Thank you for attending today’s training. By doing so you are strengthening the ability of your community-based and patient-directed health center to deliver comprehensive, culturally competent, high-quality primary health care services.

Presented by:
Daniel Goldberg, JD, PhD, Associate Professor, Center for Bioethics and Humanities, Department of Family Medicine, University of Colorado

Live Broadcast Date/Time:
Thursday, January 17, 2019
11:30–1:00PM Mountain Time / 12:30–2:00PM Central Time

Target Audience:
All staff at Region VIII CHCs who interact with patients who have SUDs, including in both clinical and administrative roles.

Event Overview:
This webcast will discuss stigma against people with substance use disorders, including how to recognize various types of bias and how to then address them at both the individual and organizational level. Dr. Goldberg will share tips and tools designed to help all health center staff identify their own internal biases and biased behaviors and work to positively change their perceptions and actions in order to effectively support patients with substance use disorders.

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LEARNING OBJECTIVES:
Upon completion of this session, participants should be able to:
1. Define stigma as it is conceptualized in health contexts;
2. Identify three challenges to eliminating SUD stigma in clinical settings;
3. Identify two interventions that may ameliorate SUD stigma in clinical and organizational settings

CHAMPS ARCHIVES
This event will be archived online. This online version will be posted within two weeks of the live event and will be available for at least one year from the live presentation date. For information about all CHAMPS archives, please visit www.CHAMPsonline.org/events-trainings/distance-learning.

DESCRIPTION OF CHAMPS
Community Health Association of Mountain/Plains States (CHAMPS) is a non-profit organization dedicated to supporting all Region VIII (CO, MT, ND, SD, UT, and WY) federally-funded Community, Migrant, and Homeless Health Centers so they can better serve our patients and communities. Currently, CHAMPS programs and services focus on education and training, collaboration and networking, workforce development, and the collection and dissemination of regional data. For more information about CHAMPS, and the benefits of CHAMPS Organizational Membership, please visit www.CHAMPsonline.org.

SPEAKER BIOGRAPHY
Dr. Goldberg is an Associate Professor in the Department of Family Medicine and the Center for Bioethics and Humanities at the University of Colorado. He holds a PhD in Medical Humanities from the University of Texas and a JD from the University of Houston Law Center, and describes himself as an historian of medicine and a public health ethicist. His current research focuses on law, policy, and bioethics related to chronic illness, health inequities, the social determinants of health, and stigma.

CONTINUING EDUCATION CREDIT
This Live Activity, Addressing Stigma Against Patients with Substance Use Disorders: Individual and Institutional Strategies, with a beginning date of 01/17/2019, has been reviewed and is acceptable for up to 1.25 Prescribed Credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Addressing Stigma Against Patients with Substance Use Disorders

Daniel S. Goldberg, J.D., Ph.D
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Hosted By:

University of Colorado Anschutz Medical Campus

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How many total people are watching this webcast at your computer, including yourself?

Please enter your answer into the questions box.
LEARNING OBJECTIVES

- Define stigma as it is conceptualized in health contexts;
- Identify three challenges to eliminating SUD stigma in clinical settings;
- Identify two interventions that may ameliorate SUD stigma in clinical and organizational settings.

CRITERIA FOR STIGMA

- Enormous literature in soc. sci & humanities
- Not simply ‘prejudice’ or ‘bias’
- Goffman 1963
- Link & Phelan 2006
  1. Difference
  2. Deviance
**DIFFERENCE + DEVIANCE**

- Difference + Deviance (Link & Phelan 2006)
  1. In-group marks out-group on basis of identifiable demographic characteristic
  2. Out-group assigned negative judgment

**SLIPPAGE . . .**

- Historically, disease stigma in West is distressingly common
- Explanations?
  - Evolutionary
  - Phenomenological (consider Book of Job in Judeo-Christian societies) (Goldberg 2010)
STIGMA AS HEALTH PROBLEM

- Stigma is bad for both empirical and ethical reasons
  - Empirical: stigma is very bad for your health (Katzenbuehler, Phelan, and Link 2013; Scambler 2006; Burris 2002)
  - Ethical: even if no adverse health effects, is pernicious

STIGMA, COMPOUND DISADVANTAGE & INEQUALITIES

- Stigma fundamentally connected to power structures
- So . . . Disadvantaged/vulnerable more likely to be stigmatized, suffer more intense stigma
- Felt Stigma (Scambler 2012)
  - “Densely-woven patterns of disadvantage” (Powers & Faden 2006)
Focus on inequalities that fuel “densely-woven patterns of disadvantage”

Twin aims
- Improvements in overall pop health
- Compression of inequities

Laws/policies that intensify stigma fail both prongs

Stigma is rooted in macrosocial structures

It is always caused by people
- “SUD stigmatizes . . .”
- #nopenopenope
- “We stigmatize people with SUD”

Confusing because manifests on individual level
**INDIVIDUAL, PERSON-CENTERED STIGMA VS. STRUCTURAL STIGMA**

- Phenomenologically, stigma often individual, person-centered
- Artificial, b/c stigma = structural
- Stigma is *scripted* – not “destiny” but dominant conceptual scheme

**ENACTMENT OF STIGMA**

- Social scripts often prompt invisible, unintentional stigma
- Reifies structures, scripts (discursive)
- Can be devastating for marginalized groups
- Integrated in laws, policies
  - i.e., overwhelming focus on supply-side restrictions
EXAMPLE (PAIN)

- C.F.R. § 404.1528(a) (2013)
  - “Your statements alone are not enough to establish that there is a physical or mental impairment.”

- American Pain Society statement:
  - “The patient’s self-report is the single most reliable indicator of pain. A clinician needs to accept and respect this self-report, absent clear reasons to doubt.”

POLL QUESTION 1

- How much stigma do you think people with SUDs generally encounter in seeking health care?

  A. A great deal
  B. Some
  C. Very little
  D. None
SUD STIGMA

- Paucity of good epi. on SUD stigma, but available evidence suggests same
- Some groups > likely to experience SUD stigma
- To extent SUD connected to pain, pain stigma also relevant
- (Interlocking stigmas)

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“Studies consistently show that public holds highly stigmatizing attitudes towards” PWUDs

“Stigmatizing attitudes towards [PWUDs] include perceiving them as dangerous, unpredictable, unable to make decisions, to blame for their conditions, and a willingness to coerce treatment and maintain social distance.”

(Yang et al., 2017)
STIGMA NOT IMPORTANT SIMPLY B/C IT IS BARRIER TO CARE

- Increasing evidence that stigma is independent SDoH (e.g., David Williams, Nancy Krieger’s work)
  - Members of marginalized groups subjected to persistent stigma get sicker and die quicker
- Stigma is corrosive and adverse to overall health
  - Deeply linked to power and social inequalities
- HCPs are one of leading sources of health & SUD stigma
DISEASE STIGMA AS HEGEMONIC

- Burris’s taxonomy of disease stigma (2002)
- Hegemonic stigma ("accepted as natural and sensible, without reflection") – often invisible
  - Australian HCPs in 2013 said T2D one of “least” stigmatized conditions
  - 93% of participants reported experiencing stigma (Browne et al., 2014)
- Good evidence HC professionals harbor negative attitudes towards persons w/ SUDs (structural) (van Boekel et al. 2013)

LAWS AND POLICIES MEDIATE STIGMA

- SUD stigma is w/o question mediated into our laws and policies (past and present):
  - (The Harrison Act of 1916 reflects all sorts of stigmas against PWUDs)
- Syringe Exchange Programs
- Substitution therapies
- Supervised Injection Facilities
STIGMA BEYOND PROVIDERS

- So why so much stigma re SUD?
  - Not just morality play w/ patients vs. providers
  - Caregivers, communities, persons with SUDs themselves (self-stigma, etc.)

THE STIGMA ENIGMA (!!)

- If humans are profoundly social animals w/ need for acceptance
- And if stigma is profoundly antisocial
- Why stigma so common in human societies?
- One theory: evolutionary adaption to deal w/ risks of social life (Kurzban & Leary 2001)
Several rounds of same conversation

Job: “why do I suffer?”

Friends: “because you have sinned”

Question of theodicy: how can an omnipotent, benevolent deity cause the innocent to suffer?

Illustration from William Blake’s The Book of Job (1825)

Nietzsche: prior to the Judeo-Christian narrative, “there was no answer to the crying question, ‘why do I suffer?’”

But suffering was not the chief problem: “the meaninglessness of suffering, not suffering itself, was the curse that lay over mankind thus far.”
### SIN-SUFFERING & DISEASE

- That we link sin & suffering because useful narrative in constructing meaning in problem of evil is apparent in history of illness, esp. infectious disease
- e.g., leprosy, cholera, Camus – especially as to aliens


### ANTI-STIGMA MECHANISMS

- Fortunately, many interventions have at least some effect
- Hegemonic stigma can be contested
  - (e.g., detailed EEOC guidelines on employment discrimination under ADA for T2D)
  - But must be named and identified
- Law/policy as a lever for cultural change?
- Fundamental change as to stigma requires social, structural change
- YET, individual providers have agency
  - Resisting stigma is ethically powerful
**ANTI-STIGMA MECHANISMS**

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**BEWARE BIOLOGIZATION**

- Poor evidence “biologizing” illness reduces stigma
- Some indication can intensify it (Buchman et al., 2014; Angermeyer et al., 2011)
- Perhaps b/c we are our bodies? (esp. brains)
Fundamental change as to stigma requires social, structural change

YET, individual providers have agency

Resisting stigma is ethically powerful

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Are specific anti-stigma mechanisms integrated into your practice environment?

A. Yes
B. No
C. I don’t know
1. Apply knowledge regarding social patterning of behavior to clinical interactions;
2. Implement anti-stigma training and programming;
3. Listen to PWUDs and others describing their lived experiences;
4. Pay attention to social structures that sustain stigma
5. Watch out for implicit bias

(Kelly, Dow & Westerhoff, 2010)
**LANGUAGE MATTERS**

Language matters but can change depending on the setting we are in. Choosing when and where to use certain language and labels can help reduce stigma and discrimination towards substance use and recovery.

**QUESTIONS?**
Thank You for Joining Us!

Your opinions about this webcast are very important to us.

Please complete the event evaluation for this webcast.
If you are applying for 1.25 CME credits, you must complete the credit questions found at the end of the Evaluation.

Each person should fill out their own Evaluation/Credit Survey.

Please refer to the SurveyMonkey link provided under the “Handouts” tab of the online event. The same link was provided in the reminder email sent out in advance of the event, and will be included in a follow-up email to those logging onto the event. Please pass the link along to others viewing the event around a shared computer.

Visit www.CHAMPSonline.org/Events/DistanceLearning.html for information about other live and archived CHAMPS webcasts.