The impact of stigma by association on workplace outcomes

A study of the alcohol, tobacco and other drugs workforce

WHAT IS STIGMA

Stigma is the process of "social spoiling"', whereby individual or group status is tarnished.[1] It is based on and upheld by stereotypes, assumptions, preconceptions and generalisations.

The stigma that is experienced by people who use alcohol, tobacco and other drugs (ATOD) is profound and underpins, or otherwise contributes to, many of the harms of ATOD use. The particular form and trajectory that stigma takes varies by substance and by the method of consumption. Importantly, it is shaped by the specific historical and contemporary social meanings that adhere to the substance in question.[2] The stigma of injecting drug use, for example, is closely tied to criminalisation and the War on Drugs, as well as social taboos on "circumvention of the body's normative points of entry and egress".[3] By way of contrast, the stigma of alcohol dependency lies in the perception of a failure to adhere to the alcohol industry's exhortation to "drink responsibly".[4] The line between acceptable and unacceptable forms of drinking and, indeed, acceptable and unacceptable forms of drunkenness, constantly shifts and can be highly dependent on factors such as location, age, gender, ethnicity and socio-economic status.[5] For the stigmatised individual there are a range of implications, including, but by no means limited to, marginalisation, social exclusion and alienation from vital services including healthcare.[6]

'The problems faced by stigmatized persons spread out in waves of diminishing intensity among those they come in contact with'.[1]

WHAT IS STIGMA BY ASSOCIATION

While the stigma that people who use ATOD experience is significant and must be addressed in its own right, it's worth noting that substance-related stigma can, to some extent, adhere to those who are connected to someone using ATOD. This may be a genuine connection (for example, a family member) or a perceived connection (for example, someone of a shared cultural background).[7] Sometimes referred to as "courtesy stigma"[8] or "secondary stigma",[9] stigma by association refers to "discrimination or prejudice experienced by individuals who are associated with people who are stigmatised, even though they do not possess the stigmatised attribute or identity themselves".[10]

There is growing recognition that healthcare professionals who work with a) people who live with stigmatised conditions, such as people with HIV or those experiencing certain mental health conditions, or b) people from stigmatised communities, such as sex workers, may experience a form of stigma by association. A 2024 study by Brener et al.[10] explored stigma by association amongst the Australian ATOD workforce and found that those who experienced more stigma by association also, perhaps unsurprisingly, reported poorer workplace wellbeing, higher burnout and greater intentions to leave the sector. Contrary to expectations, however, the experience of stigma by association was unrelated to job satisfaction. A key finding of the study was that lived experience did not act as a protective factor, unlike earlier findings from the mental health sector.[10, 11]

We sought to explore how stigma by association affects the ATOD workforce in the ACT. We hypothesised that while lived experience may not be protective, as per the findings from Brener et al., having a peer identity and being in a specified peer role might reduce the experience of stigma by association.

The stigma by association measure, developed by Brener et al.,[10] along with a range of demographic questions and workplace outcome measures were included in the most recent ACT Alcohol, Tobacco and Other Drugs Sector Workforce Profile. The Workforce Profile Workers' Survey was rolled out across the ACT ATOD sector between November 2024 and January 2025. A total of 190 valid surveys was collected from a potential pool of 400 workers employed across government and non-government ATOD services. After removing missing values and checking for outliers, 130 cases remained.

Respondents were asked whether they identified as someone with lived or living experience and whether they were in a specified ATOD peer role. Workplace wellbeing and satisfaction were examined through measures of wellbeing,[12] burnout,[13] intention to leave organisation/sector,[14] and job satisfaction.[15] Single item measures were used, where validated, as a pragmatic concession to the length of the survey (84 questions). The stigma by association measure was randomised in online versions of the survey delivered via Qualtrics. Data was analysed using SPSS by researchers at the Alcohol, Tobacco and Other Drug Association ACT (ATODA).

	1	2	3	4	5	6	7	8	9	10	11	12
1.Age												
2.Gender	-.094											
3.Education	.057	.188*										
4.Lived experience	-.004	.021	.325**									
5.Peer work role	.088	.193*	.184*	.241**								
6.Direct client contact	.053	.118	.062	.016	.131							
7.Overall wellbeing	.120	-.152	.283**	.213*	.125	-.088						
8.Burnout	-.080	.224*	-.040	.005	.000	.051	-.569**					
9.Intention to leave org	-.094	0.124	.042	.110	.070	-.012	-.228**	.603**				
10.Intention to leave sector	-.078	.165	.113	.177*	.097	.064	-0.136	.551**	.716**			
11.Job satisfaction	.010	-.116	.055	-.016	-.077	.138	.381**	-.602**	-.714**	-.500**		
12.Stigma by association	-.113	.141	.000	-.092	-.285**	-.076	-.163	.304**	.236**	.275**	-.192*	

*Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.01 level (2-tailed).

Age of worker

Mean age of workers in the sector - a slight increase since this data was first collected in 2006

42.7

Gender identity

Approximate proportion of respondents who identify their gender as 'woman'

76.2%

Highest education

Percentage of the workforce that has a Bachelor's degree or higher

58.5%

Lived & living experience

Percentage of the workforce with some form of lived experience

69.2%

Peer workforce

Percentage of survey respondents that are in peer work roles

11.5%

Direct client contact

Percentage of the workforce in direct client contact roles

78.5%

Overall wellbeing	r = -.163*	p = .063*	Weak, non-significant trend; higher stigma by association weakly linked to lower **wellbeing**
Burnout	r = .304**	p = <.001	Higher stigma by association is correlated with higher **burnout**
Intention to leave organisation	r = .236**	p = .007	Higher stigma by association is correlated with higher **intention to leave organisation**
Intention to leave sector	r = .275**	p = .002	Higher stigma by association is correlated with higher **intention to leave sector**
Job satisfaction	r = -.192*	p = .029	Higher stigma by association is correlated with lower **job satisfaction**

A MEASURE OF STIGMA BY ASSOCIATION[9]

Please indicate how strongly you agree with these statements...

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I feel stigmatised by other health professionals because I work in the ATOD sector	o	o	o	o	o
I feel stigmatised by the general public because I work in the ATOD sector	o	o	o	o	o
Other health professionals look down on me because I work in the ATOD sector	o	o	o		
The general public looks down on me because I work in the ATOD sector	o	o	o		
The ATOD sector is seen as less important than other medical fields or social services	o	o	o		
People think I should advance my career by moving out of the ATOD sector	o	o	o		
I have experienced discrimination from other health professionals because I work in the ATOD sector	o	o	o		

The findings suggest that addressing stigma by association would be particularly effective in improving those workplace outcomes that we know are directly linked to retention, including burnout, intention to leave and job satisfaction.

In line with earlier findings, lived experience does not appear to be a strong protective factor for workers exposed to possible stigma by association. However, when we add the element of peer specified roles, the correlation is stronger. Being a peer worker is associated with reduced experiences of stigma by association. Given relatively small numbers of peer workers in the ACT ATOD sector, these findings should be interpreted cautiously. What it does suggest, is that the peer work role itself or the training that peer workers undertake during induction to their role, creates an important buffer to stigma by association. Peer work frames lived experience as a valuable form of expertise, on par with other forms of knowledge and expertise that may contribute to addressing the needs of service users. This "repositions a commonly stigmatised and discriminated attribute as one of core strength, and provides a meaningful pathway for people who have significant experiences in the area to reframe their entire life as something valuable, knowledgeable and positive".[15]

ATODA Alcohol Tobacco & Other Drug Association ACT

Authors: Elisabeth Yar, Anke van der Sterren, Ava Gajdatsy, Anita Mills

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