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RECOVERY

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STIGMA SHAMES US ALL

by Founder and Chief Medical Officer Dr. Ernie Fletcher

Stigma is driven by the inclination to punish rather than treat. And what's been criminalized is of course hard to de-stigmatize. But stigma takes a toll on us all by entrenching the disorder, impeding the practice of medicine, and suppressing the natural human impulse to care for others.

This issue of our Newsletter addresses the public stigma that endorses negative stereotypes, the structural stigma that limits opportunities, and self-stigma—what W.E.B. Dubois called the “double consciousness” that allows one to see oneself, but only through the eyes of others.

This issue also shines a light on rural stigma and the “Community as Method” approach to recovery that’s proven to be so effective at mitigating the “double illness” of self-stigma.

We hope you’ll join us in supporting a public health approach to drug addiction that emphasizes evidence-based care and compassion. We will all be better for it.

Fletcher Group

The Fletcher Group Rural Center of Excellence

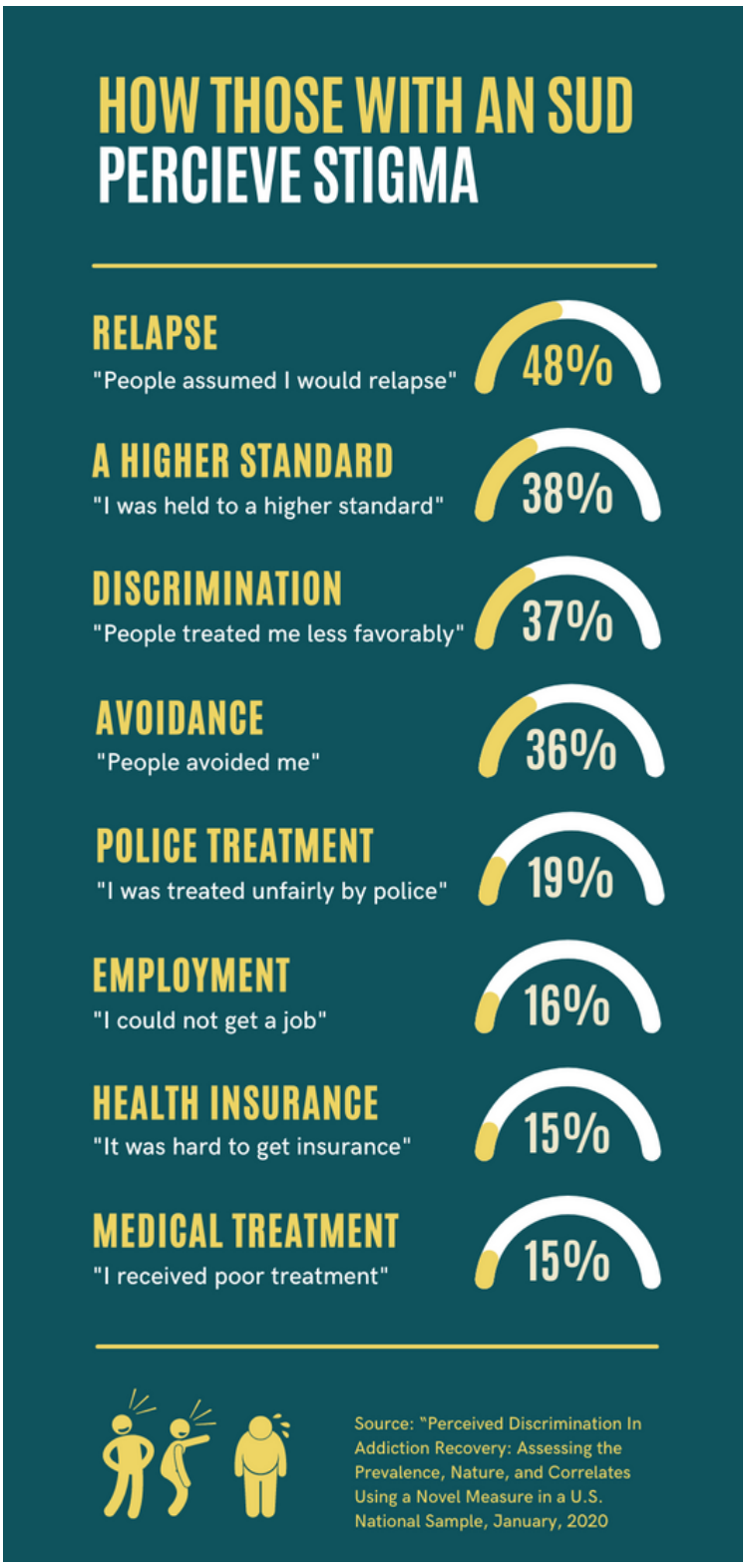
THE COSTS OF STIGMA

It's easy to think of stigma as abstract and impersonal, but its discriminatory effects are very real. Those with a Substance Use Disorder undergo a relentless attack on their "recovery capital"—the personal, social, physical, and professional resources needed to initiate and sustain recovery. The assault persists long after an individual has entered sustained recovery, creating the Catch-22 of being "damned if you talk and damned if you don't." Even more cruel, research indicates that stigma's ability to spur relapse is strongest during early recovery.

The effects of stigma can be divided into two kinds: the "macro-discriminations" exacted publicly and structurally and the "micro-discriminations" that occur in daily personal interactions, which some researchers believe are more powerful because they occur with people who are trusted or looked to for help.

Macro-discriminations can include difficulty finding accommodation; treatment that's not available, delayed, inadequate, low in quality, not evidence-based, coercive, or prohibitively expensive; restricted insurance coverage with higher deductibles and denied reimbursements; restricted access to federal food and cash assistance; delayed or denied federal financial aid assistance for higher education; segregation from other students and harsher academic discipline; unfair treatment by police; denial of the right to vote; more restricted awarding of ADA federal disability benefits; difficulty finding employment and getting promoted; and inadequate funding of scientific research.

Micro-discriminations are more personal and therefore more easily internalized. They include being perceived as untrustworthy, dishonest, or always about to relapse; being avoided, marginalized and isolated; having your human rights less valued; and being held to a higher standard even while being treated unfairly. All of which can become so overwhelming that one feels unworthy of help and fails to seek it.



"Stigmatizing treatment of people who use drugs, such as ignoring or rejecting them, may be the equivalent of an electric shock in the cycle of drug addiction: it's a powerful social penalty that spurs further drug taking."

—Dr. Nora Volkow, The New England Journal of Medicine

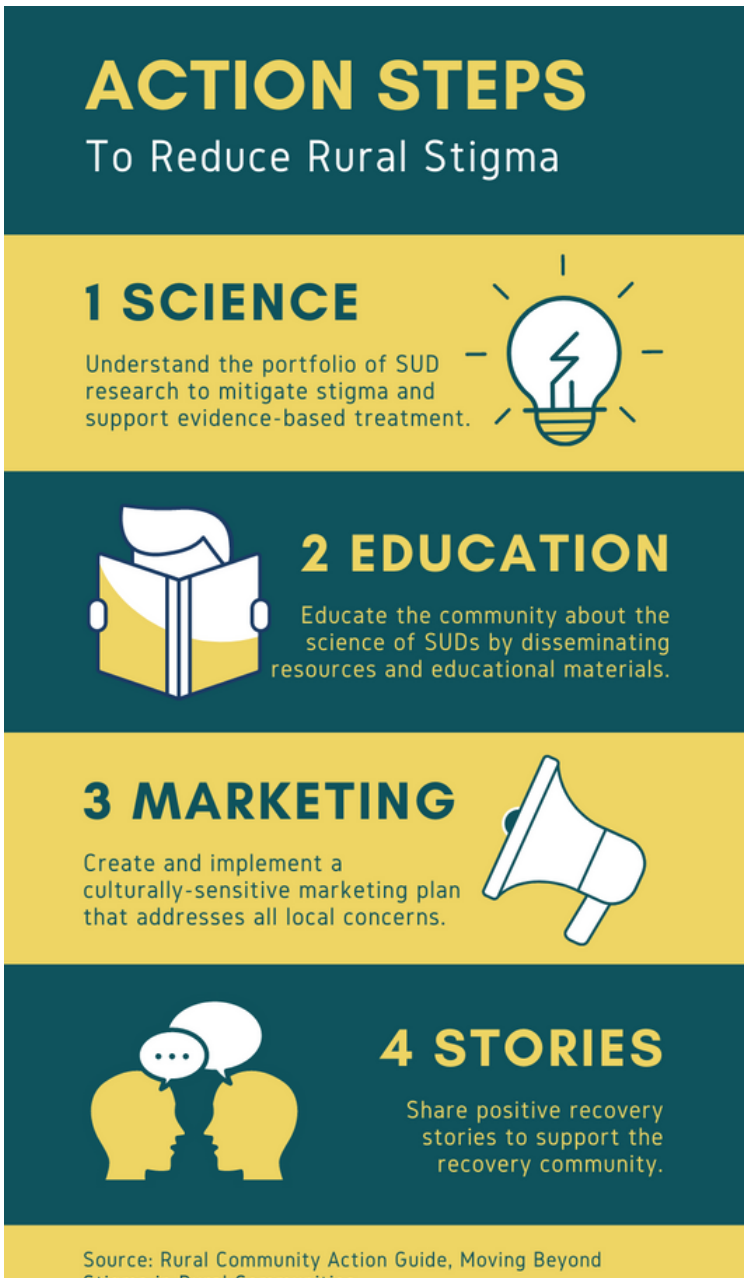
RURAL CHALLENGES

A face-to-face survey conducted by the University of Indiana* indicates that rural Americans are more likely than urban residents to both know someone who uses drugs and to hold it against them.

Seven of ten rural residents know an adult who often uses prescription drugs illicitly, compared to four in ten urban residents. Rural residents also reported higher stigma towards people who use opioids illicitly, even when those people are close friends or family members.

“Although knowing someone with a drug addiction reduces stigma in some ways,” says survey co-author Anne Krendl, “it also seems to increase stigma, particularly if the individual's addiction has caused problems or made life more difficult for those around them."

"In general, higher levels of stigma predict lower willingness to provide support,” says co-author Brea Perry. “So this pattern could have very negative downstream consequences for rural communities."



The survey shows how stigma plays out in rural communities. Respondents said that:

- Getting treatment for addiction makes someone an outsider, resulting in lost friendships and opportunities.
- Drug users are less welcome to marry into a family, move in next door, share time or work together.
- Drug users cannot be expected to manage their own money and are likely to hurt themselves and others.

According to the survey, greater stigma in rural counties translates into significantly less support for harm reduction measures such as needle exchange programs, safe injection sites, and police carrying Narcan to prevent overdose deaths. The same lack of support applies to Medication-Assisted Therapy, an evidence-based treatment that's been proven to be effective in assisting recovery.

"Stigmatization of people with non-medical opioid use has pervasive effects on both the people it is aimed at and the communities they live in," says Perry. "One of the most impactful consequences we see is a rejection of evidence-based treatments for opioid addiction and programs that have proven to reduce secondary harms of drug use, including preventing overdose death and reducing rates of HIV and Hepatitis infection."

An additional problem was highlighted in a study of treatment screenings.** It concluded: “In rural areas there are still barriers, such as a lack of training for providers, concerns about privacy and stigma, and a hesitancy to disclose substance use when a strong patient-provider relationship is not present."

• Stigma Around Substance Use Disorder Higher in Rural Areas, Indiana University
** Screening for Substance Use in Rural Primary Care: A Qualitative Study of Providers and Patients

THE DEFEAT OF STIGMA

Here's how it was supposed to go: We inform the public of all the waste and sorrow caused by punishing, rather than treating, drug addiction and—voila!—the stigma vanishes, replaced with compassion and eager financial support.

Instead, says Dr. Colleen Barry of the Johns Hopkins Bloomberg School of Public Health, "We still tend to think of addiction as a personal failing to be overcome." And that, says Barry, "has real implications for those who society blames. If you think addiction is all about an individual making bad choices, there's no role for public policy, no role for structural changes."

There's good news, however, when it comes to stigma's third leg—the self-stigma that occurs when people internalize negative stereotypes and shame. As with other movements, major advances in this field are coming not from the top down, but from the bottom up.

Endorsed by SAMHSA, the NIH, and the National Academy of Sciences, the following principles have already proven effective in reducing self-stigma:

- Disclosure in a safe setting with people who understand
- Peer-led education to dispel myths while increasing socialization and coping skills
- The nurturing of self-esteem and self-efficacy in a peer-supported aggregate living environment
- The onsite provision of effective, evidence-based treatments, including MAT
- Employment training to enable lasting recovery and social reintegration

These are also the building blocks of the recovery housing model advanced by Dr. Ernie Fletcher when governor of Kentucky. Referred to by SAMHSA as "a model that works," its expansion is now being promoted nationwide by the Fletcher Group RCOE.

The Power Of Story

Lectures on the evils of stigma are likely ineffective, but the sharing of successful recovery stories, according to one study,* leads to "less desire for social distance, greater belief in the effectiveness of treatment and less willingness to discriminate against persons with these conditions."

As a field catalyst for a much-needed transformation of the recovery housing industry, the Fletcher Group RCOE applies a "Prove It, Tell It" approach to everything it does. For the "Prove It" part, we partner with the University of Kentucky to document in a detailed Annual Report the successful outcomes of the Recovery Kentucky program. For the "Tell It" part, we use a wide variety of communications tools, including this Newsletter, to publicize both organizational and personal success stories.

Hope—the belief that challenges can be overcome—is the foundation of recovery. Though public and structural stigma has changed little, we remain optimistic. There is success, maybe not everywhere we'd like it to be, but certainly where it matters most—in the hearts of those most in need.

> *There is no agony like bearing an untold story inside of you.*
> — Maya Angelo

*** Portraying Mental Illness and Drug Addiction as Treatable Health Conditions: Effects of a Randomized Experiment on Stigma and Discrimination**

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