Stigma, Discrimination, and Addiction:

Ideas for Systemic Interventions

RICARES
Communities for Addiction Recovery Efforts

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WHY ARE WE TALKING ABOUT STIGMA?

- According to multiple studies, SUDs are the most stigmatized illness in the world.
- Among those who realize they have a problem, stigma is the largest primary barrier to treatment. (Ashford 2019) It is connected with lower treatment completion rates and delayed recovery processes. (Livingstone et al. 2012)
- Stigma can lead to discrimination regarding access to health care, quality of care, employment, housing, and education. (Yang et al. 2017)

- Stigma itself can induce stress, depression and other serious health consequences. (Kulesza et al 2013; Brewis and Wutich 2019)
- Internalized stigma is connected to greater severity of use and higher risk behaviours. (Livingston et al. 2012)
- Stigma contributes to the support for punitive policies and the underinvestment in treatment/recovery supports. (Livingston et al. 2012; Yang et al. 2017)
- The above processes "clump together," creating a vicious cycle, potentially driving problematic substance use. (Livingston et al. 2012; Brewis and Wutich 2019)

"Stigma and discrimination in relation to mental illnesses have been described as having worse consequences than the conditions themselves."

–Graham Thornicroft et al. "Evidence for Effective Interventions to Reduce Mental-Health-Related Stigma and Discrimination," LANCET (2016): 1123.

CONCEPT HISTORY

- Erving Goffman, *Stigma* (1963): discredited or spoiled identity.
- Link and Phelan, "Conceptualizing Stigma" (2001): stigma as process.
- Pescosolido and Martin, "The Stigma Complex" (2015): stigma as a multilevel, adaptive system.
- Brewis and Wutich, *Lazy, Crazy, and Disgusting* (2019): stigma as the by-product of public health campaigns.

THE DANGER OF BUZZWORDS

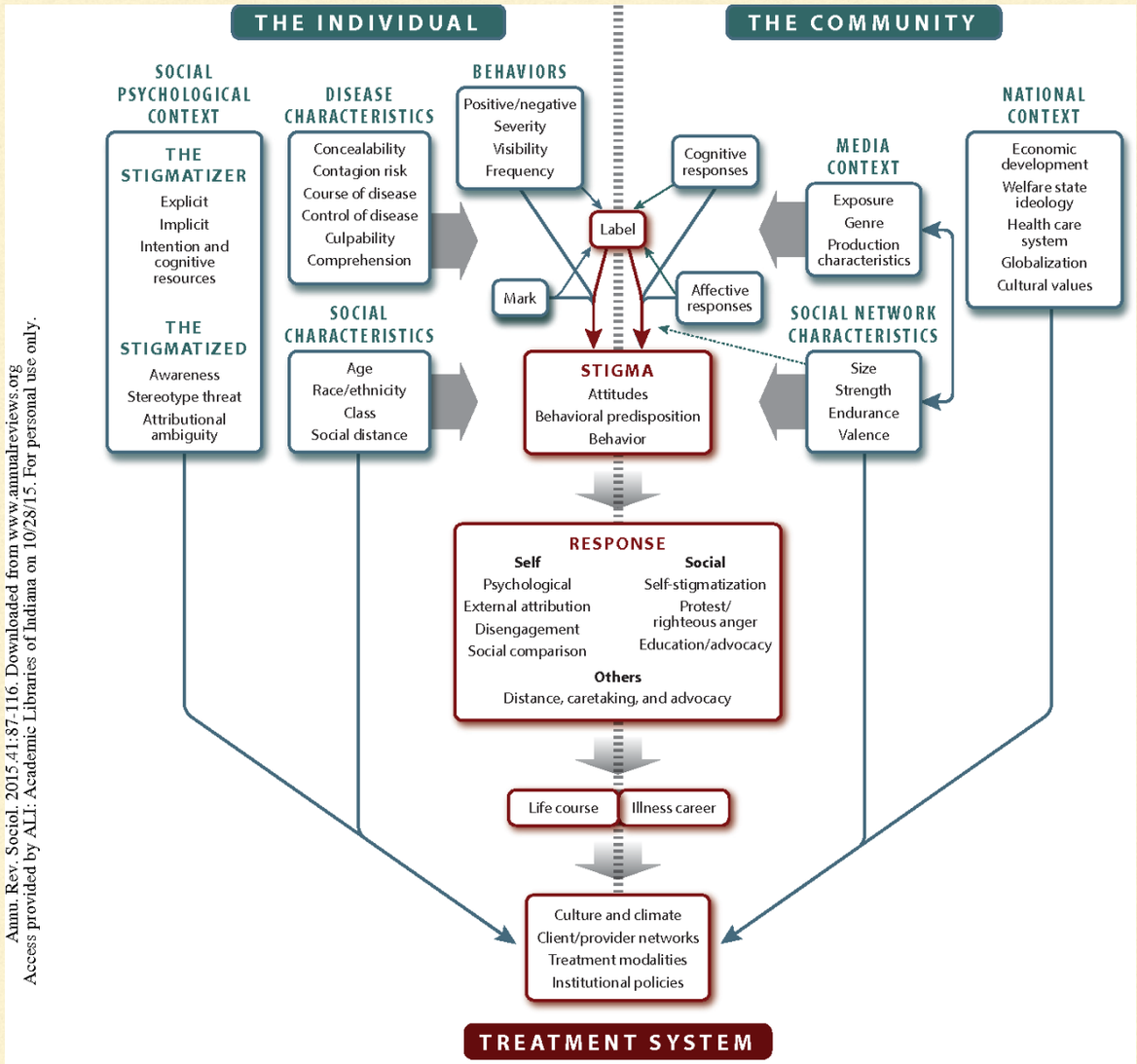
- **A**: Stigma is "the process by which a group of people becomes classified within society as less valuable, undesirable, or unwanted." (Brewis and Wutich, 2019)

- **B**: "Stigma can be defined as a label with an associated stereotype that elicits a negative response." NIDA, *Words Matter* (January 2020)

- Overtime **A** has been reduced to **B,** limiting our systemic understanding and prompting a desire to "move beyond" the focus on stigma.

MULTILEVEL STIGMA MODEL

- **Societal:** norms, stereotypes, public attitudes, laws, media
- **Institutional:** structural discrimination, institutional culture
- **Community/Family:** culture, religion, trauma history
- **Individual:** implicit/explicit bias, perceived or anticipated stigma, self-stigma

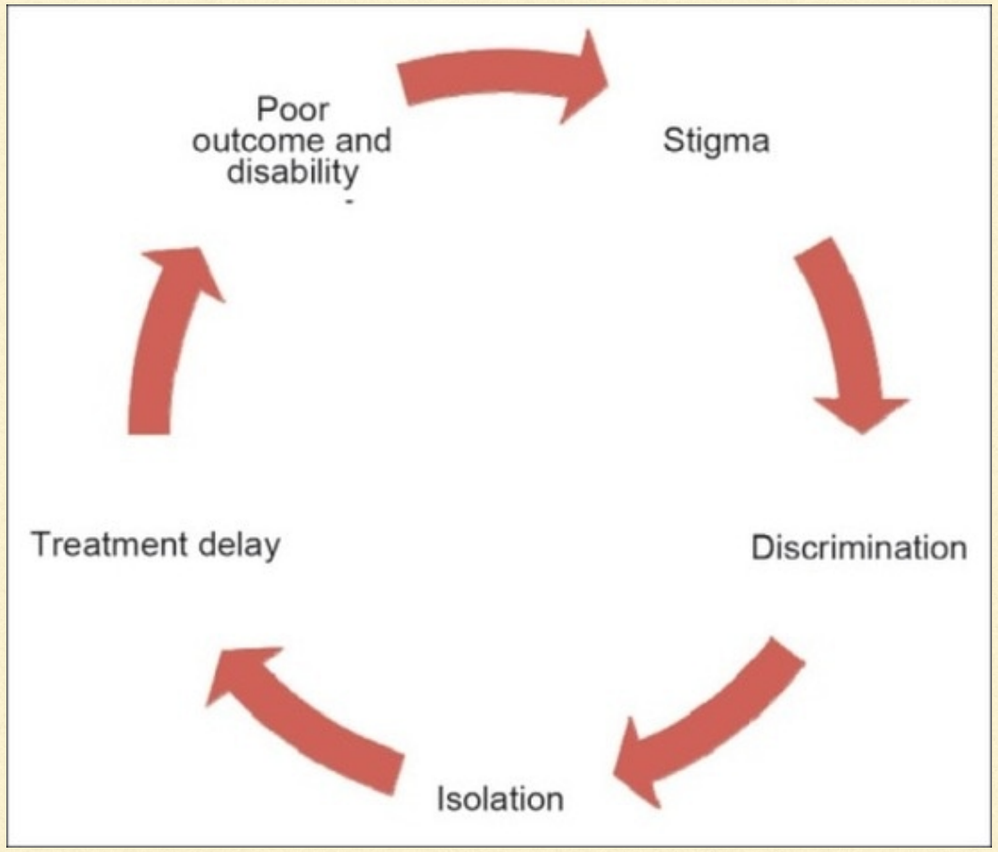


Annu. Rev. Sociol. 2015.41:87-116. Downloaded from www.annualreviews.org
Access provided by ALI: Academic Libraries of Indiana on 10/28/15. For personal use only.

Figure 2
Framework Integrating Normative Influence on Stigma (FINIS). Adapted and reprinted with permission from Pescosolido et al. 2008b.

Adapted from Link and Phelan (2001); Krupa (2009); Pescosolido and Martin (2015).

SIMPLIFIED STIGMA MODEL



- **Stereotype + Power Differential = Discrimination**

STIGMA IS INTERSECTIONAL

Kimberle Crenshaw

- The interconnected nature of social categorizations such as race, class, and gender that creates overlapping systems of discrimination. (Crenshaw 1989)
- We must talk more about how stigma interacts w/other forms of oppression: race, gender, sexuality, homelessness, sex work, history of incarceration, poverty…

ADJACENT CONVERSATIONS

- **Stigma is connected to criminalization:** we should not let "stigma" become a euphemism for managing the public health consequences of drug prohibition.

- **Stigma is compounded by medical mistrust:** addressing stigma requires rebuilding trust between marginalized groups and the health care system. (Jaiswal 2019)

- **Stigma can be related to trauma,** secondary trauma, compassion fatigue, and/or burn out, especially among health care workers and first responders. (Mitake et al., 2019)

LESSONS FROM MENTAL HEALTH STIGMA RESEARCH

- The most successful campaigns (e.g. Time to Change, UK) are long-term, multicomponent, and multilevel. (Rand Corporation 2012; Henderson 2013: Henderson et al. 2017)
- Social contact and first person interventions w/recovery emphasis show greatest short term effect. (Corrigan et a. 2012; Thornicroft et al. 2016; Gronholm et al. 2017)
- Biological explanations show contradictory effects and real harms. (Phelan 2002; Phelan 2005; Schnittker 2008; Corrigan and Shapiro 2010; Clement et al 2013)
- Evidence for social marketing campaigns is mixed. (Corrigan 2012; Clemeent et al. 2013) No connection between knowledge and reduction of prejudice (Pescosolido et al 2010; Stuart et al. 2012; Crapanzano et al 2014)

- Effect sizes are small to medium and short term. Almost no data or positive findings on behaviour change, self-stigma, perceived stigma, and few studies of longterm impact (Griffiths et al. 2014; Mehta et al 2015; Thornicroft et al. 2016)

- Lessons from one target group frequently don't generalize to other target groups. (Thornicroft et al. 2016)

- TLC 3: Targeted, Local, Credible, Contact, and Continuous. (Corrigan 2011; Ashton et al. 2018)

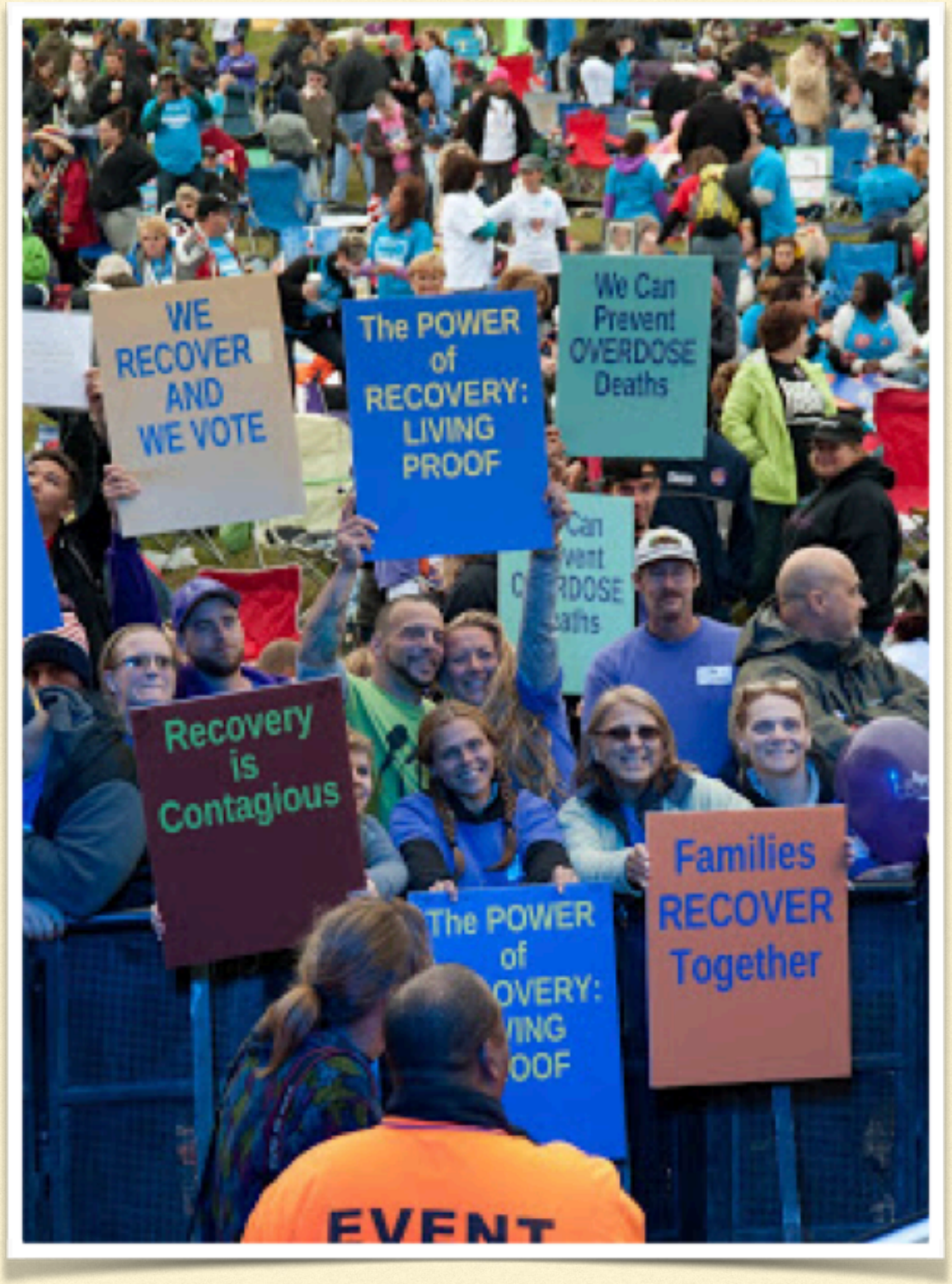
PARADIGMA SHIFT

Old: Discrete interventions ("bursts" of eduction/contact/social marketing).

New: Creating new institutional contexts by articulating and enforcing anti-discriminatory norms.

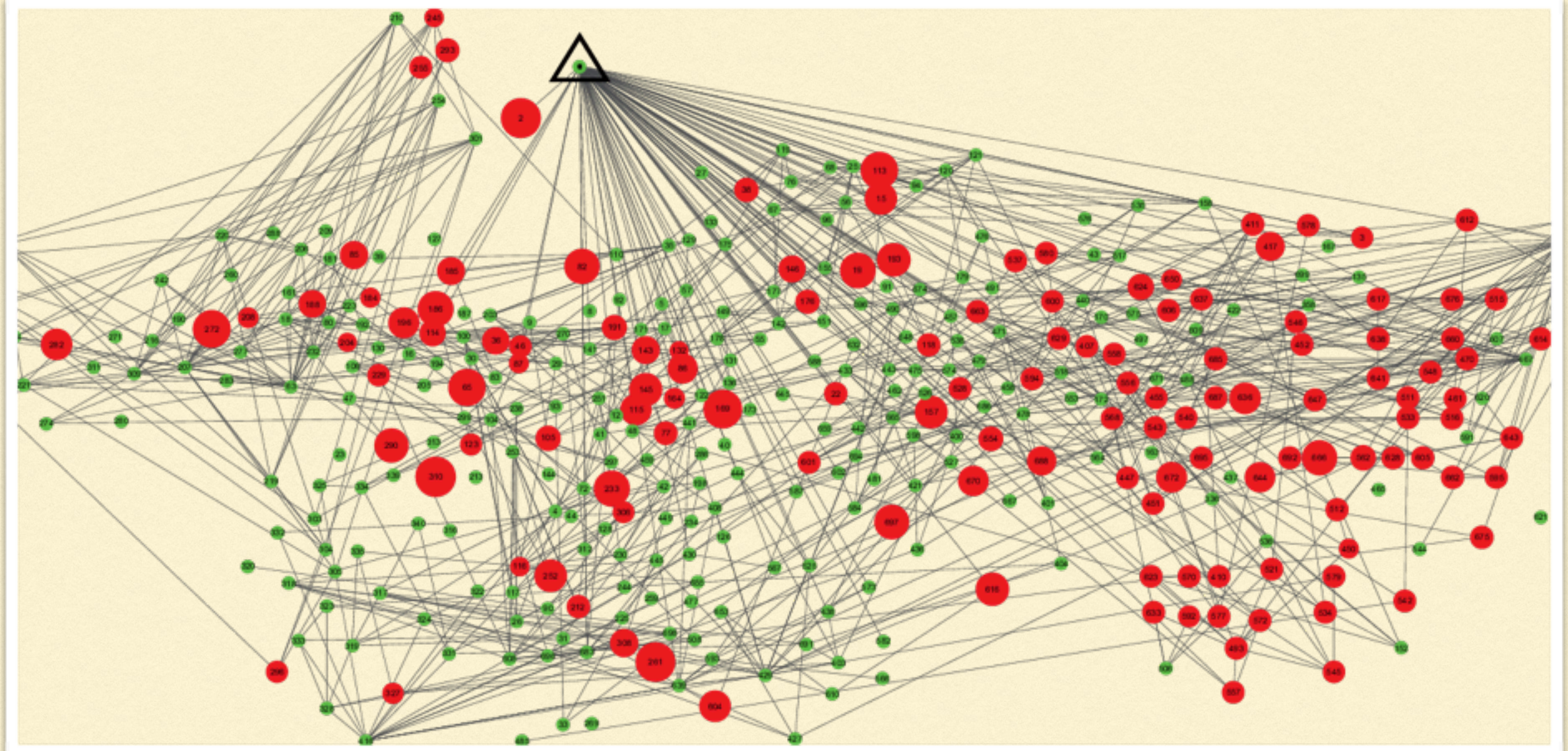
Old: Eliminating implicit bias.

New: Empowering stigmatized groups to identify and challenge acts of discrimination.



THE LANGUAGE OF ADDICTION

- Since 2010, multiple studies have connected stigma against people w/ SUDs to the language we use. (Kelly et al. 2010; Kelly et al. 2010; Ashford et al. 2019)
- Changing language is currently the most strongly supported evidence-based intervention for SUD related stigma. (Ashford 2019)
- In 2017, the Associated Press and the Office of National Drug Control Policy adopted person-centred and non-stigmatizing language.



RICARES STIGMA CAMPAIGN:

Three targeted system-level interventions

Year 1: Press and Media

Goal: All RI press adopt the 2017 AP Guidelines.

First Step: On May 28, RICARES and the City of Providence are holding an event addressed to RI media:

“Words Matter: A Conversation About Stigma, Language, and Substance Use”

Speakers will include journalists, nationally recognized experts, and people with lived experience of addiction addressing the importance of non-stigmatizing language in English and Spanish.

YEAR 2: HEALTH CARE WORKERS

- **Goal**: 80 percent of RI health workers trained in person-centred and non-stigmatizing language.
- **First step**: For major health care providers to adopt non-stigmatizing language as official policy for all of their staff.

YEAR 3: EMPLOYERS

- **Goal**: Strengthen rights/protections and the ability of people with SUDs to mobilize in defence of their rights.
- **First Step**: Non-discrimination language state-wide in hiring policies by 2022.

OUR GOAL SHOULD BE …

- A **coordinated**, multi-level plan that would address social, institutional, community, and individuals factors.

- The combination of social marketing, educational, and contact strategies employing the evidence-based principles of **TLC 3.**

- A **leadership** role of individuals and organizations representing people with lived experience, both folks in recovery and **those working to navigate the system today**, in design, implementation, and ongoing evaluation.

RICARES is a grassroots effort, focused on creating a socially just community for all Rhode Islanders affected by substance use disorder. We approach stigma like a crossroads, with a lens to advocate for change.

For more information or specific references, contact me at jsoske@ricares.org or 401-330-6215