UNC HEALTH SCIENCES at MAHEC

Reducing Stigma, Bias, and Harm When Working with Patients Using Substances

In 2017, 80 percent of Americans who needed treatment didn't receive it.[1] Often, people don't seek treatment because of stigma and bias—the many false beliefs and negative attitudes surrounding substance use disorders (SUD).

Stigma and bias restrict access to care and negatively impact health. Stigma is present in social and work settings and can also be found in healthcare and social services.

When patients feel judged negatively by healthcare providers and staff, it can prevent them from disclosing their substance use and/or seeking or participating in evidence-based treatments like medication for opioid use disorder, alcohol use disorder, and tobacco cessation also referred to as medication-assisted treatment (MAT), [2] which can be a source of internal and external stigma.

Four Factors Leading to Stigma in MAT[3]

1. Framing of SUD as a 'willful choice,' not a disease
2. Separation of SUD treatment from primary care
3. Stigmatizing language associated with SUD
4. System bias against MAT as a legitimate treatment option (in medical, behavioral health, recovery-oriented, and judicial organizations)

What Can You Do to Reduce Stigma and Bias?[4]

Start the conversation by centering on your patient

Let your patients decide what is most important to their health at that time—in their biological, psychological, and/or social domains—and any barriers they anticipate to treatment.

Ask for Feedback

Encourage patients to tell you if they experience judgmental treatment due to their substance use or treatment for it. Validate their experience and strive to create a culture that is supportive, non-judgmental, culturally responsive, and welcoming in every stage of the clinical encounter.

Educate Your Staff

Provide ongoing education and training to both clinical and nonclinical staff.

Change the conversation

According to the North Carolina Harm Reduction Coalition, using the right language has a real and direct impact on lessening stigma and influences whether people with substance use disorders get the treatment they need.

What is non-stigmatizing language?[5]

It is non-judgmental respectful language that recognizes the person first and their health condition as secondary to their intrinsic worth. The best way to ensure you are using non-stigmatizing language is to

- ❖ Ask your patients what language they prefer
- ❖ Pay attention to how your patients refer to themselves

Generally preferred terms:

- Substance use; substance user/drug user (the latter only if someone refers to themselves this way)
- Actively using/not actively using
- Person with chronic pain; chronic pain patient
- Person with a substance use disorder/opioid use disorder

In community-based research and advocacy with substance users, the following language is generally considered offensive *unless used by a directly affected person to refer to themselves*.

Avoid using:

- Addict
- Junkie
- Druggie
- Substance abuse/misuse
- Harmful use; inappropriate use
- Hazardous use; problem use

You can learn more helpful strategies in this short video, "Patients with OUD are patients," on the Provider Clinical Support System website www.pcssnow.org.

You Can Help Break the Bias

- **Put your patients first:** Ask your patients how you can support them best.
- **Establish a relationship:** Ask about your patient's health history in the context of their life experiences.
- **Use respectful language:** speak *with* the person, not to their condition.
- **Normalize care:** Explain SUD as a chronic diseases that needs careful management like any other chronic relapsing disease.
- **Provide a range of options:** Meet patients where they are. Be patient. Offer them a range of evidence-based treatments including MAT.
- **Promote harm reduction and overdose risk management:** ensure appropriate follow up with MAT patients; prescribe and distribute naloxone; identify and make referrals to community-based harm reduction organizations (e.g., syringe access and naloxone distribution programs).

For more information, reach out to MAHEC at mahec.net/safer.

References

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4. David Mee-Lee. Addiction: It Isn't All a Brain Disease – Getting Back to Biopsychosocial. TAAP Conference, San Antonio, TX, July 27, 2012.

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