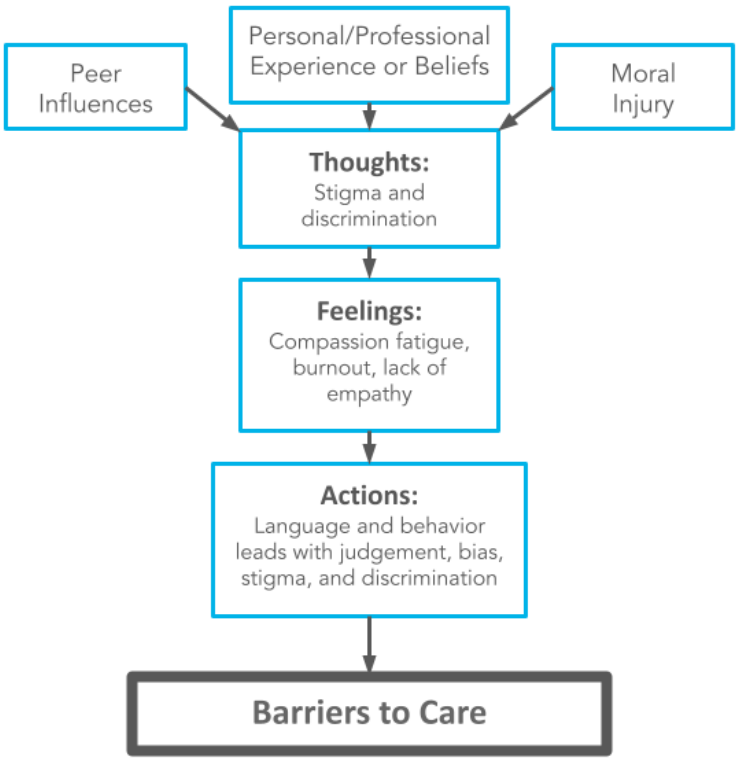
TOOL

A Caring Culture in Healthcare

Considering the **culture of healthcare** and framing **how we think about people who use drugs** is one of the most critical and challenging aspects of increasing access to treatment. Many healthcare providers have sustained moral injuries and developed discriminatory thoughts or behaviors related to substance use disorder (SUD).

"Moral injury describes the challenge of simultaneously knowing what care patients need but being unable to provide it due to constraints that are beyond our control."[1]

If people have experienced bias or stigma in the past, they may leave AMA[2] or even avoid seeking life-saving healthcare solely based on prior negative experiences or perceived discrimination. It is vital to be aware of our own perceptions and biases in order to **intentionally reduce stigma** and prioritize excellent patient care.



Empowering Healthcare Providers

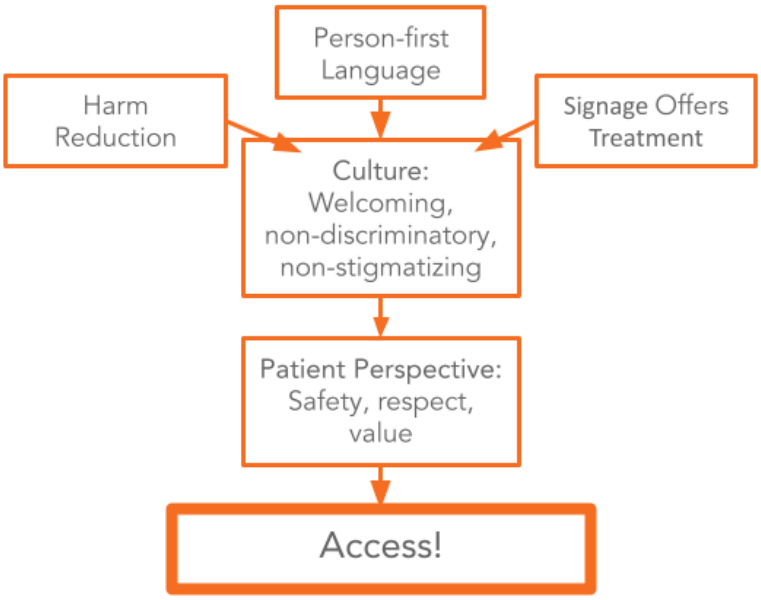
Human connections that build trust are integral to treating substance use disorder. When medical staff intentionally foster communication that **creates a culture that does not discriminate**, we encourage patient engagement in treatment and recognize substance use disorder as a medical condition, not an identity.

Equity: The negative consequences of national drug policy have fallen disproportionately on communities of color. Our goal is to **create anti-racist and socially just treatment options** for substance use. As health care providers, providers should be striving for equity in our approach to SUD treatment by making treatment **accessible and available to <u>all</u> communities**.

Harm Reduction

A key, evidence-based approach for caring for people with SUD is harm reduction. When we treat all patients with respect, we create a space where people who use drugs can actively seek out and engage in care because they do not fear stigma, judgment, and discrimination when being honest about their history and even if they start using drugs again.

"Harm reduction is incorporating a spectrum of strategies including safer techniques, managed use, and abstinence. [It is also] a framework for understanding structural inequalities (poverty, racism, homophobia, etc). Meeting people 'where they're at' but not leaving them there."[3]



Naloxone Distribution

Naloxone distribution**, not just prescribing,** is a vital aspect of harm reduction. Healthcare providers should advocate for every at-risk patient to receive naloxone in hand, or at minimum, a prescription on discharge. See CA Bridge's Guide to Naloxone Distribution for information on how to apply for and implement a naloxone distribution program.

Impact of Language

The language we use heavily impacts the way care is received. Refer to patients using **'person first' language**, such as a "person who uses drugs." This acknowledges the person first, rather than identifying them by their drug use.

Words Matter. And our decision to use words that de-stigmatize substance use disorder must be intentional.

INSTEAD OF…	USE…	BECAUSE…
Addict User Substance/drug abuser Junkie Alcoholic Drunk Former/reformed addict	• Person with opioid use disorder (OUD)/SUD or person with opioid addiction • Patient • Person in recovery or long-term recovery **For heavy alcohol use:** • Unhealthy, harmful, or hazardous alcohol use • Person with alcohol use disorder	• Person-first language. • The change shows that a person "has" a problem, rather than "is" the problem. • The terms to avoid elicit negative associations, punitive attitudes, and individual blame.
IV drug user	• Person who injects drugs	• Person-first language.
Habit Relapse	• Substance use disorder • Drug addiction • Return to use/slip	• Inaccurately implies that a person is choosing to use substances or can choose to stop. • "Habit" undermines the seriousness of the disease.
Clean	**For toxicology screen results:** • Testing negative **For non-toxicology purposes:** • Being in remission or recovery • Abstinent from drugs • Not drinking or taking drugs • Not currently or actively using drugs	• Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions. • Set an example with your own language when treating patients who might use stigmatizing slang. • Use of such terms may evoke negative and punitive implicit cognitions.
Dirty	**For toxicology screen results:** • Testing positive **For non-toxicology purposes:** • Person who uses drugs	• Use clinically accurate, non-stigmatizing terminology, similar to other medical conditions. • May decrease patients' sense of hope and self-efficacy for change.

**Adapted from NIDA's Words Matter: Terms to Use and Avoid When Talking About Addiction*

TIPS: Take action and destigmatize **From National Harm Reduction Coalition's Respect to Connect: Undoing Stigma*

- Ensure all services are provided in a culture of respect and safety within the workplace
- Review materials to ensure the use of person-first/non-stigmatizing language and change them if necessary
- Emphasize building relationships and trust with people who use drugs as important outcomes
- Consider how history of trauma, violence, layers of disadvantage, and stigma may affect a person's ability to engage
- Ensure services are grounded in an understanding of how people's health, priorities, and experiences are shaped by the criminalization of drug use

References

1. Dean W, Talbot S, Dean A. Reframing clinician distress: Moral injury not burnout. Fed Pract. 2019 Sep;36(9): 400-402.
2. Simon R, Snow R, Wakeman S. Understanding why patients with substance use disorders leave the hospital against medical advice: A qualitative study. Subst Abus. 2019 Oct 22;1-7. doi:10.1080/08897077.2019.1671942.
3. Foundations of Harm Reduction. Harm Reduction Coalition. https://harmreduction.org/issues/harm-reduction-basics/foundations-harm-reduction-facts/. Updated October 2, 2020. Accessed October 14, 2020.