RCORP-ETC Meeting: Addressing Stigma

October 18, 2024

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This content is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $10,000,000 with 0% financed with non-governmental sources from the Rural Communities Opioid Response Program (RCORP). The contents being discussed and the views they present are those of the author alone and do not necessarily represent the official views of, nor an endorsement, by JBS, HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

RCORP-TA

RURAL COMMUNITIES OPIOID RESPONSE PROGRAM - TECHNICAL ASSISTANCE

TA Session Objectives

1. Describe various types of stigma

2. Understand the relationship between stigmatizing language and wellness outcomes for people who use drugs (PWUD) and people with a substance use disorder (SUD)

3. Reflect on ways in which we all contribute to and can combat stigma within our communities, and share strategies for being champions of stigma reduction

What is stigma?

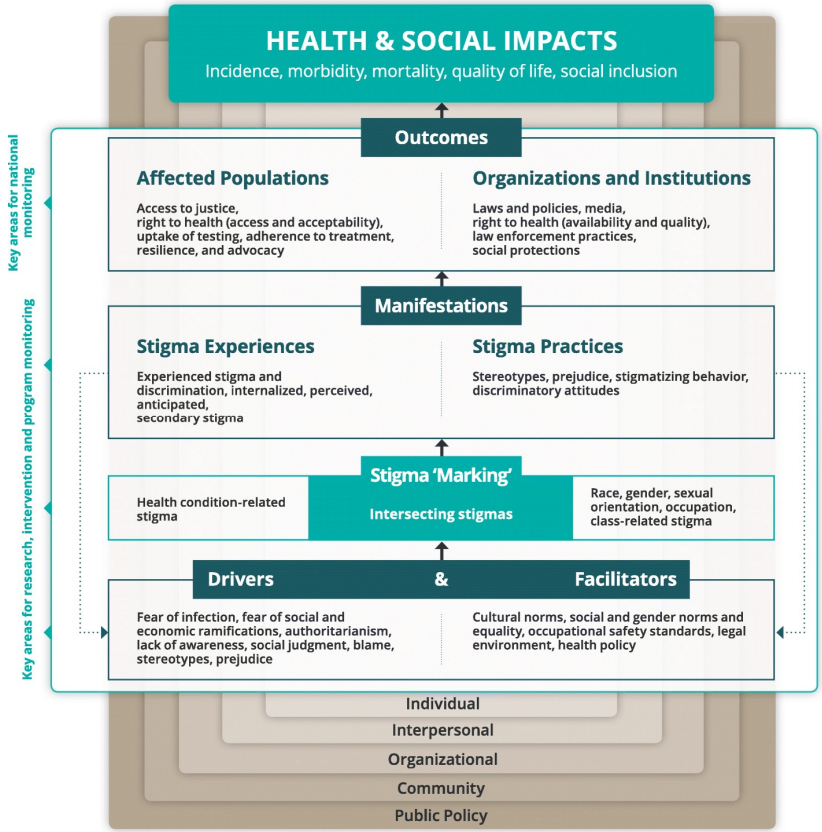
- **Stigma** is…
  - the negative social attitude attached to a characteristic of an individual that may be regarded as a mental, physical, or social deficiency. A stigma implies social disapproval and can lead unfairly to discrimination against and exclusion of the individual.
    (APA: https://dictionary.apa.org/stigma)

How can stigma manifest?

- **Types of Stigma:**
  - Public Stigma (community)
  - Self-Stigma (internalized/individual)
  - Structural Stigma (institutional/public policy)
  - Perceived Stigma
  - Label Avoidance
  - Stigma by Association
  - Health Practitioner Stigma

(NAMI: https://www.nami.org/Blogs/NAMI-Blog/October-2018/Overcoming-Stigma)

What are the types of stigma?



Stangl, A. L., Earnshaw, V. A., Logie, C. H., van Brakel, W., C Simbayi, L., Barré, I., & Dovidio, J. F. (2019). The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC medicine*, *17*(1), 31. https://doi.org/10.1186/s12916-019-1271-3

Why do people use drugs?

- To feel pleasure
- To stay awake
- To fall asleep
- To connect with others
- To be more productive
- To celebrate or unwind
- To relieve emotional or physical pain
- To replace emotional loss
- To escape traumatic memories
- To ease stress
- To manage withdrawal
- To be a better parent

In a 2024 Hamilton County survey…

71%

of respondents used drugs to **manage stress**

63%

of respondents used drugs to **avoid withdrawal**

57%

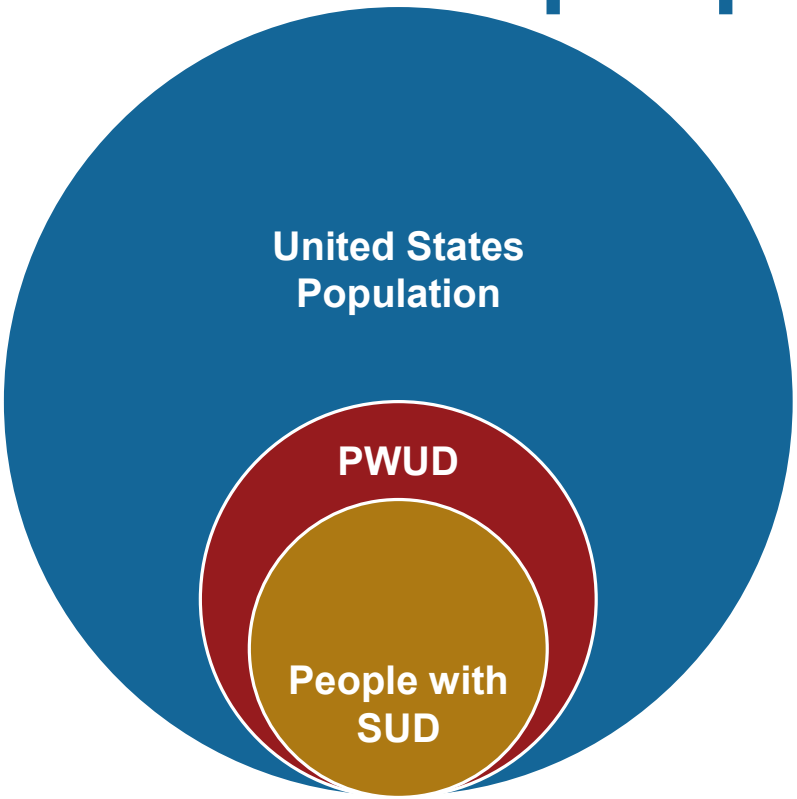
of respondents used drugs to **ease pain**

56%

of respondents used drugs for **pleasure**

Childs, R. & Cempa Community Care. (2024). A 2024 Needs Assessment of People Who Use Drugs in Hamilton, TN.

What is the difference between PWUD and people with a SUD?



Based on the 2023 National Survey on Drug Use and Health (NSDUH), of the 283.5 million people who lived in the county:

- 24.9% used an illicit drug in the past year
- 9.6% had a substance use disorder

Substance Abuse and Mental Health Services Administration. (2024). Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021, NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report

Why do some people have a SUD?

Familial/genetic influence

Co-occurring learning & mental disorders

Adverse childhood experiences

Dislocation, disconnection, and/or disorientation

Early Drug Use

Avoiding Stigmatizing Language

These hurt:	These help:
Substance abuse	Substance use
Addicts/alcoholics	People with a substance use disorder
Addiction	Substance use disorder/opioid use disorder
Dirty/clean test	Positive/negative test
Former addict	Person in recovery/people with lived experience
Relapse	Return to use
Junkies/users	People who use drugs/people with living experience

What to learn more? Check out Words Matter

Pejorative Language

Using language that is intended to disparage or belittle a group of marginalized or vulnerable people is considered harassment and discrimination.

Publicly, we refrain from pejorative expressions describing race, ethnicity, religion, national origin, sexual orientation, gender identity, disability, etc.

When we use pejorative words such as *abuser, junkie* or *crack head*, we are causing harm.

Let's resolve to stop.

Stigma in Action: Interpersonal

- **Data:** Survey completed between January 2018 and March 2020 by 2,608 people reporting past 30-day opioid use in rural areas across 10 states.
- **Key Finding:** “Felt stigma related to substance use is associated with **higher risk** of non-fatal overdose in rural-dwelling people who use drugs.”

Sibley et al. Harm Reduction Journal (2024) 21:77
https://doi.org/10.1186/s12954-024-00988-x

Harm Reduction Journal

RESEARCH Open Access

The relationship between felt stigma and non-fatal overdose among rural people who use drugs

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Abstract

Background Drug overdose deaths in the United States exceeded 100,000 in 2021 and 2022. Substance use stigma is a major barrier to treatment and harm reduction utilization and is a priority target in ending the overdose epidemic. However, little is known about the relationship between stigma and overdose, especially in rural areas. We aimed to characterize the association between felt stigma and non-fatal overdose in a multi-state sample of rural-dwelling people who use drugs.

Methods Between January 2018 and March 2020, 2,608 people reporting past 30-day opioid use were recruited via modified chain-referral sampling in rural areas across 10 states. Participants completed a computer-assisted survey of substance use and substance-related attitudes, behaviors, and experiences. We used multivariable logistic regression with generalized estimating equations to test the association between felt stigma and recent non-fatal overdose.

Results 6.6% of participants ($n = 173$) reported an overdose in the past 30 days. Recent non-fatal overdose was significantly associated with felt stigma after adjusting for demographic and substance use-related covariates (aOR: 1.47, 95% CI: 1.20–1.81). The association remained significant in sensitivity analyses on component fear of enacted stigma items (aOR: 1.48, 95% CI: 1.20–1.83) and an internalized stigma item (aOR: 1.51, 95% CI: 1.07–2.14).

Conclusions Felt stigma related to substance use is associated with higher risk of non-fatal overdose in rural-dwelling people who use drugs. Stigma reduction interventions and tailored services for those experiencing high stigma are underutilized approaches that may mitigate overdose risk.

Keywords Opioids, People who use drugs, Overdose, Stigma, Self-stigma, Rural health

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Sibley, A. L., Klein, E., Cooper, H. L. F., Livingston, M. D., 3rd, Baker, R., Walters, S. M., Gicquelais, R. E., Ruderman, S. A., Friedmann, P. D., Jenkins, W. D., Go, V. F., Miller, W. C., Westergaard, R. P., & Crane, H. M. (2024). The relationship between felt stigma and non-fatal overdose among rural people who use drugs. *Harm reduction journal*, *21*(1), 77. https://doi.org/10.1186/s12954-024-00988-x

Stigma in Action: Organizational

- **Data:** 48,651 medical center admission notes about 29,783 unique patients with diabetes, substance use disorder, and chronic pain by 1932 clinicians.
- **Key Finding:** “Stigmatizing language in hospital notes **varied by medical condition** and was **more often used to describe non-Hispanic Black patients**. Training clinicians to minimize stigmatizing language in the EHR might improve patient-clinician relationships and reduce the transmission of bias between clinicians.”

JAMA Network Open.

Original Investigation | Health Policy

Examination of Stigmatizing Language in the Electronic Health Record

Gracie Himmelstein, MD; David Bates, MD, MS; Li Zhou, MD, PhD

Abstract

IMPORTANCE Stigmatizing language in the electronic health record (EHR) may alter treatment plans, transmit biases between clinicians, and alienate patients. However, neither the frequency of stigmatizing language in hospital notes, nor whether clinicians disproportionately use it in describing patients in particular demographic subgroups are known.

OBJECTIVE To examine the prevalence of stigmatizing language in hospital admission notes and the patient and clinician characteristics associated with the use of such language.

DESIGN, SETTING, AND PARTICIPANTS This cross-sectional study of admission notes used natural language processing on 48 651 admission notes written about 29 783 unique patients by 1932 clinicians at a large, urban academic medical center between January to December 2018. The admission notes included 8738 notes about 4309 patients with diabetes written by 1204 clinicians; 6197 notes about 3058 patients with substance use disorder by 1132 clinicians; and 5176 notes about 2331 patients with chronic pain by 1056 clinicians. Statistical analyses were performed between May and September 2021.

EXPOSURES Patients' demographic characteristics (age, race and ethnicity, gender, and preferred language); clinicians' characteristics (gender, postgraduate year [PGY], and credential [physician vs advanced practice clinician]).

MAIN OUTCOME AND MEASURES Binary indicator for any vs no stigmatizing language, frequencies of specific stigmatizing words. Linear probability models were the main measure, and logistic regression and odds ratios were used for sensitivity analyses and further exploration.

RESULTS The sample included notes on 29 783 patients with a mean (SD) age of 46.9 (27.6) years. Of these patients, 1033 (3.5%) were non-Hispanic Asian, 2498 (8.4%) were non-Hispanic Black, 18 956 (63.6%) were non-Hispanic White, 17 334 (58.2%) were female, and 2939 (9.9%) preferred a language other than English. Of all admission notes, 1197 (2.5%) contained stigmatizing language. The diagnosis-specific stigmatizing language was present in 599 notes (6.9%) for patients with diabetes, 209 (3.4%) for patients with substance use disorders, and 37 (0.7%) for patients with chronic pain. In the whole sample, notes about non-Hispanic Black patients vs non-Hispanic White patients had a 0.67 (95% CI, 0.15 to 1.18) percentage points greater probability of containing stigmatizing language, with similar disparities in all 3 diagnosis-specific subgroups. Greater diabetes severity and the physician-author being less advanced in their training was associated with more stigmatizing language. A 1 point increase in the diabetes severity index was associated with a 1.23 (95% CI, .23 to 2.23) percentage point greater probability of a note containing stigmatizing language. In the sample restricted to physicians, a higher PGY was associated with less use of stigmatizing language overall (−0.05 percentage points/PGY [95% CI, −0.09 to −0.01]).

(continued)

Key Points

Question How frequently does stigmatizing language appear in the admission notes of patients who are hospitalized, and does the frequency vary by patients' medical conditions and race or ethnicity?

Findings In this cross-sectional study of 48 651 admission notes, 2.5% of all notes included stigmatizing language. Across all medical conditions studied, stigmatizing language appeared more frequently in notes written about non-Hispanic Black patients.

Meaning These findings suggest that improved conscientiousness and training around avoiding stigmatizing language in medical notes could improve health equity.

Supplemental content

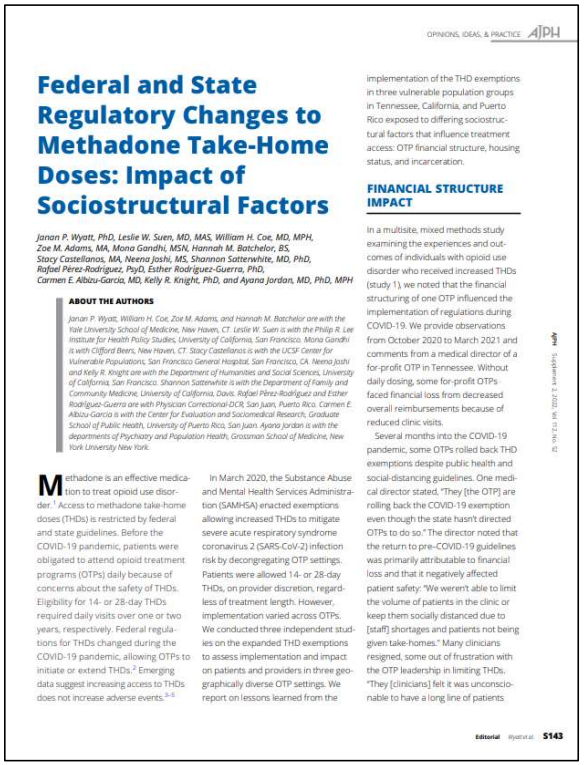
Author affiliations and article information are listed at the end of this article.

JAMA Network Open. 2022;5(1):e2144967. doi:10.1001/jamanetworkopen.2021.44967 January 27, 2022 1/14

Himmelstein, G., Bates, D., & Zhou, L. (2022). Examination of Stigmatizing Language in the Electronic Health Record. *JAMA network open*, *5*(1), e2144967. https://doi.org/10.1001/jamanetworkopen.2021.44967

Stigma in Action: Public Policy

- **Data:** Mixed method study conducted from October 2020 to March 2021 and comments from a medical director of a for-profit opioid treatment program in Tennessee.
- **Key Finding:** "Without daily dosing, some for-profit OTPs faced financial loss from decreased overall reimbursements because of reduced clinic visits. Several months into the COVID-19 pandemic, some **OTPs rolled back take-home dose (THD) exemptions despite public health and social-distancing guidelines**."



OPINIONS, IDEAS, & PRACTICE AJPH

Federal and State Regulatory Changes to Methadone Take-Home Doses: Impact of Sociostructural Factors

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Methadone is an effective medication to treat opioid use disorder.[1] Access to methadone take-home doses (THDs) is restricted by federal and state guidelines. Before the COVID-19 pandemic, patients were obligated to attend opioid treatment programs (OTPs) daily because of concerns about the safety of THDs. Eligibility for 14- or 28-day THDs required daily visits over one or two years, respectively. Federal regulations for THDs changed during the COVID-19 pandemic, allowing OTPs to initiate or extend THDs.[2] Emerging data suggest increasing access to THDs does not increase adverse events.[3–5]

In March 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) enacted exemptions allowing increased THDs to mitigate severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection risk by decongregating OTP settings. Patients were allowed 14- or 28-day THDs, on provider discretion, regardless of treatment length. However, implementation varied across OTPs. We conducted three independent studies on the expanded THD exemptions to assess implementation and impact on patients and providers in three geographically diverse OTP settings. We report on lessons learned from the implementation of the THD exemptions in three vulnerable population groups in Tennessee, California, and Puerto Rico exposed to differing sociostructural factors that influence treatment access: OTP financial structure, housing status, and incarceration.

FINANCIAL STRUCTURE IMPACT

In a multisite, mixed methods study examining the experiences and outcomes of individuals with opioid use disorder who received increased THDs (study 1), we noted that the financial structuring of one OTP influenced the implementation of regulations during COVID-19. We provide observations from October 2020 to March 2021 and comments from a medical director of a for-profit OTP in Tennessee. Without daily dosing, some for-profit OTPs faced financial loss from decreased overall reimbursements because of reduced clinic visits.

Several months into the COVID-19 pandemic, some OTPs rolled back THD exemptions despite public health and social-distancing guidelines. One medical director stated, "They [the OTP] are rolling back the COVID-19 exemption even though the state hasn't directed OTPs to do so." The director noted that the return to pre–COVID-19 guidelines was primarily attributable to financial loss and that it negatively affected patient safety: "We weren't able to limit the volume of patients in the clinic or keep them socially distanced due to [staff] shortages and patients not being given take-homes." Many clinicians resigned, some out of frustration with the OTP leadership in limiting THDs. "They [clinicians] felt it was unconscionable to have a long line of patients

Editorial Wyatt et al. S143

Wyatt, J. P., Suen, L. W., Coe, W. H., Adams, Z. M., Gandhi, M., Batchelor, H. M., Castellanos, S., Joshi, N., Satterwhite, S., Pérez-Rodríguez, R., Rodríguez-Guerra, E., Albizu-Garcia, C. E., Knight, K. R., & Jordan, A. (2022). Federal and State Regulatory Changes to Methadone Take-Home Doses: Impact of Sociostructural Factors. *American journal of public health*, *112*(S2), S143–S146. https://doi.org/10.2105/AJPH.2022.306806

Medications for Opioid Use Disorder (MOUD): Myths & Facts

Myths	Facts
MOUD substitutes one substance for another.	MOUD uses longer-acting and safer medications to help overcome more dangerous opioid use. Many studies show it has proven to reduce the risk of opioid-related deaths, keep patients healthier, reduce criminal activity, and prevent diseases such as HIV & HCV.[1]
MOUD should not be long-term.	The length of treatment with MOUD is a decision that should be made between a patient and clinician. There is no one-size-fits-all duration. If a patient is benefiting from a medication, they should remain on it.[2]

MOUD: Myths & Facts cont.

Myths	Facts
MOUD is a bad moral choice and prevents people from “true recovery”.	"Addiction [SUD] is a disease", not a moral failing. Therefore, OUD can be treated and managed with medication, much like other chronic medical conditions.[3]
Requiring people to taper off MOUD helps them get healthy faster.	Research demonstrates that requiring people to stop taking life-saving medications is counter-productive and increases the risk of returning to use and risk for overdose.[4]
MOUD is not effective because it does not immediately end drug dependence.	OUD is not “cured” by MOUD. Addiction/SUD is a “chronic” (long-lasting) disease. Medical treatment for OUD can be compared to other common chronic conditions.[5]

Boundaries & Bias: Different Hats

Person in Recovery

- Lay Volunteer
- One Pathway
- Moral Compass
- Informal Mentorship

Peer Support Specialist

- Professional Credential
- Many Pathways
- Ethical Considerations
- Supervision

Strategies to Champion Stigma Reduction

- Education & awareness (combat misinformation, give data/evidence)
- Use person-centered, inclusive language
- Storytelling & empathy (testimonials to connect)
- Training & professional development
- Collaboration & community involvement
- Accessible & non-discriminatory services
- Support groups & peer networks
- Media & social media engagement
- Celebrate any positive change (from harm reduction to recovery & resilience)

Values Continuum: Where Are You vs. Your Community?

I believe SUD/OUD is a choice.	⟷	I believe SUD/OUD is a health disorder.
I believe problematic drug use is a criminal justice issue.	⟷	I believe problematic drug use is a public health issue
I believe using methadone or buprenorphine is a crutch and not recovery.	⟷	I believe using methadone or buprenorphine is evidence-based treatment and recovery.
I believe people experiencing SUD/OUD deserve one chance.	⟷	I believe people experiencing SUD/OUD deserve many chances.

Questions & Thoughts?

Reflections

- By being here, we are committed to better outcomes for our community, but no one is right all of the time – *how do you catch yourself or hold yourself responsible when stigma comes up?*
- Most of us have experienced stigmatizing language in care and/or support settings – *what did that feel like?*
- Stigmatizing language perpetuates bias among providers and negatively affects the quality of care delivered – *how can we change that within our settings?*
- Increasing awareness can help change behaviors – *what steps might we take?*

Stigma Resources

- NIH: Stigma and Discrimination Research Toolkit
- Shatterproof: Ending Stigma
- RCORP-TA Guidance Module: Addressing Stigma (LMS)
- Respect to Connect: Undoing Stigma
- Confronting Health Misinformation: U.S. Surgeon General's 2021 Advisory
  - A Community Toolkit for Addressing Health Misinformation
- Short video for busy medical staff: Tell me What to Say and How to Say It
- Overcoming Objections to MOUD
- Faces & Voices of Recovery:
  - Recovery Messaging for Young People in Recovery
  - New Messaging From Faces & Voices of Recovery for Talking About Recovery

Thank you!

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