Stigma, Language, & Implicit Bias
Moving Towards Becoming a Stigma-Free Provider

Overview

Treatment of substance use disorder (SUD) is often eclipsed by the misperception that SUD is a personal weakness or a willful choice. Whether or not these misconceptions are consciously employed, they can have a dramatic impact on patient outcomes and adherence to treatment during recovery. Stigma can be experienced across several domains: self, social, and structural stigma. This toolkit focuses on structural stigma oriented toward health care professionals and systems-based approaches.

Providers who interact with OUD/SUD patients often cite them as their most challenging patients due to expectations of cooperation, aggression, demands, and low rates of treatment completion. It is therefore not uncommon for health professionals who interact with these patients to show unconscious bias whether or not they explicitly report negative attitudes. Stigma can come from staff interactions at all contact points and through materials provided in clinical settings.

Why We Recommend this Best Practice

Several studies have shown that perceived discrimination and stigma from providers has a significant impact on treatment completion by increasing the likelihood of dropout and decreasing retention. Whether or not adoption of stigmatizing beliefs is conscious, evidence shows that health professionals not trained to interact with patients with SUDs may avoid or shorten appointment visits or express less empathy to these patients. This may reduce quality of care and decrease patient retention.

This toolkit is from the CMQCC Mother & Baby Substance Exposure Initiative Toolkit.

Step 1: Surface and Address Biases

1. **Perform a language audit** of all internal (EHR, protocols) and external (brochures, educational pamphlets) materials. Designate a staff member to review all materials distributed or posted in the clinic regarding OUD/SUD to address any stigma-perpetuating language. An analysis of materials should identify the following terminology, and materials should be updated accordingly:

   - **Diagnosis** - In alignment with DSM - 5, replace older categories of substance "abuse", "drug habit", and "dependence" with a single classification of "substance use disorder" (SUD) or "opioid use disorder". Use clinically accurate terminology which reflects the treatable, clinical, and chronic nature of SUD and moves away from choice-based terminology.
   - **Person-first language** – Discussing substance use should follow the accepted standard for discussing people with disabilities and/or chronic medical conditions. Replace "abuse", "abuser", "addict", "druggie", "alcoholic" with "person with SUD" or "person experiencing" with "person struggling."
   - **Testing and Toxicology** – Replace "clean" and "dirty" urine drug screens with "positive" and "negative" or "expected" vs. "unexpected" and use "consistent with prescribed medications." "Person in Recovery" focuses on the process and acknowledges the consistent management of symptoms and stable conditions.
   - **Medications** – Avoid using "replacement" and "substitution" therapy. Preferred are "Medication Assisted Treatment" (MAT), "pharmacotherapy for …", and specifically "medications for OUD" (MOUD) or "medications for SUD". Additionally, once an individual is receiving MAT, "medically indicated tapering" or "decreasing of dosage" (from buprenorphine or methadone) conveys that the medications might be noxious toxins leaving the body and should also therefore be replaced.
   - **Maternal and Newborn** - Although not commonly employed in medical literature or materials, use of the language "crack baby," "opioid baby," or "drug-addicted baby" should be replaced with neonatal abstinence syndrome (NAS), for opioid or heroin exposure, and prenatal cocaine exposure, or colloquially "in utero exposure to [substance] …".

2. **Provide opportunities for individual identification of stigma**
   - Formally through Implicit Associations Test– Mental Health,
   - Informally through Stigma Self-Assessments – pg.18
   - Review maternal urine toxicology and the role of explicit/implicit bias in decision making

3. **Provide trauma-informed care training for all staff.** Compensate for staff time in wages or continued education credits and offering the training during work hours.
   - Here are some trainings you can encourage your staff to complete:
     - Maternal Mental health Access (MaMHA) ECHO Series to Support Perinatal Mental Health Care – 4 session CME accredited program for WA State providers
     - Beyond Labels (30 min – 1 hr.): Interactive site from the March of Dimes
     - Words Matter (38 min): Illinois Perinatal Quality Collaborative Annual Conference
     - The Power of Perceptions and Understanding: Four-part webcast series (CEUs available)

   - Hang posters in staff areas that demonstrates non-stigmatizing language. Here are two you can use:
     - This flyer encourages the use of person-first language, including words to use, and words to avoid.
     - This "Say This/Not That" Poster demonstrates non-stigmatizing language to use when discussing substance use disorder.

These steps are taken from the toolkit, Reducing Stigma Towards Families Impacted by Opioid Use Disorder, and the CMQCC Mother & Baby Substance Exposure Initiative Toolkit.

Step 2: Bring lived experience to the care team

Peer recovery coaches —also known as peer moms or peer mentors—are staff members in recovery who have lived experience of OUD and for those serving mothers in recovery may also have lived experience of pregnancy. They are trained to support families from the prenatal to postpartum periods, encouraging women to feel safe and confident during their pregnancy journeys. Peer recovery coaches may provide childbirth education, lactation consulting, and treatment and recovery services in addition to providing case management. They can also strengthen relationships with providers, increase treatment retention, and improve access to social supports. – Reducing Stigma Towards Families Impacted by Opioid Use Disorder

1. **Read "Strategy 1"** in *Reducing Stigma Towards Families Impacted by Opioid Use Disorder*

2. **Utilize this** <u>Peer Support Toolkit</u> to help guide the process of bringing lived experience to the care team.

Additional Resources:
Articles & Guides:
- [Advancing Health Equity: A Guide to Language, Narrative and Concepts | AMA (ama-assn.org)](#)
- [Toward an Addiction-ary; Language, Stigma, Treatment, and Policy.](#)
- [Words Matter: How Language Choice Can Reduce Stigma](#)
- [Anti-Stigma Toolkit: A Guide to Reducing Addiction-Related Stigma](#)
- [Healing the stigma of addiction: A guide for treatment professionals.](#)

Live/Online Trainings:
- <u>Trainings | Institute for Health and Recovery (healthrecovery.org)</u>
- <u>Office-Based Addiction Treatment Program (OBAT) | Boston Medical Center (bmcobat.org)</u>
- <u>Meetings and Events | neoqicma</u> (includes recording of past events)

E-modules/Webinars:
- <u>Stigma and Opioid Use Disorder: What Pediatricians Need to Know in Caring for Mothers and Children</u>. AAP Webinar. This session offers an overview of how stigma related to prenatal opioid use adversely affects the health outcomes for the mother-infant dyad.

Videos:
- <u>Stigma and OUD [Opioid Use Disorder]</u>: This course from the Providers Clinical Support System (PCSS) is led by Nurse Practitioner Vanessa Loukas, a PCCS clinical expert. She discusses the issue of stigma in treating patients with opioid use disorder—from the patients to the providers who treat them.
- <u>FPQC Video From Judgement to Healing: the Impact of Stigma</u>: Learn how to provide less biased support to mothers with substance use disorder.
- <u>Reversing the Stigma of Opioid Addiction</u>: This short video addresses stigma related to drug use in pregnancy –produced by NBC Left Field.

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