Shatterproof
Stronger than addiction

UNITE Against SUD Stigma

June 27th, 2023

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National Stigma Initiative
Shatterproof

Today's Agenda

Who is Shatterproof?

Introduction to Addiction Stigma

- What is addiction stigma?
- Shatterproof Addiction Stigma Index
- Addiction Stigma and Healthcare Professionals

What Works to Reduce Stigma?

Implications and Action Items

- Stigma Reduction Campaigns
- Individual Actions

Relevant to the content of this educational activity, I do not have a financial relationship with an ineligible company to disclose.

Uncover your bias

Notice stigmatizing language

Identify and share resources

Take time to recharge

Empathize and empower

UNITE

Shatterproof is a national nonprofit organization dedicated to reversing the addiction crisis in the United States.

Shatterproof's Plan

Revolutionizing the Treatment System

Breaking Down Addiction Stigma

Supporting and Empowering Communities

Shatterproof's Approach

Prioritized & Reviewed

100 publications and reports related to stigma reduction

Assessed

11 analogous social-change movements to understand how they shifted beliefs & behaviors

Conducted Interviews

50+ experts in social change, mental health, and addiction

Shatterproof embarked on a six-month project rigorously reviewing and analyzing analogous movements to inform Shatterproof's plans to significantly reduce the stigma associated with substance use disorder and, ultimately, behavioral health more broadly.

6 Key Success Factors in Past Movements

1. A well-funded, central actor(s) benefitted the creation of rapid change
2. Key actions taken in educating, altering language, & changing policies
3. Educational initiatives using contact-based strategies to humanize and emphasize treatment is effective
4. Movements to activate influential institutions → achieve public adoption
5. Positive & negative incentives employed to change relevant behavior
6. Action mobilized at both the "grassroots" & "grasstops"

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Key Drivers of the Overdose Crisis

1. Marketing of prescription opioids as non-addictive and overprescribing of opioids
2. Increasing access to heroin and fentanyl
3. Shame and social isolation
4. Individuals not seeking help for their addiction
5. Insufficient treatment capacity
6. Health care coverage & reimbursement disparities
7. Non-evidence based treatment
8. Criminalization of people with SUD
9. Social and structural barriers to recovery

7 of the 9 drivers of the overdose crisis are driven in part by stigma

Shatterproof's White Paper

A white paper with the latest research about stigma, stigma's societal impact, and the subsequent strategy to address it. Freely available on shatterproof.org, it went through an independent, blinded, and academically rigorous expert peer review facilitated by the National Academy of Medicine.

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SHATTER PROOF.

A Movement to End Addiction Stigma

Addressing opioid use disorder stigma: The missing element of our nation's strategy to confront the opioid epidemic

Addiction Stigma

What is Stigma?

Stigma is a mark of disgrace associated with a particular circumstance, quality, or person.

It is a barrier to receiving healthcare and engaging in help-seeking behaviors, and results in discrimination and exclusion.

Types of Stigma

Public Stigma

Society's negative attitudes towards a group of people creating environments where individuals feel unwelcome, judged, shamed, and/or blamed. This also includes stigma towards MOUD.

Structural Stigma

Systems-level discrimination caused and codified by institutional policies and/or dominant social norms.

Self-Stigma

Where individuals accept societal stereotypes and experience reduced self-esteem and self-efficacy.

Stigma Begins With...

Examples include beliefs about **competence or dangerousness** that drive desire for **social distance** and **discriminatory attitudes and behaviors.**

Stigma Components

- Labeling
- Stereotyping
- Separation (distancing)
- Status loss
- Discrimination

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Other Ways of Conceptualizing Stigma

- Traditional prejudice
- Social distance
- Internalized prejudice
- Perceived discrimination

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Changing Language to Improve Care

PERSON with the Substance Use Disorder may say:

Addict

Drug Abuser

Alcoholic

Dirty/Clean

GENERAL PUBLIC, HEALTHCARE PROFESSIONALS MUST say:

Person with a Substance Use Disorder

Recovery

Misuse

A Note on Race, Ethnicity, and Stig

OVERDOSE DEATHS

Per 100,000 People

	2019	2020
Black/Non-Hispanic	27	39
American Indian, Alaska Native/ Non-Hispanic	26	36
White/Non-Hispanic	25	31
Hispanic	17	21
Asian, Pacific Islander/ Non-Hispanic	3	3

https://www.cdc.gov/vitalsigns/overdose-death-disparities/index.html

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Stigma manifests as discrimination and isolation.

The Shatterproof Addiction Stigma Index (SASI)

The Addiction Stigma Index

In partnership with Drs. Brea Perry and Anne Krendl at IU and the global marketing firm Ipsos, Shatterproof developed and released the SASI, which:

- Is a first-of-its-kind measurement tool designed to assess attitudes about substance use and people who use substances from the public (public and structural stigma).
- Measures the perceptions of those with SUD, including the degree in which they have internalized this exclusion (self-stigma).
- Comprised of more than 50 validated stigma measures issued to a representative sample of 7,889 U.S. residents.

SASI Methodology

Utilizes Indexes

An index measures change in a representative group of individual data points. The SASI has three stigma indices that measure public, structural, and self-stigma.

Measuring Change

Measuring change in this composite manner sets a baseline and enables comprehensive progress measurement – a vital component of stigma reduction.

Vignette Strategy

Utilizes a vignette strategy, which enabled a review of how stigma varied by substance type and recovery status.

“You’re going to read a description about a person – let’s call him John. After you read the description of him, you will answer some questions about how you think and feel about him. There are no right or wrong answers. We are only interested in what you think of him.”

Why a Vignette Strategy?

- **Neutral Tone** – avoids provoking immediate bias
- **Real SUD Profile** – elicits reactions based on real SUD symptoms
- **Behavior vs. Label** – standardizes the type of person
- **Experimental Manipulations** – replicates how a typical person would interact with someone with SUD

Stigma Scales

Public Stigma Scale

A 14-item scale that measure stigmatizing attitudes and beliefs about people with substance use disorders, including indicators of traditional prejudice and preference for social exclusion.

Structural Stigma Scale

A 5-item scale that measures support for discrimination against people with substance use disorders in major social institutions.

Stigma against medications for opioid use disorder is a subset of the public stigma scale

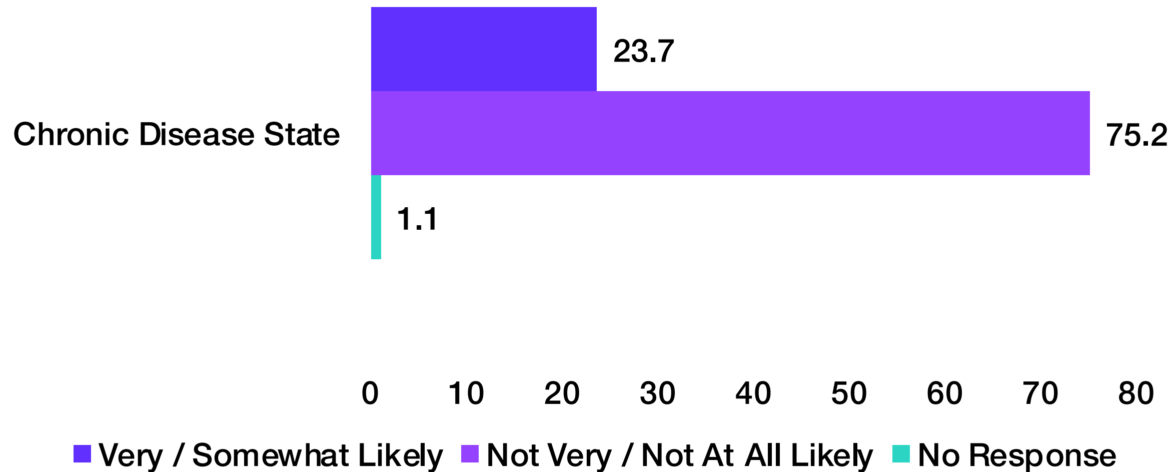
Self-Stigma Scale

A 15-item scale that measures internalization of stigmatizing attitudes and beliefs about substance use and resulting negative emotions and opinions of oneself.

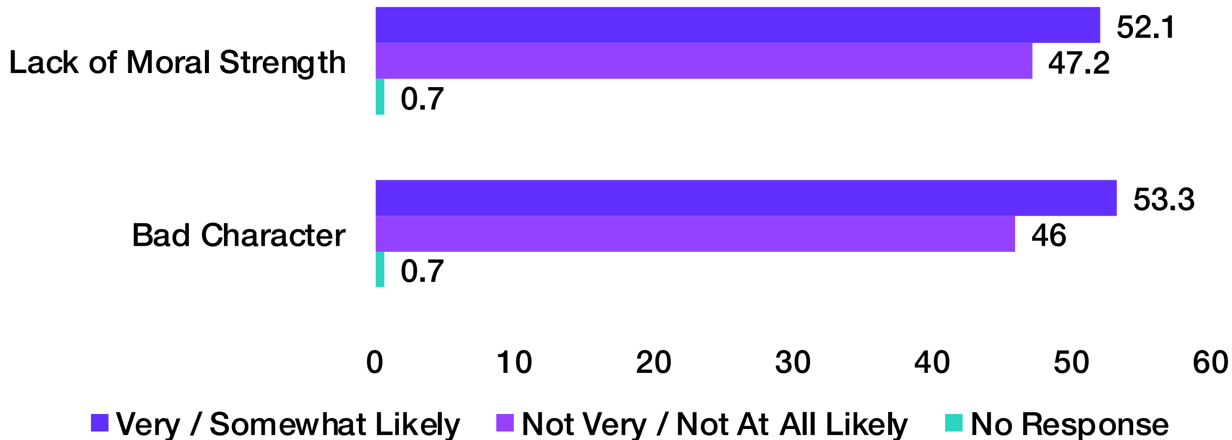
What Else Can We Learn?

- Diagnostic labeling – what is John experiencing?
- Causal attributions – what is John's SUD caused by?
- Desire for social distance – what level of proximity to John is acceptable?
- Traditional prejudice – what do we believe about John as a person?

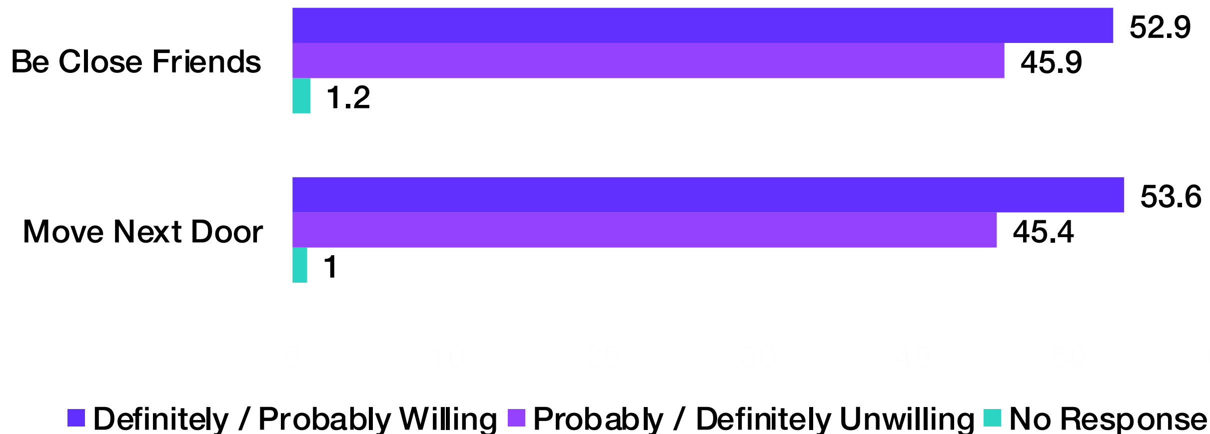
SASI Results of Interest



SASI Results of Interest



SASI Results of Interest

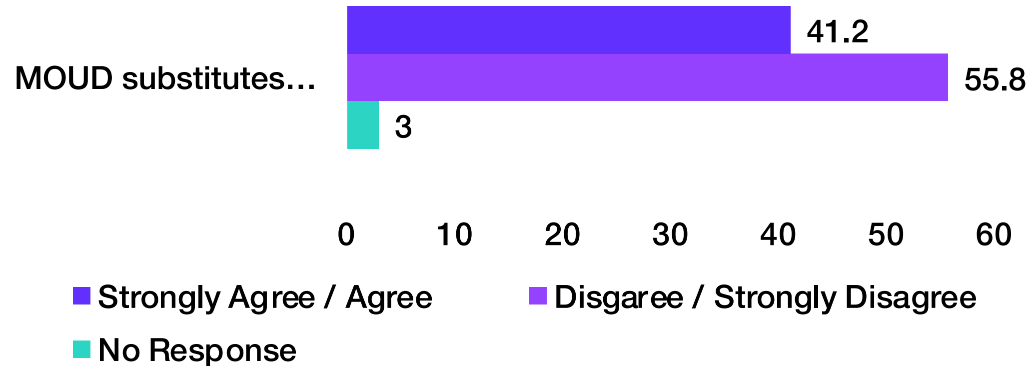


SASI Results of Interest

Stigma persists even when a person is **in long-term recovery.**

	Definitely / Probably Willing	Probably / Definitely Unwilling	No Response
Supervisor At Work	47.8	50.7	1.5
Marry Into Family	45.8	52.4	1.8

SASI Results of Interest



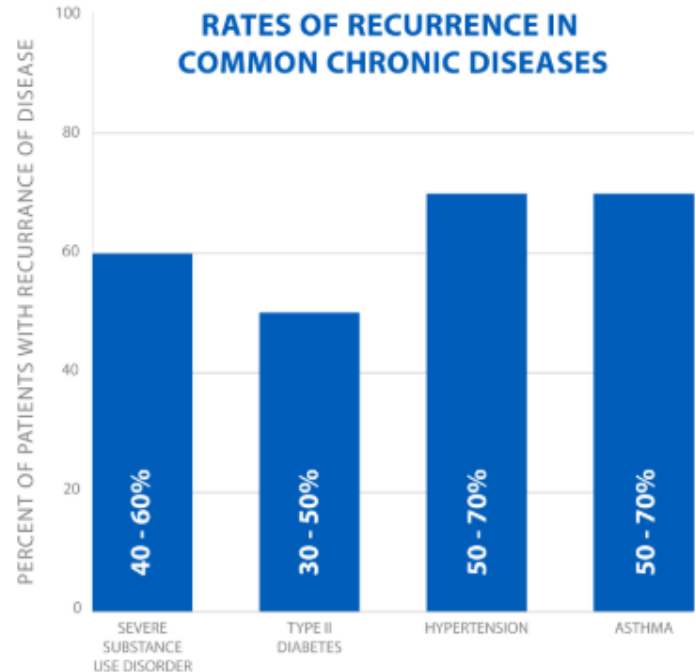
Addiction Stigma and Healthcare Professionals

How Does Addiction 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



Healthcare Professionals and SUD Stigma

Shatterproof's Addiction Stigma Index identified the following:

65% of healthcare professionals falsely believe that **SUD is not a chronic disease.**

44% of healthcare professionals would be unwilling **to move next door** to someone with SUD, and **47%** would be unwilling to have a person with SUD **as a close friend.**

45% of healthcare professionals endorsed the harmful belief that use of **MOUDs is substituting one drug for another.**

It starts before seeing a single patient

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

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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.

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

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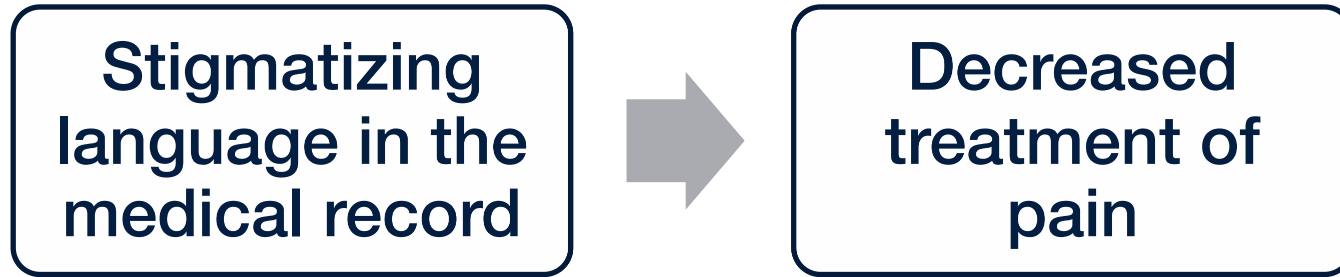
How Does Addiction Stigma Manifest in Clinical Practice?

Health professionals have a negative attitude towards patients with SUDs.



How Does Addiction Stigma Manifest in Clinical Practice?

Some examples:

- 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

Not Just Doctors

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

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ABSTRACT

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.

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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.

Stigma and Healthcare

- The healthcare system is not designed to support individuals with SUDs
- Attitudes toward individuals with SUDs tend to decline during residency training and negatively affect patient care
- Access to treatment and care is even more challenging with BIPOC communities

BUT…
Attitudes toward individuals with SUDs improved after taking an online training module

An Example…

Words shape how we view people and how we treat them

“an individual with substance use disorder”

vs

“substance abuser”

Clinicians more likely to say the patient was personally responsible for their illness and support punitive action.

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Key Actions

Stigma Reduction Opportunities

Use person-first & recovery-centered language

Identify & eliminate structural barriers

Sympathetic narratives – sharing stories

Incorporate stigma awareness & reduction trainings

Key Components of Stigma Reduction

Tailored Messaging

Contact Based Strategies

Person-first Language Education

Continuous Evaluation

Collective Impact

Q&A

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Thank you!

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Additional Stigma Resources

Shatterproof White Paper: A Movement to End Addiction Stigma

Shatterproof Addiction Language Guide

Shatterproof Addiction Stigma Index

- First-of-its-kind research tool confirms stigma, discrimination deepen addiction as a public health crisis

Changing the Narrative

- A network of reporters, researchers, academics, and advocates concerned about the way media represents drug use and addiction.

Reducing Stigma Education Tools (ReSET)

- Need to make an account, but it is free
- The aim of these modules is to help health care providers confidently identify and address stigma surrounding opioid use disorder, to ensure the delivery of equitable and compassionate health care for all patients living with opioid addiction.