

A New Pair of Glasses; Changing Our Perceptions...

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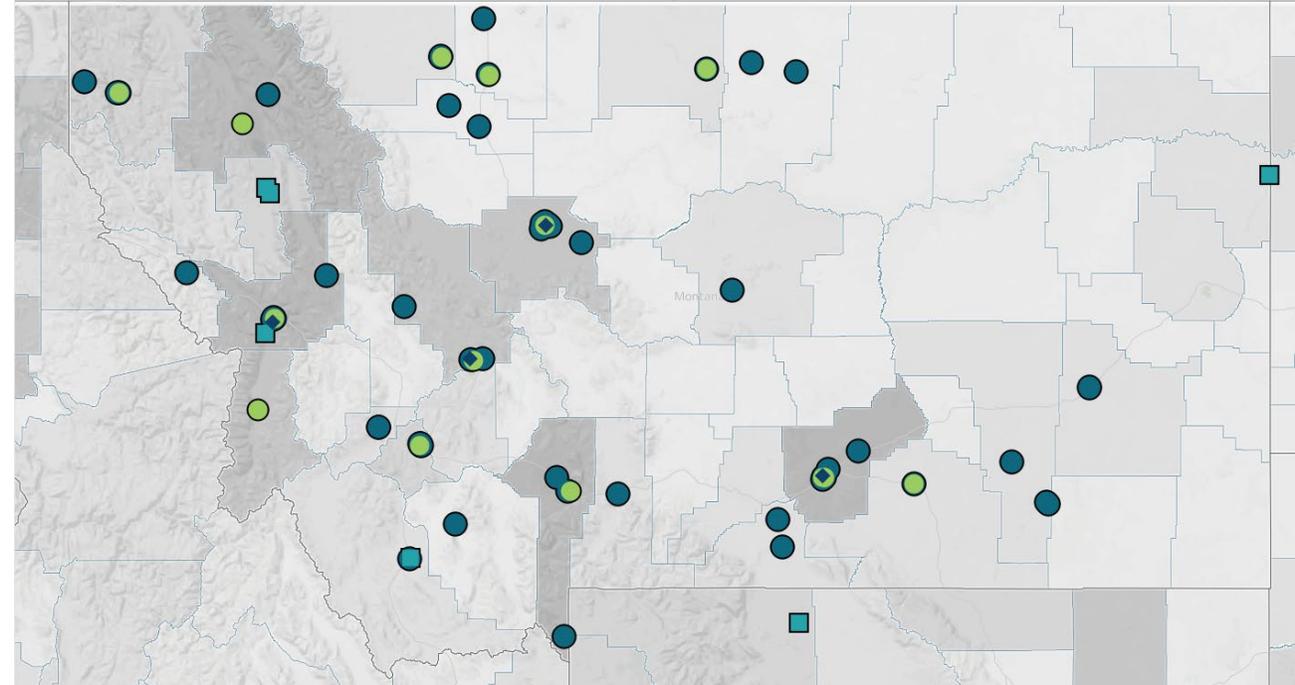
MPCA

The **Mission** of the Montana Primary Care Association is to promote integrated primary healthcare to achieve health and well-being for Montana's most vulnerable populations.

The **Vision** of MPCA is health equity for all Montanans.

MPCA values integrity, collaborations, and innovation.

The Montana Primary Care Association is the support organization for Montana's 14 Community Health Centers and 4 of our Urban Indian Centers. MPCA centers serve over 117,500 patients across Montana.

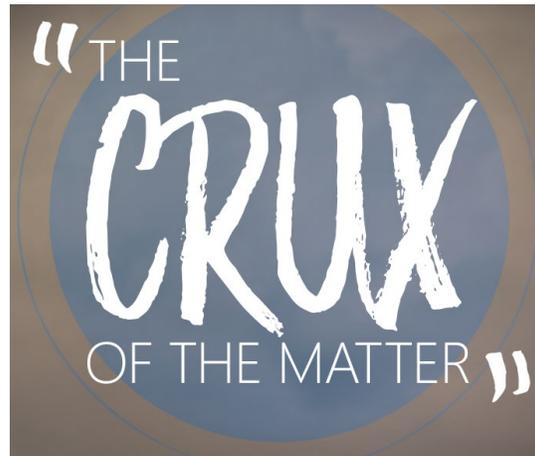


No Disclosures

This training is supported by SOR funds through BHDD from SAMHSA

We offer a multitude of training for SUD, MOUD, healthcare workers, front line workers, providers, clinicians, etc., and have found over and over again that...

...stigma is the crux of the matter....



Agenda

What is Bias and What Does it Matter?

- How we become biased and how biases impact patient care

How did we get here?

- Gain awareness of how substance use has been a thorny public health concern throughout human history
- Understand Substance Use as a public health issue and Substance Use Disorders as Chronic Illness

Recognizing Stigma and How it Plays to Negative Outcomes

- Realize stigma as a major barrier to individuals' access to care
- Understand the negative effects on providers

Language

- Identify stigmatizing language that supports negative attitudes that can lead to intentional and unintentional stigma and discrimination

Bias Mitigation Strategies



Getting Here and Grounding



You are Not Alone

Prevalence of Past Month Substance Use: Persons Aged 12 or Older (2020)

<i>Substance</i>	<i>Female</i>	<i>Male</i>
Tobacco	16.5%	25.1%
Alcohol (current drinkers)	47.6%	52.6%
Illicit Drugs	12.1%	14.9%

Source: Center for Behavioral Health Statistics and Quality. (2020). Results from the 2019 National Survey on Drug Use and Health: Detailed tables. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>



Untreated Drug and Alcohol Use

Over 107,000 individuals died of drug poisoning in 2021, (CDC)

Only 6.5% of the 41.1 million people with SUD received necessary treatment. (2020 National Survey on Drug Use and Health)

Imagine the outrage if only 10% of people that suffered a heart attack received access to evidence-based care



Roughly 1 U.S. Drug Poisoning Death Every 5 Minutes



Stereotype

Widely held, but fixed and oversimplified image or idea that can lead to **bias**



EXPLICIT BIAS

Explicit Bias

Conscious
Speaks of it
Learned

Can result in micro-aggression

I say it out loud, I believe it, I know it, it is fact!



IMPLICIT BIAS

Implicit Bias

Develops early in life from repeated social stereotypes

Occurs without conscious awareness and is often in conflict with our personal beliefs

Even though we may actively reject these negative ideas and images, they may unconsciously affect our understanding, actions and decisions



Implicit bias is associated with negative health outcomes

- ✓ *Affect Patient/Provider relationships – Patients will not return for follow up appointments, patients may not contact healthcare provider to report changes in their health.*
- ✓ *Patients can sense biases from healthcare providers (verbal or non-verbal)*
- ✓ *Providers biases may tell them patients do not have the needed health literacy to engage in their healthcare. This may limit referrals to specialists.*
- ✓ *NOTE: NOT INTENTIONAL BY ANY PROVIDER (unconscious biases)*

What elements are needed to build positive relationships?

Trust

Respect

Accuracy



Blind Spots

Our lived experiences are limited and can create “blind spots” we all have blind spots

We may experience challenges recognizing patient vulnerabilities, particularly if our lived experience is largely from socially dominant, privileged spaces.

*Blind spots can be exacerbated by negative messages we have received about certain identities and stored unconsciously, resulting in **Implicit Bias**.*



When Stereotypes and Bias are not Addressed...Can Lead to Stigma Which Can Lead to Discrimination

Withholds treatment

Withholds medication

Housing

Ability to get a job

Ability to get insurance

Ability to keep a family together



Micro-aggression

Experiences of micro-aggressions have been associated with anger, mistrust, loss of self-esteem, the triggering of old wounds, thinking about and replaying the event;

“Did that really happen?”,

and triggering feelings of internalized colonization, racism and homophobia, stress, self-doubt, frustration, isolation, and shame. (Solórzano et al, 2000)



How Do Biases/Discrimination play a role?

- ❖ *Social and Health care providers are committed to providing the best care possible to all clients/patients*
- ❖ *Reducing disparities and inequities are shared responsibilities and as such, we must identify and address all possible contributing factors*
- ❖ *Implicit Bias is one of those factors*
- ❖ *We all have bias. This bias is rooted in:*
 - ❖ *Our privilege*
 - ❖ *Our worldview*
 - ❖ *Our upbringing and socialization*





The Fatal Attraction

Substance Use

To understand the pain connected with addictive behavior, one must first understand the pleasure side of these activities.

“The culture of drink endures because it offers so many rewards: confidence for the shy, clarity for the uncertain, solace to the wounded and lonely”.

Pete Hamill (1994) “A Drinking Life”



Nora Volkow (2010) states when asked... "Why do people take drugs?"

*"First, they take drugs to feel **good**, to enhance their sense of pleasure. "For example, with stimulants such as cocaine, the high is followed by feelings of power, self-confidence, and increased energy. In contrast, the euphoria caused by opiates such as heroin is followed by feelings of relaxation and satisfaction. Second are people who suffer from anxiety and stress-related disorders. They maybe attracted to intoxicants to feel **better**. The third temptation to use drugs is to **do better**, such as to enhance athletic or work performance."*



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Substance Use Disorders (SUD) are Chronic Illnesses

“From a neurobiological perspective, drug addiction is a disease of the brain, and the associated abnormal behavior is the result of dysfunction of brain tissue.”

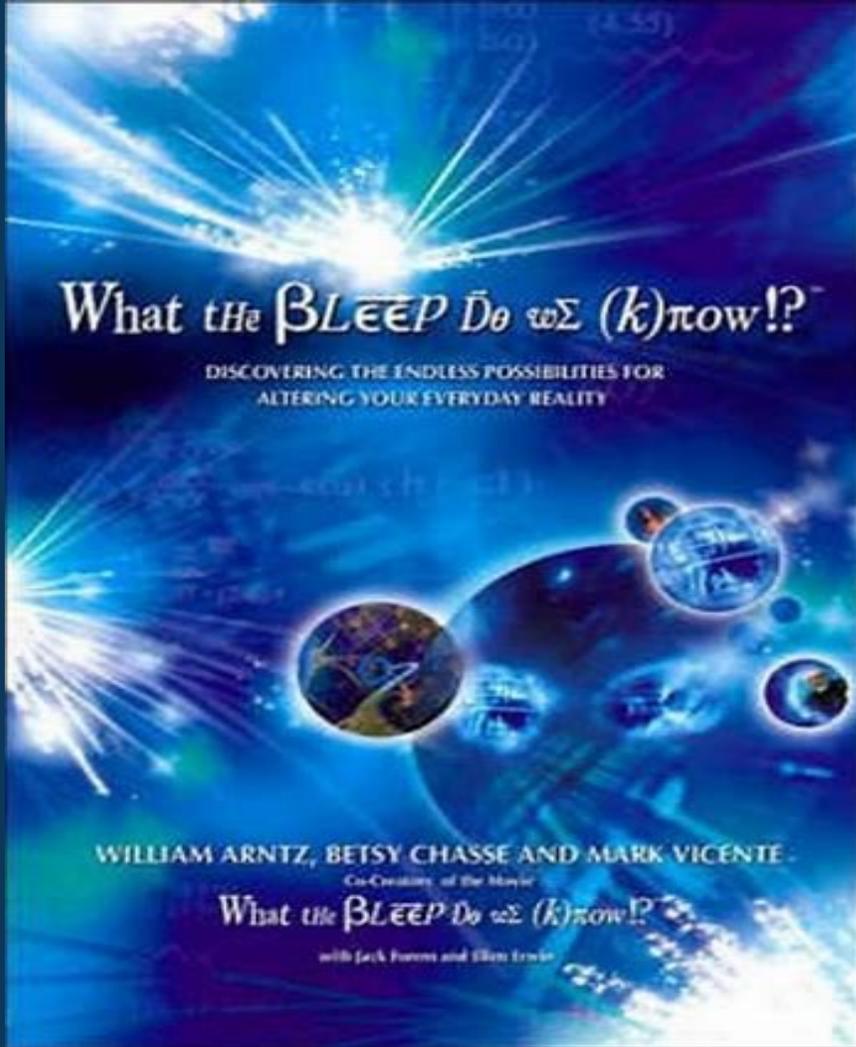
~Christopher Cavacuiti –
“*Principles of Addiction Medicine: The Essentials*”



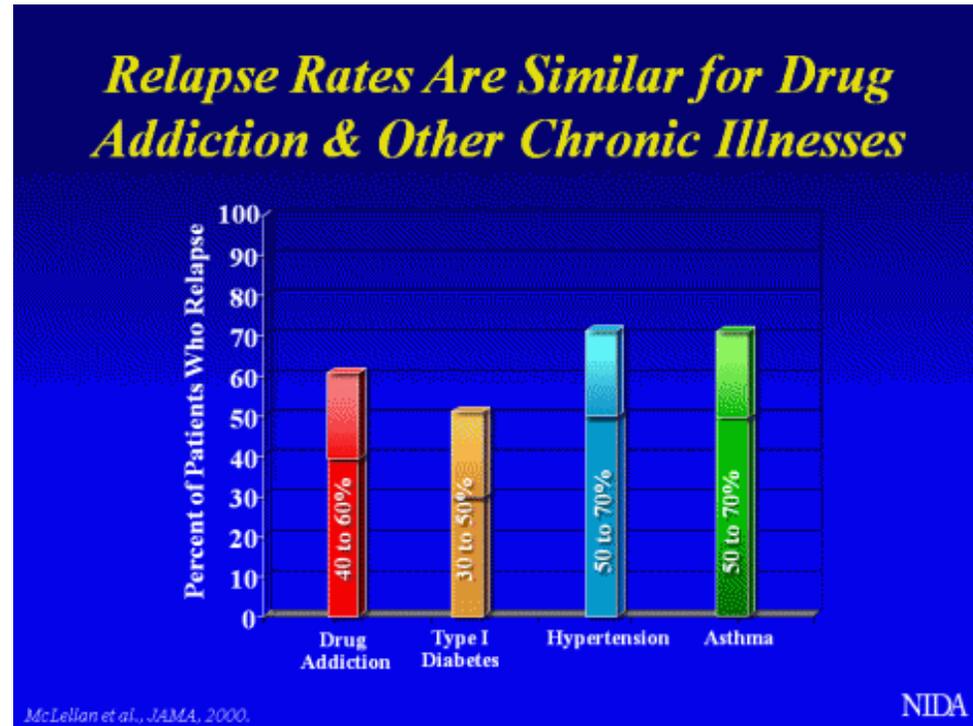
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Chronic Disease

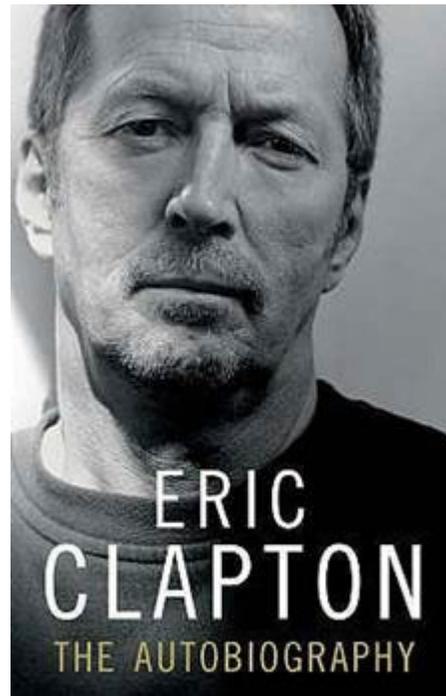


Rates of reoccurrence and recovery in the treatment of addiction are very similar to those of other chronic medical diseases



The Hijacked Brain

In my lowest moments, the only reason I didn't commit suicide was that I knew I wouldn't be able to drink any more if I was dead.



ERIC CLAPTON, *Clapton: The Autobiography*



The idea that somehow, someday he will control and enjoy his drinking is the great obsession of every abnormal drinker.” p.30

Big Book of Alcoholics Anonymous



How Did We Get Here?

BRIEF HISTORY OF SUBSTANCE USE IN THE US



1600s – 1700s



The issue of loss of control of substance use was discussed in some publications (1600s)

Sobriety Circles (1700s)

http://www.williamwhitepapers.com/addiction_history_briefs/



1800s

Inebriety Asylums – 1864 New York State

1879 – Dr. Leslie Keeley announces, “Drunkenness is a disease, and I can cure it” (the beginning of franchised, private, for-profit institutes in America)

Freud recommends cocaine and morphine to treat alcoholism

1890s Sears & Roebuck Catalogue syringe & small amount of cocaine \$1.50

http://www.williamwhitepapers.com/addiction_history_briefs/





OPIUM—THE POOR CHILD'S NURSE.

Cartoon from *Harper's Weekly* depicts how opiates were used in the 1800s to help babies cope with teething.

1900- 1959

State laws passed (1907-1913) calling for mandatory sterilization of “defectives”: the mentally ill, the developmentally disabled, and “alcoholics and addicts

1914 The Harrison Narcotics Tax Act

The first federal “narcotics farm” (U.S. Public Health Prison Hospital) [1935]

The book, Alcoholics Anonymous, is published [1939] (Note: Medications for SUD and MH were not utilized at this time)

AMA first defines alcoholism as an illness. Recognizes “alcoholics” as legitimate patients. Hospitals urged to consider admissions [1956]

American Hospital Association passes resolution to prevent discrimination [1957]



The end—and the beginning. A. A.'s will not help a drunk unless he admits liquor has licked him as thoroughly as the man in this scene.

Deflagging. Called to a hospital bedside, A. A.'s will come any time of the day or night, because they help themselves by helping a dipsomaniac.

In Akron, as in other manufacturing centers, the groups include a heavy element of manual workers. In the Cleveland Athletic Club I had luncheon with five lawyers, an accountant, an engineer, three salaried men, an insurance man, a buyer, a bartender, a chain-store manager, a manager of an independent store and a manufacturer's representative. They were members of a central committee which coordinates the work of nine neighborhood groups. Cleveland, with more than 450 members, is the biggest of the A. A. centers. The next largest are located in Chicago, Akron, Philadelphia, Los Angeles, Washington and New York. All told, there are groups in about fifty cities and towns.

Self-Insurance Against Demon Rum

IN DISCUSSING their work, the A. A.'s spoke of their drunk-rescuing as “insurance” for themselves. Experience within the group has shown, they said, that once a recovered drinker slows up in this work he is likely to go back to drinking, himself. There is, they agreed, no such thing as an ex-alcoholic. If one is an alcoholic—that is, a person who is unable to drink normally—one remains an alcoholic until he dies, just as a diabetic remains a diabetic. The best he can hope for is to become an arrested case, with drunk-saving as his insulin. At least, the A. A.'s say so, and medical opinions tends to support them. All but a few said that they had lost all desire for alcohol. Most serve liquor in their homes when friends drop in and they still go to bars with companions who drink. The A. A.'s tippie on



One-hundred-per-cent. effectiveness with non- In Chicago, twenty-five doctors work hand in



1960s

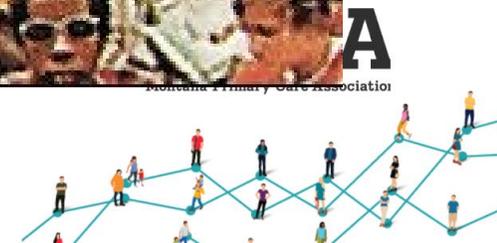
Two federal Appeals Court decision support the disease concept [1966]

The American Medical Association passes resolution identifying alcoholism as a “complex disease that merits the serious concern of all members of the health professions” [1967]

President Johnson address’ nation...“The alcoholic suffers from a disease which will yield eventually to scientific research and adequate treatment.” [1968]

Insurance industry begins to reimburse treatment, which lead to expansion in private and hospital-based inpatient programs [1964-1975]

Silos



1970s

Congress passes the “Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act [1970]

Legislation establishes the National Institute on Alcohol Abuse and Alcoholism (NIAAA) [1970]

Methadone is approved by FDA for detoxification [1970]

FDA approves Narcan (1971).



American College of Internal Medicine includes alcoholism questions on board examinations

Methadone is approved by FDA for maintenance

1971

1973

1973

1973

U.S. first describes fetal alcohol syndrome

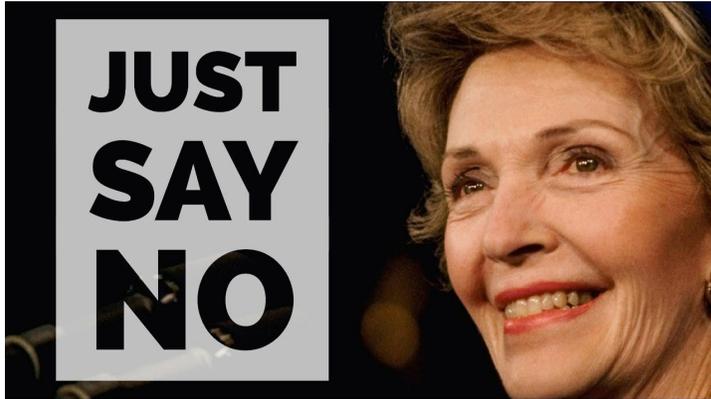
Drug Enforcement Administration (DEA) created





Stigma designated the person as being of less value than you, even perhaps, an “enemy” (Nixon declares war on drugs 1971).

1980s



Federal Block Grant Program transfers responsibility for the delivery of treatment and prevention services to the states. [1981]

Anti-Drug Abuse Act authorizes \$4 billion to fight drugs, primarily through law enforcement (1986)

President Reagan formally announces a renewed "War on Drugs"; the shift away from treatment toward punishment and incarceration intensifies [1987]

- Erosion of treatment reimbursement benefits by insurance
- All but eliminates the 28-day inpatient treatment programs



1990s

President Clinton includes a treatment benefit for “alcoholism” and other addictions in his national health care reform proposal [1993]

Naltrexone approved for alcoholism (1994).

OxyContin launched (1996)

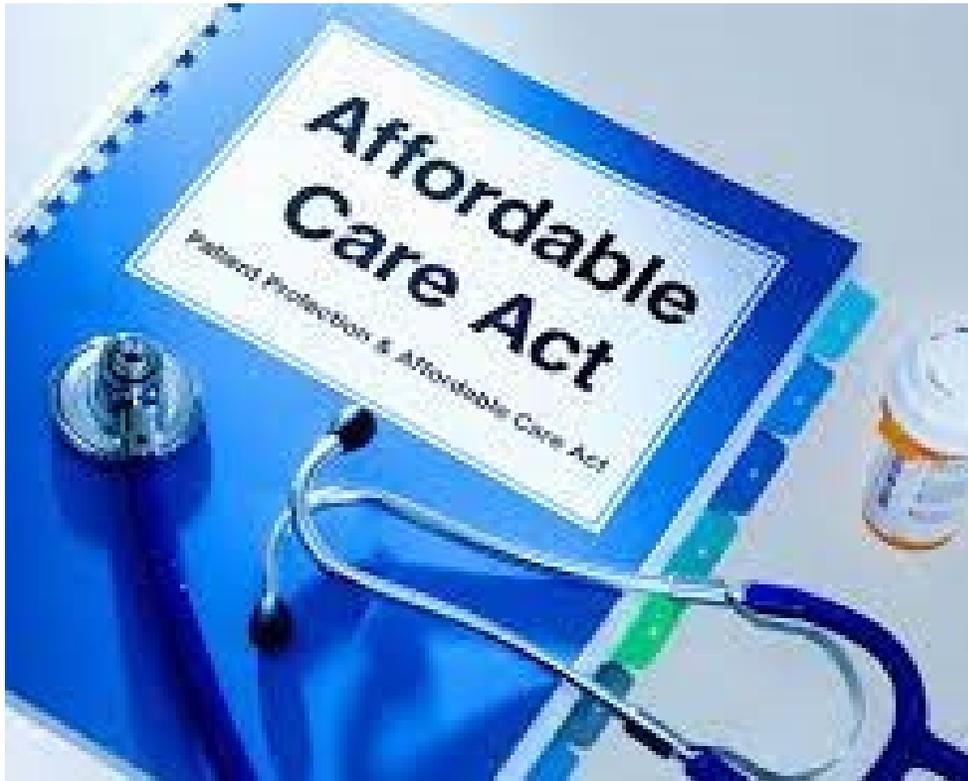




Pain as 5th Vital Sign (1999)

Pain recognized as the fifth vital sign, giving pain equal status with blood pressure, heart rate, respiratory rate and temperature as vital signs.

2000-2010



Drug Addiction Treatment Act of 2000 (DATA 2000) allows qualified physicians to offer Office Based Opioid Treatment (OBOT)

FDA approves buprenorphine for clinical use. (2002)

The Mental Health Parity and Addiction Equity Act (MHPAEA) passed. This act required insurance companies and group health plans to provide similar benefits for mental health and/or substance use treatment and services as other types of medical care. [2008]

AMA recommends that pain be removed as a “fifth vital sign” [2009]

The Affordable Care Act (ACA) expanded coverage for addiction treatment (2010).



2010 - Present

Comprehensive Addiction and Recovery Act (CARA) Allows Nurse Practitioners and Physicians Assistants to become eligible to prescribe Buprenorphine for treatment of Opioid Use Disorders (2016)

Opioid epidemic declared a national public health emergency [2017]

Support for Patients and Communities Act signed- directs funding to make access to addiction treatment a priority [2018]

U.S. Opioid Poisoning Deaths Top 107,000 a Year as Opioid Crisis Worsens (2021)

Still...EVERY FIVE MINUTES SOMEONE IS DYING FROM AN OPIOID POISONING

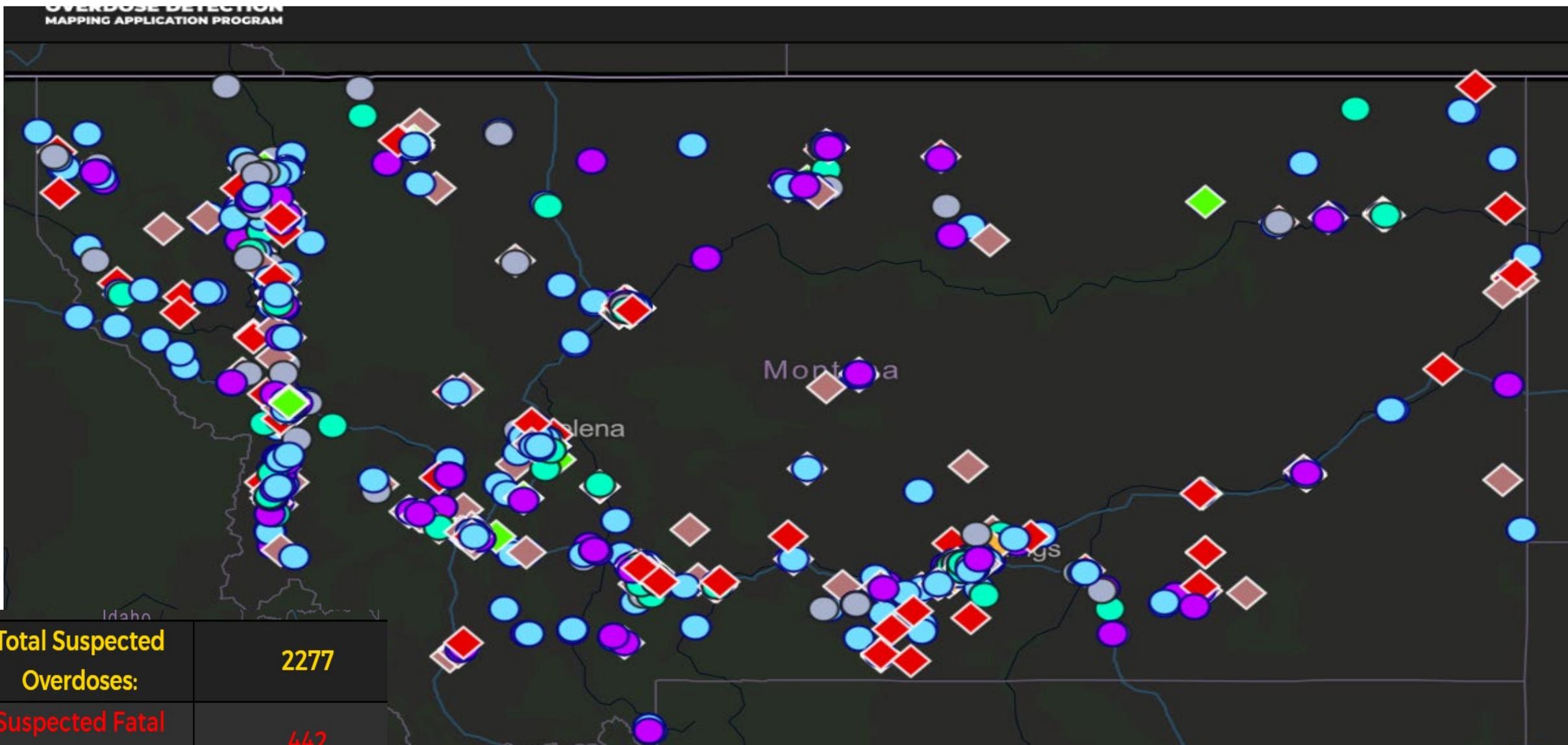


What did we just talk about?

- Prevalence of Substance Use -Alcohol #1 substance used
- 107,000 deaths in 2021 (CDC) from Opioid Poisoning – 1 death every 5 minutes
- Stereotyping can lead to bias, which can lead to discrimination
- Know your biases and blind spots – Robert’s case
- Substance Use Disorders are chronic illnesses that can be treated
- Our history of treating substance use is long and slow, yet we are making progress
- Treating Opioid Use Disorders with Medication



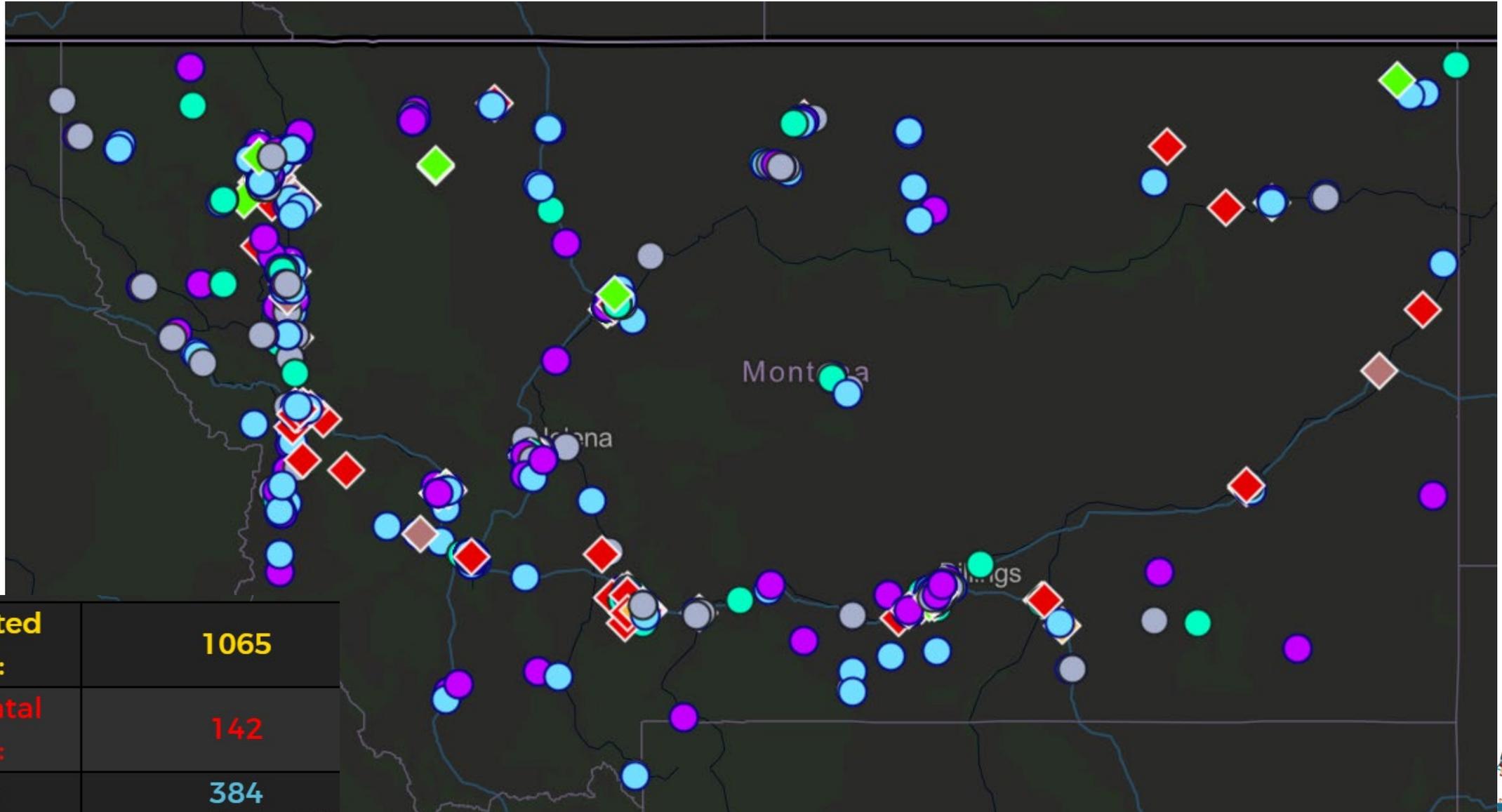
MT OD Map Jan 1, 2020 – Dec. 31, 2022



Total Suspected Overdoses:	2277
Suspected Fatal Overdoses:	442
Naloxone:	796



January 2023 - Yesterday



**Total Suspected
Overdoses:**

1065

**Suspected Fatal
Overdoses:**

142

Naloxone:

384

Why provide treatment for OUD – National Stats

2.5 million Americans are addicted to opioids

1999 - .3 per 100,00 O/D Deaths
2019 - 11.4 per 100,000 Deaths

519.38% increase from 1999 to 2019

Cost to society of \$1.02 trillion in 2017 (CDC)

71.8-80% of overdose deaths involve opioids



Why provide treatment for OUD – MT. Stats

45.7% of overdose deaths involve opioids – 4th Leading Cause of Death

Unintentional deaths increased 39% in 2019-20. These were the majority.

.15% of hospital births are cases of NOWS

Enough rx. are written for 50.6 % of residents to have one. This follows a 21% decrease in rx 2014-19



Why Provide MOUD?

Treating OUD with medication is 5-10 times more effective than treating OUD without medication.

There are few medical interventions that have this level of effectiveness.

By treating OUD, you can prevent deaths and give people the stability to get back their lives that have been devastated by their OUD.

MAT to MOUD – A Change in Perspective

“Strong scientific evidence unequivocally shows that for opioid use disorder, **medication is the essential component of treatment**, not merely one component.” It is not “assisted treatment”. Behavioral treatment can be helpful when the person is ready.





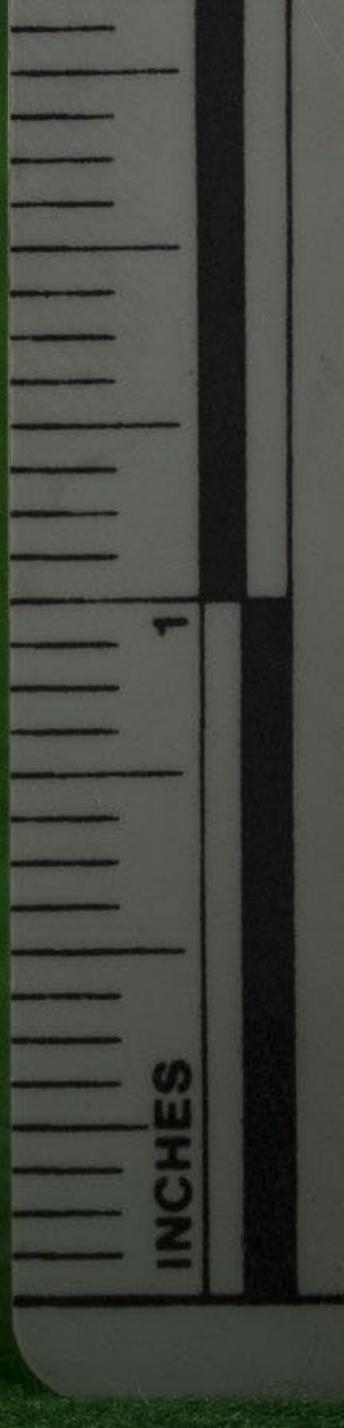
HEROIN



FENTANYL

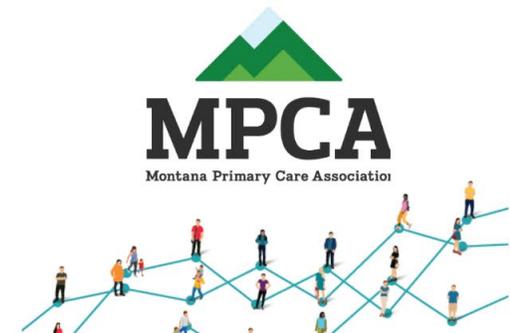
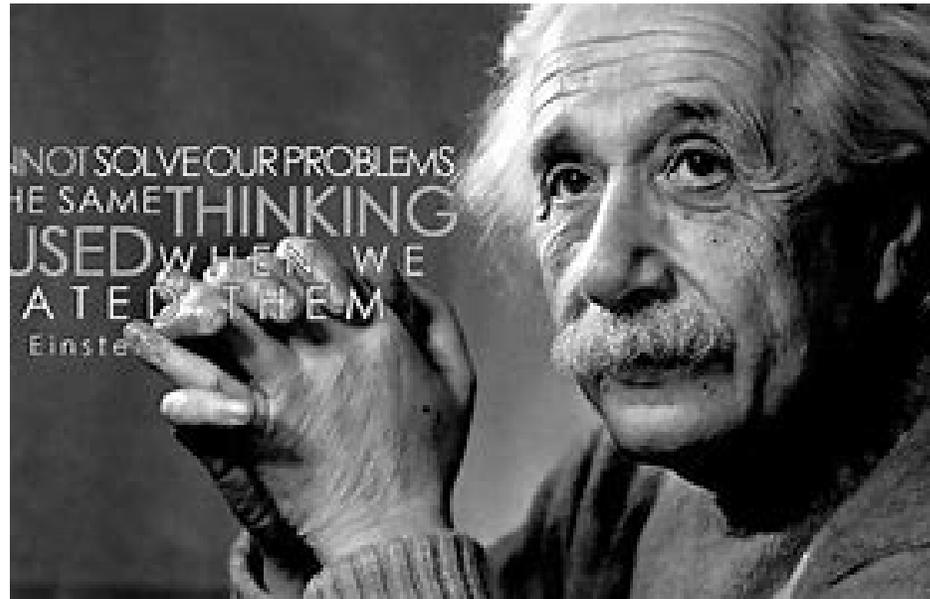


CARFENTANYL



INCHES

1



MYTH

MOUD is trading one addiction for another

FACT:

Using MOUD does not create a high. They are eliminating their usage of drugs of abuse and the medication facilitates the mental and emotional stability required for participating in other aspects of recovery.



MYTH

MOUD is only
for short term
treatment

FACT:

People can and should remain on medications for as long as the medication is effective. For some this could be a year, for others a lifetime. There is no evidence to support benefits from stopping MOUD.



MYTH
MOUD
increases
overdose risks
for patients

FACT:

MOUD is the most effective intervention for treating opioid use disorder. The reductions in harmful opioid use are significant compared to approaches that don't use medication, and reduced use in turn leads to reduced risk of overdose.



MYTH

MOUD only delays and disrupts true recovery.

FACT:

MOUD has been shown to assist patients in recovery by improving quality of life, level of functioning, and the ability to handle everyday events.



MYTH

Pregnant
women can't
receive MOUD

FACT:

The American College of Obstetricians and Gynecologists (ACOG) specifies that MOUD is the recommended treatment for pregnant women with an opioid disorder.



MYTH

Cold Turkey is
better than
MOUD

FACT:

Going cold turkey also has the disadvantage of doing nothing to address drug cravings. A central component of MOUD is satisfying the brain's need for opioids and quieting urges to abuse drugs, making it significantly easier to abstain from drugs of abuse.



MYTH

MOUD is trading one addiction for another

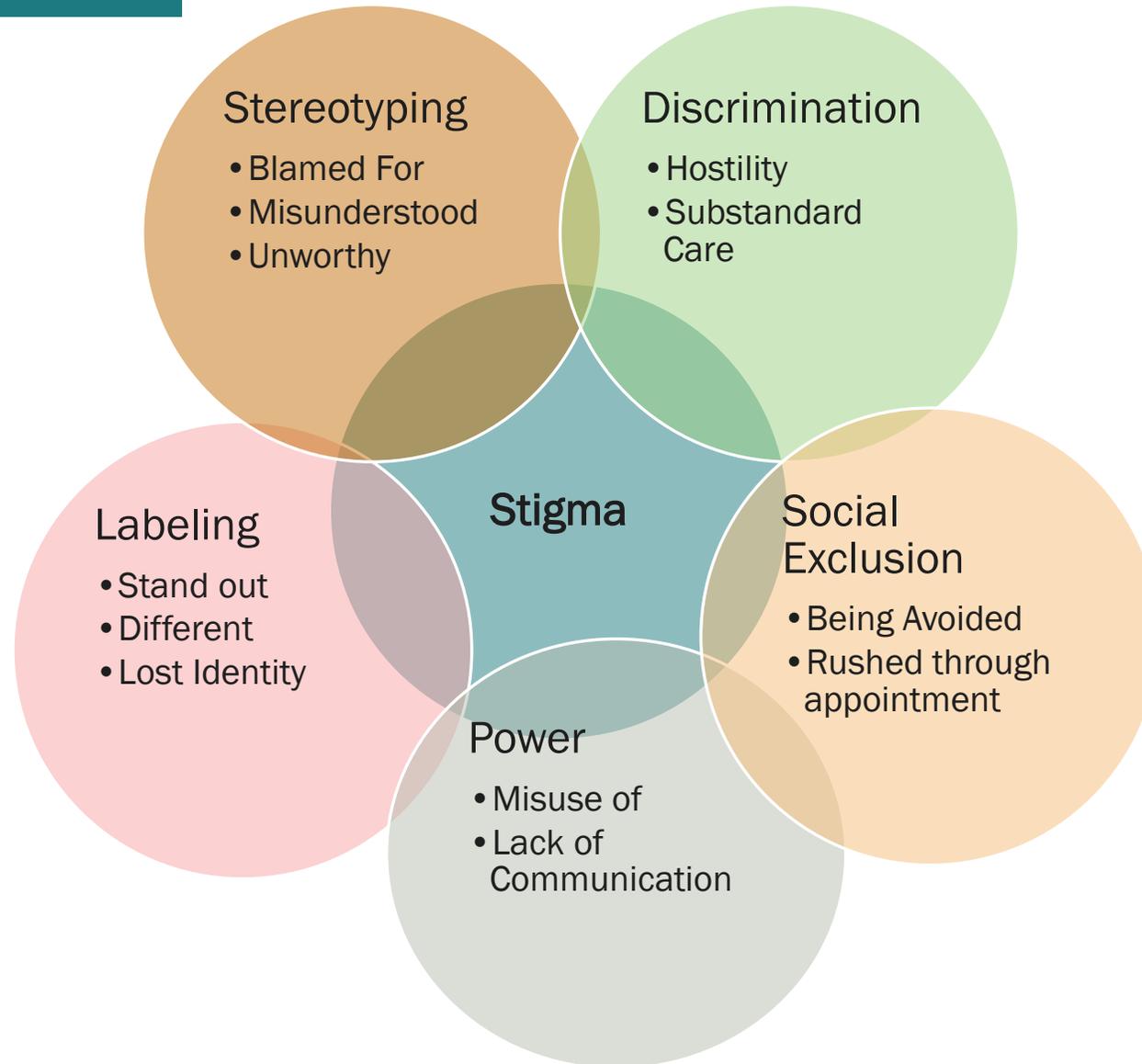
FACT:

Using MOUD does not create a high. They are eliminating their usage of drugs of abuse and the medication facilitates the mental and emotional stability required for participating in other aspects of recovery.



Stigma

Stigma assumes many forms. It appears as prejudice, discrimination, fear, shame, distrust, and stereotyping.



Social Stigma



Social stigma manifests as the disapproval of a person because they do not fit the required social norms that are given in society



Media using sensational or fear-based language



Self-Stigma



Perhaps the most malignant trigger for an individual to have a reoccurrence is the guilt and shame that they have about the harm they might have caused to others and to themselves



Self-Stigma

Becoming aware of stigmatization	“Society thinks that people who use drugs are bad”
Agreeing with public stereotypes and prejudice	“They’re right”
Self-application	“I have this condition; therefore, I am a bad person/mother”
Decrease in self-esteem and self-efficacy	“Why should I even try”

(Adapted from Recto et al, 2020)



Pre/Peri Natal and Complex Stigma

Mothers with SUDs perceive stigma throughout the perinatal period from:

- Healthcare Providers
- General Public
- Loved Ones
- Themselves
- Addiction Community

Frazer, McConnell, Janssen, 2019; Paterno, Low, Gubrium, Sanger, 2019)

Time Frame	Perception
Preconception	You shouldn't have a baby
Prenatal	You are hurting your baby
Postpartum	You can't care for your baby



Pre/Peri Natal and Complex Stigma

Mislabeled

- “Crack babies”

Misinformation

- “Babies are born addicted”
 - Infants may experience withdrawal symptoms from exposure to maternal substance use and abuse, BUT they are not born addicted.
 - American Society of Addiction Medicine describes addiction as a “treatable, chronic medical disease involving *complex interaction among brain circuits, genetics, the environment, and an individual’s life experiences*. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.” (ASAM, 2019)
- “MOUD should not be used during pregnancy/ breastfeeding”
 - Our best evidence reports safety of use in the perinatal period



Justice System

Courts – it has taken the judges some years to recognize the importance of evidence-based care. For many years when patients were ordered into treatment the judge would tell them to come off buprenorphine or not to start it.

Law Enforcement – powerfully impacted and overwhelmed by drug poisoning and crime. Local PD and County Sheriff's need support and education

Jails – slowly beginning to introduce buprenorphine, however it is with a high level of resistance.



Stigma and the Opioid Epidemic

Because stigma caused the slow response to the opioid epidemic, people with opioid and other substance use disorders have spiraled further down into homelessness, incarceration, unemployment, broken families and death. The struggle to find adequate care for our patients is a case management challenge (nightmare!) – piecing together a patchwork of care.



MOUD Stigma

A MAT program patient recently shared about Suboxone in a local NA meeting and someone in the group suggested that they no longer share because they are on suboxone and not “clean”.

The discussion of tapering off of buprenorphine with providers and counselors is often couched in the context of not being viewed as abstinent. Or in the context that the patient is using a “crutch”.



Stigma and Health Care

View patients with SUDs differently

Have lower expectations for health outcomes

Perceived Control

Perceived Fault

Individuals are suffering in the shadows because they are afraid to go to medical for help



Stigma and Health Care

Implicitly stigmatizing terms like “addict,” “alcoholic,” “abuser,” and so on persistently are used, even in professional literature. So not surprising that the treatment gap is so wide.

Even though we are in the midst of a devastating, widely publicized opioid crisis, and despite the existence of three effective medications to treat opioid use disorder (OUD), in 2019 only 18% of people with OUD received medications to treat it.

Treatment rates for AUD are especially low (e.g., 7.6% in 2019)

There are three effective medications to treat AUD, yet in 2019 fewer than 2% of people with AUD received any of those medications .

Volkow, N.D., Gordon, J.A. & Koob, G.F. Choosing appropriate language to reduce the stigma around mental illness and substance use disorders. *Neuropsychopharmacol.* **46**, 2230–2232 (2021). <https://doi.org/10.1038/s41386-021-01069-4>



Negative Encounters With Service Providers

People with SUD report experiencing these negative encounters

Judgmental

- Sense providers' disapproval of SUD
- "Look down on them"
- Sense blame when infants experience withdrawal symptoms
- Feelings of shame, frustration, irritation and being dismissed during visits

Scrutinizing

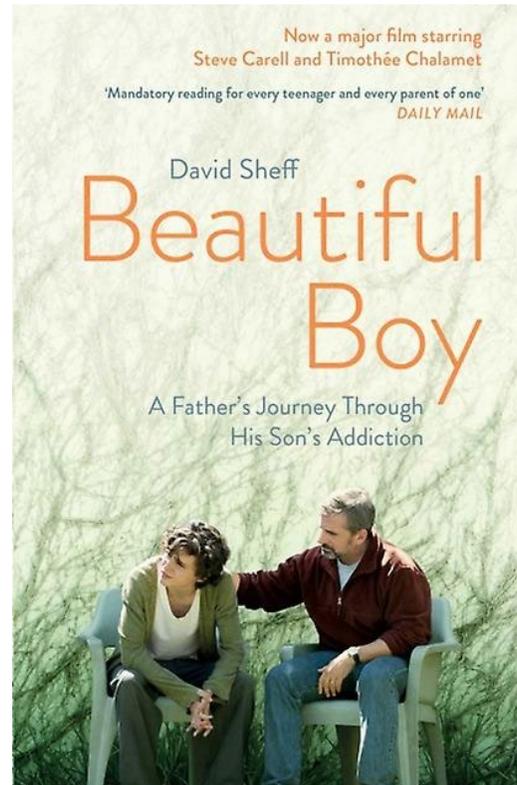
- Feel closely observed or monitored
- Identified as "Drug User"
- Causes mothers to avoid prenatal care, lie about SUD, use other women's urine for drug testing
- Feel watched for indications they were "high" when holding infants, visiting NICU, breastfeeding
- Feel questioned about ability to mother
 - Inhibits mother-infant bonding



Video - Shatterproof



Family -Stigma



Stigma Within Families

The shame around substance use disorders often starts in childhood with parents with alcohol or drug problems. This leads to early isolation and exclusion and internalized shame.

Because of shame, families tend to struggle in secret. “We are only as sick as our secrets.”

Strong parental resistance have been the reason patients decline buprenorphine and methadone treatment because of their views often informed by internet conversations, community prejudice and the fear of a new dependency.

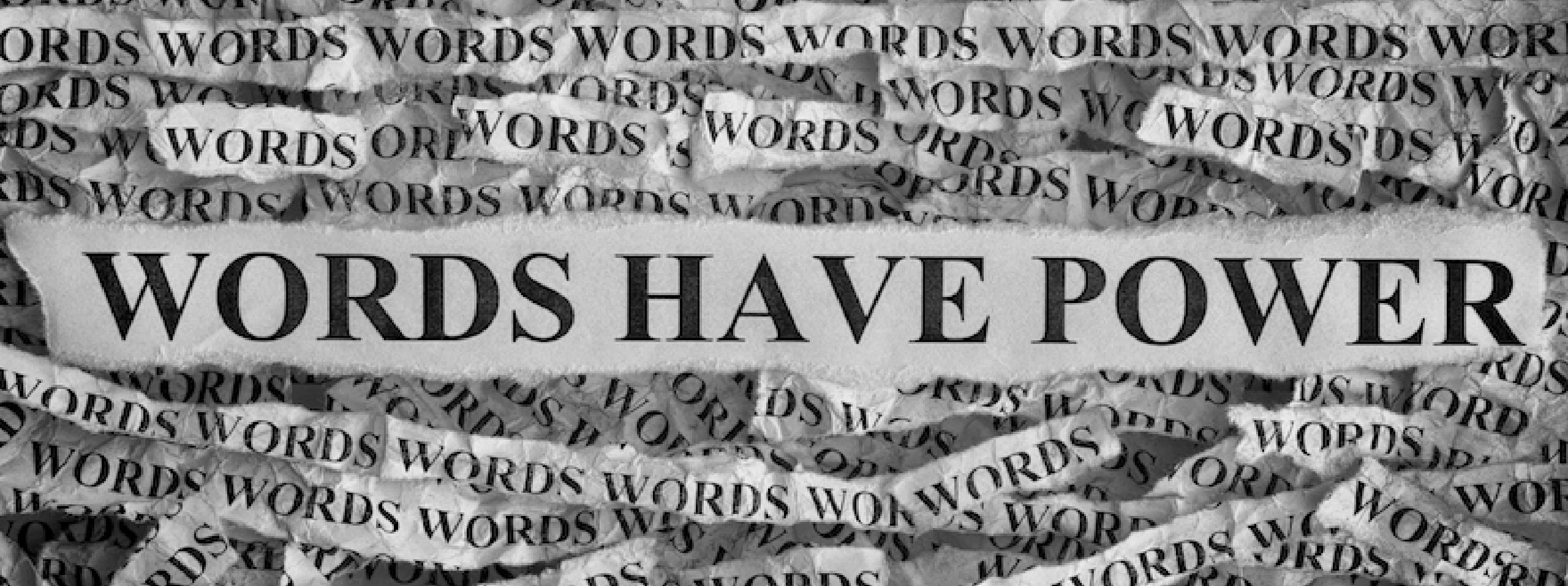
Solution: educate parents. With patient’s permission, meet with the parent and the patient to answer questions about the treatment and plan of care.



Stigma – in our thinking, attitude and behavior – summing it up

- ✓ Stigma is shaped by our **thinking** – a bias and perception that substance users are “bad” and immoral rather than ill with a chronic condition requiring care and treatment. Often there is more than one chronic condition such as mental health disorders which also require care.
- ✓ Stigma is communicated by **tone, interpersonal attitude, body language.**
- ✓ Stigma is communicated by **words.**
- ✓ Stigma becomes **internalized** by the person seeking help. The person views themselves as bad, as dirty, as weak which fuels the shame of stigma.





WORDS HAVE POWER

Non-Stigmatizing Language

Patient-Centered Care - Language plays a major role in shaping people's thoughts and beliefs – we believe what we say – harmful stereotypes & assumptions

Words Matter

“Words have power. They have the power to teach, the power to wound, the power to shape the way people think, feel, and act toward others.”

~Otto Wahl



Montana Primary Care Association



The Impact of Language

- Dr. John Kelly, Harvard-MGH Recovery Research Institute published a 2010 study & 2015 editorial in American Journal of Medicine which showed an impact on clinical care
- Trained clinicians were given identical scenarios about someone with a substance use disorder and the only thing changed was in one scenario the person was called a 'substance abuser,' and in the other scenario, a 'person with a substance abuse disorder.' Dr. John Kelly found that when you called someone a substance abuser, it elicited, even from trained clinicians, a **much more punitive response**.



Study by Recovery Research Institute

SUBSCALES COMPARING THE SUBSTANCE ABUSER & SUBSTANCE USE DISORDER DISORDER DESCRIPTIVE LABELS

■ Substance Abuser ■ Substance Use Disorder



50% of participants were in health care

20% students

29% outside healthcare

01% nothing listed

Average age 31 (range 17-68)

81% White

76% Female

50% Bachelors degree or higher



Language Matters

If we want to nurture something, we call it a flower.

If we want to kill something, we call it a weed.

~unknown



Montana Primary Care Association



Where do we go from here? Addressing Barriers



IT IS BECAUSE OF STIGMA THAT:

- * Some people don't seek out treatment
- * Some doctors won't treat people with SUDs
- * Some pharmaceutical companies won't work toward developing new treatments for individuals with SUDs

~The National Institute on Drug Abuse (NIDA)



Are you using first person language?



Why we use first person language

- A person is a person first and behavior is something that can be changed, addict or user implies that someone is “something” instead of describing a behavior
- Stigma is a barrier to care and we want people to feel comfortable when accessing services
- People are more than their drug use and harm reduction focuses on the whole person



Language & Stigma

STIGMATIZING

Addict, Alcoholic, Junkie, Abuser

Problem with the terms: It can be demeaning because the person is labeled by their illness and can imply a permanency to their condition, leaving no room for the hope of change in their condition

PREFERRED

Person with a Substance Use Disorder

First person language is the accepted standard for discussing people with a chronic medical condition. The person has, or the person with...



Language & Stigma

STIGMATIZING

Clean (When referring to recovery)

Problem with the Term: It implies that when the person was in active addiction, they were dirty, unclean and unwanted (Stigmatizing , pushing away)

PREFERRED

In remission (partial-sustained)

Remission is a medical term that describes a period of time in which signs and symptoms of the illness have disappeared and that addiction is indeed a medical condition



Language & Stigma

STIGMATIZING

Clean/Dirty (When referring to urine screen)

Problem with the terms: Treats the urine of a person with a SUD differently than a person with other medical conditions

PREFERRED

Positive/Negative for (substance)

Treats the urine of the individual with a SUD in the same way that they would any other chronic illness



Language & Stigma

STIGMATIZING

Drug Overdose

Problem with the term: Implies that the individual caused the condition

PREFERRED

Drug Poisoning

According to a CDC report, 86% of drug poisoning deaths were unintentional. Approximately 8% were suicides, while there is no precise determination of the real intent in 6% of cases.



Language & Stigma

STIGMATIZING

Relapse

Problem with the term: Can imply a moral failing as the origin of the word states that there is a return to heresy or wrongdoing

PREFERRED

Reoccurrence/Return to Use

The terms tend to be less moralizing and carry greater hope



Language & Stigma

STIGMATIZING

Medication Assisted Treatment (MAT)

Problem with the term: The term MAT implies that medication should have a supplemental or temporary role in treatment.

PREFERRED

Opioid agonist therapy/Pharmacotherapy/
Addiction medication/Medication for a
substance use disorder/Medication for
opioid use disorder (MOUD)

The terms align with the way other
psychiatric medications are understood
(e.g., antidepressants, antipsychotics, as
critical tool that are central to a patient's
treatment plan



What can I do to
change the
impact of my
language?



Montana Primary Care Association



BIAS MITIGATION STRATEGIES

- Get comfortable talking about substance use and discrimination
- Recognize and remedy through modeling appropriate language
- Chart review and documentation
- Not only change what we do but also change the environment
- Be kind to ourselves and each other
- Become aware of our own biases
- Caring for families impacted by SUDs can be connected to ethical distress, moral distress, and compassion fatigue
- Continue to increase personal knowledge about mental health and SUDS



Documentation Language

- The APA style book released in 2017 made a change stating that media should no longer use stigmatizing language because of its impact on individuals and policy.
- Instructs addict should no longer be used as a noun and to avoid using alcoholic, addict, user and abuser
- Instructs to avoid words like abuse or problem in favor of the word use with an appropriate modifier such as risky, unhealthy, excessive, or heavy. Misuse is also acceptable.



Conditions where bias and stigma is most likely to surface:

- When judgments are subjective
- When you are busy or distracted
- When you feel threatened or insecure



Interpersonal Strategies :: Breakout

Consciousness Raising

- Consider where bias can creep into your work and personal activities or interactions
- What are possible solutions in our context?
- Share your experiences with bias in your work and discuss the challenges with applying solutions

Remember, everyone has the potential to show bias – forgive yourself and others for being human



Stigma

“For far too long, too many in our country have viewed addiction as a moral failing. This *unfortunate stigma* has created an added burden of shame that has made people with substance use disorders less likely to come forward and seek help. It has also made it more challenging to marshal the necessary investments in prevention and treatment. We must help everyone see that addiction is not a character flaw – it is a chronic illness that we must approach with the same skill and compassion with which we approach heart disease, diabetes, and cancer.”

- Facing Addiction in America The Surgeon General's Report on
Alcohol, Drugs and Health 2017





“Here is what we seek... a compassion that can stand in awe at what (people) have to carry rather than stand in judgement about how they carry it”

Fr. Greg Boyle, Tattoos on the Heart; the Power of Boundless Compassion

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