## SESSION C 1

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<th>Theme</th>
<th>Socially and Culturally Situated Voices in Healthcare</th>
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<td>Structural, Social, and Self Stigma: Ethical Dimensions of Health Disparities Experienced by Individuals who use Drugs</td>
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<td>Speaker(s)</td>
<td>Robin Baker, M.S., Ph.D.</td>
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<td>Friday, April 12, 2019</td>
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<td>Time</td>
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### SESSION C 1 OBJECTIVES

- Discuss the landscape of health services and the health disparities experienced by individuals who use drugs.
- Define stigma and distinguish the three types of stigma that impact access and quality of health services for individuals who use drugs.
- Interpret the health disparities experienced by individuals who use drugs and evaluate different approaches to treatment with an ethical lens.

### SESSION C 1 SPEAKER

Robin Baker, M.S., Ph.D.
Dr. Robin Baker is an Assistant Professor in the OHSU-PSU School of Public Health. Dr. Baker graduated with a doctorate in Health Systems and Policy and teaches courses in the Health Management and Policy, Primary Health Care & Health Care Disparities, and Public Health Practice MPH programs. Her research interests include evidence-based treatment for substance use disorders, integration of behavioral health and primary care, care management for individuals with mental illness, and systemic and organizational factors that impact quality and access of services.
Structural, social, and self stigma: Ethical dimensions of health disparities experienced by individuals who use drugs

ROBIN BAKER, PHD

APRIL 12, 2019

Who am I?

- PhD in Health Systems & Policy from the OHSU-PSU School of Public Health
- Assistant Professor in the OHSU-PSU School of Public Health
- Research experience includes:
  - Navigation of stigma and the resilience of formerly incarcerated women
  - Opportunities and challenges of integrating behavioral health and primary care
  - Implementation of MOUD in primary care, criminal justice settings, and HIV clinics
Learning Objectives

1. Discuss the landscape of health services and the health disparities experienced by people who use drugs
2. Define stigma and distinguish the three types of stigma that impact access and quality of health services for people who use drugs
3. Interpret the health disparities experienced by people who use drugs and evaluate different approaches to treatment with an ethical lens

Glossary

SUD – Substance Use Disorder
OUD – Opioid Use Disorder
MOUD – Medications for Opioid Use Disorders (often referred to as MAT)
PWUD – People Who Use Drugs
PWID – People Who Inject Drugs
IDU – Injection Drug Use
Tx – Treatment
CJ – Criminal Justice
HIV – Human Immunodeficiency Virus
HCV – Hepatitis C Virus
SMI – Serious Mental Illness
In 2016, ~48.5 million aged 12+ reported use of illicit drugs or misuse of prescription drugs in the past year [1]

The Continuum of Drug Use

<table>
<thead>
<tr>
<th>No Use</th>
<th>Social Use</th>
<th>Problem Use</th>
<th>Dependence Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>person is not using a particular drug</td>
<td>use is irregular, usually confined to special occasions, availability, accessibility, and affordability influence use</td>
<td>use tends to become excessive, using higher doses due to increased tolerance or trying stronger drugs, begins to compromise personal values and/or health</td>
<td>a serious medical &amp; psychological condition in which one is physically dependent on the substance to function</td>
</tr>
</tbody>
</table>

- No Use
- Social Use
- Experimental Use
- Regular Use
- Problem Use
- Dependence Use

Public health concerns

- In 2015, 9% of HIV infections were attributed to injection drug use [2]
- From 2010 to 2016, there was a ~3.5 fold increase in reported cases of acute HCV infection (850 to 2,967 reported cases) – the increase was associated with the rise in the number of PWID [3]
- In 2015, there were 547,543 emergency department visits for all drug-related poisonings [4]
- In 2016, 63,632 drug overdose deaths occurred – 66.4% involved prescription and/or illicit opioids [5]
  - Illicitly manufactured fentanyl (19,413 deaths)
  - Prescription opioids (17,087 deaths)
  - Heroin (15,469 deaths)
In 2017, 20.7 million people aged 12+ needed substance use treatment, but only 4 million people received any treatment in the past year and only 2.5 million received treatment at a specialty facility.

Perceived Need for Substance Use Treatment among People Aged 12 or Older Who Needed but Did Not Receive Specialty Substance Use Treatment in the Past Year: 2017

- 1.0 Million Felt They Needed Treatment (5.7%)
- 17.1 Million Did Not Feel They Needed Treatment (94.3%)
- 10.2 Million People Needed but Did Not Receive Specialty Substance Use Treatment
Disparities Experienced by PWUD

PWUD are at greater risk for contracting and spreading infectious diseases such as HIV and HCV, due to injection drug use and risky sexual behavior [7]

Use of some substances—including alcohol, heroin, prescription stimulants, methamphetamine, and cocaine—is associated with increased risk for cardiovascular and heart disease [8]

25% of people with SMI also have a SUD and 10% of people with SUD have SMI (SMI = includes major depression, schizophrenia, bipolar disorder, & other mental disorders that cause serious impairment) [9]
What is the ideal treatment system?

REFLECTING A CONTINUUM OF CARE

Note:
Within the five broad levels of care (0, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.

https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/
Medications for the Treatment of OUD

The Food and Drug Administration (FDA) has approved the following medications the treatment of OUD:

- Methadone
- Buprenorphine
- Naltrexone

The ASAM guideline recommends that all OUD medications be offered in conjunction with the appropriate level of psychosocial treatment, which is most often delivered in the context of outpatient treatment (either level 1 outpatient or level 2 intensive outpatient) [10].

What are barriers to treatment?
Insurance Barriers

What is Mental Health and Substance Use Disorder Parity?

- Lack of insurance
- Lack of awareness regarding parity
- Fail-first & prior authorization policies

Mental health and substance use disorder parity means comparable insurance coverage for mental health, substance use disorder, and physical health care.

Source: Substance Abuse and Mental Health Services Administration

#parity

Health System

- Fragmented health system
- Lack of education in SUD
- Lack of metrics or measures to assess quality
- Problematic treatment philosophies
Stigma is enacted at 3 levels

1. Structural Stigma – opportunities and resources denied or limited
2. Social Stigma – labelling and avoidance, isolation, humiliation
3. Self Stigma – individual psychological processes in response to stigma (i.e., shame, concealment, internalization)

Structural Stigma

Structural stigma are the societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized [12]

As a society, we have moralized drug use – rather than dealing with it as a public health issue

The result has been policies that criminalize drug use and addiction → higher levels of incarceration and CJ involvement among PWUD
Social Stigma

Social stigma refers to the attitudes and beliefs of individuals (i.e., the general public, health care providers, family, friends) towards PWUD.

PWUD may experience social isolation as people avoid them.

In health care settings, it can result in humiliating and dehumanizing interactions with health care professionals.
The result is that PWUD are less likely to be offered help than are people with a mental illness or physical disability.

The way we talk about PWUD can create or uphold stigma. Words like ‘crackhead’ and ‘junkie’ dehumanize a person who may be struggling with a SUD.

Many healthcare professionals hold negative, stereotyped views of people who use illicit drugs.

“People say, well, oh my gosh, why would you want to do that? You’re taking on all the addicts. People think that it’s inviting addicts to your clinic as if that would be the worst thing that you could have happen.”

“Well and here’s the thing, nobody wants a bunch of addicts in the waiting room with grandma and her grandkids.”

Self Stigma

Self stigma is the internalization of the negative stereotype, a resultant loss of self-esteem, and acting out the negative public image. [13]

Those who experience stigma often report engaging in maladaptive emotion regulation strategies such as rumination and suppression as well as maladaptive coping behaviors such as smoking, drinking, and drug use. [14]

Exposure to chronic stress may lead to diastolic blood pressure reactivity and increased cortisol output. [14]

Those affected may isolate themselves (i.e., quit work, stop engaging in health care, stop engaging with family/friends) [14]
“Guilt and shame kept me out there [on the streets] for a lot of years. You know, I didn’t feel like anything. I didn’t want to feel anything.”

“I just felt like maybe they were right, maybe I was just a junkie. I was out there choosing to use. Wasn’t doing nothing good with my life and my family, they want nothing to do with me.”

We evaluate SUD Tx differently.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage of Patients Who Relapse</th>
</tr>
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<tbody>
<tr>
<td>Type I Diabetes</td>
<td>30-50%</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>40-60%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>50-70%</td>
</tr>
<tr>
<td>Asthma</td>
<td>50-70%</td>
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</tbody>
</table>
Abstinence only Tx Philosophy

Drugs are not only viewed within a schema of facts, but of morality—an ideology that views psychoactive substances as fundamentally wrong.

~ Gopalan, 2017

- A treatment philosophy that embraces abstinence as the end goal or true measure of recovery
- Most common are programs that rely on the 12 steps such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA)
- Being drug free is the only measure of success and any level of use is unacceptable, this often includes MOUD
- Assumption that PWUD need to hit rock bottom before they are willing to make changes

Potential Consequences of Substance Use and SUD Tx relapse

Structural
- Loss of resources (i.e., health, social services)
- Discrimination (i.e., housing, employment)
- CJ involvement

Social
- Labelled as an addict and failure
- Loss of social support & isolation
- Dehumanizing and humiliating interactions

Self
- Concealment of drug use/relapse
- Internalized shame
- Withdrawal or lack of engagement with health services

Literature suggests that stigmatization may have direct negative effects on mental and physiological health. These effects are due to exposure to chronic stress including experience of discrimination.
Layers of Disparities related to Drug Use Stigma

Not all drug use is equally stigmatized
- Crack vs Cocaine
- IV drug use vs Pills

Not all PWUDs are equally stigmatized
- Intersectional understanding of stigma

Is there another way?

What are the concerns?
- Negative consequences on health
- Safety concerns (self & others)
- Spread of infectious diseases

What are the goals?
- Improved individual health
- Prevention of fatal & non-fatal overdoses
- Improved community health

“Its time to change how we view addiction…not as a moral failing but as a chronic illness that must be treated with skill, urgency, and compassion. The way we address this crisis is a test for America.”

~Surgeon General Dr. Vivek Murthy
Perceived Need for Substance Use Treatment among People Aged 12 or Older Who Needed but Did Not Receive Specialty Substance Use Treatment in the Past Year: 2017

Image from: https://habitslab.umbc.edu/the-model-2/
Harm Reduction

Harm Reduction is a perspective and a set of practical strategies to reduce the negative consequences of drug use.

- Moves past judgement of another person to address their drug use and sexual activity and the harm that’s occurring to that person
- Incorporates a spectrum of strategies including safer techniques, managed use, and abstinence
- Meets people “where they are at” but doesn’t leave them there

What Harm Reduction is NOT:
- Harm reduction does not mean “anything goes”
- Harm reduction does not condone, endorse, or encourage drug use or high risk behaviors
- Harm reduction does not exclude or dismiss abstinence-based treatment models as viable options

Harm reduction & bioethics?
Bioethical principles

Autonomy is the principle that a person should be free to make his or her own decisions. It is the counterweight to the medical profession’s long-practiced paternalism, wherein the provider acted on what they thought was “good” for the patient, whether or not the patient agreed.

Nonmaleficence is the philosophical principle that encompasses the medical student’s principal rule, “first, do no harm.” It derives from knowing that patient encounters with providers can prove harmful as well as helpful. This principle includes not doing harm, preventing harm, and removing harmful conditions.

Beneficence is the principle that health care providers have a duty to be of a benefit to the patient, as well as to take positive steps to prevent and to remove harm from the patient.

Justice has multiple dimensions. It can be described as the moral obligation to act on the basis of fair adjudication between competing claims. It is linked to fairness, entitlement and equality.
1. Health and Dignity

Harm reduction establishes the quality of individual and community life and well-being as the criteria for successful interventions and policies.

Treating PWUD—along with their families and communities—with compassion and dignity is integral.

2. Participant-Centered

Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live.

Recognizes that PWUD deserve to have their health needs met regardless of whether they choose abstinence or choose to continue to use drugs.
3. Participant Involvement

Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.

http://www.oregonrecovers.org/

4. Participant Autonomy

Recognizes PWUD are experts in their own lives. It is the individual who makes their own changes, when they feel they can make them, under their own circumstances.

Seeks to empower PWUD to share information and support each other in strategies which reduce the potential harm from their drug use.
5. Intersectional

Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.

Justice

6. Pragmatism

Accepts, for better or worse, that drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.

Acknowledges that some ways of using drugs are clearly safer than others.

Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

Beneficence
What are some harm reduction strategies?

Harm Reduction Strategies

Syringe exchange
- Storefront
- Street-based mobile out reach
- Secondary or peer-delivered
- Pharmacy

MOUD
- Methadone
- Buprenorphine
- Naltrexone

Distribution of and training to use Naloxone

Rapid HIV and HCV testing + linkage to resources and care

Education
- Safer drug use
- Safer sex practices

Motivational interviewing

Peer support programs

Fentanyl test strips

Safe Consumption Sites
Education

Support

Access

Linkages

www.harmreduction.org

Test Your Dope!

Abcesses...

Here's how it happens.

When you mix the agent, you mix the dirt. But that’s not the only problem. A needle that’s been inserted and causing an abscess. This can happen when your vein is cut, too, letting the germs into vessels with more than just drugs.

Get an extra syringe for splitting drugs. Use an extra sterile syringe to split drugs, using your own cooker and cotton. Avoid drawing up from a cooker if someone else has used it. There may still be blood on it.

www.harmreduction.org
Access

 ONE LINE
FENTANYL!

 TWO LINES
NO FENTANYL

NARCAN
(NALOXONE HCl)
NASAL SPRAY
4 mg

Fix with a friend

Image: Robert F. Bukaty/AP

Support

FULL PRINCIPLES OF MOTIVATIONAL INTERVIEWING
- Express empathy for the client
- Develop discrepancy between the client’s goals and values and their current behaviors
- Avoid argumentation and direct confrontation
- Roll with client resistance instead of fighting it
- Support the client’s self-efficacy, or their belief that they can change

Readiness Ruler

<table>
<thead>
<tr>
<th>Not Ready</th>
<th>Unsure</th>
<th>Ready</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1-2</td>
<td>3-5</td>
</tr>
<tr>
<td>6-7</td>
<td>8-9</td>
<td>10</td>
</tr>
</tbody>
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Planning

Evoking

Focusing

Engaging
What does harm reduction look like in practice?
Harm Reduction interventions and policies should be designed to reflect specific individual and community needs.

There is no universal formula for implementing harm reduction.

The degree of harm associated with risk behavior varies based upon numerous factors, including drug, set, and setting.

Mindset, demographic & social characteristics, physical & mental health, interpersonal skills

Drug used, how its used, how much is used, drug pharmacology

Physical, social, economic, cultural, & emotional background

Zinberg, 1984
Case Study

It's a busy day on the general surgery unit and it's Katherine's first day back after her days off. Katherine is a nurse who has been working on the unit for three months. One of her clients is Alex, a 35-year-old man, post-operative day three. During report, the night shift nurse reviews his post-op care, history, pain management and medical history including diabetes, asthma and substance use. “He has a history of using drugs. He's probably a drug addict and drug seeking. He keeps asking for PRN pain medications,” the night shift nurse tells Katherine.

When Katherine checks in on Alex, he tells her that he is in incredible pain and once again restates his request for PRN pain medication.

Katherine is unsure how she should approach Alex’s care. While she is uncomfortable with the night shift nurse’s comments, she also hasn't cared for many clients with a history of substance use. Katherine understands that she is responsible and accountable for providing safe, competent, and ethical care, but given her limited experience, she wonders whether providing PRN pain medications will further encourage Alex’s drug use.

Discussion

1. What might be motivating each person in the scenario (i.e., night shift nurse, Katherine, Alex)?

2. Why might Katherine be uncomfortable with the night shift nurse’s comments?

3. What are the possible choices available to Katherine?
   a) What are the underlying assumptions of those choices?
   b) What are possible outcomes of those choices?

4. How could systems and processes be designed differently to better support all three individuals in this scenario?
What would be the biggest barrier to implementing harm reduction at your clinic/agency?

What components of harm reduction do you think you could implement into your daily work with clients/patients?
What good comes out of harm reduction?

Harm reduction directly challenges stigma

Harm reduction helps you increase trust with your clients/patients and fosters engagement

Harm reduction improves public health by supporting individuals and communities to reduce the spread of infectious diseases

Harm reduction literally saves lives

Questions
Citations


7. CDC. HIV and Injection Drug Use: Syringe Services Program for HIV Prevention.

8. NIDA. Common Comorbidities with Substance Use Disorders, updated February 2018.

9. NIDA. Comorbidity: Substance Use Disorders and Other Mental Illnesses, updated August 2018.


