From control to care. Using education to reduce stigma towards addiction patients in health care settings

Pedagogiskt docenturarbete

Andrea Johansson Capusan
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Using education to reduce stigma towards addiction patients in health care settings.

Andrea Johansson Capusan, MD PhD

Pedagogical resource person:
Pia Tingström, Senior associate professor, HMV

Purpose:
To explore pedagogical approaches aimed to improve attitudes towards addiction patients in health care providers. To identify techniques which cultivate a mindset of collaboration and care instead of control.

Rationale and background:
Stigma, described in social psychology as labeling, stereotyping, and separation, leads to status loss and discrimination in the context of power imbalance [1]. It is considered one of the causes for inequality in access to health care and a potential source for poorer treatment outcomes for affected patient groups, a metanalysis indicates [2].

A systematic review from 2011 identified patients with alcohol or illicit substance addiction as particularly vulnerable to stigma in their contact with health care providers [3]. Staff often perceived these patients as aggressive, manipulative, and lacking in motivation [3]. In their turn, patients facing negative attitudes and stigma were more likely to delay seeking help for a multitude of medical conditions [4, 5]. These delays resulted in poorer health outcomes and an increased risk for death and disease in people with severe addiction problems [4, 5].
In Sweden restrictive drug policies, criminalization of use and national guidelines characterized by control [6], as well as restricted and unequal access to treatment [7] and harm reduction services [8] have contributed to attitudes of suspicion in health care staff and patients alike.

Staff in addiction clinics, especially those working in opioid agonist treatment (OAT) programs for opioid use disorder (OUD) (in Swedish Läkemedelsassisterad behandling för opioidberoende, LARO) have dual and often conflicting responsibilities. On one hand they provide good and accessible care for the patients, while on the other they are expected to reliably handle medications with high potential for misuse, diversion and toxicity [7]. Daily supervised intake of medication for several months is a common strategy to achieve the latter goals but is also one of the identified barriers to treatment and factors leading to mistrust between health care providers and patients. Recently approved weekly and monthly depot buprenorphine injections [9, 10] exclude diversion and open for less need for control. Their introduction in the clinic has highlighted the need for changing attitudes in addiction treatment from control to care. This change in attitudes necessitates adequate education for health care providers working in addiction clinics.

Method:

This paper is based on both a literature search and personal reflection. The literature search was aimed to identify pedagogical tools used to reduce stigma in health care for patients with addiction and improve attitudes in health care providers. I searched ERIC; Scopus, Pubmed and Google Scholar using search terms such as “stigma”, “education”, “pedagogic tools”, “health care providers”, “addiction”, “substance use disorder”, “substance misuse” to identify metanalyses, systematic reviews, controlled studies evaluating pedagogical tools on these subjects, as well as relevant national and international guidelines.

I also reflect on five years of experience with teaching staff in OAT clinics across Sweden, using a comprehensive educational material produced by the Swedish Society for Addiction Medicine,
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focusing on current scientific data on OUD as a chronic treatable condition and modern opioid agonist treatment principles and practice.

Results:

Addiction as a brain disease

Already in the late 90s advances in neuroscience provided evidence for addiction as a chronic relapsing brain disease, similar to other complex but treatable medical conditions such as diabetes, or asthma [11]. Although more than two decades later [12], the debate on the nature of addiction is still ongoing, several studies have highlighted that considering addiction as a brain disease, instead of a fault in the individuals’ character or merely a social problem, can help reduce associated stigma [13] [14] [15]. For instance in a cross sectional survey, conducted in the USA, participants rated “chronically relapsing brain disease” as least stigmatizing [13].

Education is effective in changing attitudes in medical students towards addiction patients. A recent study in the Netherlands and Indonesia [14] demonstrated that educating students in addiction medicine improved their attitudes towards addiction patients. Another study described combining lectures on addiction as a treatable disease with simulation cases in an emergency setting to combat stigma in health care [16]. A baseline initial survey showed non-stigmatizing description of cases in most students, although students considered addiction patients as more challenging and less satisfying to treat compared to other medical cases. This training program resulted only in a minority (5%) to changed attitudes, but increased students’ confidence in treating patients with addiction.

Education can also be used to reduce stigma in the community, as described in a study which combined an online campaign and an education program including online information and seminars on addiction as a treatable disease to reduce stigma towards OUD [15].
Changing attitudes through teaching

Anti stigma programs have been used and evaluated in primary health care setting to improve attitudes towards patients with mental illness and addiction [17]. Also, teaching medical students about addiction, in a 15 hour course, lead to in significant changes in students’ attitudes towards addiction patients [18].

A qualitative study explored how various forms of reflection (discussion times, mandatory end-of-rotation reflection papers) in an addiction-psychiatry postgraduate training improved attitudes towards addiction patients [19]. Reflections highlighted attitudes, stereotypes, and stigmas, increased self-awareness in participants. Participants endorsed reflection as valuable in helping them develop professional attitudes towards patients.

Changing attitudes can be life-saving [20]. Preconceived ideas about this patient group may prevent them from accessing effective treatments, especially in settings where patients or their medication are perceived as a risk, such as in prisons or treatment facilities. Fear for diversion or stigma against medical treatment in addiction may lead to denying access to treatment [21].

Words matter

Language used in association to SUD can be both stigmatizing and empowering [22]. The way patients with addiction are referred to and described in health care and educational settings can contribute to stigma. A study using the Delphi method, explored in three different stakeholder groups: patients with SUD in recovery, relatives and health care professionals, which terms they considered negative and stigmatizing respectively positive and empowering [23]. All stakeholders considered terms like addict, alcoholic, junkie, crackhead, criminals, drunk, boozers, sinners, felon to be stigmatizing. Words and expressions such as people with SUD, person in recovery, person in long-
term recovery, former drug user, sober, recurrence of use, person/people, recovered/ing person, person with alcohol use disorder, drug user/substance user were deemed as positive.

NIDA has recently published [24] a continuous medical education (CME) activity regarding reduction of stigma in health care. According to NIDA, stigma for people with SUD may stem from inaccurate beliefs of addiction as a moral failing, instead of a chronic, treatable disease from which patients can recover with the help of adequate treatment. In Sweden, the Swedish Society for Addiction Medicine has argued that the stigmatizing and unprecise words such as “missbruk” (missuse) should be replaced by problematic substance use and/or addiction (skadligt substansbruk eller/ och beroende) [25].

*Teaching staff in OAT (LARO) programs about treatment for OUD*

The Swedish Society for Addiction Medicine developed in 2018-2019 a comprehensive training program comprising seven modules on epidemiology, neurobiology, diagnosis, medical and psychosocial treatment of OUD within the Swedish OAT programs (LARO).

Since 2019 I have, together with colleagues, taught eight whole-day courses, and several shorter 1–2-hour lectures regarding treatment of OUD, with focus on OUD as a treatable chronic disease. The need for discussion was immense, especially after the introduction in the spring of 2019 of buprenorphine depot injections. This new form of medication created the possibility for increased access to treatment and challenged old attitudes regarding control. Staff participating in education programs started discussing “whom the control was for” – for the patients or for the staff? In order to address this problem, we found it useful to help staff differentiate between patients according to treatment phases (active use, early remission or sustained remission) and individual goals. General rules of control easily become irrelevant in a diverse population.

Qualitative studies during recent years have focused on what patients in OAT want. Interviews highlight the need to shift focus to comorbidities, both medical and psychiatric. Providing adequate
information and increasing agency, through evidence-based treatments, is also considered important by the patients. When staff can adjust from enforcing general rules to perceiving patients as individuals, with individual needs in different phases in their recovery, then control or the lack of it also becomes easier to understand and communicate with the patients.

During the past year, based on positive feedback and participant’s suggestions, we added case-based seminars to the theoretical teaching moments, to provide opportunities for dialogue and reflection to gradually shift attitudes in staff from control to care.

**Summary and conclusions**

Stigma in health care is affecting patients with addiction and reducing their access to treatment. Health care professionals can, through their attitudes and the language they use, either increase or decrease the stigma which affects patients with substance use related problems. Use of adequate language and understanding addiction as chronic relapsing disease may contribute to changing attitudes at different levels of health care education, from students to specialized care settings. The literature provides various examples of effective pedagogical tools to reduce stigma. The majority of these underscore the importance of teaching about addiction as a chronic but treatable disease and the use of language which signals respect and has the potential to empower patients struggling with substance related disorders. Training programs need to provide opportunities for self-reflection and support for staff, in order to facilitate change of dynamics from suspicion to collaboration and from control to care.
References

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