February 2022

The University of Texas at Austin
Dell Medical School

STIGMA IS KILLING OUR PATIENTS

Dismantling the Stigma of Substance Use Disorders

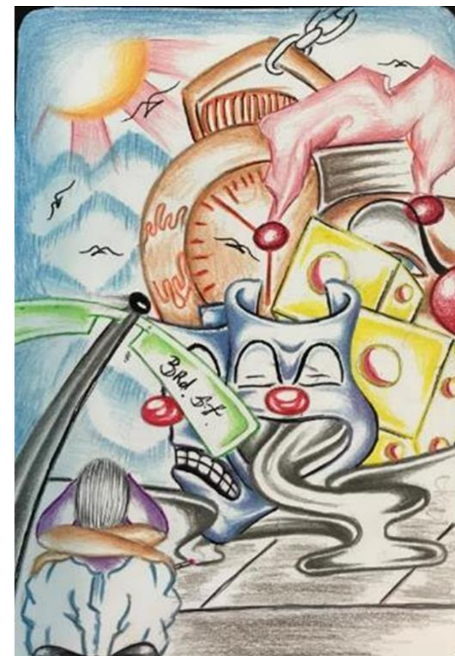
ALANNA BOULTON, MSHS, MSHA, PMP
Program Manager, Support Hospital Opioid Use Treatment (SHOUT) Texas
Dell Medical School at The University of Texas at Austin

DISCLOSURES

I have no relevant relationships with ineligible companies to disclose within the past 24 months. Ineligible companies are defined as those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

LEARNING OBJECTIVES

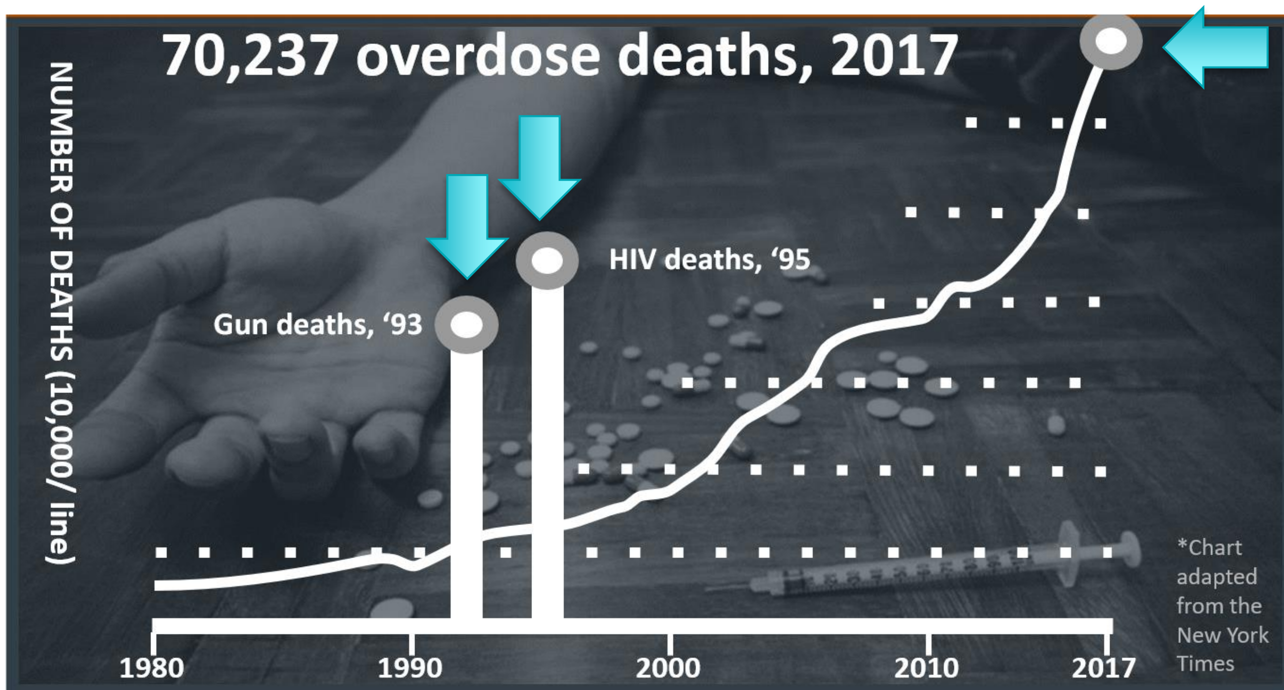
- Define the three main types of stigma and apply these definitions to the care of people with substance use disorders (SUD)
- Explore the role of early training in producing and reinforcing stigma of people with SUD
- Develop strategies and best practices for integrating training related to stigma and bias into health professional education across different settings
- Describe available tools that can be used to address the current gap in health professional education in stigma and bias for people with substance use disorder



WHY AM I SPEAKING TODAY?

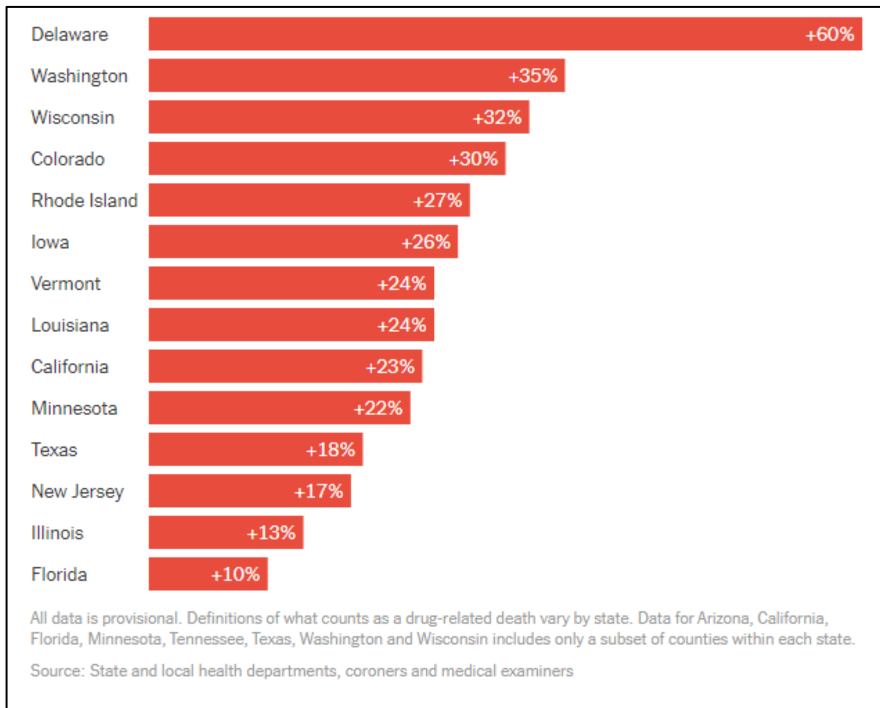
The University of Texas at Austin
Dell Medical School

OVERDOSE DEATHS, 2017



New York Times, 2017

INCREASE IN DRUG-RELATED DEATHS 2019 - Q1 2020



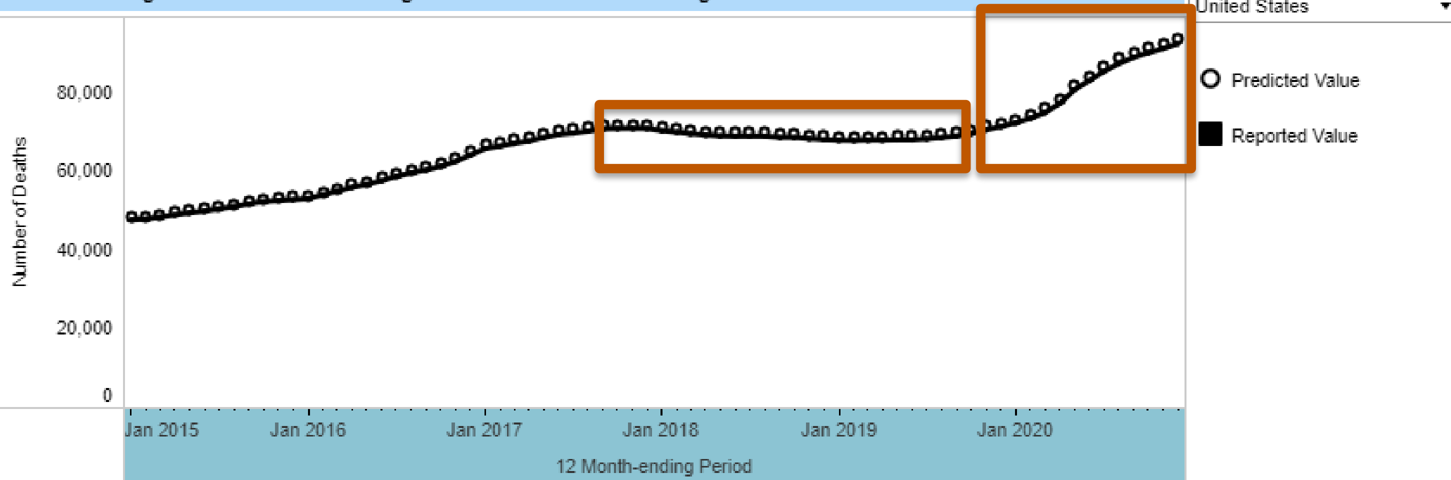
New York Times, 2020

OVERDOSE DEATHS, 2020

Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic

Distributed via the CDC Health Alert Network
December 17, 2020, 8:00 AM ET
CDCHAN-00438

OVERDOSE DEATHS, YEAR END 2020



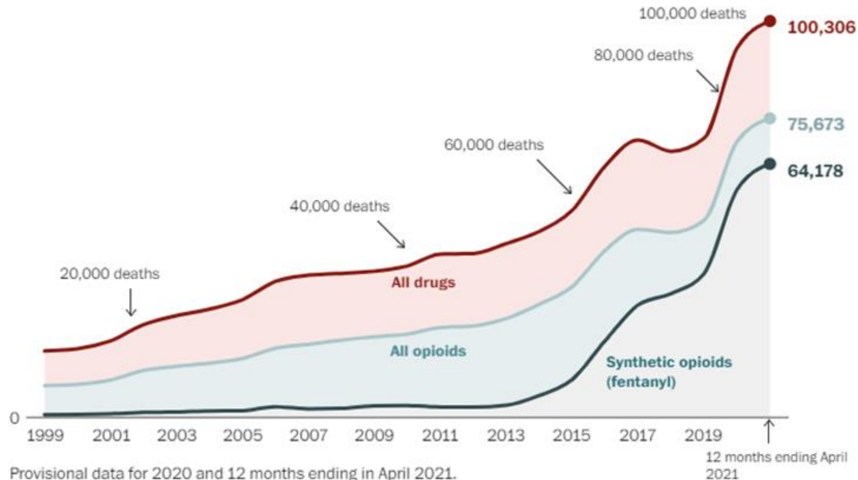
OVERDOSE DEATHS, 2021

The Washington Post *Democracy Dies in Darkness*

100,000 Americans died of drug overdoses in 12 months during the pandemic

By Dan Keating and Lenny Bernstein

November 17, 2021 | Updated November 17, 2021 at 11:43 a.m. EST



OVERDOSE DEATHS, YEAR END 2021

People are dying from drug use at historic rates

TAKEAWAY #1

WHAT IS STIGMA?

DEFINITION OF STIGMA

Originates from Greek “stizein” [1]

A mark burned onto the skin of slaves to signify their low place in the social hierarchy in ancient times

“A social construct whereby a distinguished mark of social disgrace is attached to others in order to identify and to devalue them. Thus, stigma and the process of stigmatization consist of two fundamental elements: the recognition of the differentiating ‘mark’ and the subsequent devaluation of the person.” [2]

“An attribute that links a person to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one.” [3]

1. Link & Phelan, 2001
2. Jacobsson & Arboleda-Flórez, 2002, p.25
3. Goffman, 1963, p. 11

WHAT EXACTLY IS STIGMA?

Corrigan & Nieweglowski, 2018

STIGMA IS COMPLICATED

Describing Stigma:
What stigma looks and feels like

- Negative attitudes, judgements, and stereotypes
- Problematic labels and language use
- Negative client-provider interactions
- Shame and the internalization of addiction
- Punitive and exclusionary policies and practices

Impacts of Stigma:
How stigma gets in the way

- Affects how we conceptualize, frame, and prioritize the current crisis
- Leads to hiding and creates barriers to help seeking
- Contributes to ongoing system mistrust and avoidance of services, particularly among marginalized populations
- Results in poorer quality care and response

Sources of Stigma:
Tension points and contributing factors

- Punitive views about addiction, treatment, and recovery
- Illegality of certain opioids and other drugs
- Viewing people with opioid use problems through a paradigm of worthiness and deservingness
- The ‘double-edged sword’ of emergency relief
- Trauma, compassion fatigue, and burnout

Tackling Stigma:
Promising approaches

- Education on addiction, treatment, and recovery
- Interventions focused on building client-provider trust
- Social contact as a key stigma reduction tool
- Training in trauma informed practice and care
- Inward-facing training to build resilience and mitigate burnout
- Address system gaps and barriers

Pivovarova & Stein (2019); Ashford, Brown, & Curtis (2019)

TYPES OF STIGMA

- Structural Stigma ↓
- Social Stigma ↓↑
- Self Stigma →

Awareness

Agreement

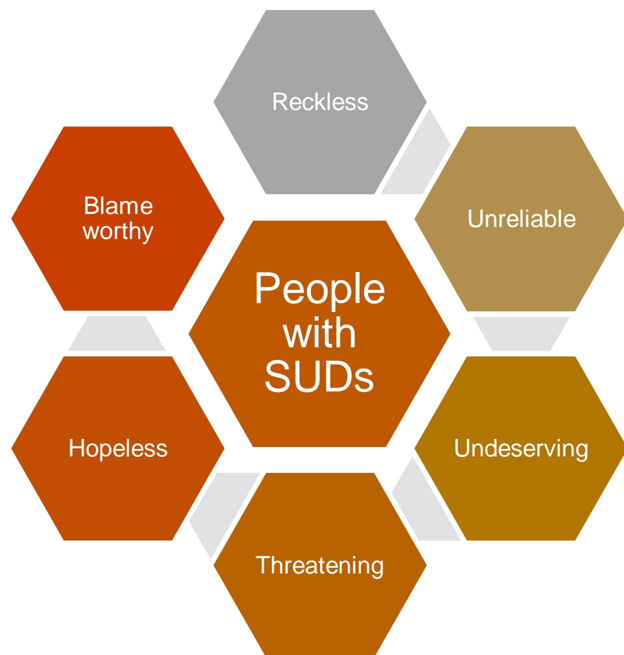
Application

Harm

Why even try?

Corrigan & Rao, 2012; Akdağ et al., 2018; Can & Tanrıverdi, 2015

HOW DOES THE GENERAL PUBLIC THINK ABOUT SUDs?



- SUDs are seen as being intimately linked to HIV, hep C, and DUI.
- In a survey of 1,000 adults, 75% felt patients with OUD were, themselves, to blame.

(Nieweglowski et al., 2019); Kennedy-Hendricks et al. (2017); (Furr-Holden et al., 2016)

ADDICTION STIGMA AND ITS IMPACT ON HEALTHCARE TRAINING

IT STARTS BEFORE WE EVEN SEE OUR FIRST PATIENTS

"Abusers" and "Addicts": Towards Abolishing Language of Criminality in US Medical Licensing Exam Step 1 Preparation Materials

Zoe M. Adams, BA, Elizabeth Fitzsousa, BA, and Marina Gaeta, BS

Yale School of Medicine, New Haven, CT, USA.

J Gen Intern Med
DOI: 10.1007/s11606-021-06616-9
© Society of General Internal Medicine 2021

Preparation materials for Step 1 of the United States Medical Licensing Exam (USMLE) describe patients with substance use disorders (SUDs) using outdated, stigmatizing terminology. In preparation for the Step 1 exam, students complete question banks with thousands of vignette-based, board-style questions and answer explanations. As medical students preparing for Step 1 in 2020, we noted terms like "abuser," "addict," and "alcoholic" within popular question banks (UWorld, Kaplan, and USMLERx) and National Board of Medical Examiners (NBME) practice exams. This language derives from the systematic criminalization of people who use drugs and has been replaced by contemporary terms (e.g., use disorders) within the medical community.

Terms like "substance abuser" perpetuate provider stigma and negatively influence patient care and outcomes.[1] In 2013, the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-5) introduced contemporary diagnostic categories for SUDs and person-first terminology. Person-first terminology, originating from the disability rights movement, aims to humanize patients and retain their identities separate from their medical conditions. An example of person-first terminology is a "person with an opioid use disorder" as opposed to a "heroin user." Additionally, many medical fields have removed pejorative terms, like "abuser," "addict," or "alcoholic," from their literature.[2] These changes aim to reduce the high level of bias healthcare providers harbor about SUDs, which discourages people with SUDs from seeking or continuing care and reduces the quality of care they receive.[3]

Step 1 is the first USMLE taken by aspiring physicians and integrates basic science into clinical scenarios. Students succeed by recognizing patterns and forming associations to identify medical conditions. On Step 1, a woman of childbearing age with dyspnea and a recent plane trip always has a pulmonary embolism; a patient who spelunks on weekends with a cough has histoplasmosis. In Step 1 preparation materials, patients with SUDs are not just mischaracterized as "addicts"; they are portrayed as irresponsible and negligent parents, "aggressive" and "uncooperative" patients, and "verbally abusive" to care providers. The 37-year-old who dies of pneumonia is called an "alcoholic" so students can easily identify *Klebsiella*; a cocaine "abuser" gets restrained in the Emergency Department for "belligerent" behavior so there's no question of his diagnosis; an IV drug "abuser" is "unwilling" to seek prenatal care and transmits HIV to her baby—cementing connections not just between HIV and IV drug use but neglectful parenting as well. Most students in the US sit for Step 1 before clinical rotations, making these patients in sample questions—depersonalized and without the opportunity to share their stories—their first exposure to patients with SUDs.

The terms "abuser" and "addict" stem from the historical framing of addiction as a moral failing. Colloquially, the word "abuse" is reserved for crimes by people with power exploiting those without, such as child abuse or sexual abuse. A highly effective rhetoric denouncing those who used substances as "drug abusers" in the 1960s and 70s reinforced associations between drug use and criminality. This fueled tough-on-crime federal policies, culminating in the War on Drugs. In the decades since, the average sentence length has nearly tripled and there are over ten times as many Americans incarcerated for drug-related charges.[4] There is no evidence that criminalizing people who use drugs reduces substance use: data shows no correlation between imprisonment for drugs and drug use or overdose deaths.[5]

Prior to studying for Step 1, each of us already had personal and clinical experiences with people experiencing addiction. It was disturbing to realize medical students across the country were introduced to SUDs and people who have them in a very different way: harmful stereotypes and stigmatizing language. How could they *not* internalize this terminology when Step 1, by design, rewards pattern recognition that reinforces clinical and diagnostic stereotypes? We wondered whether question writers considered how a student with a personal or family experience of an SUD might feel reading these vignettes. Most importantly, we wondered how our patients might feel

Zoe M. Adams, Elizabeth Fitzsousa and Marina Gaeta contributed equally to this work.

Received October 7, 2020
Accepted January 7, 2021

Published online: 28 January 2021

"Abuser," "addict," and "alcoholic" frequently used within popular question banks (UWorld, Kaplan, and USMLERx) and National Board of Medical Examiners (NBME) practice exams

"In Step 1 preparation materials, patients with SUDs are not just mischaracterized as "addicts"; they are portrayed as irresponsible and negligent parents, "aggressive" and "uncooperative" patients, and "verbally abusive" to care providers."

"Most students in the US sit for Step 1 before clinical rotations, making these patients in sample questions—depersonalized and without the opportunity to share their stories—their first exposure to patients with SUDs."

J Gen Intern Med. 2021

DO WORDS MATTER?

Do Words Matter? Stigmatizing Language and the Transmission of Bias in the Medical Record

Anna P. Goddu, MSc[1], Katie J. O'Conor, BA[1], Sophie Lanzkron, MD, MHS[2], Mustapha O. Saheed, MD[3], Somnath Saha, MD, MPH[4,5], Monica E. Peek, MD, MPH, MSc[6], Carlton Haywood, Jr., PhD, MA[2], and Mary Catherine Beach, MD, MPH[1]

[1]Johns Hopkins University School of Medicine, Baltimore, MD, USA; [2]Division of Hematology, Johns Hopkins University School of Medicine, Baltimore, MD, USA; [3]Department of Emergency Medicine, Johns Hopkins University School of Medicine, Baltimore, MD, USA; [4]Section of General Internal Medicine, VA Portland Health Care System, Portland, OR, USA; [5]Division of General Internal Medicine and Geriatrics, Oregon Health and Science University, Portland, OR, USA; [6]Section of General Internal Medicine, The University of Chicago, Chicago, IL, USA.

BACKGROUND: Clinician bias contributes to healthcare disparities, and the language used to describe a patient may reflect that bias. Although medical records are an integral method of communicating about patients, no studies have evaluated patient records as a means of transmitting bias from one clinician to another.

OBJECTIVE: To assess whether stigmatizing language written in a patient medical record is associated with a subsequent physician-in-training's attitudes towards the patient and clinical decision-making.

DESIGN: Randomized vignette study of two chart notes employing stigmatizing versus neutral language to describe the same hypothetical patient, a 28-year-old man with sickle cell disease.

PARTICIPANTS: A total of 413 physicians-in-training: medical students and residents in internal and emergency medicine programs at an urban academic medical center (54% response rate).

MAIN MEASURES: Attitudes towards the hypothetical patient using the previously validated Positive Attitudes towards Sickle Cell Patients Scale (range 7–35) and pain management decisions (residents only) using two multiple-choice questions (composite range 2–7 representing intensity of pain treatment).

KEY RESULTS: Exposure to the stigmatizing language note was associated with more negative attitudes towards the patient (20.6 stigmatizing vs. 25.6 neutral, $p < 0.001$). Furthermore, reading the stigmatizing language note was associated with less aggressive management of the patient's pain (5.56 stigmatizing vs. 6.22 neutral, $p = 0.003$).

CONCLUSIONS: Stigmatizing language used in medical records to describe patients can influence subsequent physicians-in-training in terms of their attitudes towards the patient and their medication prescribing behavior. This is an important and overlooked pathway by which bias can be propagated from one clinician to another. Attention to the language used in medical records may help to promote patient-centered care and to reduce healthcare disparities for stigmatized populations.

Received July 9, 2017
Revised November 13, 2017
Accepted December 13, 2017
Published online January 26, 2018

KEY WORDS: bias; stigma; language; disparities; medical record; communication; clinical decision-making.

J Gen Intern Med 33(5):685–91
DOI: 10.1007/s11606-017-4289-2
© Society of General Internal Medicine 2018

INTRODUCTION

It is well documented that patients are not treated equally in our healthcare system: some receive poorer quality of healthcare than others based on their racial/ethnic identity,[1–4] independent of social class. Others, such as older adults[5,6] and individuals with low health literacy,[7,8] obesity,[9,10] and substance use disorders[11] may also be viewed negatively by health professionals in a way that adversely impacts their healthcare quality. Implicit bias among clinicians is one factor that perpetuates these disparities.[1,12,13] Implicit bias is the automatic activation of stereotypes derived from common cultural experiences, which may override deliberate thought and influence one's judgment in unintentional and unrecognized ways,[2,14,15] and may affect communication behaviors and treatment decisions.[3,16–18]

Clinicians may acquire implicit bias towards patients from one another when communicating verbally or when writing or reading medical records; physicians-in-training may absorb these attitudes as part of the "hidden curriculum" of medical training.[19–22] Few studies have examined the medical record as a mechanism for transmitting bias from one clinician to another. A recent randomized study demonstrated that physicians who read a vignette with the term "substance abuser" as opposed to "having a substance use disorder" were more likely to agree that the depicted character was personally culpable and should have punitive measures taken against him or her.[11] Those participants were also less likely to agree with the notion that a "substance abuser" needed treatment as compared to a person "with substance use disorder."[23]

In this study, we explored whether stigmatizing language written in a patient medical record was associated with a subsequent physician-in-training's attitudes towards the patient and clinical decision-making. We hypothesized that

Exposure to stigmatizing language in the note was associated with more negative attitudes toward the patient (p<0.0001) and with less aggressive management of the patient's pain (p=0.003)

J Gen Intern Med. 2018;33(5):685–91

HOW PREPARED DO YOU FEEL TO TREAT ADDICTION IN YOUR CARE SETTING?

- Very prepared
- Prepared
- Unprepared
- Very unprepared

WE LACK PREPARATION AND TRAINING

SUBSTANCE ABUSE, 34: 363–370, 2013
Copyright © Taylor & Francis Group, LLC
ISSN: 0889-7077 print / 1547-0164 online
DOI: 10.1080/08897077.2013.797540

Internal Medicine Residents' Training in Substance Use Disorders: A Survey of the Quality of Instruction and Residents' Self-Perceived Preparedness to Diagnose and Treat Addiction

Sarah E. Wakeman, MD
Department of Medicine, Massachusetts General Hospital, Boston, Massachusetts, USA; and Department of Medicine, Harvard Medical School, Boston, Massachusetts, USA

Meridale V. Baggett, MD
Department of Medicine, Massachusetts General Hospital, Boston, Massachusetts, USA

Genevieve Pham-Kanter, PhD
Mongan Institute for Health Policy, Boston, Massachusetts, USA; Edmond J. Safra Center for Ethics, Harvard University, Cambridge, Massachusetts, USA; and Department of Health Systems, Management, and Policy, Colorado School of Public Health, University of Colorado Anschutz Medical Campus, Denver, Colorado, USA

Eric G. Campbell, PhD
Department of Medicine, Harvard Medical School, Boston, Massachusetts, USA; and Mongan Institute for Health Policy, Boston, Massachusetts, USA

ABSTRACT. *Background:* Resident physicians are the direct care providers for many patients with addiction. This study assesses residents' self-perceived preparedness to diagnose and treat addiction, measures residents' perceptions of the quality of addictions instruction, and evaluates basic knowledge of addictions. *Methods:* A survey was e-mailed to 184 internal medicine residents at Massachusetts General Hospital in May 2012. *Results:* Responses were obtained from 55% of residents. Residents estimated that 26% of inpatients they cared for met criteria for a substance use disorder (SUD). Twenty-five percent of residents felt unprepared to diagnose and 62% felt unprepared to treat addiction. Only 13% felt very prepared to diagnose addiction. No residents felt very prepared to treat addiction. Preparedness to diagnose or treat addiction did not differ significantly across postgraduate year (PGY) level. Fifty-five percent rated the overall instruction in addictions as poor or fair. Seventy-two percent of residents rated the quality of addictions training as poor or fair in the outpatient clinical setting, and 56% in the inpatient setting. No resident answered all 6 knowledge questions correctly. Slightly more than half correctly identified the mechanism of buprenorphine and 19% correctly answered a question about naltrexone. Nine percent of residents responded that someone had expressed concern about the respondent's substance use. *Conclusions:* Despite providing care for a substantial population with addiction, the majority of internal medicine residents in this study feel unprepared to treat SUDs. More than half rate the quality of addictions instruction as fair or poor. Structured and comprehensive addictions curriculum and faculty development are needed to address the deficiencies of the current training system.

Correspondence should be addressed to Sarah E. Wakeman, MD, Massachusetts General Hospital, 55 Fruit Street, GRB 740, Boston, MA 02114, USA. E-mail: swakeman@partners.org

184 internal medicine residents at Mass General Hospital in 2012

62% felt unprepared to treat addiction

No residents felt "very prepared"

No residents answered all 6 knowledge questions correctly

Preparedness to diagnose or treat addiction did not differ significantly across PGY level

SUBSTANCE ABUSE, 34: 363–370, 2013

NOT JUST DOCTORS

Drug and Alcohol Dependence 131 (2013) 23–35

Contents lists available at SciVerse ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdep

ELSEVIER

Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review

Leonieke C. van Boekel[a,*], Evelien P.M. Brouwers[a], Jaap van Weeghel[a,b,c], Henk F.L. Garretsen[a]

[a] Department Tranzo, Tilburg University, Tilburg School of Social and Behavioral Sciences, PO Box 90153, 5000 LE Tilburg, The Netherlands
[b] Phrenos Centre of Expertise, PO Box 1203, 3500 BE Utrecht, The Netherlands
[c] Parnassia Bavo Group, Dijk en Duin Mental Health Center, PO Box 305, 1900 AH Castricum, The Netherlands

A R T I C L E I N F O

Article history:
Received 17 December 2012
Received in revised form 18 February 2013
Accepted 18 February 2013
Available online 13 March 2013

Keywords:
Substance-related disorders
Attitude of health personnel
Stigma
Delivery of health care

A B S T R A C T

Background: Healthcare professionals are crucial in the identification and accessibility to treatment for people with substance use disorders. Our objective was to assess health professionals' attitudes towards patients with substance use disorders and examine the consequences of these attitudes on healthcare delivery for these patients in Western countries.
Methods: Pubmed, PsycINFO and Embase were systematically searched for articles published between 2000 and 2011. Studies evaluating health professionals' attitudes towards patients with substance use disorders and consequences of negative attitudes were included. An inclusion criterion was that studies addressed alcohol or illicit drug abuse. Reviews, commentaries and letters were excluded, as were studies originating from non-Western countries.
Results: The search process yielded 1562 citations. After selection and quality assessment, 28 studies were included. Health professionals generally had a negative attitude towards patients with substance use disorders. They perceived violence, manipulation, and poor motivation as impeding factors in the healthcare delivery for these patients. Health professionals also lacked adequate education, training and support structures in working with this patient group. Negative attitudes of health professionals diminished patients' feelings of empowerment and subsequent treatment outcomes. Health professionals are less involved and have a more task-oriented approach in the delivery of healthcare, resulting in less personal engagement and diminished empathy.
Conclusions: This review indicates that negative attitudes of health professionals towards patients with substance use disorders are common and contribute to suboptimal health care for these patients. However, few studies have evaluated the consequences of health professionals' negative attitudes towards patients with substance use disorders.

© 2013 Elsevier Ireland Ltd. All rights reserved.

Contents

1. Introduction 24
2. Methods 24
   2.1. Search strategy 24
   2.2. Study selection 24
   2.3. Data extraction 25
3. Results 25
   3.1. Search results 25
   3.2. General findings 26
   3.3. Attitudes of health professionals 26
   3.4. Explanations for negative attitudes 29
   3.5. Consequences of attitudes on healthcare delivery 32

* Corresponding author at: Warandelaan 2, PO Box 90153, 5000 LE Tilburg, The Netherlands. Tel.: +31 0 13 466 4160; fax: +31 0 13 466 3637.
E-mail address: L.vanBoekel@tilburguniversity.edu (L.C. van Boekel).

0376-8716/$ – see front matter © 2013 Elsevier Ireland Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.drugalcdep.2013.02.018

Downloaded for Anonymous User (n/a) at University of Texas at Austin School of Nursing from ClinicalKey.com by Elsevier on August 31, 2020.
For personal use only. No other uses without permission. Copyright ©2020. Elsevier Inc. All rights reserved.

Systematic review

Health professionals generally had a negative attitude towards patients with SUDs.

Perceived as "manipulative, aggressive, rude and poorly motivated"

Health professionals lacked adequate education, training and support structures in working with this patient group.

Five studies found that health professionals who had more personal or work experience or contact with substance use reported more positive or different attitudes.

Patients are dying from drug use at an increased rate

TAKEAWAY #1

Healthcare education programs are not preparing trainees to effectively address addiction and substance use disorders in clinical practice

TAKEAWAY #2

HOW DOES ADDICTION STIGMA MANIFEST IN HEALTHCARE SETTINGS?

WWW.RESETSTIGMA.ORG

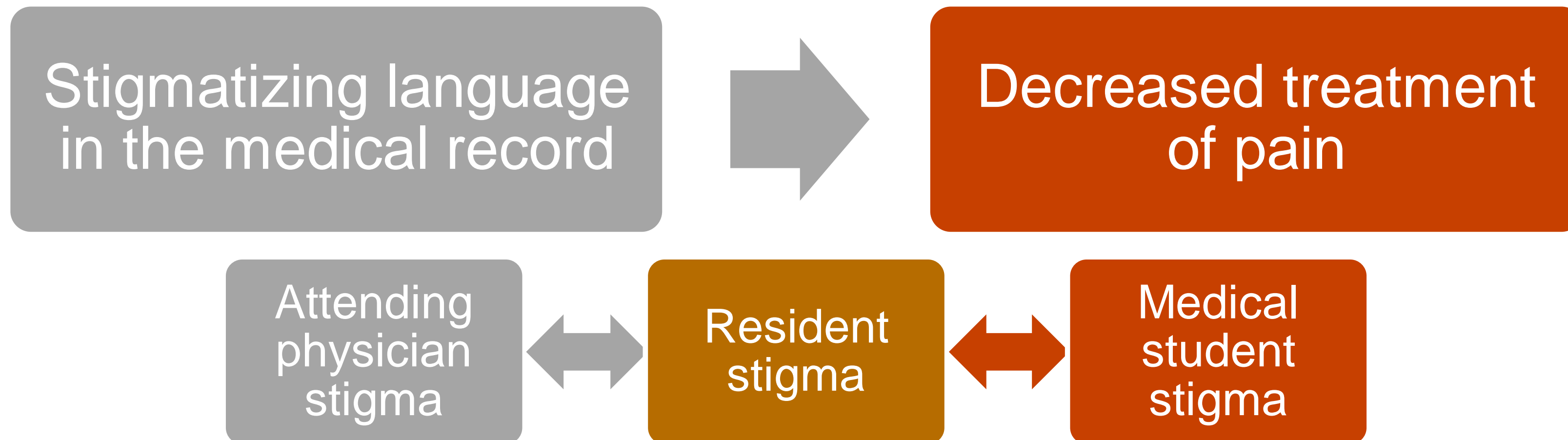
HOW DOES ADDICTION STIGMA MANIFEST IN CLINICAL PRACTICE?

- Discontinuation of life-saving treatment to receive liver transplant
- Denial of valve repair surgery in endocarditis
- Reduced access to necessary primary care and pharmaceuticals
- Shame, prolonged hospitalization, and potential justice-system involvement for pregnant patients

Wakeman et al., (2018); Aultman et al., (2018); Hill et al., (2020); Howard, (2015)

HOW DOES STIGMA MANIFEST IN CLINICAL PRACTICE?

Health professionals have a negative attitude towards patients with SUDs.



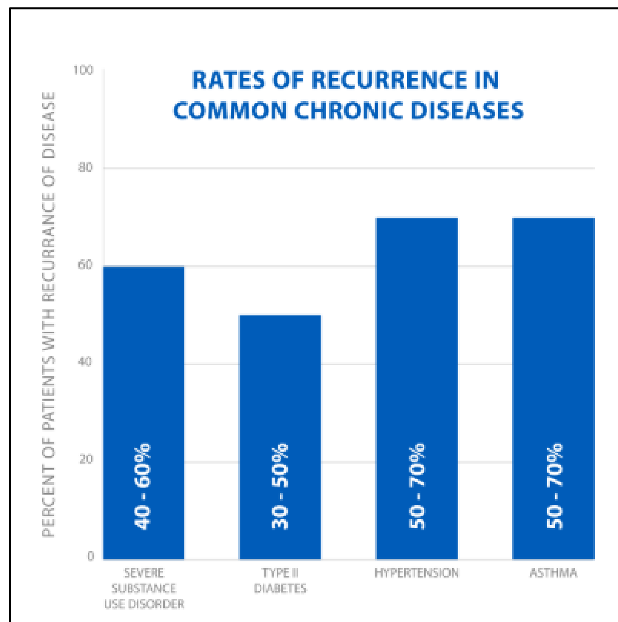
Goddu et al. (2018); Goddu, Anna et al., 2018; van Boekel et al., 2013

HOW DOES STIGMA MANIFEST IN CLINICAL PRACTICE?

Substance use disorders are treated as an acute illness associated with moral failing.

In reality:

- SUDs are driven by genetic and environmental factors
- Rates of recurrence very similar to other chronic diseases

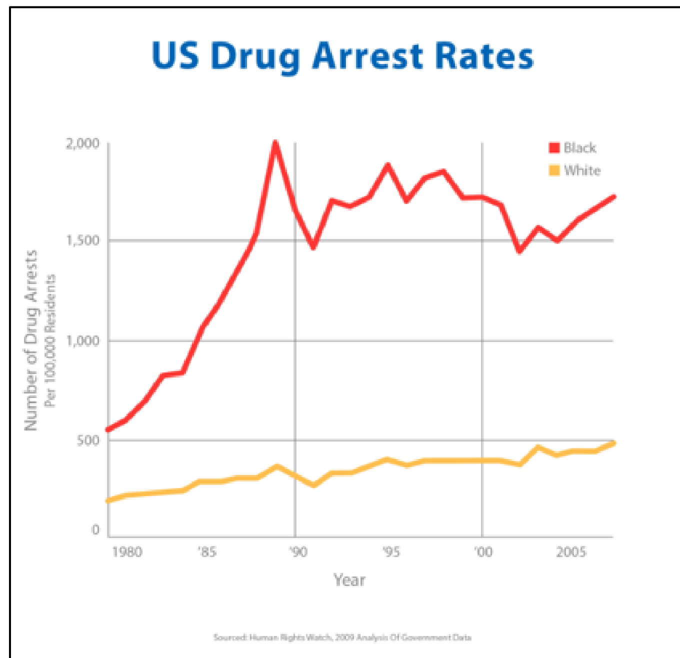


(NIDA, 2005)

DRUG POLICY

1970s “War on Drugs”

- Cocaine then, heroin now.
- Responsible for large disparities among individuals of racial minority groups.
- Today, White patients are **35 times more likely** to receive treatment for OUD compared to Black patients. →



Santoro & Santoro (2018); Lagisetty et al (2019)

Patients are dying from drug use at an increased rate

TAKEAWAY #1

Healthcare education programs are not preparing trainees to effectively address addiction and substance use disorders in clinical practice

TAKEAWAY #2

Social and structural stigma negatively influence the way that patients with any history of drug use or addiction access and experience healthcare delivery

TAKEAWAY #3

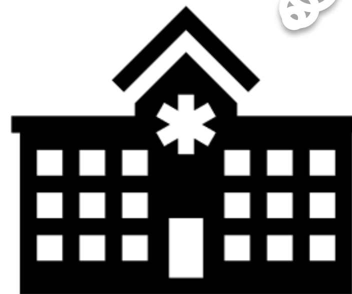
HOSPITALIZATION: A RECOVERY OPPORTUNITY

WHAT ARE WE CURRENTLY DOING FOR PEOPLE WITH OUD?

Hospitals are **CRITICAL** access points.

but…

OUD screening, management, treatment, and harm reduction must be better addressed in hospitals.



(Furr-Holden et al., 2016)

INTERVENTIONS TARGET PRESCRIPTION OPIOID MISUSE

Original Investigation | Substance Use and Addiction

February 1, 2019

Prevention of Prescription Opioid Misuse and Projected Overdose Deaths in the United States

Qiushi Chen, PhD[1,2,3]; Marc R. Larochelle, MD, MPH[4]; Davis T. Weaver, BS[2,5]; et al

Author Affiliations | Article Information

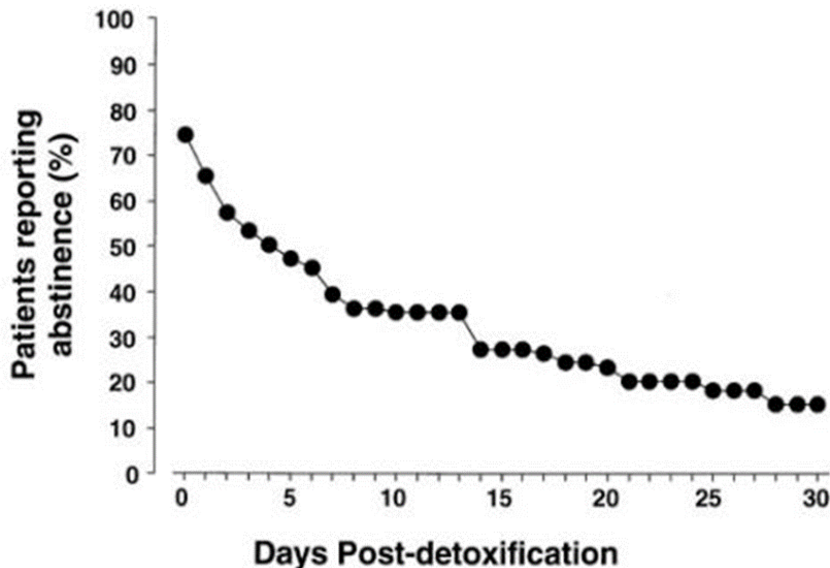
JAMA Netw Open. 2019;2(2):e187621. doi:10.1001/jamanetworkopen.2018.7621

Status Quo?
Reduction in overdose by 5% by 2025!

Conclusions and Relevance:
"…interventions targeting prescription opioid misuse such as prescription monitoring programs may have a modest effect, at best, on the number of opioid overdose deaths in the near future. Additional policy interventions are urgently needed to change the course of the epidemic."

INEFFECTIVE DETOXIFICATION

Gradual decline in patients reporting abstinence after detoxification



Chatuape, et al., 2001

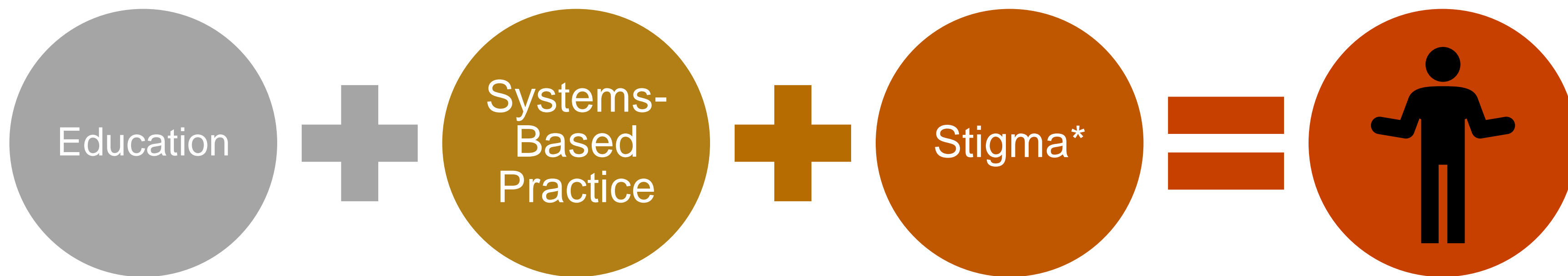
"TREAT AND STREET"

National estimates of total charges and disposition for hospitalizations related to opioid abuse/dependence and associated infections

	2002	2012[a]
Number of hospitalizations with opioid abuse/dependence	301,707	520,275
Length of stay in days (mean)	5.8	5.2
Number of procedures (mean)	1.1	1.1
Total charges	$4,574,263,003	$14,850,435,892
Disposition (percent of total discharges with opioid abuse/dependence)		
In-hospital death	1%	1%
Home	75	79
Facility[b]	9	10
Left against medical advice	13	8
Other or missing	2	2
Number of hospitalizations with opioid abuse/dependence with infection[c]	3,421	6,535
Length of stay in days (mean)	16.8	14.6
Number of procedures (mean)	3.1	3.3
Total charges	$190,678,889	$700,663,008
Disposition (percent of total discharges with opioid abuse/dependence with infection)		
In-hospital death	5%	3%
Home	49	49
Facility[b]	26	27
Left against medical advice	11	12
Other or missing	8	9

Ronan & Herzig, 2016

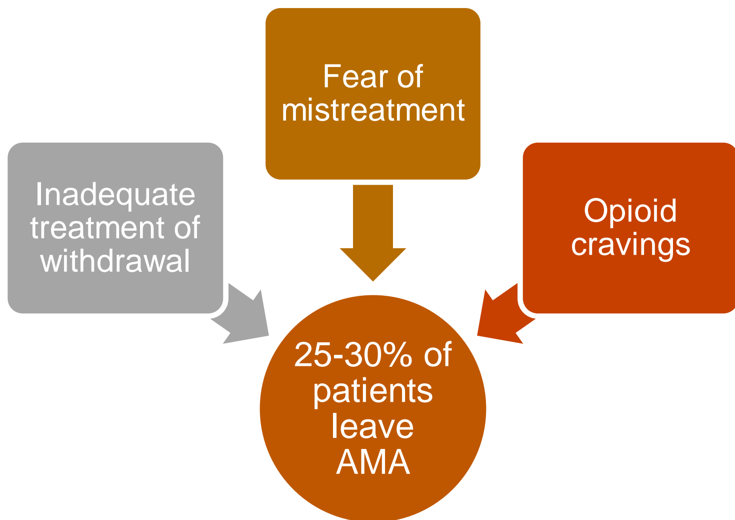
WHY ISN'T SUD TREATMENT THE STANDARD OF MEDICAL CARE?

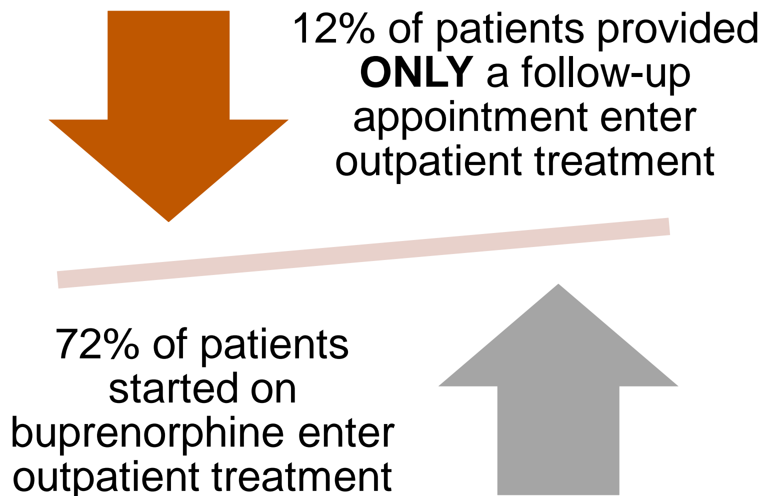


WHAT SHOULD WE BE DOING:
TREATING SUD DURING ACUTE HOSPITALIZATION

HOSPITALIZATION: A RECOVERY OPPORTUNITY

Hospitalization is a reachable moment.



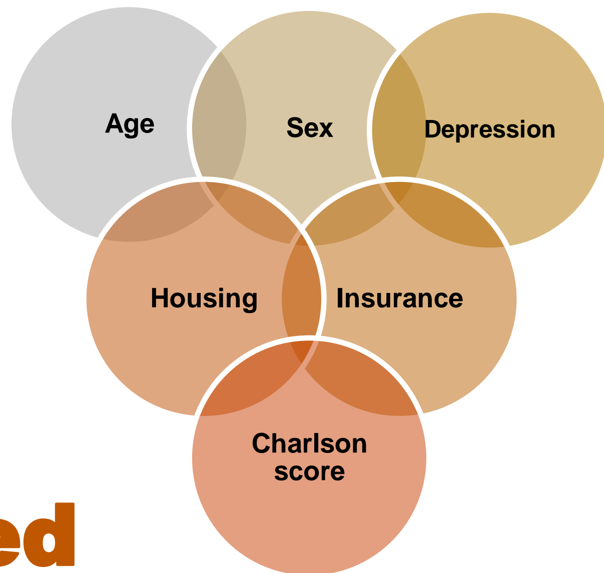


Lianping Ti et al. (2015); Liebschutz et al. (2014)

READMISSIONS

Patients with SUDs are more likely to be readmitted within 30-days.

Even when adjusted for:



1.7 times more likely to be readmitted

Walley (2012)

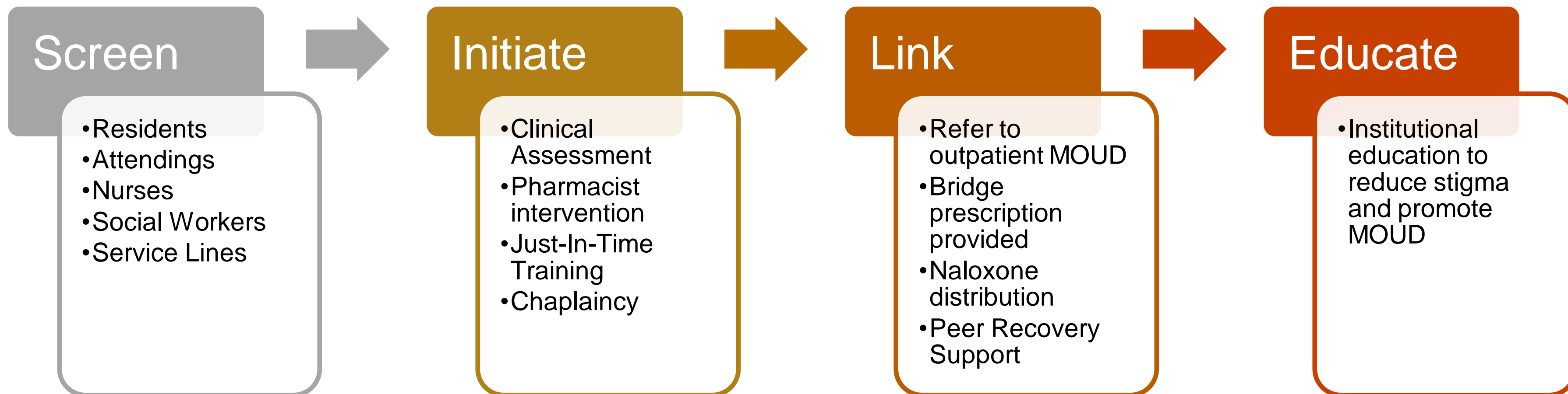
Among patients with opioid use disorder taking buprenorphine at the time of hospital admission...

53% reduction

Moreno, Jessica L., PharmD; Wakeman, Sarah E., MD, et al. Predictors for 30-Day and 90-Day Hospital Readmission Among Patients With Opioid Use Disorder. J Addict Med. doi: 10.1097/ADM.0000000000000499

THE BUPRENORPHINE TEAM

An interprofessional and multidisciplinary group that works to:



* Without the presence of addiction medicine consultation service but with planned obsolescence

WHAT WE LEARNED ABOUT OUD TREATMENT AND STIGMA

Our initial focus was on medication administration but we inadvertently reduced stigma by:

- Education
- Messaging
- Facilitating conversation
- Role-modeling

A NOTE:

Addiction "recovery" should be defined by the patient

Patients should be involved in shared decision making regarding their self-directed recovery journey

Abstinence is not the only successful "recovery" outcome

WHAT SHOULD WE BE DOING:
REDUCING STRUCTURAL AND SOCIAL STIGMA WITHIN OUR INSTITUTIONS

STIGMA REDUCTION OPPORTUNITIES

Use person-first recovery-centered language

Identify and eliminate structural barriers

Sympathetic narratives → share patient stories

Incorporate stigma awareness and reduction trainings

USE APPROPRIATE LANGUAGE

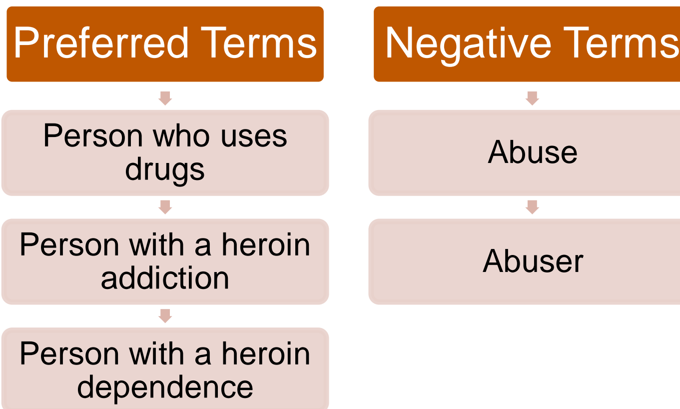
Changing the Language of Addiction

Terms that stigmatize addiction can affect the perspective and behavior of patients, clients, scientists, and clinicians. Clinicians especially need to be aware of person-first language and avoid more stigmatizing terms.

Terms Not to Use	Terms to Use
addict, abuser, user, junkie, druggie	person with a substance use disorder
alcoholic, drunk	person with an alcohol use disorder
oxy-addict, meth-head	person with an opioid use disorder
ex-addict, former alcoholic	person in recovery
clean/dirty (drug test)	negative/positive result(s)
addictions, addictive disorders	addiction, substance use disorder

HOW DO PATIENTS REFER TO THEMSELVES?

250+ patients evaluated at a Massachusetts substance use clinic



Pivovarova & Stein (2019); Ashford, Brown, & Curtis (2019)

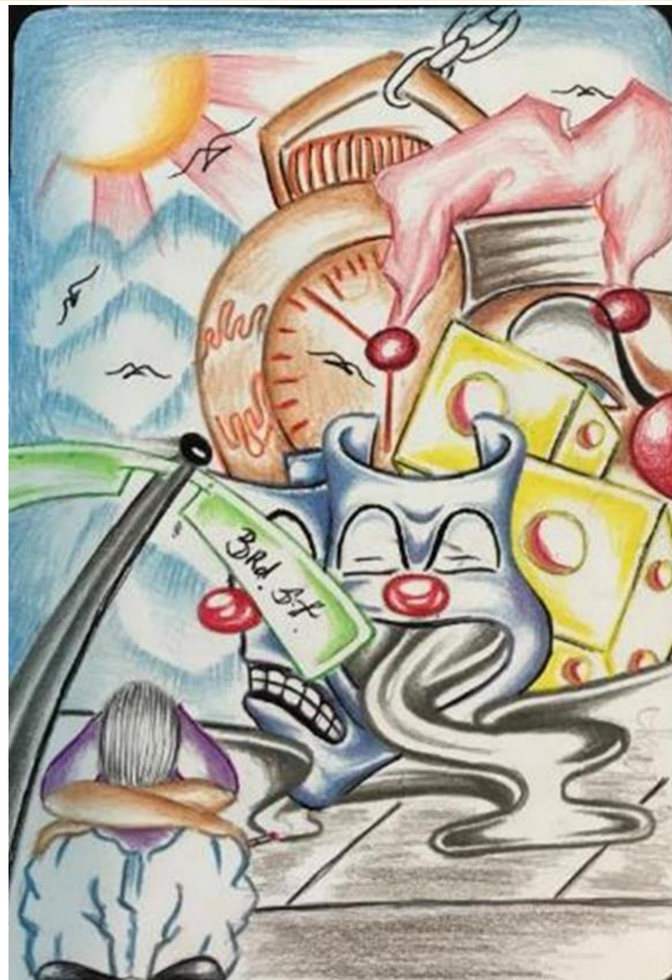
IDENTIFY STRUCTURAL BARRIERS

Policies or institutional actions that restrict the opportunities of targeted groups, whether intentional or not.

- Starting or continuing treatment during hospitalization
- Formulary restrictions
- Care coordination
- Misunderstanding of regulatory environment

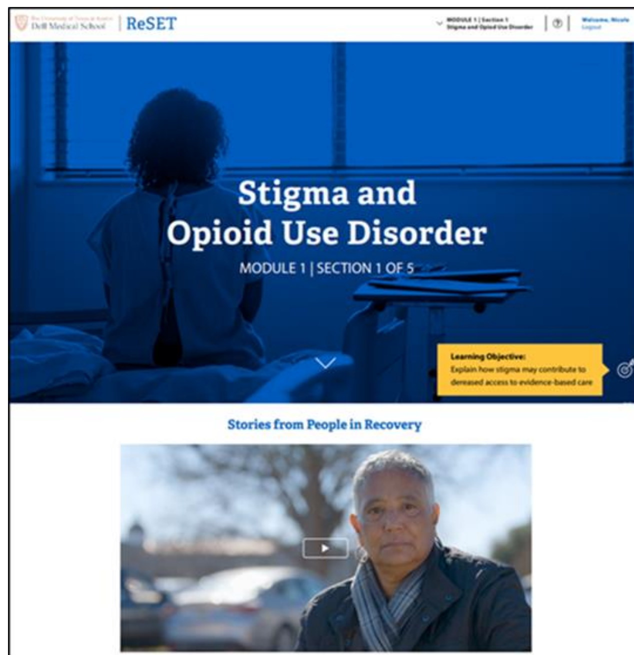
Corrigan 2004

SYMPATHETIC NARRATIVE AND PATIENT STORIES



STIGMA REDUCTION

Health professionals have a negative attitude towards patients with SUDs.



www.resetstigma.org

STIGMA REDUCTION IN EDUCATION PROGRAMS

Idaho State University

Improving behavioral health patient experiences and healthcare worker wellness through empathy-grounded training in health professions

Washington State University

Combating Stigma surrounding Chronic Pain and Substance Use with Interprofessional Education

Yale University School of Medicine

Addressing stigma as part of a massive open online foundational addiction course for professional healthcare training programs

University of Colorado

Combatting Opioid Use Disorder Stigma with White Coat Lapel Pins at the University of Colorado Anschutz Medical Campus

University of Louisville

A blended learning program to reduce stigmatizing beliefs and behaviors of nurses towards patients with substance use disorders

Clemson University

Systematic education about substance use disorders and pharmacotherapies

Rush Medical College

Interdisciplinary bias awareness and stigma reduction training

Patients are dying from drug use at an increased rate

TAKEAWAY #1

Healthcare education programs are not preparing trainees to effectively address addiction and substance use disorders in practice

TAKEAWAY #2

Social and structural stigma negatively influence the way that patients with any history of drug use or addiction access and experience healthcare delivery

TAKEAWAY #3

Using non-stigmatizing language, elimination of structural barriers, using patient stories, and completing stigma awareness and reduction trainings can increase individual and institutional ability to effectively care for patients with SUD and ultimately save lives.

TAKEAWAY #4

Patients are dying from drug use at an increased rate

TAKEAWAY #1

Healthcare education programs are not preparing trainees to effectively address addiction and substance use disorders in practice

TAKEAWAY #2

Social and structural stigma negatively influence the way that patients with any history of drug use or addiction access and experience healthcare delivery

TAKEAWAY #3

Using non-stigmatizing language, elimination of structural barriers, using patient stories, and completing stigma awareness and reduction trainings can increase individual and institutional ability to effectively care for patients with SUD and ultimately save lives.

TAKEAWAY #4

QUESTIONS?

Please reach out with questions and collaborations!

Alanna Boulton, MSHS, MSHA, PMP
alanna.boulton@austin.utexas.edu
www.shoutx.org | www.resetstigma.org