beverages made with hashish or likewise to inhale the smoke from seeds of hashish. Habitual drinkers and smokers of this plant lose their reason and are victims of violent delirium which is the lot of those who give themselves full to excesses of all sorts.’</td>
<td>This is the first widely recorded drug prohibition of the modern era, and the religious overtones of Napoleon’s decree are obvious. Prohibition was to have a lengthy future as a discriminatory tool. Napoleon’s soldiers are credited with bringing cannabis back to France, despite their leader’s ruling.</td>
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<td>1858</td>
<td>UK</td>
<td>Passage of the Poisons Act.</td>
<td>This Act, a more extensive follow-up to the Arsenic Act of 1851, regulated the supply of poisonous substances, primarily to stop them falling into the hands of murderers. Such regulation became a basis for future legislation prohibiting various drugs.</td>
<td>The drug historian S.W.F. Holloway sees the Act, and the circumstances that produced it, as indicative and formative of the subsequent, overwhelmingly prohibitive drug policy. Throughout the nineteenth century, British governments declined to accept responsibility for the promotion of pharmaceutical science, education and practice. Their sole concern in prompting poisons legislation was the prevention of crime. And in that, perhaps, lies the cause of all our woes. A fervid concern for the liberty of the individual has produced, on an international scale, a bureaucratic regulation of the supply of drugs in which the rights of individuals, and even nations are systematically violated.</td>
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<td>1860</td>
<td>China, UK</td>
<td>Convention of Peking.</td>
<td>Ends Second Opium War. Among other trade-related conditions imposed by the British, the opium trade is legalised after many years of British smuggling of Indian-grown opium into China.</td>
<td>The Convention precedes a rising awareness of opium use in the USA, leading to a few disparate and generally ineffectual laws in individual states, most of which were openly enacted as a means of discrimination against local Chinese communities, commonly leaving such opium derivatives as morphine and laudanum unregulated, and, as with the San Francisco Opium Exclusion Act of 1875, ignoring opium use by whites.</td>
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<td>1868</td>
<td>USA</td>
<td>Passage of the Pharmacy Act.</td>
<td>The Act regulates the purchase of poisons such as arsenic, cyanide and prussic acid. [Opium is hastily added to the list.] Substances must be purchased from a registered chemist, who must record the buyer’s name, the date and the details of the purchase.</td>
<td>The effect of this is more foundational than direct, foreshadowing the Harrison Narcotics Act of 1914.</td>
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<td>1906-1910</td>
<td>UK, China, USA</td>
<td>1906 Amendment to the UK Pharmacy Act of 1869.</td>
<td>Opium and preparations thereof greater than 1% are included in the Pharmacy Act, aimed at regulating the supply of various drugs by pharmacists and medical professionals [though not prohibiting the use of said substances]. The US goes further in 1909, banning imported, non-medicinal opium smoking altogether.</td>
<td>US governance of the Philippines features the prohibition of opium on religious and moral grounds. This is the first national—as opposed to racial—prohibition of opium. The application of a similar model to China is discussed at the Shanghai Commission, after the US has rushed through its first federal drug prohibition law in 1909.</td>
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<td>1912</td>
<td>Germany</td>
<td>Merck Pharmaceuticals synthesises MDMA (Ecstasy).</td>
<td>The drug was synthesised during attempts to create a blood-clotting agent, and not as a potential appetite suppressant as is sometimes reported.</td>
<td>MDMA lay dormant until the late 1950s, when small groups of people began to experiment with it. The celebrated drug chemist Alexander Shulgin re-synthesised it in the late 1960s, and it soon entered therapeutic use, which persists sporadically today.</td>
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<td>1912-1913</td>
<td>Netherlands [International]</td>
<td>1912 First International Opium Conference. Hague Convention. 1913 Second International Opium Conference.</td>
<td>The Convention obliges signatories to restrict opiates to medical purposes, penalise their unauthorised possession and prohibit their sale to unauthorised persons.</td>
<td>The First World War intervened, and signatories were not fully committed to the measures until the incorporation of the Convention under Article 295 of the Treaty of Versailles in 1919.</td>
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<td>1914</td>
<td>USA</td>
<td>Passage of Harrison Narcotics Act</td>
<td>After the failure of the Foster Antinarcotics Bill of 1911, and much constitutional wrangling, the final Act brought the USA into line with the Hague Convention, forcing purveyors of opium and cocaine to register with the government, keep sales records and pay taxes.</td>
<td>The impetus is less on prohibition for its own sake and more on fulfilling international obligations, but the Act severely limits non-medical availability of the relevant drugs. It also sets a precedent for the incorrect, ignorant use of the word 'narcotics', as the Act encompasses cocaine, a CNS stimulant.</td>
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<td>1916</td>
<td>UK</td>
<td>Passage of the Defence of the Realm Act (DORA)—a piece of emergency wartime legislation—undeclared in Parliament.</td>
<td>Under DORA regulation 40b, the possession, distribution and sale of cocaine and opium were controlled under the authority of the Home Office. This control, obtained under emergency conditions, was to be retained, setting a precedent of treating drugs as a criminal matter and a threat to national security.</td>
<td>Though the circumstances perhaps warranted the move, and the emphasis was on ensuring the availability of medicinal drugs when needed, these restrictions drew on several years of growing 'anti-narcotic' posture closely related to that which was simultaneously becoming established in the United States.</td>
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<td>1920-1923</td>
<td>UK</td>
<td>1920 Passage of the Dangerous Drugs Act. 1921 Report of Home Secretary’s committee to consider outstanding objections to the 1920 legislation. 1923 Passage of the Dangerous Drugs Amendment Act.</td>
<td>The 1920 Act implements the Hague Convention in Britain by extending and reinforcing DORA 40b. As well as opium, the Act places controls on tincture of cannabis and preparations containing hydromorphone, and bans cocaine following stories of ‘crushed soldiers’ in WWI. It also creates the offence of being an occupier of premises permitting the smoking of prepared opium and introduces the offence of performing acts in this country resulting in the commission of an offence contrary to corresponding law abroad.</td>
<td>The Act represents Britain’s first formal drug legislation, and solidifies the precedence of the Home Office over the Ministry of Health in the area of drugs policy. The 1923 Amendment Act continues the punitive emphasis, introducing more severe penalties and imposing stricter controls on physicians and pharmacists. Perhaps most significantly, it expands the search powers of the police.</td>
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<td>1926</td>
<td>UK [USA]</td>
<td>Report of the Departmental Committee on Morphine and Heroin Addiction, chaired by Sir Humphry Rolleston (‘the Rolleston Committee’).</td>
<td>The Committee, established in 1924, is concerned with assessing the best approach to the problem of addiction. The approach favoured in the UK thus far has largely been more punitive than medical. The findings of the Committee aim to reverse this situation, emphasising addiction as a disease as opposed to ‘a mere form of vicious indulgence’ and recommending that policy be changed to reflect this.</td>
<td>This represents a major divergence between the policy of the UK and the USA. The report forms the basis of the ‘British System’ of allowing doctors to prescribe drugs to addicts in a regulated and safe manner, which survives several decades before coming under fire in the 1960s. The USA fared less well, ruling against the doctors in a number of high-profile court cases in the 1920s, despite the emergence of a body of expert opinion along similar lines to the Rolleston Report.</td>
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## Year | Relevant Parties | Event Details | Commentary
---|---|---|---
1928 | UK | Amendment to Dangerous Drugs Act 1920. | The amendment adds cannabis (plant material, resin and oil) to the Act, and includes other drugs, in an effort to address the increasing use of opium at home due to a lack of accurate drug information and the press-driven association of both drugs with immigrants. An internal memo at the Home Office suggested that coverage of one particular overalloon cannabis case were evidence of journalists having nothing better to do.3
1928 | Switzerland | International Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs signed at Geneva. | The detailed stipulations of the Convention foreshadow the drug grouping or 'Schedule' system in common worldwide use to this day. The system has more recently attracted criticism that it is not based on the genuine risks of each drug, but rather on popular opinion, rather than being based on evidence of effectiveness and a scale of the genuine risks of each drug.
1931 | USA | Passage of the Marihuana Tax Act 1937. | Cannabis remained legal, but commercial dealers were taxed a low flat rate. The true bite of the Act was its bureaucratic and punishment structure; even minor violations could result in a fine up to $2000 and five years' imprisonment, and the burden of paperwork was significant. The Act itself was later found to be unconstitutional and superseded by the Controlled Substances Act of 1970.
1934 | USA | Formation of the Home Office Drugs Branch. | The new body maintains addiction statistics and monitors physicians and pharmacists prescribing and dispensing drugs to addicts.
1936 | USA | Release of film Reefer Madness | The heavily propagandised film tells the story of a group of 'beatniks' who become 'hooked' on the 'devil's weed' and their subsequent decline into illegality and squalor. The film began as a church-group project entitled Tell Your Children, but was then purchased by director Dwain Esper and sensationalised with compromising insert shots and a new title. The film lay dormant until the National Organization for the Reform of Marijuana Laws (NORML) was founded in 1970 and began showing the film at pro-pot rallies. Since then, Reefer Madness has become a humorous cult classic among college students and other aficionados of drug arcana.
1937 | Switzerland | Albert Hofmann synthesises lysergic acid diethylamide (LSD). | Hofmann returned to the substance 5 years later. Accidentally absorbing a small amount through his skin, he discovered the psychoactive effects and proceeded to work rigorously with the drug, LSD, which he then developed into a Truth drug and investigated it for suitable social engineering and mind control applications, but proved unsuitable for that purpose. It had also been used in therapy.
1942 | Germany | Methadone is manufactured and distributed in the USA | Methadone has since become better known as a substitute treatment option for heroin addiction, as its longer lasting effect makes it easier to administer and dissociates it from the need for a high. However, users experience variable and prolonged withdrawal periods. Numerous other disadvantages include a more politically acceptable substitute for heroin, rather than injecting, and a more politically acceptable substitute for heroin itself.
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<tr>
<th>Year</th>
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<th>Event</th>
<th>Details</th>
<th>Commentary</th>
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<tr>
<td>1948</td>
<td>France [International]</td>
<td>The Paris Protocol 1948.</td>
<td>The Protocol introduced the 'similarity concept' into drug legislation in order to prevent drug manufacturers evading legislation by producing analogues of prohibited drugs.</td>
<td>The similarity concept is a common tenet of modern drug prohibition legislation, facilitating the clampdown on 'designer' drugs. Relevant legislative provisions were made in the USA in 1986 with the passing of the Federal Analog Act, and the US government was more recently given emergency powers to 'schedule' any substance for up to eighteen months, pending scientific evidence. Similar analogue legislation was implemented in the UK.</td>
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</table>

**1960-1996**

<p>| 1961-1965 | UK [International—UN] | 1961 First report of the Interdepartmental Committee on Drug Addiction, chaired by Sir Russell Brain (the First Brain Committee). | The First Brain Report confirms and reinforces the findings of the Rolleston Report of 1926, favouring the status quo of drug prescription where necessary and emphasising the small scale of drug use in the UK. The report is publicly criticised for failing to recognise the extent of the problem. In the same year, the UN consolidates and broadens previous drug treaties into a coherent whole, forming the bedrock for the global penal response to drug use. The Convention formally introduces the four-schedule scheme, which has since become the basis of US and UK drug classification. Cannabis is notably added to the list of proscribed substances. The UK complies with this legislation in the Dangerous Drugs Act of 1964. Meanwhile, methadone treatment is being successfully trialled in the USA. Following a sharp rise in the number of UK heroin addicts on record, and reports of cavalier prescription by doctors, the Second Brain Report is commissioned and concludes that tighter restrictions are needed. | This marks the beginning of the end for the 'British System' of opiate prescribing. The main recommendations of the 1965 report included the notification of addicts, wide-ranging restrictions on the prescribing rights of doctors, and the establishment of special treatment centres or clinics for the provision of drug treatment. The right to prescribe heroin and cocaine to addicts was now limited to specialist psychiatrists working in clinics and equipped with a license from the Home Office. From this point, in addition, the quantity of these drugs prescribed was reduced dramatically, the heroin substitute methadone being supplied in their place. The 1961 UN drugs convention marks a key turning point in global prohibition—enshrining prohibition in domestic law across the globe, and closing down any possibility of regulated models of production and supply for the prescribed drugs (anomalously excluding alcohol and tobacco) being introduced by individual countries even if they democratically determined to do so. An entire avenue of policy options was closed. |
| 1963 | USA [International] | Methadone Maintenance Treatment (MMT) pioneered in the US by Nyswander and Dole | | |
| 1964 | UK | Dangerous Drugs Act 1964 | | |
| 1965 | UK | Second Brain Report | | |
| 1966 | UK | LSD is prohibited | The measure comes after usage spills over from research to recreation and reaches levels thought to be problematic, fuelled in part by the emerging psychedelic music scene and predictably hysterical media coverage. | The use of LSD in therapy continued until the early 1970s before finally being halted. |
| 1967 | UK | Passage of the Dangerous Drugs Act 1967 | The Act implements the Brain Committee recommendations of 1965. | A clause is appended that gives the police 'stop and search' powers, which are retained to this day despite concerns over racial profiling. The campaign states: 'The law against marijuana is immoral in principle and unworkable in practice.' Signatories to the petition include the Beatles, RD Laing and Graham Greene. |
| 1967 | UK | 'Legalise Pot' rally in Hyde Park | The rally is accompanied by an advertisement in the <em>Times</em>, sponsored by SOMA, a drug research organisation. | The zeal with which Operation Intercept is conducted is at odds with its short timescale and relatively low effectiveness in stemming the flow of cannabis, adding weight to the impression that the drug 'problem' is being used for geo-political leverage. G. Gordon Liddy writes in his autobiography: 'The Mexicans, using diplomatic language of course, told us to go piss up a rope. The Nixon administration didn't believe in the United States taking crap from any foreign government. Its reply was Operation Intercept.' |
| 1969 | USA | 'Operation Intercept' targets the smuggling of cannabis into the USA over the Mexican border. | The two-week operation involving a three-minute inspection for every vehicle passing over the border adversely impacts the local economy on both sides, and has a 'negligible' effect on cannabis supply to the US. | |</p>
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<th>Year</th>
<th>USA</th>
<th>Event</th>
<th>Commentary</th>
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<td>1969-1970</td>
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<td>USA</td>
<td>The psychiatrist Dr. Robert DuPont conducts a study which finds that 44% of inmates under his care test positive for heroin. DuPont convinces his superiors to allow him to supply methadone to heroin addicts. Washington's mayor later allows him to supply methadone to heroin addicts. DuPont's program is controversial due to widespread ignorance about methadone and worries that the program might be a tool to control minorities and the funding to be a great success. As Nixon's drugs czar, Jerome Jaffe, comments: We never thought we would be doing this. Nixon does not have the data that we now have that methadone is helping, but it's terrific. We thought that was wrong.</td>
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<td>1970</td>
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<td>USA</td>
<td>Passage of the Comprehensive Drug Abuse Prevention and Control Act. Nixon formally initiates the 'War On Drugs'. Foundation of Special Action Office for Drug Abuse Policy (SAODAP) under Dr. Jerome Jaffe. The 1970 Act consolidates previous drug laws and reduces penalties for marijuana possession. The act includes five categories (schedules) for regulating drugs based on their medicinal value and potential for addiction. Nixon follows this up in 1971 by declaring drugs to be 'Public Enemy Number One' and creating SAODAP to deal with the perceived problem. Jaffe is given a free rein in recruitment, finance and policy. The Act also strengthens law enforcement by allowing police to conduct no-knock searches. The shifting of power back towards the law enforcement agencies, despite some complaints of no evidence, is spent on research, not treatment. The confusing policy is at odds with the president's tough rhetoric, and the inconsistency gradually comes to light as both counterproductive and embarrassing.</td>
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<td>1971</td>
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<td>UK</td>
<td>United Nations Convention on Psychotropic Substances. The Convention addressed the limitation of the Single Convention of 1961 to named, straightforwardly organic drugs (opium, heroin and cocaine and their derivatives) in view of the experimentation with many new drugs such as LSD, mescaline, amphetamines and tranquilizers in the 1960s. The Act also strengthens law enforcement by allowing police to conduct no-knock searches. The shifting of power back towards the law enforcement agencies, despite some complaints of no evidence, is spent on research, not treatment. The confusing policy is at odds with the president's tough rhetoric, and the inconsistency gradually comes to light as both counterproductive and embarrassing.</td>
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<td>1973</td>
<td></td>
<td>USA</td>
<td>Establishment of the Drug Enforcement Administration (DEA), headed by John R. Bartels. The DEA is intended as a super agency to deal with all aspects of the illegal drug issue in the US. It consolidates several departments from the Bureau of Narcotics and Dangerous Drugs (BNDD), the CIA, Customs and the Office of Drug Law Enforcement (ODLE), set up in 1971. Today, perhaps the most notorious and US-specific strand of the DEAs is in the area of drug education for youth. The route of providing harmful advice, whilst still strongly discouraging drug use, that has become predominant in the US, is largely spliced here, instead, all illegal drugs are spuriously conflated and demonised under a pervasive 'Just Say No' policy.</td>
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<td>1976</td>
<td>USA</td>
<td>Presidential candidate Jimmy Carter campaigns on the decriminalisation of cannabis.</td>
<td>Carter is merely proposing the extension of several state laws into federal law. The proposal suggests decriminalising the possession of up to one ounce of marijuana.</td>
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<td>1976</td>
<td>USA</td>
<td>Parents' anti-drug movement established.</td>
<td>Troubled by marijuana usage at her 13-year old daughter's birthday party, Keith Schuchard and her neighbour Sue Rusche form Families in Action, the first parents' organisation designed to fight teenage drug abuse.</td>
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<td>1977</td>
<td>UK</td>
<td>Amendment of Misuse of Drugs Act 1971 to include MDMA (Ecstasy) as a Class A drug.</td>
<td>Ecstasy was previously unmentioned in UK law.</td>
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<td>1982</td>
<td>Colombia, USA</td>
<td>Election of Pablo Escobar, one of the most notorious drug lords in history, to the Colombian Congress.</td>
<td>Escobar makes himself popular with the people, building a 'Robin Hood' image by investment in housing and sport, giving monetary handouts and even appearing throughout the city accompanied by Catholic priests.</td>
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<td>1984</td>
<td>USA</td>
<td>Launch of 'Just Say No' movement, spearheaded by Nancy Reagan.</td>
<td>Nancy Reagan's 'Just Say No' anti-drug campaign becomes a centrepiece of the Reagan administration's anti-drug campaign. The movement focuses on white, middle class children and is funded by corporate and private donations. The slogan is backed by a slew of new drug education movements, most notoriously Drug Abuse Resistance Education (DARE). Marsha Rosenbaum of the Lindesmith Center, a drug policy reform organisation, comments on DARE's 'Just Say No' methods: 'What I don't want kids to hear is that all drugs and any amount you do will be the road to devastation. Once kids get to an age where they're experimenting... they know that is not true, so they throw away the entire prevention message. It isn't really education. It's indoctrination.'</td>
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<td>1985-1986</td>
<td>USA, UK</td>
<td>1985 Crack cocaine takes off in New York. 1985 UK Passage of the Controlled Drugs (Penalties) Act 1986 Death of Len Bias, a promising college basketball player, from a cocaine overdose. 1986 Televised 'Just Say No' address from Ronald and Nancy Reagan. 1986 USA Passage of the Anti-Drug Abuse Act of 1986.</td>
<td>Crack, a potent form of smokeable cocaine developed in the early 1980s, begins to flourish in the New York region. The New York Times brings this to the nation's attention. Crack is cheap, powerfully addictive and is quickly associated with ethnic minorities and violent crime. The death of Len Bias, a popular and seemingly clean-cut sportsman, provides the anti-drug movement with a sacrificial lamb on whom to pin the 'Just Say No' slogan. Two days after Nancy Reagan's televised address, Congress passes the Anti-Drug Abuse Act. $1.7 billion is committed. The 1986 USA Anti Drug Abuse Act is most significant for its introduction of mandatory minimum sentences. Possession of at least one kilogram of heroin or five kilograms of cocaine is punishable by at least ten years in prison. In response to the crack epidemic, the sale of five grams of the drug leads to a mandatory five-year sentence. Mandatory minimums become increasingly criticised over the years for promoting significant racial disparities in the prison population, because of the differences in sentencing for crack vs. powder cocaine. In the UK, the 1985 Act has already introduced life imprisonment as a maximum penalty for drug trafficking.</td>
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<td>1987-1989</td>
<td>UK</td>
<td>MDMA (Ecstasy) use is popularised.</td>
<td>The US tendency for recreational use of MDMA in sedentary social settings along with niche use in the gay scene and amongst 'dead-heads' gives way to the European tendency, famously formed in Ibiza, of widespread use at raves and dance parties. Ecstasy becomes a cornerstone of British rave culture.</td>
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<td>1989</td>
<td>UK</td>
<td>First UK media-reported death from Ecstasy, of an underage girl, Claire Leighton, in the Haçienda club in Manchester.</td>
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<td>1990</td>
<td>USA</td>
<td>President Bush proposes a 50% increase in 'War On Drugs' spending.</td>
<td>The proposal adds an additional $1.2 billion to the coffers of prohibition enforcement.</td>
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<td>1992</td>
<td>USA</td>
<td>President Clinton admits to having smoked cannabis in his youth.</td>
<td>When I was in England, I experimented with marijuana a time or two, and I didn’t like it. I didn’t inhale and never tried it again.</td>
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<td>1995</td>
<td>Australia</td>
<td>MDMA-related deaths of Anna Wood (Aus) and Leah Betts (UK) within weeks of each other.</td>
<td>Details to emerge later suggest that both girls were teenagers who died from a cerebral oedema caused by overhydration, rather than a direct toxic effect of MDMA.</td>
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<td>1995</td>
<td>USA</td>
<td>Sentencing Commission recommends revising mandatory minimum sentences.</td>
<td>The U.S. Sentencing Commission, which administers federal sentencing guidelines, releases a report which notes the racial disparities in cocaine vs. crack sentencing. The commission proposes reducing the discrepancy.</td>
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<td>1996</td>
<td>UK</td>
<td>Establishment of Transform Drugs Campaign (re-titled the Transform Drug Policy Foundation in 2003).</td>
<td>The campaign/foundation aims to reduce drug related harms to individuals and communities by promoting a pragmatic discourse on the counterproductive nature prohibition and the benefits to be gained from moves towards legally regulated drug production and supply.</td>
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<td>1998</td>
<td>International [UN UK]</td>
<td>UN General Assembly Special Session on Drugs [UNGASS 1998] produces a new ten-year drug strategy. Appointment of Keith Hellawell, former Chief Constable of West Yorkshire, as the UK’s National Anti-Drugs Coordinator, or ‘Drugs Tsar’. (occasionally Tzar or Czar)</td>
<td>The somewhat aspirational strategy commits signatories to working towards a ‘drug free world’ by 2008. Kofi Annan stated: ‘Our commitment is to make real progress towards eliminating drug crops by the year 2008. It is my hope that this session will go down in history as the time the international community found common ground to take on this task in earnest.’</td>
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<td>1999</td>
<td>UK</td>
<td>House of Commons Committee of Public Accounts report entitled ‘HM Customs and Excise: The Prevention of Drug Smuggling’ is released.</td>
<td>The report questions the efficacy of Customs in reducing the supply of drugs—the key objective of supply side prohibitionist interventions—and concludes that there is a lack of evidence that prohibition-based customs policy produces either a direct effect on drug availability or a deterrent effect on other potential drug smugglers.</td>
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<td>2000</td>
<td>UK</td>
<td>Publication of the Police Foundation report on the Misuse of Drugs Act 1971, chaired by Dame Ruth Runciman (often referred to as ‘the Runciman Report’).</td>
<td>The report is a comprehensive analysis of the failings of UK drug policy, making a series of pragmatic short term recommendations, including calls for cannabis to be reclassified from Class B to Class C, and MDMA from A to B. The aim is to restore some credibility to drug law enforcement by moving away from a scaremongering educational model portraying ‘drugs’ as a homogenous, uniformly harmful entity.</td>
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<td>2000</td>
<td>UK</td>
<td>The human rights organisation Liberty passes a motion to call on the government for an end to absolute prohibition.</td>
<td>This AGM upholds the right of access of every adult to the lawful supply of psychoactive substances for personal consumption save where expressly constrained by or under the law for the purpose of protecting minors, countering crime, treating addiction, or some other legitimate public purpose and calls on the government to reform the laws accordingly.</td>
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<td>2002</td>
<td>UK</td>
<td>House of Commons Home Affairs Select Committee Report entitled 'The Government's drugs policy: is it working?' is released.</td>
<td>The Select Committee was mandated to review the government's ten-year drug strategy, put in place by Keith Hellawell et al. in 1998. This three-year appraisal concluded that the targets set in 1998 were 'unmeasurable and insufficiently grounded in evidence'. Given its criticisms of the Government's drug strategy, the recommendations of the report were disappointingly timid. The report considered (and rejected) outright decriminalisation although left the door open if conditions change in the future, but supported the reclassification of cannabis to Class C and the Police Foundation recommendations that MDMA should be made Class B, while maintaining a firm 'deterrent' line on drug education and refusing to lower penalties for 'social supply'. More interesting was the recommendation that the Government initiates a discussion within the Commission on Narcotic Drugs of alternative ways—including the possibility of legalisation and regulation—to tackle the global drugs dilemma. It is this which will allow future policy changes to go beyond the incremental. The recommendation was notably supported by Committee member, and prime ministerial contender David Cameron.</td>
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<td>2002</td>
<td>UN</td>
<td>Resignation of Pino Arlacchi, the Executive Director of the United Nations Office of Drug Control and Crime Prevention (ODCCP).</td>
<td>Arlacchi's resignation follows a disastrous period in charge of ODCCP, during which a number of senior officials were provoked to resign by his mismanagement and refusal to face the fact that UN administered global prohibition was not delivering. This led to Arlacchi's ruthless editing of the World Drug Report 2000 to reflect his illusory progress, at which point the expert Francisco Thoumi resigned in disgust. Though Arlacchi was, by the end of his term, almost universally acknowledged as incompetent and delusional, his downfall failed to provoke a major change in UN drug policy. The internal mismanagement issues with which Arlacchi was associated were allowed to cloud the wider issue of the failure of UN prohibitionist policy, and the UN 10-year drugs strategy was allowed to limp on towards its inevitable negative assessment in 2008. The episode briefly showed that the judicial, authoritative, impartial façade of the United Nations barely disguised a highly ideological US dominated (rather than evidence-led) drug policy.</td>
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<td>2002</td>
<td>UK</td>
<td>Liberal Democrat Party launches new drug policy.</td>
<td>The policy paper ‘Honesty, Realism, Responsibility: Proposals for the Reform of Drugs Law’, (written with the help of consultation from Transform), set out the failures of prohibition and proposed changes that would challenge, but remain within, the United Nations drug treaties. Treating each drug on an individual basis, the Lib Dems followed the Runciman Report of 2000 by proposing the reclassification of cannabis to Class C and of MDMA to Class B. It went further by calling for the legal regulation of cannabis if UN treaties issue could be addressed. More importantly, it was proposed that imprisonment should no longer be a punishment option, at least for offences involving Class B and C drugs. Other proposals included a major investment in drug treatment and the replacement of the Advisory Council on the Misuse of Drugs (ACMD) with a standing Drugs Commission, which would monitor legal as well as illegal drugs. The new policies represented a crucial break with the other two major political parties, shattering the tripartite consensus on drug policy that had hitherto quietly existed. The Lib Dem policies were evidence-based, rejecting artificial distinctions between the harm caused by legal and illegal drugs, and rejecting enforcement and prison as primary policy tools based on evidence of ineffectiveness. This sound apolitical basis made the Lib Dems' later failure to promote their policies (which came under considerable political and ideological fire) all the more bitter.</td>
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<td>2003</td>
<td>UK</td>
<td>Launch of FRANK drug education campaign.</td>
<td>The campaign aims to promote open discussion of drugs among youth, parents and teachers, and to provide relatively unbiased factual information, continuing the attempt to gain credibility. Though vastly superior to US counterparts, FRANK leaves much to be desired in terms of drugs included, harm reduction advice offered and level of detail.</td>
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<td>2003</td>
<td>UK</td>
<td>Number 10 Strategy Unit document on drug policy.</td>
<td>The report, commissioned by and presented to Tony Blair, concludes that supply side enforcement of drug laws is ineffective and counterproductive.</td>
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<td>2002-2004</td>
<td>Portugal, Canada, Switzerland, Russia, Spain, UK, Italy</td>
<td>2002 Portugal amends laws to de facto decriminalise possession of all drugs for personal use.</td>
<td>In an unprecedented move, the chief of the UN unit on Drugs and Crime praises the Russian decision. The UK, however, is condemned by UN drug agencies for its new policy on cannabis.</td>
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<td>2003</td>
<td>Russia</td>
<td>2003 Canadian court case sets a precedent for the de facto decriminalisation of small amounts of cannabis. Swiss bill to legalise and tax cannabis is narrowly defeated.</td>
<td>2004 Russia makes possession of all drugs in amounts for personal use a civil rather than a criminal offence, subject to a fine.</td>
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<td>2004</td>
<td>Spain</td>
<td>2004 Spain moves drugs brief from Ministry of the Interior to Ministry of Health.</td>
<td>2004 UK reclassifies cannabis to Class C. Punitive measures and arrest are not applied unless circumstances considered 'aggrevated'.</td>
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<td>2004</td>
<td>UK</td>
<td>2004 Israel deems up to 5 ecstasy pills to be 'personal use'.</td>
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<td>2005</td>
<td>Canada</td>
<td>Transform Drug Policy Foundation</td>
<td>Within a few months of each other, ‘After the War on Drugs: Options for Control’, ‘Effective Drug Control: Toward a New Legal Framework’ and ‘A Public Health Approach to Drug Control in Canada’ all argue, from similar (though variously accented) pragmatic bases, for an end to prohibition and immediate serious investigation of legal regulatory frameworks for drugs.</td>
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<td>Canada, UK, USA</td>
<td>Foundation and Health Officers Council of British Columbia</td>
<td>Canada and Health Officers Council of British Columbia</td>
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<td>release papers, covering the failings of prohibition and suggesting models for legalisation and regulation of currently illegal drugs.</td>
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<td>2005</td>
<td>UK</td>
<td>The UK Advisory Council on the Misuse of Drugs</td>
<td>The report concludes that khat, if consumed under typical usage patterns (which are habitual and heavy), has various adverse effects on health. However, these are insufficient to warrant its inclusion in the list of proscribed drugs.</td>
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<td>report on Khat</td>
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<td>(a Somali derived plant stimulant) is released.</td>
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<td>2006</td>
<td>UK</td>
<td>Ketamine made illegal, following a report and recommendation from the ACMD.</td>
<td>Previously a controlled drug under the Medicines Act, but not technically illegal to possess, ketamine is now a Class C drug, illegal to possess or supply.</td>
</tr>
<tr>
<td>2006</td>
<td>UK</td>
<td>House of Commons Select Committee on Science and Technology report on drug classifications is released.</td>
<td>The report roundly condemns the Home Office and the ACMD for their rigid defence of the current A-C drug classification system. The system is based on historical precedent, vagaries of public opinion and media hysteria and the misuse of the criminal justice system to send out a signal, rather than on an evidence-based hierarchy of harm as it is supposed to be—a circumstance demonstrated most blatantly by the fact that alcohol and tobacco are not included in this supposed scale of harms. Furthermore, these signals are completely ineffective in deterring drug use.</td>
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</tbody>
</table>
Table References

1. *Marijuana—The First Twelve Thousand Years*


3. Mills, Dr. James, *Poisons, the police and the Pharmaceutical Society: cannabis and the law in the 1920s*.

4. Letter from Mexican Foreign Secretary, Antonio Carrillo Flores, to US President Nixon in September 1969.


6. Interview with Dr. Jerome Jaffe, former US Drug Policy Director

7. Estimate by *Forbes* magazine


11. Lady Runciman, Chairman of the Police Foundation, quoted in Travis, Alan, ‘The joint is jumping’ [The Guardian, October 9th, 2000]


14. ibid.


19. Dave Bewley Taylor—Question and Answer session

The 1920s cocaine epidemic in Australia

Australia’s so-called ‘cocaine epidemic’ of the 1920s was a result of returned soldiers bringing the habit home. The soldiers had been dispensed stimulants liberally during the war since there had been restrictions on alcohol use and penalties for drunkenness. In Sydney and Melbourne cocaine became associated with prostitutes and the underworld. Both the class and the criminal milieu of the cocaine users branded them a threat to social order, and labelling their drug use as evil was a way to further marginalise and control them.

Newspapers reported on unethical pharmacists who were supplying cocaine to prostitutes. In response to this unwanted exposure the Victorian Pharmacy Guild authorised the ‘dangerous drugs’ legislation of 1922. The legislation required that customers not purchase cocaine or heroin without a doctor’s prescription, and each prescription could be dispensed only four times. The pharmacists were, however, unable to do anything about illicit sales.

State police forces formed specialist drug squads to enforce drug laws. New South Wales had a politically influential pharmaceutical industry represented by members of parliament. It was not until 1934 that state legislation assigned to the Police Bureau responsibility for the suppression of illicit drug use.

The following quote, cited by Manderson, provides an insight into how people thought of drug users at that time, and it still resonates today:

*The illegal use of cocaine is an extreme danger to the community*, declared Dr Stanley Argyle, the Premier and Chief Secretary. ‘Why not shoot them?’ interjected an Honourable Member. ‘It might be desirable’ conceded the Premier, adding with some regret that ‘it is not done in civilised countries’.63
Coco anisee: Cocaine advertisements from this period
The 1930s marijuana epidemic in the United States

In the United States much of the impetus for prohibiting marijuana use in the 1930s came from racists and the capitalist agenda. Mexican immigrants who smoked the drug were blamed for taking jobs from white Americans. Marijuana had been widely used as a medicinal drug and was readily available in pharmacies and general stores; recreational use of the drug was limited until this influx of workers. The Depression, with its attendant unemployment and poverty, increased resentment toward Mexican workers, who then became linked to marijuana, which was in turn linked to crime and the ‘lower classes’.64

‘Marijuana’ was not the word associated with the drug at that time: the term was a colloquialism of the Mexican community. White America simply referred to the substance as ‘hemp’. William Randolph Hearst, Pierre Du Pont and Henry Anslinger embarked on a media blitz and replaced the word ‘hemp’ with ‘marijuana’, all the while demonising the drug and its users.

Several scholars have argued that hemp had the potential to be a cheap substitute for the paper pulp used in the newspaper industry. But Hearst felt this was a threat to his extensive timber holdings, while Andrew Mellon, the Secretary of the Treasury and the wealthiest man in the United States, had invested heavily in Du Pont’s new synthetic fibre, nylon, and considered its success dependent on its replacing the traditional resource, hemp.65

Drugs, race and class became intermingled and played to people’s deepest fears:

There are 100,000 marijuana smokers in the US and most are Negros, Hispanics, Filipinos and entertainers. Their satanic music, jazz and swing result from marijuana usage. This marijuana causes women to seek sexual relations with Negros and entertainers and any others.66

It was easy to sway the population with hyperbole and inaccurate rhetoric since most people did not come across drugs or drug users in their day-to-day life. Intoxicants of any kind seem to have always been a thorn in the American psyche.

In the 1930s government was an authority the people did not challenge. What is more, if something was in print and on the radio it was true. But the media were owned by people with vested interests: their promise on behalf of the government to keep US citizens safe from the scourge of these immigrants and their deviant habits resonated.67

Marijuana is the drug that during President Richard Nixon’s era was the scourge of middle-class America: it made them ‘indolent and lazy’. Fitting drugs into the political and economic agendas was becoming a successful ploy.
"Why wouldn't I discriminate against all of them?"
The counterculture revolution and the Vietnam War

The term ‘counterculture revolution’ refers to events that took place between 1963 and 1974 in much of the Western world. As the 1960s progressed widespread tensions developed in the United States, Australia and other countries in relation to such concerns as the Vietnam War, sexual mores, women’s rights, and race relations.

Soldiers returned from the Vietnam War having been exposed to marijuana and heroin because they found the drugs helped them deal with the stresses and horrors that beset them at war. They brought this experience back with them to a culture that was abuzz with the writings of people such as Jack Kerouac and Alan Ginsberg. The post–World War 2 baby boomers were educated and affluent, and they were questioning the status quo. With this questioning came the resort to illicit drugs that had previously been used in only small amounts in specific sections of the community. The soldiers returning from Vietnam, to both Australia and the United States, brought the potential for young people to try a drug that had not been in broad circulation. Disaffected with the older generation, these young people sought to do things the establishment had banned or prohibited, and drugs were part of this.
Ever since the publication in 1821 of Thomas De Quincey’s *Confessions of an English Opium-eater* drug users—but more particularly opium users—had been viewed as artists or disaffected people on the edge of homelessness and consorting with prostitutes—people who did not fit into ‘normal’ society. Drug taking was a visible, easy and pleasurable way to reject the mainstream world.

The early 1960s experience of heroin in Australia was mainly concentrated in the Kings Cross area in Sydney, where US soldiers on ‘R and R’ went. By the late 1960s the market originally established to meet the demand of the US soldiers provided access to heroin for Sydneysiders. The Cross was considered an avant garde area, with artists, musicians and other bohemians present alongside criminal elements. Young people from all over Australia flocked there because this was where things were happening in the arts, music, theatre and drugs.

The changing demographic of drug use affected the ‘legal fiction’—doctors were prescribing opiates for medical reasons rather than to maintain an addiction—that had operated so well to protect ‘therapeutic addicts’ when numbers were limited. With the rise in drug use, however, such an approach became impractical.

Not having much local experience to counter the political rhetoric about ‘evil drug pushers’ and ‘dope fiends’, Australians became infected by the US hysteria, so when drug use and drug users became more apparent the response was shock, anger and fear.

It is known that importation of and trafficking in drugs in Australia has been the province of criminal elements and the police, certainly from the 1960s well into the 1980s. ‘As … McCoy has argued, politicians were complicit in the organisation of the criminal milieu in Sydney.’ Then, as now, young Australians were being sent to jail and ostracised while the establishment was well ensconced in and profiting from the drug trade its members were at the same time decrying.

**From reds under the beds to junkies in the cupboard:**

**Nixon and the war on drugs**

The ‘Cold War’ refers to the period of political tension between the communist world and the Western allies after World War 2. It was fundamental to US foreign policy and was used to ratchet up fear, secure funding, and expand the military in the name of ‘protection’.

The United States’ previous interweaving of drug addiction with venereal disease made such a link possible in the minds of US citizens—and, in fact, Australians. Drug use had been spoken about in terms of contagion: it was no great leap for people to perceive a link. Courtwright et al. write:

> … ‘addiction’ went from being a pathetic condition to being a stigmatised one. Like venereal disease, it came to be understood as a condition that was acquired through forbidden indulgences with evil associates. Also like venereal disease, it was a condition that could afflict or destroy the lives of innocent others—the spouse, the family, the foetus or the newborn child. Both diseases were, in a broad sense, communicable: addicts [and venereal patients] were alarming not only because they had gotten themselves into trouble but because they might put others in the same fix.

Henry Anslinger, in his position as Commissioner of the Federal Bureau of Narcotics, interwove the communist threat with the drug threat partly to ensure there was always something the government was being seen to be proactive about in terms of national security. The notion was all about contagion.

‘Why wouldn’t I discriminate against all of them?’
We must remember that during this time the United States—and particularly Hollywood—was reeling under the impact of McCarthyism, with its witch-hunt of the intelligentsia and the artistic soul of the nation. People were living in a state of heightened anxiety.

Ainslinger had become an expert by constant repetition and emphatic reinforcement of his ... opinions. His speeches and articles, often ignorant and frequently hateful, appeared in every newspaper and relevant journal in the world. But during the 1950s America’s anti-drug campaign was accompanied and intensified by a twin paranoia which warped public debate in the United States for years: communism. The fear of communism and the fear of drugs had much in common: both were ‘pathogens’ deemed responsible for everything bad. In both cases the larger the lie, the more sweeping the language to justify it and the vaguer the accusations ... The fear of drugs was used to justify anti-communism and the fear of communism was used to fuel anti-drug extremism.72

On 17 June 1971 US President Richard Nixon mentioned the ‘war on drugs’ for the first time. He spoke to Congress about drug abuse, prevention and control, noting that until recently addiction to narcotics had been viewed as a ‘class’ [that is, minority] problem but that it now was affecting many groups. He proposed to respond to this ‘national emergency’ by creating the Special Action Office of Drug Abuse, answerable directly to the President.

The atmosphere associated with drugs during this time is apparent from Nixon’s response to a report prepared by the National Commission on Marijuana and Drug Abuse, chaired by Raymond P Schafer, which was presented to Congress in March 1972. The report concluded that the widespread belief that marijuana was violence-inducing was erroneous and that a more sensible approach to dealing with the problem was by means of legislation. When Nixon heard this he denounced the commission: he saw marijuana as part of the culture that was destroying the United States and believed the communists were ‘pushing the stuff to destroy us’. Nixon also believed that ‘homosexuality, dope and immorality in general’ were the enemies of a strong society. The year after he declared his ‘all-out war’ the number of marijuana users jumped by 128 000.73

According to Jack Cole, a former US police officer:

The war on drugs ... had nothing to do with the ‘drug problem’. It had to do with the fact that Mr Nixon was running for the presidency of the United States for the second time and at that time he thought it would be really nice if he won. He knew a tough on drugs platform would garner a lot of votes but if he could be in charge of a war—wow. How those votes would pour in. Of course, as we all know, it worked.74

Don Baume puts it thus:

First of all there was never a drug epidemic when the Nixon Justice Department declared its dirty little war. More Americans—1824—died falling down stairs in 1969 than perished from every illegal drug combined and twice as many choked on food. Not to mention in 1972 a body count of 3618 cirrhoted livers and 55 000 highway accidents, mostly alcohol related; and do not even think about cigarettes, which in 1989 killed 395 000, whereas coke killed 3189, or not as many as anterior horn cell disease.75

Nixon’s so-called war on drugs was to be a war where the baton has passed from one president to another during the ensuing decades. In the past 40 years the impact of this ongoing war has been felt well beyond the boundaries of the United States. Promotion of the war on drugs and the associated
rhetoric is reflected in the policies and practices of governments all over the world, as well as through the United Nations. It has come to permeate all aspects of economic, political and community life and has been responsible for unprecedented levels of crime, corruption, imprisonment, discrimination, disease and death. As a result, the global community has been left with a conundrum that seems almost untouchable—something that appears to defy best practice, good science, decent behaviour and commonsense. Our lack of real action to end the war on drugs has not only given the ‘green light’ to poor attitudes towards people who inject drugs: it has actively fuelled the epidemic of discrimination and human rights violations we live with today.

The question is not just whether a drug-free world is possible, but how many violations of human dignity and ethical conduct are seen as acceptable in the effort to achieve it. How can drug control interventions aimed at ‘reducing human suffering’ be permitted to excuse so much hardship and humiliation? Today, and in the decades to come, the goal should be to achieve the total elimination or a significant reduction in these unconscionable abuses committed in the name of drug control.76

Disease and the fear of contagion

The idea that drug use is a transmissible ‘disease’ continues to be played out in the community. Early transmissible diseases were not understood; for example, cholera could decimate cities, particularly following times of famine or other hardship. As with all things unknown, myths and folklore thrived, and later the church stepped in to claim ownership of the solution to avoiding contagion. Wearing certain herbs as a talisman or avoiding certain foods or places became replaced by tithing and living a sin-free life. Superstition and fear shrouded disease, which spread extremely quickly in the crowded and unsanitary conditions of the early cities. In the 1830s and the 1840s there were a couple of massive waves of contagion: the first, from 1831 to 1833, included two influenza epidemics and the initial appearance of cholera; the second, from 1836 to 1842, encompassed major epidemics of influenza, typhoid and cholera. Throughout much of this period—when the causes and patterns of disease were very much matters of speculation—it was difficult to feel comfortable about anyone’s state of health.77

The fear of contracting disease has persisted, and pandemics have distressed the world at various times. (It is well known that the Spanish flu epidemic of 1918 to 1920 was responsible for more deaths than World War 1.) This fear provides some context for the stigmatisation of drug users since historically people with contagious diseases were stigmatised. (Leper colonies were a fact of life until the middle of the 1900s.) The difference with drug use is that it is not a disease: it is a behaviour, and it has been manipulated by others to instil fear into the wider community. Hence the discrimination.

‘Fear of contagion’ strategies provided a perfect backdrop and readied the general community’s psyche for the HIV/AIDS epidemic, which emerged in the 1980s. Injecting drug users were immediately seen as continuing their history as vectors of disease, and HIV/AIDS was viewed as another way in which we were endangering the community at large. With the exception of Australia and a few other nations, government after government refused to introduce needle and syringe programs and opiate replacement programs.

The advent of hepatitis C and the acknowledgment of hepatitis B as a cause of disease in the injecting drug user community served only to fuel the anxiety and the discriminatory behaviour. The number of injecting drug users who are living with this contagion–vector mindset on the part of the global community runs to millions. Of the 158 countries reporting injecting drug use, almost half lack essential harm-reduction services.78
Epidemics are currently affecting injecting drug user communities at differing rates around the world—among them hepatitis C in Australia and HIV, hepatitis C, hepatitis B and tuberculosis in Russia.

The estimated number of injecting drug users worldwide had risen to 15.9 million by 2007. The number of injecting drug users infected with HIV is estimated to be 3 million. Hepatitis C and B are being transmitted in our community at a frightening rate and have been for decades: globally, 170 million people are infected with hepatitis C.

The evidence shows that at the end of 2008 an estimated 284,000 people in Australia had been exposed to hepatitis C; an estimated 212,000 of these will move on to develop chronic hepatitis C infection. Of those with chronic hepatitis C infection, at least 80 per cent are thought to be people with a history of injecting drug use.

Compared with HIV, hepatitis C is not as easily transmitted to the wider community and is not classified as a sexually transmitted disease. It is relatively well contained in the injecting drug user community—with the exception of those countries that have had epidemics in the general population as a result of poorly run immunisation programs and the reusing of needles or inadequate care and control in blood banks. Containment efforts have been inadequate in not providing needle and syringe programs or less successful than one might hope because the injecting drug user community fears the discrimination they will encounter when they have contact with the medical profession.

Hepatitis B was a feature of injecting drug users’ lives before needle and syringe programs: we all shared injecting equipment, and most of us eventually contracted the disease. Again, that was of only marginal interest to the broader community. Apart from the implementation of abstinence-based programs, we were not on the mainstream agenda. We were not sure why hepatitis B was so rife, and we had no idea how to protect ourselves: we just assumed it was part of being an injecting drug user. Peer education worked to a degree but, because of the lack of accurate information, there developed a set of myths about how to deal with most situations—particularly emergencies. For example, the idea that giving a person who has overdosed a shot of salt water to revive them had considerable currency among drug users in the late 1970s and the 1980s.

The outsider status of injecting drug users is illustrated by the fact that we had many current or former nurses, wardspeople and doctors among our cohort. But the aseptic practices that were part of their working life were not generally transferred to the injecting subculture. Drug users had no way of reaching out for information because asking for information meant disclosing.

Globally, there are 2 billion people infected with hepatitis B, of whom 360 million have chronic hepatitis B infection. Much of this infection occurs in countries where the disease is endemic, and most injecting drug users who contract hepatitis B do so as adults and do not go on to become chronic carriers. The problem for users is that if they have HIV they will almost certainly have hepatitis B (HBV) or hepatitis C infection (HCV), or both. The ramifications of this for the management of their HIV disease are significant:

Several studies have demonstrated that HIV/HBV co-infected individuals have a three to sixfold increased risk of developing chronic HBV liver disease, an increased risk of cirrhosis and a seventeenfold increased risk of death when compared with HBV individuals without HIV infection.

... HCV/HIV co-infection is also significantly associated with progression to advanced liver disease and is a leading cause of death among people living with HIV. Data suggests that HIV infection accelerates HCV related disease progression and mortality.
Most estimates of the number of people who inject drugs or the number infected with various blood-borne viruses are just that: the stigma is so powerful that drug users shrink from ‘outing’ themselves to researchers, doctors and government officials.

The community’s fear of injecting drug users as vectors of disease is as strong today as it ever was. This has very negative effects for public health interventions associated with hepatitis B and C prevention: drug users do not go to services because they are traumatised by repeated discrimination. The past mixing of drug use with venereal disease and communism for political expediency has resulted in an isolated, neglected group of people.

**Needles and syringes as symbolic weapons**

Amidst all the legislative, social and economic changes there were also changes in the drugs themselves and the ways they were being used. In the early 1850s drugs such as morphine were being refined into pure crystalline salts soluble in water. It was thought that if the lungs and digestive system were bypassed addiction would not occur.85

The word ‘syringe’ comes from the Greek syrinx, which means ‘tube’, and originally a tube was used. In 1884 an Irish physician, Francis Rynd, invented hollow needles. Then, simultaneously although independently, two physicians—Scotsman Alexander Wood and Frenchman Charles Pavez—developed the first practical hypodermic syringes in 1953, putting together a metal syringe and a hollow-point needle that could penetrate the skin without the need to cut an opening.86

When the syringe was not found to be the panacea medical professionals had hoped for they became somewhat disenchanted with it. In contrast, people found it to offer a cheap and effective way of using drugs. Family kits were sold by travelling salesmen.

*Drugs can be emblems of status and class. In fin de siècle Paris absinthe drinkers and opium smokers were deplored as lost, degraded souls while ‘morphinism’, as it was called, was an upper class pursuit. As Marcus Boon observes in The Road to Excess: a history of writers on drugs, morphine was beyond the means of most people in French society and ‘morphinists’ usually carried boxes with elegant handmade syringes, recasting drug taking an as ‘elegant refinement’.*87
1900 Injecting Women—Hearst: The fashion accessory every woman must have
Drugs change, and attitudes to them change when the type of person taking them changes. Once a drug becomes used by the so-called dangerous classes it no longer has any socially redeeming qualities: it is simply bad. That is exactly what happened to heroin in both the United States and Australia, despite the drug’s efficacy as an aid in childbirth and for controlling cancer pain. The method by which it was administered was also tainted notwithstanding the fact the syringe has offered so many advances in medical practice. The syringe has come to symbolise danger and fear.

Even though it provides the means for vaccinating our children, for alleviating severe pain and for keeping diabetics alive, the syringe is seen as a vehicle of contagion—both as a means of catching the disease of addiction and as a way of transmitting blood-borne viruses.

The hepatitis B virus, the hepatitis C virus and the human immuno-deficiency virus (HIV) can all survive outside the body for several weeks, survival being influenced by virus titre (concentration), the volume of blood, the ambient temperature, exposure to sunlight, and humidity. The prevalence of hepatitis B and HIV is only 1 to 2 per cent in the Australian injecting drug user population. In contrast, the prevalence of hepatitis C is 50–60 per cent in this group.

One of the most common community concerns about needles and syringes is the fear that a child might acquire a needlestick injury in the park or at the beach. Given that most children in Australia are vaccinated against hepatitis B, it is hepatitis C and HIV that are the causes for concern. There have, however, been no documented cases of blood-borne virus transmission following community needlestick injury in Australia.88

But the hue and cry that accompanies the discovery of a needle in a public place borders on the hysterical and is used as a rationale for trying to close down programs that allow the supply of these products to people who need them. In fact, the argument is counter-intuitive: the fewer the programs, the more sharing will occur and the greater the chance that a discarded syringe will be infected.

It is often police pressure and the fear of discovery that set the foundation for people to fear being found with used equipment.

The media as a weapon

The ways in which the printing press affected the growth and development of the human race are almost too numerous to count. The development of the steam-powered press allowed printing to be done on an industrial scale. The first edition of the Times was printed on November 28th 1814; this began the process of making information available to a mass audience and helped spread literacy.89

Development of the steam-powered press not only facilitated the widespread availability of information: it also helped governments and print media owners to promote their own agendas. It allowed thousands of people to be reading the same information at the same time and had the effect of shaping behaviour very quickly. Before this, the established church had for centuries ensured that heretical and subversive ideas were punished and had controlled much of the literate population’s reading material. Once the print media came into operation and more people had access to other ideas and theories, censorship became much more widely and heavily imposed.

Throughout its 400-year history the press has been the first hostage taken by occupying forces in times of war; as a rule, it has been gagged or forced to close down if it was not spreading information that
suited the occupier’s agenda. The war of words is no less lethal than the war of weapons, and the media have been using their weapons to great effect during the past century to stereotype and vilify drug users.90

The pejorative language that comes to the tongue of most people when talking about drug use or drug users would not be so available were it not for the continual use of such language by the media when airing these things. The media—with their ability to prop up a government or to destroy it—have in the main been supportive of the government’s agenda when it comes to illicit drugs.

This document touches on the various ways the media have approached the question of drugs for both political and financial gain. Nothing sells a newspaper faster than a horror story, and the drug user is an easy target. Despite anti-discrimination laws and human rights treaties, the previous two centuries have left the community of people who inject drugs with very little power to respond to inappropriate or untrue reporting of their lives.
Chapter 2 and 3 review the historical, political, social and economic changes that occurred during the previous two centuries. All these events and circumstances gradually coalesced into the current discourse on drug use and drug users that has resulted in drug users being stigmatised. We outline the progression from a haphazard and quickly moving era of change that had an effect on drug use in the community to a rather more deliberate use of drugs as a means of manipulating certain groups and proscribing certain behaviours.

This chapter discusses in detail the findings of the market research conducted for AIVL in relation to stigma and discrimination in the lives of drug users in contemporary Australia. In order to gain a good understanding of this community behaviour, however, it is necessary to understand some of the current thinking that underpins the attitude to stigma and discrimination. In addition, this chapter touches on the added burden imposed on drug users and the community by the criminalisation of drug users—a direct outcome of stigma and discrimination.

One of the most disconcerting findings to emerge from the market research was that people reported they were ‘happy to discriminate against’ people who inject drugs. Paradoxically, though, the market research participants also admitted they did not actually know any injecting drug users. Fighting caricatures and stereotypes is akin to shadow boxing—an ephemeral shape never staying in one place long enough for a punch to be landed.
Stigmatised, ostracised, excluded—no matter what name is attributed to the community’s attitude to injecting drug users, the discrimination is everywhere. Stigmatisation has always been a feature of human society: the stigmatised group can change, but there is always a group (or more than one group) whose behaviour is not seen as positive in terms of the ‘greater good’. Today it is injecting drug users.

History is replete with examples of people and communities who have been stigmatised. Before recorded history it appears that laws proscribing certain behaviours were developed in order to ensure the continuing health and prosperity of the tribal group or to placate or worship the gods. This has led some authors, such as Neuberg and Gilbert, to argue that such stigmatisation has a biological basis in our need to live in functional groups. Group survival was linked to individuals acting in a reciprocal manner. Those who for whatever reason—be it a congenital abnormality or premeditated theft—threatened the group’s survival were stigmatised.91 As Nueberg, Smith and Asher point out, though, ‘Just because certain stigmas were adapted for the social and physical environments of our evolutionary past this does not imply that they are adaptive today or morally justifiable’.92

Ironically, stigma (like drug use) is not static: it changes according to social beliefs and practices, economies and values. In some circumstances it is cyclical—in force, then not, and later returning. It is resurrected, resulting in discrimination and ostracism and at times the expunging of a behaviour or community. The history of the Jewish people is perhaps the most telling example of cyclical stigma and discrimination.

Some of the current stigmatised behaviours are based on tabus designed to keep communities healthy and safe; an example is the proscription of incest. Although incest is not universally forbidden, there is a biological imperative for proscribing such behaviour—to try to limit familial flaws and the consequent weakening of the gene pool. Although incest remains an almost universally stigmatised behaviour, many previously stigmatised individuals and groups, such as single mothers and their illegitimate offspring, have with time lost their negative labels.
But new groups are being ‘othered’ to take their place. In the Western world people who are overweight are experiencing growing opprobrium. According to Basham and Luik:

… the latest victims of the UK public health establishment’s attempt to socially engineer our cultural and political environment so that the public becomes less tolerant of obesity and those the government characterises as obese … In practice denormalisation means that the government attempts to shame adults into changing their behaviour. For the government’s denormalisation attempt to succeed these adults must be stigmatised … Denormalisation pushes obesity from being a health hazard to being a moral hazard, nothing less than blots on the moral landscape.93

Campaigns of this nature fail to take account of the social and financial reasons people are eating foods that are heavy in fats and carbohydrates. They blame the individual, who is eventually ostracised and vilified. In many communities in which obesity is a problem people have low incomes and offer high-fat, calorie-rich foods to their families because these foods are relatively inexpensive and filling. Fresh, healthier foods are too expensive for many low-income families. This is how stigma and the resulting discrimination arise. Regardless of the health impacts for individuals and subsequently for health infrastructure, anti-obesity campaigns rely at least in part on the dominant social ‘culture’ to direct censure at a section of the community.

In Australia today we are experiencing a campaign of discrimination against people who smoke tobacco. The campaign is prosecuted largely through deliberate ostracism (the introduction of legislation governing where smokers can and cannot partake), media ‘fear campaigns’, selective community education, and higher and higher taxes on tobacco products.

The methods being used in campaigns of this nature are reminiscent of the methods that were used to make some drugs illegal and therefore ‘bad’. Government decides that a form of drug use is ‘a problem’, and government departments and workers initiate campaigns to target this behaviour—generally through the media. The media help form public opinion and reflect government policy (although it could be argued that the media form public opinion and government policy is subsequently developed). Drug users are targeted as ‘other’, or less than ‘normal’. Individuals eventually come to believe this of themselves, so that the process becomes self-perpetuating. It is an insidious progression. Once the stigma is accepted as a social norm, it is very difficult to change the situation.

Stigma and the resultant discrimination against the drug using community do not exist in a vacuum: a number of complex and interrelated factors feed into the practice, and a number of ‘players’ act in concert to stigmatise the drug users—the general community, largely fuelled by inappropriate media coverage; the health profession in general; and drug users themselves, who are not oblivious to society’s customs and values. Additionally, although drug use is generally viewed as a health problem (AIVL would argue that it should also be viewed as a human rights concern), it is most often treated as a legal matter and drug users are seen as ‘criminal’ or, again, as ‘other’.

**Social theories underpinning current stigma and discrimination**

The majority of modern-day theorists share a belief that ‘stigma’ refers to the collective sanctioning of a group as ‘other’, or separate from the ‘norm’, an acknowledgment of social rejection. ‘Discrimination’, on the other hand, is the physical and mental, visible or tangible response to stigma, resulting in stereotyping, prejudice and social exclusion. Discriminatory behaviours take many forms but all involve some form of exclusion or rejection. In short, AIVL suggests that stigma is the thought and discrimination is the ensuing action or outcome.
One could spend a lifetime researching theories to do with stigma and discrimination and their impact on individuals, groups and the broader community. When developing this document, however, AIWL found that there has been very little research into drug user–related stigma, particularly in terms of drug users doing their own research. As a result, much of the discussion here draws on research into other stigmatised communities. (It could be argued that this lack of self-determined social research—and of the funding to conduct such research—is in itself a part of the process of stigmatising drug users.)

There is limited research evidence available that directly links the stigma associated with injecting drug use to reductions in social status and social conditions and to the determinants of ill-health—reduced access to health services, increased economic disadvantage and increased social exclusion. There is, however, sufficient research evidence linking HIV-related and mental health–related stigma and discrimination to reduced quality healthcare and avoidance of potentially stigmatising experiences (particularly in relation to health service provision). It is possible to extrapolate that evidence to match the experience of injecting drug users and health services, particularly as those services relate to hepatitis C testing, treatment, care and support.

One theme that seems almost universally accepted by researchers writing on stigma and people who inject drugs is that injecting drug use is seen as the ‘problem’. The multiple layers of disadvantage that people who inject face, and how those layers have an effect on the outcome of discrimination, have been all but ignored. Once the stigma and discrimination start taking effect, the health and wellbeing of the individual is usually forever compromised. Going to drug treatment, having a child and seeking access to hepatitis C treatment are all tainted by the label of ‘injecting drug user’. If the individual also has other culturally stigmatised attributes—such as ethnicity and gender, or economic, cultural or religious differences—these are seen to have little or no impact, although they greatly add to that person’s experience of stigmatisation.

Most social commentators in this area would suggest that modern theories of stigma generally begin with the work of Goffman in the 1950s and 1960s.

The term ‘stigma’ comes from the ancient Greeks and was used to describe the signs that were cut or burnt into a person to mark that person as someone of unusual or bad moral status. The bearers of these stigma signs were slaves and traitors: people to be avoided in public places … Two and a half thousand years later the term stigma has come to describe the disgrace or social disqualification which arises from possession of an attribute, visible or unseen, that is considered deeply discrediting.94

Goffman’s theory is useful in that it allows interpretation of stigma to traverse from the symbolic to the social, so that stigma can be explored in relation to social processes and customs. Some modern social theorists have, however, also observed that Goffman’s theory is somewhat limited, particularly in relation to its usefulness in interpreting contemporary multicultural and multinational societies and in the application of health research and policy:

The language and taxonomy of abominations, blemishes and tribal identities is antiquated … [the] range of phenomena to which the concept of stigma has been applied is so vast that the concept fails to adequately address health-related interests of social and health policy … the conceptual framework based on normalcy and deviance is both inadequate and inappropriate for cross-cultural research and policymaking … although innovative and effective in shifting the formulation of stigma from symbols to social processes … [Modifications] in the concept and research agenda are required to serve the practical interests of health research, disease control and community action.95
Many theorists discuss the process and application of stigma, but few elaborate on ‘why’ stigma and the resulting discrimination occur in our culture. Among those who do speak of societal and individual purposes for stigma is Lloyd:

A number of ‘functional’ theories of stigmatisation have been proffered. At the individual level, it can enhance the self-esteem and or social identity of the stigmatiser through downward comparison with devalued groups ... It has been argued by many ... that stigmatisation, like stereotyping is a way of making sense of the world. It provides us with a set of expectations about people: their likely behaviour, values and lifestyles. Part of this function may be to help us identify and avoid potentially dangerous people. This threat can be tangible and physical or psychological ... 96

In preparing this document, AIVL encountered a small number of exemplary works on stigma theory that, when re-contextualised and married with the concept of ‘structural violence’, illustrate the experience of people who inject drugs in Australia. In short, AIVL proposes a definition of ‘why’ drug users are subjected to stigma and discrimination and the impact of that stigma and discrimination—‘how’ they experience discrimination.

We suggest that this can be found in the suggestion of Reidpath et al. that stigma and the resulting discrimination have both an economic and a social function in contemporary society97, coupled with Galtung’s theory of structural violence (the way social structures and institutions can systematically prevent individuals or stigmatised groups from meeting their basic human needs).98 Galtung describes this as ‘violence that is built into the structure and shows up as unequal power and consequently unequal life choices’.99 We also marry these theories with the work of Link and Phelan, who suggest that stigma and discrimination have an adverse impact on health, on health service access or avoidance of such services, as well as directly on physical health through indicators such as stress.100

These notions encompass the aforementioned purposes for stigma, placing them in a solid (if somewhat confronting) socio-economic framework in which the stigmatised person or group is gauged according to their limited capacity or inability to engage in social and economic reciprocity [discussed in more detail shortly]. Individuals’ and groups’ social capital or social value is ‘calculated’—albeit on the basis of stereotypes—and the result is social inclusion or exclusion. Social exclusion is discrimination, a direct result of stigma. This exclusion can be viewed as a component of ‘structural discrimination’ or ‘structural violence’, which encompasses both cultural violence [any cultural aspect that legitimises stigma and discrimination] and symbolic violence [actions that have a discriminatory implication].101

This definition of the purpose of stigmatisation of those perceived to be ‘outside’, or ‘other’, when compared with those who are ‘normal’ members of society [who are more entitled and consequently more powerful] rings true for drug users’ experience of stigmatisation and discrimination in Australian society today.

Acts associated with structural violence are legitimised and made acceptable in society. According to Galtung, cultural violence can make structural violence against a particular group feel acceptable by changing the ‘moral colour’ of an act, often through ideology.102 This process of legitimising structural violence through cultural violence is very apparent in relation to people with a history of injecting drug use, especially people who are actively using and people in pharmacotherapy treatment. Systems and institutions in society—for example, the current drug control laws—routinely reinforce the ‘acceptability’ of stigmatising and discriminating against people with a history of injecting drug use, and over time a pattern of cultural violence emerges.
The ultimate outcome of structural violence is ‘social exclusion’, and it is this that has the greatest impact on drug users’ access to the social, legal, economic and cultural determinants of health. The World Health Organization defines the social determinants of health as follows:

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries.103

Further, the WHO Commission on the Social Determinants of Health opened its interim statement on building a global movement for health equity with these words:

Strengthening health equity—globally and within countries—means going beyond contemporary concentration on the immediate causes of disease. More than any other global health endeavour, the Commission focuses on the ‘causes of the causes’—the fundamental structures of social hierarchy and the socially determined conditions these structures create in which people grow, live, work and age—the social determinants of health. The time for action is now: not just because better health makes economic sense, but because it is right and just.104

Such an approach to understanding health inequities is highly relevant for people with a history of injecting drug use and particularly while people are in active injecting drug use or on pharmacotherapy programs. It should be stated at the outset, however, that the health inequities experienced by people who inject drugs often have long-term and even life-long impacts that require continued understanding and responses, even if a person ceases injecting. This is exemplified when we see people who have not injected for 20 or more years who are still reluctant to seek out hepatitis-related health services for fear of being labelled and treated as ‘junkies’.

Individuals can and frequently do carry a greater burden of health inequities at different points in their lives. AIVL also recognises that there can be multiple and confounding social determinants of health that can disproportionately affect people with a history of injecting drug use from Aboriginal and Torres Strait Islander backgrounds and [culturally and linguistically diverse] backgrounds. This is evidenced by the fact that although illicit drug use occurs within all cultural and socio-economic groups in society, drug-related injury, illness and death are disproportionately higher among people living in poverty and those from Indigenous and [culturally and linguistically diverse] backgrounds.105

Research suggests that there could be a number of ways in which social determinants affect health, but there is general agreement in the literature that ‘specific social factors play a role in determining health, indirectly or directly, either detrimentally or protectively’.104 For example, it is now well accepted that the health of people who inject drugs has a direct relationship to their social environment and that the drugs people use and how they use them—particularly in terms of drug taking behaviours and individual risk practices—are not independent factors but are a product of these people’s social environment.107

Too often when injecting drug use and health are examined the focus does not extend beyond the drug taking behaviour itself or individual risk practices that are seen as directly responsible for poorer health outcomes among people with a history of injecting drug use. The limitations of this approach to understanding drug users’ health and health inequities are captured by Galea and Vlahov in their work on social determinants and the health of drug users:
Behavioural research fits a traditional epidemiologic risk factor model. Although this work has guided public health interventions and some have been successful in reducing the burden of disease among [injecting drug users], it does not recognize the fundamental social circumstances that shape behaviour and ultimately influence the health of drug users. Under-specification of the range of factors associated with risk behaviours and health outcomes can bias epidemiologic inquiry and limit the potential scope of successful interventions.108

Although specific drug taking behaviours and individual risk practices undoubtedly contribute to adverse health consequences, they do not on their own explain the degree of health disparity routinely documented either between individual drug users or between drug users and the rest of the population.

If we accept that structural violence has a purpose or design based not on the biological need for group survival but rather on access to resources and power, the reason for contemporary stigma and discrimination toward drug users (and other groups in society) becomes evident. Not only is such behaviour inhumane, with direct impacts on users’ health and wellbeing: being denied access to social resources has an adverse effect on all aspects of an individual’s life. Reidpath et al. argue:

Goods and resources are finite, and social forces heavily pattern their distribution. One of the principal mechanisms for shaping the distribution of resources is by regulating entitlement to community membership itself. By restricting groups’ membership of community, so access to social goods and resources diminishes, which in turn has a negative impact on the health and wellbeing of the excluded groups ... Community membership is determined on the basis of the perceived social value of groups and individuals and stigmatisation is the marking of individuals and groups who are ‘unworthy’ of social investment. Using the notion of reciprocity ... groups may be stigmatised and socially excluded as a mechanism for protecting limited social resources from exploitation.109

It is noted earlier that the perceived ability or inability of individuals or groups to participate in reciprocal exchange is often based on stereotypes. If we accept that stigma and the resulting discrimination have an economic purpose, then we can further deduce that drug users are considered a burden on society and its economic infrastructure.

In general, the stereotypical drug user [and this concept is discussed later] does not contribute to society and the social order. Drug users are considered:

• unemployed and unemployable and therefore not taxpayers
• a drain on the public purse through use of drug treatments, needle and syringe programs, and so on
• criminals—and consequently a cost to the community and the legal system
• inflictors of harm on themselves through overdose, physical damage and disease
• the cause of fear and hypervigilance as a result of the threat they pose from violence and contagion from blood-borne viruses and potential needlestick injuries
• not ‘innocent victims’ of their behaviour.

In AIVL’s view these interconnected theories, stereotypes and social structures are all part of the reason discrimination against drug users is so readily perpetuated and remain unchallenged.
The impact of the criminalisation of drug use

AIVL considers that any full discussion of stigma and discrimination in relation to drug users cannot occur without a discussion of the ‘criminalisation of drug users’. It is unarguable that the criminalisation of drugs and drug users is a direct result of stigma and adversely affects the health and wellbeing of drug users. Although more research is needed in order to gain a better understanding of the link between drug user-related stigma, discrimination, moral attitudes and criminalisation, it is clear that criminalisation and negative attitudes towards people with a history of injecting drug use are creating potent barriers to access to health services. It is also clear from AIVL’s recently commissioned market research that the current drug laws directly contribute to the way in which drug use is perceived as ‘immoral’ and effectively give the green light to social exclusion and discrimination against people who inject drugs:

Criminalisation of behaviour is most pronounced in the case of injecting drug users, which is a barrier to access to prevention measures and treatment, as well as information. Historically society has dealt with diseases by demonising ‘vectors of infection’, such as the plague, leprosy, cholera and polo—this response exposes deep-rooted shame and fears associated with contagion, illness, pleasure and death.110

The criminalisation of drug users has a major impact on their ability to manage their health—particularly in relation to hepatitis C monitoring and treatment. Anecdotal reports from people with a history of injecting drug use confirm that the continued pressure of outstanding warrants, legal matters, court appearances and imprisonment is one of the factors that have led people to ‘de-prioritise’ their health generally and problems such as hepatitis C in particular.

A recent article in the British Medical Journal openly called for an end to the illegality of drug use and the criminalisation of drug users through a process of structural change, including a review of national drug laws and policies.111 The need to review and reform the current drug control laws and policies was also identified as one of the priority actions in the recently released National Hepatitis C and National HIV Strategies. The National Hepatitis C Testing Policy document asserts that there is a need to harmonise drug control laws with public health policies and outcomes in order to create a better social and legal environment for responding to hepatitis C.112

It is well known that drug use is common in Australia; it also well accepted that actually having been in prison is an independent risk factor for hepatitis C infection. In fact, the 2007 National Prisons Entrants Bloodborne Virus and Risk Behaviour Survey found that 35 per cent of prisoners tested positive for hepatitis C antibodies—a level 40 times higher than in the general population.113

It is AIVL’s view that the illegality and criminalisation associated with injecting drug use are causing unacceptable harm among people with a history of injecting drug use and are acting to create systemic barriers to health equity for this group in the community.

Passing, or getting by, in society

The stereotypical drug user is a homeless, unemployed, hygienically challenged individual with bad teeth. In reality, though, the people who fit that description are a minority in the drug using community. These people almost always have multiple social and emotional problems, but it is their drug use that is always highlighted. Every individual is imbued with varying degrees of social and cultural capital,
and the extent of this plays a large part in how they manage and how they are accepted in the wider community.

Given the treatment that is meted out to people identified as injecting drug users, it is not unreasonable that those users who can will try to ensure that their drug use and any associated behaviours are not overt or recognisable. It is 'shameful' to be labelled a drug user in contemporary society, and the potential repercussions need to be avoided wherever possible. Most drug users do not fit the stereotype of a 'junkie' and are able to go about their day-to-day business without being labelled. But, once labelled a drug user or junkie, one is never quite able to completely shake off the associated stigma.

Efforts to avoid the label can be described as 'image management'—trying to 'pass into society' by modifying the way one dresses, talks, lives, and so on, so as not to appear to be a stereotypical junkie and in doing so gain access to what the person needs or simply to avoid poor treatment. This is supported by Bourdieu, who posits, 'Everything we say, do, wear and enjoy displays our social and cultural capital for the world to see and exploit. Symbolic capital such as prestige honour and attention is seen as a crucial source of power ...'

Bourdieu's interpretation of social and class capital resonates when discussing social capital and its effect on drug users' ability to 'get by in society'. Different classes in the social structure have different attitudes and ways of behaving that are recognised by other members of that class. To a degree, the class within which one resides determines the level of social and economic reciprocity that is expected. Once a person is labelled a drug user, their social capital can begin to erode as a result of the stigma and discrimination that is attracted.

Bourdieu also noted:

> Subtleties of language such as accent, grammar, spelling and style, all part of cultural capital, are major factors in social mobility ... The ruling classes preserve their social privilege across generations despite the myth in post-industrial society that boasts equal opportunity through formal education.

There are clear and definable ways in which we become labelled a drug user in the eyes of the general community. We might start drug treatment, go to gaol for a drug-related offence, start a 12-step program, or just 'out' ourselves. In contrast, there are no actions or activities whereby one can become 'unlabelled': 'Entrance into deviance from pivotal normality is much more frequent than entrance onto normality from pivotal deviance'.

To even hope to be accepted again we must redeem ourselves in the community's eyes by giving up drugs or at the very least going into drug treatment. Very few drug users are, however, able to overcome that labelling and return to the fold. We have the 'rehabilitated drug user', the 'treatment user', the 'criminal user', the 'recalcitrant user' and the 'ex-user': it is always a 'something' user. 'Having an identity as a deviant is extremely difficult to change as the stigmatised label is “sticky”.'

A very small number of stigmatised, or 'deviant', people manage to transcend that status and achieve 'charismatic deviance'. This includes 'both achieved and ascribed deviants, and their role is expressed in such social forms as guest speakers, research subjects or speech givers'.

But even charismatic deviants are never quite accepted. They are seen at conferences on HIV/AIDS and drugs; they sometimes receive an invitation to participate in committees or other forums, but they are not often invited to participate in the associated social networking activities. Additionally, although drug
users can have a lifetime of experience, other skills and expertise, it is only the drug use information that people are interested in. The charismatic ‘something’ user will never really be accepted as part of the general community, no matter what they have achieved.

It is little wonder, then, that drug users do not want to be acknowledged as such. In the drug user movement we often talk about how important it is for drug users who do not fit the stereotype to ‘come out’, yet we acknowledge that the price is still too high:

I was one of only two people representing consumers who were invited to the NSW Drug Summit ... Over the first day of the summit lots of negative things were being said, and it looked as if positive interventions such as the methadone program might be rolled back. I decided to stand up in Parliament House and admit that I injected drugs and I was on a methadone program, yet I had a university degree and held a responsible job ... While I would do it again, I was naive and I wish I had thought it through more ... I wish I had gone to my family first and talked to them. Until then my use had been the family’s ‘dirty little secret’ and suddenly it was all over the media. This led to some years of estrangement.120

This quote raises another reason why drug users want to ‘pass’—to protect their families. They do not want their family and friends to be exposed to and the recipients of what Goffman calls ‘courtesy stigma’—stigma extended to those who are seen to be in the company of a stigmatised individual. Byrne describes this as ‘drug user stigma by association’.121

**Stigma and the media**

Earlier in this chapter passing reference is made to an interesting question: do public opinion and public policy influence the media or is it the converse—the media swaying public opinion and influencing the development of government policy? To be sure, there is influence both ways, but the outcome is the same for drug users—negative press and hostility. The majority of the general public rely on the media for their information about what constitutes drug use and what represents a drug user. This is problematic in that most media articles are ‘... disproportionately aimed at specific stereotypes of drug users ... to the point where simplistic notions have developed at the expense of a much wider and more complex discussion, to the detriment of a holistic drugs discourse ...’122

Numerous journals and other publications—including the report on the AIVL-commissioned market research—note that most members of the general public do not personally know any drug users, and their only source of information on illicit drugs and drug users is the media. We can infer from this that their information is second-hand, filtered through the sieve of the media. In the main, however, contemporary media portrayals of drug users depict these people as a risk-taking, potentially violent and threatening group who do not contribute to society:

Non-users identify the news media as one of their main sources of information about illicit drugs and in this way the media shapes community perceptions of risk and of illicit drug users more generally. For example, in the lead-up to the opening of the medically supervised injecting centre in Sydney in 2001, press coverage was found to be ‘unnecessarily alarmist’. Coverage by the Daily Telegraph particularly was found to have fuelled speculation through the use of ‘risk language’, increasing the public perception of community threats.123
Not only is inaccurate and sensationalist reporting by the media the source of stereotypes and the resulting discrimination: it can also cause actual harm. Inaccurate, out-of-context commentary triggers ‘drug scares’ and moral outrage, leading to knee-jerk crackdowns and punitive public policy responses. Additionally, this public commentary, when put forward as the ‘truth’ by the media, might not be accompanied by substantiating evidence and can become public opinion (the dominant ideology). In the case of drug users this is problematic: they feel powerless and are less likely to voice their opinions or try to justify their reality—what Noelle-Neumann refers to as the ‘spiral of silence’. What is perceived as public opinion can be powerful: it can prevent harm-reduction programs from being established or lead to their closure. This is exemplified by the Howard government’s stance in response to Murdoch press coverage of the proposed heroin trial in the ACT in 1997: ‘... media vilification of the trial [was] an important factor in the government’s decision that [the trial] should not proceed’.

**Shooting gallery trial an overdose of failure**

PIERS AKERMAN | The Daily Telegraph | May 2, 2007

“Two months ago, Britain’s Independent newspaper published a front page apology for campaigning for the decriminalisation of marijuana a decade ago. It took some guts for the soft-Left newspaper to admit its error but the facts about the arm caused by marijuana use were too alarming for even The Independent’s inner-urban editors to live with... In Australia, the state and territory governments have yet to come to their senses about marijuana, with various dopey lobby groups attempting to legalise weed by stealth... But instead of responding to this threat the states prefer to roll along with the libertarians as The Independent and the British Government did until this year. The most obscene evidence of the states softly-softly approach to drugs remains the NSW Governments embrace of its Kings Cross Shooting Gallery despite the absence of any hard evidence that it serves any purpose other than to ensure that addicts will always have a place to legally shoot – up if they so choose when they happen to be in the area and in possession if illicit drugs. Put simply, the reports produced by the heroically named Medically supervised Injecting Centre fall apart when examined by competent and genuinely independent experts.....”

**Does the media drive public policy or does policy drive the media?**

Constant vilification in the press leads to the demonisation of drug users as ‘other’ and not deserving of access to health or social services. Further, since it is not illegal to discriminate against illicit drug users, we are seen as not even having the right to complain and be heard. An example of this can be found in the response to the call for submissions to the 2001 New South Wales Anti-Discrimination Board’s inquiry into hepatitis C–related discrimination, which eventually resulted in publication of the C-Change report, the recommendations of which have largely been ignored. In response to the call for submissions, Miranda Devine wrote in the Daily Telegraph, under the heading ‘Our money to burn’:

*If you ever wondered what happens to the millions the NSW Government rakes off us every year ... [the] board wants to hear from anyone who has witnessed or experienced ‘discrimination based on a perception or knowledge of someone’s hepatitis C status or lifestyle’ ... God forbid that anyone would discriminate against drug addicts or even privately believe they should keep their bodily fluids to themselves ... You wouldn’t want to inhibit their ability to spread a disease ... Rooting out such discrimination, whether it exists or not, is such an urgent priority the board feels compelled to conduct hearings—at great expense ... Really. What on earth is this taxpayer-funded body doing conscripting complainants? ... Is the discrimination business so lean it has to drum up allegations?*”
In addition to insinuating that drug users with hepatitis C do not merit a hearing on the stigma and discrimination they face, this article promotes several standpoints:

- an ‘us and them’ attitude in relation to drug users and the rest of society
- through the expression ‘millions the ... Government rakes off us’, an attitude that drug users are unemployed and therefore do not pay tax
- through the statement ‘they should keep their bodily fluids to themselves’, an attitude that drug users are deliberately infecting the general public with the hepatitis C virus.

Similar media coverage has been linked to HIV/AIDS in the past: it was seen to be particularly poignant to differentiate between ‘innocent victims’ of AIDS and others, whom we must assume are therefore ‘guilty’ or deserving of their fate.

The media portrayal of the heroin-addicted ‘junkie’ as a menace who poses a threat to the rest of society has both racist and class connotations. Historically, in Australia we have witnessed this phenomenon in relation to, originally, Chinese immigrants, opium smokers, Vietnamese Australians (through the drug user–dealer association with the south-western Sydney suburb of Cabramatta in the 1990s) and, more recently, Arabic-speaking Australians, particularly in relation to Afghanistan and the so-called war on terror. Drug users and drug dealers are a threat to white middle-class morality, and white middle-class Australia needs to be protected. Consider the following extracts from the popular Australian press:

### Aussie swallows 41 balloons of heroin

*The Daily Telegraph | November 6, 2010*

… New South Wales police said the unidentified 37-year-old woman, who had recently returned to Australia from a holiday in Vietnam, had been charged with supply of a prohibited drug … Paramedics were called to her home in suburban Cabramatta, southwestern Sydney.127

### Heroin a hit in migrant centres

*The Daily Telegraph | May 29, 2011*

Heroin addicts are being held in immigration detention centres and provided with methadone … [Authorities] refused to reveal how many detainees are serious drug addicts … Immigration insists the addicts brought their drug habit into detention … The Sunday Telegraph can reveal the health bill inside our detention centres—which includes the methadone program—has blown out to $273 million over the past two years … Each detainee is racking up a medical bill on average of almost $8000 during their stay.128
These examples illustrate how the media can selectively link drug use and drug dealing with a group already considered ‘outside’ of normal society. The language used suggests that these individuals from differing cultural backgrounds, together with their drug use and dealing, are a cost to ‘honest’ tax-paying members of the general community.

The media can also sensationalise the fate of individuals who die from drug use but do not reflect the stereotype in terms of apparent lifestyle and status. Take, for example, the way the deaths of Anna Wood in 1995 and Heath Ledger in 2009 were depicted in the popular press and on television.

Anna Wood, a 15-year-old schoolgirl, died after using the ‘party drug’ ecstasy, or MDMA. She did not die from the ecstasy use itself but rather from the effects of water on the brain. Had her friends felt safe in calling an ambulance or seeking assistance from others at the time she may well have lived. In any event, in the days following her death the public was bombarded with images of her in her
school uniform and headlines proclaiming her ‘the girl next door’ and ‘a normal Australian girl ... not a junkie’. In fact, this middle-class suburban girl just did not fit the stereotype of a drug user.

Similarly, in England in September 2010 schoolgirl Francis Scane died following illicit drug use, and the media reporting on the autopsy findings ran along the following lines:

**Schoolgirl Francis Scane ‘found hanged amid drug abuse’**

SIMON GARNER | Metro Online | June 29, 2011

A gifted schoolgirl who dreamed of joining the army ... hanged herself after descending into drug abuse and depression ...

The coverage of her death was as melodramatic as that dealing with Anna Woods. In Anna’s case, there was intense moral concern about the use of ecstasy by young people at dance parties, largely aroused by the *Daily Telegraph*, which saw its duty as:

... setting the key terms of debate about ecstasy consumption and dance parties and ... influencing [the policy responses of the state government]. The ongoing legacy of the moral panic engendered by Anna Wood’s death is evident in the ways that media and government articulate discourses of ‘risk’ in relation to young people’s ecstasy consumption when compared with the contexts and uses of alcohol. Further ... these different discourses have produced clearly iniquitous policing strategies in relation to Sydney dance clubs and hotels ...

These and other examples explore how the media’s representations can, through selective omission or inclusion, frame an argument. Clegg-Smith et al. suggest:

*Newsmakers have the power to shape the way a story is presented ... The power is demonstrated through strategic ideological framing of not only the facts of the story itself but of the actors, leaders, affected communities, relevant arguments and proposed solutions ... For example, the selection and omission of particular sources contributes to the framing of an issue, with official sources such as politicians and government figures often dominating drug stories in the media ... whereas ‘alternative voices’ tend to be marginalised ... In the same way, choice of language is important in framing problems and solutions. For example, the ‘drug war’ metaphor used in the United States media coverage suggests strong intervention of a military or law enforcement nature as the logical solution to a war-like problem, rather than suggesting health or economic interventions ... Framing therefore affects what is said about issues, by whom and the definition of optimum solutions ...*

In the framing of Anna Wood’s death, we see the deployment of parental grief: while by no means downplaying the family’s dreadful loss, we find that some 16 years after Anna’s death she remains the ‘poster girl’ for the ‘just say no’, zero-tolerance, abstinence-supporting campaigners—a middle-class schoolgirl taken in the prime of her life because of the use of illicit drugs.
Heath Ledger’s final days as scruffy loner

The Daily Telegraph | January 26, 2008

FAR away from the idolised lifestyle of a Hollywood star, Heath Ledger lived his final days as a scruffy loner.

Drifting between acting gigs and fleeting visits from his beloved daughter Matilda, Ledger would wander the Manhattan cobblestone streets alone, usually wearing ragged jeans, an old jacket and an unshaven chin.

When he returned to the SoHo apartment he rented for $26,000 a month, a forlorn sight greeted him.

If we can establish that the media framed the debate about dance party drugs in the mid-1990s, so too can we establish that the debate about the misuse of prescription opiates was framed with the death of Heath Ledger in 2009. The media determine which drugs are ‘problematic’ at any particular time—regardless of reality and regardless of the reality for drug users.

Of course, people do die as a result of drug use, but it would appear that to raise debate one must be non-stereotypical or famous or, better, both. In the late 1990s there were many deaths caused by heroin overdose—to the extent that such deaths rivalled the national road toll. These mortals were, however, perceived as ‘junkies’, so there were no big headlines, and no one was interested in the parents’ grief: the drug users had brought it upon themselves and the media were largely silent. Dead junkies don’t sell newspapers; dead celebrities who happen to overdose do, though.

After the death of Heath Ledger, who apparently died from an overdose of prescription drugs, the media leapt on the notion of a ‘crisis’ in relation to prescription drug use. As noted, the media frames a crisis, the government reacts, often in a knee-jerk manner, and Australia is now developing a National Pharmaceutical Drug Misuse Strategy. There can, however, be little doubt that Heath Ledger’s death as a result of taking a cocktail of prescription opiates and other drugs gave the media the ammunition they needed to argue that a new ‘drugs crisis’ was upon us:

Australia risks a surge in people overdosing on prescription painkillers unless doctors do more to tackle the nation’s growing dependence on opioids, a drug and alcohol expert says … [Dr X] says Australia could follow in the footsteps of the United States, where the number of deaths linked to powerful prescription opioids like oxycodone outstripped those from heroin and cocaine combined … fuelled by the number of GPs willing to prescribe them for longer periods, and a thriving black market … The main message really is Australia has had the warnings from the United States and Canada and unless we start doing a lot of things real soon we will go down the US path and we will see a lot of people die from prescription drug overdoses … He [doctor] often has patients hooked on painkillers referred to him for treatment—and they are mostly not stereotypical junkies … They are very often people who have a lot going for them in terms of education, relationships and employment and they have an emotional crisis or illness and get exposed to these drugs and a percentage of them start going down a spiral and they get hooked on these drugs … Heath Ledger was probably the archetypal kind of user. He had some problems that weren’t insurmountable … and some back pain and started to get hooked.136 [emphasis added]

Ironically, some media reports detailed Heath Ledger’s descent from celebrity to stereotypical drug user, the image being of an individual with all the opportunities as ‘fallen’—from charismatic to deviant:
The language the media use in their creation of a ‘drug crisis’ has a direct relationship to what are considered ‘upper’ or ‘lower’ class illicit drugs. The media’s position can determine which drugs are perceived to be the most ‘harmful’ and which users the most ‘dangerous’, reinforcing the notion that users of illicit drugs that are injected are ‘worse’ than other drug users. The language chosen also demonstrates that drug-related matters are not described in an even-handed way: articles about drug use by ‘elites’ and drugs considered ‘elite’ are treated differently from those about ‘non-elite’ drugs and users.

Some drug types were much more likely to be mentioned and discussed as the main issue while, conversely, other drug types were more often mentioned in a peripheral manner. In particular, cocaine was more prominent in articles that mentioned drugs in passing (17.4%) and mentioned less often in articles where drugs were the main issue (9.9%). For amphetamines the opposite was true, with amphetamines representing 11.2% of articles where drugs were mentioned in passing, but 16.1% of articles which had drugs as the main focus. This means that some drug types [such as amphetamines] are more likely to be focused on and discussed in news stories while other drug types [such as cocaine] are presented in a peripheral manner. By framing drugs as a crisis, the media significantly contributed to shifts in public attitudes, with 50–60% of the public regarding drugs as the United States’ most important problem. Amphetamines are reported differently to cocaine ['poor' versus 'wealthy' drugs?] ... Heroin [is] the drug most likely to appear on the front page (29.9% of all front page articles), followed by mixed drug types (29.6%) and cannabis (20.4%).

Potentially stigmatising marks have a vastly different fate, depending on whether they are associated with high or low social status—with wealth, prestige and winners or with poverty, ignorance and losers. Certain ‘deviant’ behaviours are inherently expensive and may take on cachet because of that. The use of cocaine seems almost restricted to the wealthy, and users are, by and large, less stigmatised than heroin addicts. One reason for this may be the association of heroin with squalid surroundings and ‘buys’ financed by muggings and larceny. The popular image of cocaine does not include such discordant notes.

This, in fact, mimics the response to the morphine users of the previous century: morphine was more expensive than opium and was associated with wealthy people. A passage from the National Drug Strategy document provides a perfect illustration of this differentiation of classes of drugs and their users and how the media can use stereotypes to influence public policy:

An expansion of the cocaine market is reflected in recent increases in arrests, seizures and reported use. Two distinct user groups have been identified. The first is employed, well-educated and socially integrated individuals and the second injecting drug users.

The media also deliberately ignore facts in order to sensationalise drug-related topics; this is evident in the way they report stories about syringes. The media would have us believe that any syringe seen on the street harbours danger in the form of transmissible disease. At face value, one could easily believe, therefore, that there have been innumerable needlestick injuries resulting in infection. The fact is, however, that ‘needlestick injuries from discarded injecting equipment in public places are considered to pose a very low risk’—to the extent that in Australia there are only two known cases of hepatitis C transmission in a community setting.

Headlines and articles such as those that follow feed hysteria and fear in the community. The general public becomes so fearful of the stereotypical needle-wielding junkie that the threat appears to be a potent reality:
Some columnists would appear to genuinely believe that drug user–related health services are morally indefensible in themselves and use sensationalist language to push the public into believing untruths and unsubstantiated ‘facts’ while ignoring research evidence. This is of concern since, as noted, health services for drug users have been closed down following negative media attention. This negative attention has particularly focused on the medically supervised injecting centre in Kings Cross, Sydney: for years there have been calls in the popular press for the centre’s closure.

In 2006 used syringes were found dumped outside the medically supervised injecting centre’s premises. The centre categorically stated that the dumped syringes were not the brand used on the premises. This denial was paid scant attention, and sensationalist stories in the popular press resulted. For example:

**Girl, 6, jabbed by needle in restaurant**

C CUNEO | Daily Telegraph | July 23, 2010

A terrified mother has told of the moment her six-year-old daughter was pricked by a discarded needle while playing at a … playground … Girls went to the nearby play equipment, where police believe a female junkie had been shooting up just minutes earlier … ‘[The child] had only been in there a second, and next I knew there was blood … it was terrible’, the woman said … [The child] was rushed to a local doctor for a series of blood tests … The family now has an agonising six-month wait for the results.

**A disgrace—addicts dump dirty needles next to school**

L HOULHAN | Daily Telegraph

Users of a needle program based next door to a primary school are injecting drugs within sight of children and dumping the needles just metres from where [the children] play …

**Addicts in family’s backyard**

Z JACKSON | Ipswich News | May 11, 2010

An Ipswich mother says she fears her young children will one day be infected by one of the many dirty drug needles dumped in the backyard of her family home. She said she wanted to raise the issue so other … residents and nearby households would be aware. ‘Every morning I have to come down and check the yard before my kids get out so they don’t step on a needle … It’s disgusting’ … ‘We need to be tougher on these morons’, [police] said.

‘Why wouldn’t I discriminate against all of them?’
Deadly neglect … needles dumped in city streets

Daily Telegraph | July 27, 2006

These are the photographs that shame the so-called ‘safe’ injecting room … dozens of syringes spilling from a bin in a public street. At best, the photographs prove critics’ claims that the taxpayer-funded centre is a honeypot that attracts and keeps drug addicts in the area. At worst, they show that centre staff are exposing the public to potentially deadly blood-tainted needles by showing no care in their disposal.145

Get your Daily Telegraph today and have a look at the ‘safe injecting room’—ha, ha … It proves critics’ claims that the centre is a honeypot that attracts and keeps drug addicts in the area.146

Unfortunately for the centre’s detractors, the needles that were the subject of the media scrutiny belonged to a local resident who had used them to treat his pet cat. It is not known how they came to be where they were found. Despite repeated calls for its closure, the centre remains open as a health service for drug users, and there have been pleas for the establishment of a similar service in Melbourne.

The media stereotyping is so persuasive for some members of the general public that they do not question the reality of drug use and drug users and actually start to hate:

Yeah, never mind the victims of crime who get robbed by these addicts so they can buy their drugs and go inject safely …

——Luke of the Blue Mountains147

How will a drug injecting room rid the street of dirty junkies. There is only one way to break the cycle of drug use: cold turkey … The dealers are having a field day, just wait till the government starts opening them up in other suburbs. Every government official and worker who supports this and other injecting rooms should be charged with conspiracy to supply heroin.

——Neville of Sydney148

Honestly, these rooms and the whole methadone program need to go. Who really cares if these people use dirty needles and die? I for one would think it was a good thing; these idiots not only ruin their own lives but those of their families and loved ones and are now invading the lives of everyone. Many of them steal to support their habit, continue to have babies who suffer untold pain and distress after they are born. Really, people need to stand up and wake up … these users are not a worthwhile part of society … We support them as they don’t work and don’t care … I say get off it or OD …

——Loretta Hanley149

The stereotype is such that injecting drug users are thought incapable of being a positive influence on their children and possibly unwilling to care for their offspring. In the media mind there is the ‘good parent’ and the ‘junkie parent’. As one columnist reported:

Mothers must have wept to see free child care was to be provided to junkie mothers … What about those unfortunate women who are receiving medical treatment and will look with dismay at the 40 or more hours of child-minding a week being doled out to druggies.150
The media have a responsibility to inform the public in an unbiased, factual manner. The Australian Communications and Media Authority oversees media compliance with standards and codes of practice, but little seems to be done about ensuring that those standards and codes are complied with when it comes to reporting about drug use and drug users:

A century from now historians may ponder this construction of drug demons just as they now ponder the burning of witches and heretics. But what is already clear is that centuries of scapegoating chemical bogeymen left even the very best journalists quite prepared to believe the very worst of drug users.151

Drug users understanding and experience of stigma

As part of part of AIVL’s commissioned market research exercise, GfK Blue Moon held a focus group consisting of representatives of AIVL member organisations at our National Annual Meeting. The market researchers were seeking background information in order to gain a better understanding of how drug users believe members of the general public perceive them and why.

The drug users saw themselves as stereotyped, consistent with what the market researchers found later. Users are a group of people who clearly understand the community’s attitudes to them, and this must play a part in their feelings of self-worth and belonging. Focus group participants felt the general public’s perception of injecting drug users embodied the following features:

• being ‘criminals’ and ‘thieves’ who are willing to do anything to get what they need, without considering others
• having poor hygiene habits
• being ‘bad’ parents who neglect their children and are unreliable
• using dirty needles in their desperation to use drugs
• being irresponsible in the disposal of needles
• being likely to have disease of some kind caused by using dirty needles or poor hygiene habits
• being selfish, with no consideration of others.152

It is not necessary to cite all the studies that support these findings; suffice it to say they are many, varied and universal.

The drug users themselves felt that the general public has no idea of who is or is not a drug user. Most injecting drug users or past users negotiated the day without anyone realising they were or had been an injecting drug user. Keeping your drug use hidden so that you can get by, or ‘pass’, in society was an automatic reflex for most people—if they could get away with it, and most could, the majority of times.

Drug users are seen as ‘other’ and are seen to bring this on themselves. People who are assumed to have some agency over their stigmatised persona are treated much more harshly than those whose stigma is not seen not to be their ‘fault’. This is supported by Lavack:

If the stigmatised individual is not considered to be responsible for the onset of stigma [e.g. in the case of physical disability] then bystanders are more likely to have a reaction of pity. If the stigmatised individual is deemed to be responsible for the onset of the stigma [e.g. in the case of addiction] then bystanders are more likely to have reactions involving anger or irritation, and are less likely to offer help.153
Drug users believe the stereotype is readily accepted by the wider community because of the fear in which the drug using community is held. Several factors are seen to give rise to that fear:

- fear of needles—representing contagion, disease and drug use itself
- an inability to understand how a person could inject themselves for a non-medical reason
- a feeling that injecting is a self-harming and risky behaviour
- the knowledge that drugs are illegal and illegality is equated with immoral behaviour—that is, being a ‘junkie’.

The drug users also felt that government policies and programs that ‘problematise’ and often accentuate drug user characteristics—combined with the media’s penchant for negative depictions—served only to reinforce these stereotypes. Examples of government’s contribution are the Howard government’s ‘Tough on Drugs’ Strategy, the use of phrases such as the ‘war on drugs’, and suggestions that drug users contribute to the ‘war on terror’.

The media’s reporting on drugs and drug users often supports the government rhetoric. Not only does this reinforce the wider community’s stereotyping: it also serves to reinforce drug users’ own negative self-image. As Jones reports:

> This repeated rhetoric, across the nation, has the effect of ejecting drug users, as an identified group, from what is considered to be the mainstream community and the sort of values privileged by this community. Such identified and stereotyped drug users are constructed as outsiders … Many other peoples, who find themselves being discriminated against, also find themselves being rhetorically constructed as outsiders by the mainstream media.154

A fear of needles was established in many people’s minds through childhood vaccination experiences and syringes’ association with illness and disease. This fear is easily played on by media hyperbole, particularly in an era of ‘AIDS hysteria’. The syringe has become a weapon; drug use is associated with syringes; drug users are therefore to be feared.

Giving an example of the media’s misuse of the syringe as a symbol of addiction and hence violence, Jones states:

> … graphic representation of a syringe … graphic is rich in the semiotics of stereotyped addiction. Reports of syringes used in robberies also appear in the newspapers from time to time. The image of the syringe when combined with the threat of being full of AIDS-infected blood has taken up such a powerful effect that it becomes represented as a weapon for armed robberies. The same degree of horror that can be gained by aiming a gun at someone can be drawn from this use of a syringe, it so appears …155

Obviously, not everyone who uses a syringe is marked in this way—as potentially violent. Only when the syringe is attached to illicit drug use does it become a weapon in people’s minds. Diabetics go about their day-to-day business free of the negative stereotypes and labelling associated with the use of needles.

Injecting drug use is seen as synonymous with addiction, and people who are ‘addicted’ are seen to engage in risky or dangerous behaviours to feed that addiction. Such behaviours entail not only self-injection but also taking too much of a drug, leading to an overdose, and transmitting and contracting blood-borne viruses such as HIV and hepatitis. Drug users see themselves as being stereotyped because behaviour of this kind is perceived to be willful and selfish.
Perhaps the most powerful influence in the stereotyping of injecting drug users is the fact that the drugs users choose to inject are illegal. It is easy for people to believe that because the drugs are illegal they are ‘bad’ and the people who use such drugs are criminals: they are, after all, breaking the law. Users felt that the illegal status of drugs had an enormous impact on the general public’s attitude:

They … equate this illegality with immoral and deviant behaviour … However, people who inject drugs feel that the positives are never seen by the general public, only the negatives. People who inject drugs identify themselves as being survivalists, resilient and resourceful, with their drug use a small part of what they are as opposed to the ‘out of control’ junkie for whom drug use is perceived to override all other characteristics or qualities.156

It is both interesting and ironic that within the drug-using community itself there also exists drug-related stigma and the resulting discrimination and stereotyping. In this instance, it is associated with the drug of choice and the method of use: alcohol drinkers think illegal drug users are beyond the pale; amphetamine snorters think heroin smokers are a lost cause; they all think injectors are despicable junkies. And the junkies think the others are not real drug users anyway!

This situation arises because the stigma against the ‘symbolic junkie’ is so potent that drug users want to remove themselves as far as possible from that stereotype. In this way they can believe that the drug use they themselves indulge in does not have those stereotypical characteristics, so they will be able to ‘pass’ in the wider community.

When drug users participating in AIVL’s focus group were asked to comment about discrimination experienced at the hands of specific groups in the broader community, pharmacists and medical professionals topped the list. In relation to pharmacy experiences, examples included being made to wait to be dosed with their medication while the pharmacist served people who had come into the pharmacy after them, being asked to enter and leave the pharmacy by a different route, and only being able to have access to the pharmacist at a specific time, regardless of convenience or personal and work commitments.157

Being discriminated against by shop staff and workers at clubs or hotels is annoying and embarrassing. Yet, although such incidents contribute to the lowering of self-esteem, they do not have the potentially extremely negative impact on the health and wellbeing of individual drug users that discrimination by medical professionals has. Not only do many drug users avoid potentially discriminatory situations with the medical profession (and it is acknowledged that stigma increases stress and hence plays a part in overall ill-health)—some members of the medical profession actually avoid treating drug users:

Frequently, when hepatology specialists are asked whether they would treat a current injecting drug user, the answer is ‘no’ … This assumes that all drug users are problematic and that injecting drug users’ lives are chaotic, regardless of lack of evidence of instability.158

An individual’s experience in a medical setting has broader implications for the injecting drug user community since all such experiences are discussed and help create the lived story of drug users. Users view them as cautionary, and they think hard before they expose themselves to similar treatment.

I have had three male doctors upon finding out I was a user immediately want to discuss sex and prostitution with me. This has been very embarrassing …159

I told him I was hepatitis C positive because I thought it was the right thing to do. But then when he cut his finger he flew into a panic and didn’t finish the job … I have been walking around with my mouth like this for two months …160
I was supposed to have a lot of baths. The nurse came in and in no uncertain terms told me that I wasn’t allowed to use the bath and she was just really unpleasant [because] I was a dirty junkie who had hep C ... She didn’t say ‘junkie’ but that was the implication. That I would scum up the bath for someone else.161

One might assume that healthcare professionals working with hepatitis C–positive injecting drug users would have a more accepting and less discriminatory attitude: they have had the opportunity to meet individuals and should not just be influenced by stereotypes. Brener et al. found, however, that when healthcare workers were exposed to other stigmatised communities [such as people living with HIV/AIDS] they were less inclined to discriminate but that when it came to hepatitis C–positive drug users the care workers were outwardly expressing positive attitudes while internally discrimination was intensified: ‘while health care workers who have had more contact with people with HCV show more positive explicit attitudes, they also show less favourable implicit attitudes.’162

Such discrimination is particularly problematic in view of the high levels of hepatitis C transmission among the drug-using community and the low rate of hepatitis B vaccination in this group. Avoidance of hepatitis C treatment by injecting drug users is also concerning. These medical factors are at present only dealt with in the primary healthcare setting, requiring continued interaction and repeated appointments. Hopwood refers to the dilemma for drug users:

Stigma is increasingly seen as an added burden on the health of affected individuals who are often already dealing with stigma associated with poverty and or minority group status. Stigma influences the health seeking behaviour of many health consumers, it can delay appropriate help seeking, interfere with access to treatment for treatable problems and impede the effectiveness of case finding and treatment, which are key interests of public health.163

When people who inject drugs choose to stay away from healthcare services because of the stigma and the consequent discrimination and stereotyping, the result is unnecessary damage to their health and wellbeing.

Some might say that injecting drug users are overly sensitive to discrimination by the general community and medical professionals. We would argue, though, it is in fact that continual exposure to discrimination that makes a person overly aware: when others might shrug it off as a ‘one-off’, for drug users it is a constant in daily life. It is difficult to be cavalier about such treatment.

Stigma and the general community

This section looks at the way the general community frames drug use and drug users and the stigma and discrimination drug users experience as a result. The two most stigmatised epidemics of the past few decades have been HIV/AIDS and hepatitis C—both affecting already marginalised communities. HIV/AIDS was initially blamed on the homosexual community, and hepatitis C is perceived to be the result of injecting drug use.

The panic and uncertainty that accompany epidemic disease may lead to a desperate search for explanations ... Stigmatisation seems to provide a partial [although spurious] answer ... The convenience of having an already despised or suspect group in the vicinity allows for quick attribution of causality and blame.164
The poorest and most marginalised people in our community often bear the burden of many stigmas, illustrating how the powerful can impose rules on the less powerful. In the early 21st century the injecting drug user community is being blamed for the hepatitis C epidemic:

In ancient mythology the [scape]goat is loaded with representatives of pestilence affecting the community. The goat, carrying this pestilence on its back, is exiled into the proverbial desert where without food and water [it] faces certain death ... Again, through its sacrifice it cleanses the remaining community.165

Injecting drug users are seen as the architects of their own downfall: they used drugs, they took up injecting, they contracted a virus, they can and probably will transmit their disease(s) through inappropriate use and disposal of syringes. Additionally, they are a threat to the wellbeing of the general community. In short, they are to be blamed.

By and large, the general public has wholeheartedly embraced the drug user stereotype, and the result is day-to-day stigmatisation of and discrimination against drug users. This has profound adverse effects on users’ health and wellbeing. They are among the most feared and disliked populations in the community.

The sample of the general public that AIVL’s commissioned market researchers focus-tested contained people of varying ages, socio-economic status and occupations. Among the occupations were media, information technology, law, teaching, construction, hospitality and retail. The majority of the sample had a relatively liberal attitude towards illicit drug use: in their pre-questioning interview they did not express overt prohibitionist or zero-tolerance views. Many younger members of the focus group admitted to using soft drugs such as marijuana and ‘club’ drugs; older, more conservative respondents admitted to drinking alcohol but had little experience of or exposure to illicit drugs.

WHO IS THE INJECTING DRUG USER?

- Sadly Jim is homeless because of some mental health issues
- And David, who runs his own business is an injecting drug user

Leave your prejudices at the door ...

Market Research: Who is the injecting drug user?
As noted, the majority of the general community appears to have had no personal contact with illicit, and particularly injecting, drug users. Despite this, though, their perception of drug users is based on the notion of injecting drug users as violent, criminal and unpredictable: in the commissioned market research participants described drug users by using expressions such as ‘mood swings, nasty, can be violent’. As discussed, such stereotypical views are largely derived from the media discourse. Peretti-Watel suggests, however, that the media are not the only influencing factor, and the general community ‘sees’ only the problematic drug user who fits the stereotype:

Since the most visible heroin users are those who fit the ‘dope fiend’ stereotype, while those who lead a normal life are hidden ... drug use is considered immoral in our societies: according to the asceticism of the Protestant work ethic, people should never lose their self control nor become dependent on any drug ...

Campbell sums up this difficulty well:

[The relatively small] group of problem [illicit] drug users disproportionally exhibit the indicators of deprivation and social exclusion—poverty, mental health issues, unsettled childhood, low educational attainment, unstable accommodation.

This widespread image of drug users shows just how successful the media’s portrayal of the ‘junkie’ has been. The image is taken to be representative of all injecting drug users:

- ‘skinny, unclean, pimples, no job, vacant eyes’
- ‘thin not healthy looking’
- ‘furtive, skinny, malnourished, dirty, selfish’
- ‘gaunt, frail, pale, very skinny, black circles under eyes, dilated pupils’.

Such stereotyping reduces the ‘diversity of reality to a limited set of easily recognisable images’. It is much easier to blame the individual for having a lack of self-discipline: their drug use is their own fault, and the community at large ignores, or perhaps does not even consider, the impact that social inequalities and the disproportionate outcome of social policies can have. The ‘junkie’ is not part of the reciprocal social exchange and is therefore ‘othered’.

This is illustrated by the statement that ‘They made the decision [to use drugs] and too often then you’re supposed to feel sorry for them, that’s the thing that’s always irked me’. Researchers have also found that ‘three quarters of those surveyed considered heroin users dangerous for their relatives … most of them considered that heroin users had no will of their own’.

The general population’s reaction to drug users is not specific to Australia. In a French study, Peretti-Watel found:

Nevertheless, conceiving a perfect stranger as a devil who concentrates all the vices [the ‘dope fiend’ is supposed to steal, to lie, to even kill without being able to control himself ...] can prove useful in order to reassure our values, to draw a clear boundary between good and evil: our moral universe is inhabited by many stereotypes which are clearly either good or bad, and which provide us with models to follow as well as with scarecrows to avoid.

Peretti-Watel’s findings are very similar to those of the market research AIVL commissioned and those of a survey in Britain, which found, ‘Over 58% of people believe lack of self-discipline and willpower is the cause of drug dependence’. These researchers also reported that ‘most people would not want to live near a drug user’.

A report on stigma and discrimination towards the injecting drug user community
AIVL’s commissioned market research revealed not only that members of the general public do not want to live near or be associated with injecting drug users: they also do not want to be seen to support drug users lest they, too, be judged and tainted—Goffman’s ‘courtesy stigma’. Moreover, the general community felt that discriminating against injecting drug users was ‘good’ for the users; that it might make them reconsider their injecting drug use and dissuade others from taking up injecting drug use in the future. Community members openly admitted to labelling and stigmatising injecting drug users. One participant went so far as to say, ‘Why wouldn’t I discriminate against all of them?’ They believe this labelling and stigma has an important role in minimising the potential acceptance and spread of injecting drug use:

Many among the general public believe that marginalising people who inject drugs was positive for society as a whole. Having a strong stigma associated with injecting drugs and acting to discriminate against them were thought to be a powerful means of minimising the chance of people starting to inject drugs in the first place. Essentially, stigma and discrimination toward people who inject drugs is perceived to be a useful prevention strategy among a large portion of the general public. It was seen as a means of containing the problem. Although it was recognised that this type and level of stigma and discrimination was likely to make situations difficult for people who inject drugs, the general consensus was that this should then act as an incentive for them to overcome their addiction [the ‘tough love’ concept].

In addition, the general public felt that injecting drug users would not be concerned about what society as a whole thought of them since a drug user’s primary concern would be about ‘finding and using their drug ... I think that most of them wouldn’t give a stuff what the general population thought about them’.

It is interesting to note that the drug users had a very clear understanding of how the general community felt about them, whereas the general community had little or no understanding of drug users in this regard. Drug users do care about what society thinks and how they are treated, as evidenced by their desire to ‘pass’ in society.

Surprisingly, although members of the general community felt that it was alright for drug users to be discriminated against in shops, in cafes, and so on, in order to help dissuade others from contemplating injecting drug use, they felt it was inappropriate for health professionals to act in a discriminatory way towards injecting drug users. They thought it ‘unethical’ for health professionals to take advantage of people in a vulnerable situation. They also thought health professionals should have greater knowledge in relation to people who inject drugs because that knowledge would lead to greater understanding and better treatment.

As noted, another fear that pulses through the general community when the subject of injecting drug use comes up is the fear of needles. There is widespread fear that one could either be attacked by a drug-crazed, needle-wielding individual or inadvertently step on a thoughtlessly discarded used syringe, potentially contracting a blood-borne virus:

I feel like they’re going to stab me with a needle. I know it’s not going to happen.

A few years ago I went to Q Bar. There was a needle on the floor in the bathroom. I felt disgusted, I left.

People are fearful of needles, particularly discarded needles, although very few have actually seen them. The fear is based on the idea of potential infection and reinforces the perception that injecting drug users are fundamentally selfish—unable and unwilling to think of the impact their actions could
have on others. Only someone with these traits would leave items such as needles around and not
dispose of them.180 ‘Heroin users are “very frightening people” who don’t have normal empathy of
people in the community …’.181

One important factor that is often overlooked is that for the majority of the general public injecting
oneself is viewed as ‘unnatural’ in that none of the body’s ‘natural openings’ (for instance, the mouth
and nose) are used in the process:

I think it’s foul … The common view that it is ‘dirty’ presumably stems from the fact that in
an unhygienic environment it provides the means to inject bacteria, viruses and contaminants
directly into the bloodstream. People feel very strongly about injectors, as the widespread nature
of injection phobia demonstrates.182

The stereotypical drug user is perceived as both an unemployed burden on society and unemployable.
The general public see them as the recipients of welfare benefits: they need their days to commit
crimes in order to feed their addiction. They are considered unemployable because they are thought
to be unreliable and at risk of relapse and intoxication at work (if they were to work).183 The AIVL-
commissioned market research findings support this view:

It was felt unlikely that employers would be able to trust:

- that the injecting drug users would not steal cash or product to help fund their drug habit
- that the injecting drug user would be responsible enough to attend every day and do their job,
as the perception is they would always be looking for the next shot of their drug, or would be
suffering from the after-effects; and/or
- for similar reasons even if they did attend work when they should their productivity in the
workplace would be less than others.184

This belief that all drug users are incapable of employment is not supported by the evidence. It also
has a very negative effect on employed drug users if their use is discovered, even if it was long in the
past: AIVL and its member organisations have received many anecdotal reports of injecting drug users
who have had their employment terminated or their previously unquestioned work practices queried or
who have been suspected or accused of theft following drug use disclosure or having had their opioid
replacement therapy or hepatitis C status revealed. The C-Change report also noted this:

Mary was employed as a chef … She had been experiencing bouts of intense fatigue as a result
of hepatitis C … [She] was confident that she was a valued employee as she was often given
positive feedback by her manager … She decided she would disclose her hepatitis C status to
her employer … She was subsequently sacked … [A friend], who had … become manager at
the restaurant, told her that one of the reasons given to other staff for her dismissal was that
she was a drug addict … [Mary stated]: ‘Nothing in my demeanour or conduct could have been
read as someone affected by drugs as I was not using. The only way he could have come to this
conclusion is because I have hep C. For the first time I became very paranoid about my illness
and have not disclosed to anyone I work with in my new job … I believe that my employer made
an assumption that because I had hep C I was an IV user … While this was true in the past, it’s
not the case now’.185

In addition to exemplifying the employed drug user’s continual fear of exposure and potential job loss,
this woman’s experience exposes the community acting out its own prejudice. It also illustrates the
stickiness’ of the injecting label: most of the community will not let the past be in the past; ‘drug user’ is a label that follows you forever.

The only time there seems to be a little reprieve for injecting drug users is if they are perceived to be ‘doing something to help themselves’, although this would always be in terms of the eventual cessation of drug use, booking into a detoxification unit, working a 12-step program or going ‘cold turkey’. The reprieve is less forgiving if the drug user chooses to undergo pharmacotherapy with a treatment such as methadone: this is seen as still taking drugs, but legally, and the taxpayer has to support that particular habit—‘Methadone, they get it for nothing and they get the hit that they wanted from the heroin’.186

Attitudes towards injecting drug users are negative, entrenched and generally unhelpful. They leave the general population living in fear of a subset of the community they really have no need to afraid of, and the people they are stigmatising and discriminating against are left with reduced access to health care, housing, employment and other social needs. This must inevitably be a net loss to society.

The media have a responsibility to be even-handed and to report accurately and without bias. After all, that is their ‘calling’.

**Stigma and the medical profession**

The stigma projected onto injecting drug users by members of the medical profession has the most debilitating and harmful effects of all. It results in damage to physical health and mental wellbeing, and it limits access to the services users and their families need. It must be said that members of the medical profession are also members of the wider community and are not immune to behaving in a discriminatory manner. Discrimination in healthcare settings is rife.187,188

There is ample evidence that one’s blood-borne virus status (particularly in relation to hepatitis C) leads to an assumption of injecting drug use:

> Of 300 injecting drug users interviewed … ‘ill treatment’ had been experienced [at the hands of] … hospital staff (60%), doctors (57%), pharmacists (57%) … dentists (33%), methadone providers (33%), drug treatment services (33%) and community health workers (7%) …189

> My experience informs me that people with hepatitis C in this society are usually labelled as IV drug users and therefore as ‘criminals’, ‘addicts’ or at least ‘deviants’ or ‘failures’ and treated according to those labels. As a health care worker myself I am ashamed to note that the most shocking episodes of discrimination that I have heard from clients were perpetrated against them by healthcare workers and usually at a time when the client was vulnerable …190

The AIVL-commissioned market researchers focus-tested a number of medical professionals—among them nurses, pharmacists, physicians and hospital emergency staff—who were representative of the broad spectrum of workers that people who inject drugs interact with when seeking access to health services. There were a variety of ages in the group, and all had had some experience of working with injecting drug users.

Younger medical professionals tended to be more negative towards people who inject drugs than older professionals. This negativity was based on a perception that, compared with the general patient population, it takes more time to monitor and look after people who inject drugs: ‘Some [nurses] used to [say], ‘We haven’t got time for you, there are sicker people than you’ … It was because I was a criminal...
and a drug user’. Pharmacists, in contrast, were concerned about shoplifting and the effect that drug users’ mere presence would have on ‘normal’ customers.

The more discriminatory behaviour of younger health professionals is indicative of the fact that they have had little exposure to drug users generally and are relying on a stereotype. They were the most vocal in claiming that a physical stereotype of injecting drug users existed—‘the junkie look with rotten teeth’.

These medical professionals know, at least to some extent, that they are stereotyping, and it influences their interactions with obvious drug users: ‘When challenged, these medical professionals identified that they did have preconceived expectations as to what their likely interaction with the person would be based on their appearance.’ They are pre-judging the experience because they are looking for signs of problematic behaviour, and this usually results in a negative experience, reinforcing the stereotype and colouring future interactions.

Emergency nurses in the focus group expressed the greatest degree of frustration with injecting drug users. Injectors being brought to Emergency are most probably in crisis, but the nurses were concerned that any expression of crisis was a ploy to obtain medication, and they claimed that pain complained of was suspect—something commonly referred to as ‘drug-seeking behaviour’.

Drug users experience the same range of illnesses and mishaps as members of the broader community. Their interaction with doctors, however, is often skewed by the doctor’s concern that a known drug user is complaining of pain in order to be prescribed opiates and get ‘stoned’. AIVL and its member organisations have heard thousands of accounts of accusations of ‘drug-seeking behaviour’ and denial of pain relief. In the more than 20 years since the establishment of drug user groups in Australia, there has been little improvement in this regard:

One of the most devastating consequences of discrimination, user phobia and ignorance is the refusal of some doctors to prescribe adequate pain relief medication for HIV-positive [injecting drug users] with chronic pain.

When I had my hip replacement they cracked my pelvis while jamming in the new one. I kept complaining about the pain and the doctor said to me, ‘My mother just had her hip replaced and she’s not in any pain’. They didn’t test or scan for three months; they just assumed I was trying to make the most of the opportunity and get prescription drugs … They cracked my pelvis, for f— sake!

I had an abscess on my tooth and my mouth was swollen to the size of a small football. It was extremely painful. I went to the doctor for antibiotics and pain relief, and as he went to write the script for Panadene Forte® he looked up at me with concern and asked, ‘You’re not addicted to these pills are you?’ I nearly fell off the chair laughing; I was on 120 mg of methadone, but of course I didn’t tell him that.

A positive woman suffered severe colic for over a week. Despite repeated hospital visits she was denied pain relief because she was a heroin user. She received no other treatment to ease her condition.

What pain relief? If I was an animal I could get a shot. But seeing I’m a junkie then no way …

I broke my leg in three places after a motorbike accident. At the hospital they wouldn’t give me anything other than Panadol, even though the bone was sticking out through the skin.
These examples relate to doctors’ concerns about users being drug seekers. But the denial of health treatment to drug users because they are thought to be malingerers can have devastating consequences, well beyond mere pain:

I was in hospital having my daughter and I was in the Drugs in Pregnancy Unit ... Most of us were positive and my treatment was bad enough, but there was this other girl in there who had had a caesarean. She was there for a week and the nursing staff were trying to get her to leave and go home, but she kept complaining she was in agony. They ignored her and eventually she went out one day. She was in Burwood shopping mall and started haemorrhaging ... they called the ambulance and brought her back to the hospital ... they’d left a sponge inside from the operation ... they didn’t even apologise.198

In addition to being denied pain relief, being thought of as malingerers or having their lives put at risk, drug users who are hepatitis C positive are assumed to be injecting drug users. Some healthcare professionals consider that these individuals are not deserving of health treatment at all:

A woman called [the Hepatitis C Helpline], asking if she was obliged to tell a dentist that she had hepatitis C ... [The counsellor] began to explain that the practice of universal precautions in infection control meant that it was not necessary to disclose one’s status to one’s treating dentist and the woman began to sob. For two months she had been left with unfinished dental work, with a hole in her gum with a peg in it, and on prophylactic antibiotics. The local public dentist who began the dental work failed to complete it after cutting his finger while working in her mouth ... [She] said, ‘I told him I was hepatitis C positive because I thought it was the right thing to do. But then when he cut his finger he flew into a panic and didn’t finish the job ...’199

I went to the doctor for antibiotics for an infected and really badly swollen arm. He came out into the waiting room, took one look at me, told me ‘I don’t treat scum like you’, and then picked up my bag and threw it out on the footpath.200

One doesn’t need to be outwardly identified as an injecting drug user, rather, by simply fitting a stereotype an individual can be placed in life-threatening situations. As mentioned previously, the medical profession is not immune to stereotypes and having them guide their actions, as the following account so horrifyingly describes:

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**Doctor rejected dying man as an addict**

Sydney Morning Herald | July 15, 2011

A gravely ill man, wrongly assumed to be as addict craving strong drugs, died in agony hours after being discharged from a NSW country hospital, a coroner has found....he was refused pain relief for his “excruciating condition”...[the hospital] had failed to diagnose [the man’s] life-threatening condition, failed to give him adequate pain relief and discharged him although he was clearly very ill....[he] had clung to his hospital bed begging not to be sent home....[he] had told others the staff thought he was a “junkie” who had been “wanting drugs like an addict”...[the doctor had] made a gross error of judgement after forming a fixed view that “his underlying problem was substance abuse”...[the doctor] had refused pain relief except for a couple of tablets of paracetamol...the doctor admitted making critical errors, including “without a proper or reasonable basis” prematurely concluding the [the man] was drug-seeking...Nurses seemed to have been more sensitive to [his] condition, but were rebuffed by [the doctor]...told a nurse: “what is he still doing in my department.”...201

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"Why wouldn’t I discriminate against all of them?"
Drug users’ experience of discrimination in healthcare settings is so widespread it has been reported that it ‘is so common and relentless that many users fail to then recognise that they are being discriminated against. It seems normal to be treated badly and vilified if you are a user’. 202 For some users the cumulative effect of discrimination by the healthcare workforce has resulted in them delaying or avoiding seeking treatment, even in the face of great pain or obvious symptoms of disease:

[He] had rectal bleeding and abdominal discomfort for some months. Everyone, all his friends and people at work, advised him to seek medical treatment ... He continually demurred, saying, 'I hate the way doctors treat me'. After he finally found the courage to attend a consultation he was diagnosed with stage 4 terminal cancer and was dead in six months ... 203

Health care is a basic human right in contemporary Australian society, yet injecting drug users are avoiding potentially stigmatising situations to the extent that their health is being jeopardised. There have recently been public calls for health services to advise patients of their rights in relation to health care and health service provision. One might ask why injecting drug users who do recognise discrimination and the adverse treatment they receive from some in the healthcare sector do not complain. Watchirs summarises the situation:

Due to illegality and the process of criminalisation, people with a history of injecting drug use are an extremely vulnerable and marginalised group within our community. Currently there are no legislative protections to prevent poor treatment or discrimination against a person on the basis of presumed or actual, current or past injecting drug use. While there are some legal protections under anti-discrimination and disability law to protect people with hepatitis C, it is often near impossible for people to prove that the poor treatment was on the grounds of hepatitis C rather than presumed or actual illicit drug use. Even if this was possible, the process of criminalisation ... means that people with a history of injecting drug use are extremely unlikely to lodge a formal report or complaint due to fear of the consequences.204

The medical profession’s continued discrimination against injecting drug users should give rise to some serious questions in the general community. The researchers AIVL commissioned found that members of the wider community were very disturbed by the thought that the medical profession would discriminate against drug users: people feel that medical professionals should be above such human flaws. Once vocations such as the medical profession start treating one group differently, where might it end?
5 Conclusion

The absence of any real understanding of drugs and drug use as a part of the human condition has made it difficult for any rational discourse to take place. Use of illicit drugs continues to be viewed as an aberrant individual behaviour, such that none of the social, economic, religious and political factors that influence it and the way it is perceived are accepted: all blame remains with the individual’s ‘failings’.

This document outlines the development of drug use, from its perception as a matter of personal taste to its being seen as a ‘disease’ during the Industrial Revolution. With changing times, drug use became firmly placed in the criminal justice system, and today it uncomfortably straddles both the medical and the criminal justice spheres.

An unacceptable number of the world’s citizens are being penalised by the current drug laws. The amount of harm that befalls people who inject drugs is inhumane—HIV/AIDS, hepatitis, tuberculosis, overdose, imprisonment, and so on. Drug use and drug users are viewed as so odious that none of the human rights afforded other citizens have any relevance to users.

Discrimination against drug users—particularly those who inject—is one of the final bastions of legitimised discrimination. It must be tackled on numerous levels:

• through government and our adherence to inappropriate international treaties
• through the criminal justice system and laws that are allowed to remain in the statute books
• through the medical profession because of the inability of some its members to observe the Hippocratic oath in relation to individual drug users and their health needs
• through the mass media that deliberately misrepresent drug users in the interest of higher ratings and greater profits
• in the education of every individual who jeers at or berates drug users while knowing nothing about them and happily indulging in their own drug of choice.

We outline in this document how drug use and drug users have come to be stigmatised through various processes and over time. We look at the current theories of stigma and discrimination and how they affect drug users’ health. We discuss the development of the stereotype of the injecting drug user and how the media influence public opinion and ultimately drug users’ health through governments’ development of overblown public policy. We take those stereotypes and show how the general community and the medical profession use them to discriminate against drug users. Finally, we discuss how drug users are aware of what society thinks of them and the consequences of this for their self-esteem and their ability to gain access to adequate health services.
All players must have a role in eradicating these harmful attitudes and social injustices. Stigma and discrimination can be redressed if people have the will.

At the time we were preparing this document the Irish Independent published an article entitled ‘Sterilising junkies may seem harsh, but it does make sense’. The journalist in question went on to comment favourably on a doctor’s suggestion that drug users be offered money to be sterilised. The article also described a group of people whose anti-social activities the journalist had witnessed as ‘junkies’ and ‘feral, worthless scumbags’. The writer’s opinion was that ‘if every junkie in this country were to die tomorrow I would cheer’.

This article ‘went viral’ among members of the drug using community and supportive agencies, who wrote letters to the Irish Independent and lodged formal complaints with the Press Ombudsman. The ombudsman upheld the complaints, saying the article breached principle 8 (prejudice) of the code of practice for newspapers and magazines because it was likely to cause great offence to or incite hatred against individuals or groups addicted to drugs on the basis of their ‘illness’. This incident demonstrated that if we work together and go through formal processes we will be able to gradually reduce the stigma and discrimination injecting drug users experience.

There are many ways members of the general community, medical professionals and injecting drug users themselves can work together to bring about beneficial change for the drug using community and thus the community and society as a whole.
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Notes
“Why wouldn’t I DISCRIMINATE AGAINST ALL OF THEM?”

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