Reducing Bias Against People with Substance Use Disorders

Nurses can help combat the stigma surrounding addiction.

ABSTRACT

Addiction is a highly misunderstood and stigmatized chronic illness frequently encountered by health care providers during routine medical care. People with substance use disorders, in particular, face extraordinary stigma and bias when interacting with health care providers, including nurses. Stigma associated with addiction contributes to health inequities and is recognized as a significant barrier to people seeking and receiving necessary health care. Since patients often spend the most time with nurses in the clinical setting, nurses are ideally positioned to address addiction stigma. However, many nurses lack knowledge about addiction, stigma, and the impact of the words they use, whether in conversation or in clinical documentation. This article reviews the consequences of addiction stigma (labeling, stereotyping, or discrimination) and the steps nurses can take to reduce biases related to substance use. A case scenario based on our experience will be used to guide a discussion of opportunities for nurses to intervene and improve care.

Keywords: addiction, implicit bias, language, stigma, substance use disorder

Emily Harper is a 27-year-old, unmarried White woman who is pregnant for the first time and presents to the ED in active labor. (This case is a composite based on our experience.) She is 40 weeks and two days pregnant, with contractions occurring every 10 minutes. Ms. Harper is admitted to the labor and delivery unit, with Olivia Carter as her assigned nurse. Ms. Carter begins obtaining the patient's vital signs and performing her admission intake. The patient's medical history is significant for opioid use disorder (OUD). She is currently in recovery and taking buprenorphine.

The patient overhears her nurse and the other nurses expressing their dislike for having to care for people with substance use disorders (SUDs)—"These junkies are so needy and annoying"—and using stigmatizing language, calling Ms. Harper an "addict" and her unborn child a "crack baby." Ms. Harper begins experiencing pain related to childbirth; however, her nurse labels her as "drug seeking," and does not further evaluate her pain. Ms. Harper can access her chart via her smartphone and reads the progress notes written by the staff, who refer to her as a "drug abuser claiming to be in pain" and note that she is "reportedly clean."

HEALTH CARE–RELATED STIGMA

Forty-six million people in the United States ages 12 years or older suffer from addiction, yet nine out of 10 people do not receive treatment, according to the Substance Abuse and Mental Health Services Administration.[1] Moreover, people with SUDs face extraordinary stigma and bias when interacting with health care providers, including nurses.[2] Stigma contributes to health inequities and is recognized as a significant barrier to people seeking and receiving necessary medical care.[3] Since patients often spend the most time with nurses in the clinical setting, nurses are ideally positioned to address addiction stigma.

Stigma has been characterized as involving labeling, stereotyping, the loss of status, separation, and discrimination, all occurring simultaneously in the context of a power situation.[4] Public stigma occurs when a community engages in stereotyping and discriminates against a certain group of people.[5] Health

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Figure 1. Stages of the Addiction Cycle
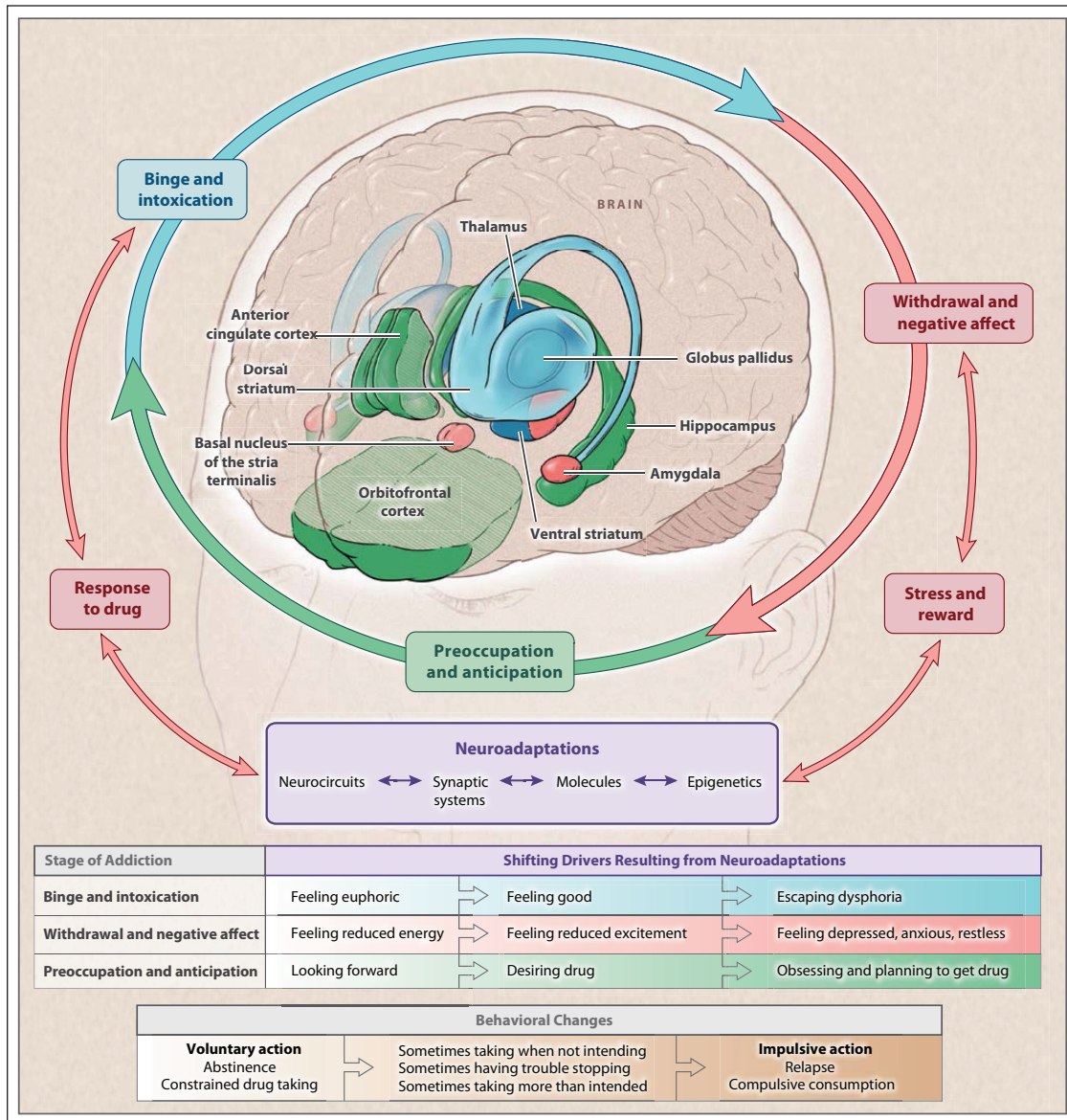
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care–related stigma is considered particularly egregious as it negatively affects people when they are seeking treatment and are most vulnerable, adversely affecting health outcomes.[6,7] Stigma results in people not receiving the treatment they need.

In addition to financial costs and the person's geographic location (that is, living in a location where treatment is not available), stigma is a leading reason why people with SUDs do not seek and/or receive medical attention.[8] When addiction is not recognized as a medical condition, providers can be dismissive of people with SUDs. Patients may be denied care when presenting to EDs because they are perceived as problematic or "drug seeking." Staff may not feel obligated to care for people with SUDs because it is not "part of their job."[9] In the opening case scenario, the nurse does not acknowledge or further evaluate her patient's complaints of pain. Stigma results in

substandard care and decreased patient–nurse collaboration.

Other examples of stigma experiences in the health care environment include verbal abuse (name-calling) or even physical abuse (being rough when assisting in moving a patient, for example). Stigma may negatively affect clinical care when nursing care is limited (shorter visits), more task oriented, or delegated to personnel who lack knowledge and adequate training. The quality of care may also be intentionally compromised by increasing patients' wait times or delaying interventions.[6]

It is not surprising that significant health care inequities result from health care–related stigma. Similar to the experience of the patient in the case scenario, people with SUDs frequently feel "written off" or abandoned by health care staff and experience shame about their current or past substance use. People who

will probably be an "addict" when it is born. "How could any mother do that to their baby?" The oncoming nurse shrugs her shoulders in response.

KNOWLEDGE DEFICITS RELATED TO ADDICTION

Knowledge deficits among health care professionals promote misconceptions, which contribute to the development of health care–related stigma.[13] Health care professionals, including nurses, often hold the common misconceptions that addiction is a weakness, a lifestyle choice, and/or a moral failing, despite scientific evidence to support addiction as a complex brain disorder with behavioral components.[14-17] People with SUDs are often perceived as being able to control their drug use when they cannot and are blamed for their disease. These erroneous attitudes lead to stigma and create barriers that prevent patients from receiving high-quality care.

It is not surprising that significant health care inequities result from health care–related stigma.

inject drugs describe being mistreated, dehumanized, and receiving decreased quality of care.[10] Inevitably, people with SUDs internalize stigma and often refuse to return for care despite potentially severe health consequences. Strategies used by people with SUDs to avoid experiencing stigma in health care settings include delaying care and not disclosing their substance use. When internalized, stigma results in painful social isolation, which further exacerbates the disease.[9]

Stigma creates missed opportunities not only to provide evidence-based treatment for SUDs but also to prevent and treat potential complications.[10] People who experience stigma about their substance use are less likely to seek treatment, including treatment for other conditions, and this results in significant economic, social, and medical costs.[11] Accordingly, health care–related stigma can lead to the perpetuation of SUDs, undermine treatment efforts, and cause persistent health inequities.[12] Knowledge deficits among health care professionals, including nurses, remain a large contributor to health care–related stigma.

Case scenario: the nurse's view. Shift report occurs outside of the hospital room. As Ms. Carter gives report to the oncoming nurse, she comments that the patient is probably from a "bad" neighborhood and must have hung out with a "bad" crowd. She tells the oncoming nurse that she thinks the patient "only chose to stop using drugs when she found out she was pregnant" and that although she is "sober, now she is addicted to buprenorphine instead of heroin." Ms. Carter voices her concerns about whether the patient will be a "fit mother," and that her baby

A recent study examined perceptions of SUDs among individuals in recovery, physicians, nurses, and medical students to see if their viewpoints diverged.[18] Participants were asked to rate their level of agreement with a series of statements about SUDs. About the statement "Nurses understand the difficulty of recovering from substance use disorder," the authors found that nurses had the lowest level of agreement of all the groups; moreover, their views were in stark contrast to those of individuals in recovery (mean difference = –0.31; 95% CI, –0.61 to –0.01; $P = 0.032$). Nurses also had lower levels of agreement regarding perceptions about the effectiveness of using medication to treat OUD. Of all groups, nurses were less likely to agree with the statement, "Medication for Opioid Use Disorder (MOUD) is an effective treatment for opioid use disorder," compared with individuals in recovery (mean difference = –0.86; 95% CI, –1.19 to –0.53), physicians (mean difference = –0.78; 95% CI, –1.00 to –0.56), and medical students (mean difference = –0.58; 95% CI, –0.85 to –0.30; $P < 0.001$).

Nurses frequently report experiencing moral distress, burnout, and feelings of frustration and futility when caring for people with SUDs, often describing them as "defensive and difficult to help."[19] Mutual mistrust and the need for more training and support are often identified as key challenges to caring for people with SUDs.[18, 19] These findings highlight an opportunity to facilitate better understanding of the differing perceptions of nurses and patients to increase mutual engagement in care. Understanding the patho-

physiology of addiction is critical to improving care of people with SUDs. It is imperative that nurses recognize addiction as a medical disease, not a moral failing or a choice, and understand that people with SUDs cannot control their use without help.

The addiction cycle. Learning about the neurobiology of and risk factors for addiction can help health care professionals better understand SUDs and the people they affect. The American Society of Addiction Medicine defines addiction as a "treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences."[20] Addiction leads to physical changes in areas of the brain critical to judgment, decision-making, learning and memory, and behavior control.[21] Substance use may become compulsive and continue despite harmful consequences. Like other chronic diseases, addiction is cyclical in nature with remissions and relapses.

Certain substances can hijack, overactivate, and compromise the brain's reward-processing system and associated networks.[22] The disease of addiction begins with an initiation phase, during which the substance produces pleasurable effects when consumed.[22] Substances bind to and activate receptors throughout the brain's reward pathway, which indirectly causes the release of dopamine in response to pleasurable experiences.[23] This perpetuates an intense desire to repeat these pleasurable experiences. As the amygdala (a region of the brain involved in emotions, stress, and desires) experiences the rush of dopamine that produces euphoria, the brain thinks, "This is great! Let's do it again!" and the hippocampus (a region involved in memory) remembers this sensation.[24] Repeated consumption of the substance leads to compulsive drug seeking and drug taking.[22]

Neuroplastic changes take place during all the stages of addiction and contribute to the vicious cycle of addiction. These include reduced self-control, enhanced motivation to seek rewarding stimuli, dysregulation of reward processing and stress reactivity, and the development of a negative affective state upon withdrawal or with protracted abstinence.[22] At some point, a person needs to keep taking the substance in order to diminish the crippling distress associated with cravings and to experience a normal level of reward, which subsequently worsens the problem and feeds into the vicious cycle (see Figure 1[24]).

Risk factors for addiction. Addiction is multifactorial and is influenced by both genetic and environmental factors. The disease can affect anyone, and no one is immune.[23] It is important to consider the many factors that can increase a person's vulnerability to addiction. Biological factors play a role in addiction development; genes, for example, can account for up to 50% of a person's risk of addiction.[17, 25] A person's stage of development and age of first use can increase

their risk of developing addiction, with earlier use linked to higher rates of addiction.[17, 25] Environmental factors such as negative peer influences, high drug availability, poverty, and crime can also increase a person's vulnerability to addiction.[17, 25]

Individual factors like a chaotic home and family life further compound addiction risk. Living in an unstable home or home with little to no parental/adult monitoring and being exposed to trauma increase a person's risk.[17,25] Adverse childhood experiences (ACEs) are potentially traumatic events that take place during critical years of development (0 to 17 years) and can include experiencing or witnessing violence at home or in the community, suffering physical or emotional abuse and/or neglect, and having a caregiver who has a mental illness.[26] As the number of ACEs experienced by a person increases, so too does the person's risk of developing SUDs.[17, 25] A difficult home life and/or early trauma such as poor school achievement and social isolation worsen vulnerability to addiction.[17, 25]

Social factors outside the home and community also impact the development and treatment of SUDs. The Joint Commission's effort to improve pain management by stating in its *Pain Standards for 2001* that "pain is considered a 'fifth' vital sign in the hospital's care of patients," may have led to unintended consequences, such as the more aggressive use of opioids to treat pain.[27] The U.S. government's punitive "war on drugs" initiative contributed to incarceration and failed to recognize addiction as a medical disease requiring treatment.[28] These factors further promoted stigma and marginalization, creating barriers to lifesaving therapies.[28] Moreover, traumatic events such as the COVID-19 pandemic have increased social isolation and restricted access to treatment providers and facilities as well as to harm reduction interventions.[29]

While not all risk factors for developing a SUD can be prevented (the risk conferred by genetics, for example), many can be modified or eliminated. Nurses can help educate people in the community about identifying risks for substance use and also teach specific strategies to improve outcomes. Targeting high-risk groups like adolescents and promoting evidence-based, tailored interventions can reduce several modifiable risk factors. For example, nurses can teach adolescents relationship-strengthening strategies, conflict resolution approaches, and stress management skills to reduce risk factors such as negative peer influence, crime, and social isolation.

Case scenario: the patient's response. Ms. Harper overhears her nurse's comments to the oncoming nurse and feels demoralized. How can she trust the staff to safely care for her and her unborn baby? She internalizes the stigma and feels guilty about her history of addiction. She is worried and scared—fearful of the unknown. After overhearing the nurses' conversation, she wonders if her baby will be born

healthy, if she is a bad mom, and if she will lose custody. She begins wishing she had never come to the hospital and vows never to do so again.

STIGMA MITIGATION STRATEGIES

Health care professionals who recognize that addiction is a medical disease are less likely to perpetuate stigma and more likely to support evidence-based treatment and endorse harm reduction interventions.[30] The following stigma reduction strategies, using person-centered care; choosing person-first, medically appropriate language; and addressing implicit bias, overlap with one another and are intended for simultaneous use (see *Stigma Mitigation Strategies*[24, 31-35]).

Person-centered care. Patient-centered care in nursing aims to provide holistic care that focuses on the needs of the individual patient.[31] Person-centered care, which has more recently been introduced, expands the patient-centered perspective to include

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Stigma Mitigation Strategies[24, 31-35]

Building knowledge.
- Addiction is a chronic brain disease.
- Chronic diseases require long-term comprehensive treatment, although there is always a risk of relapse.
- Treatment may include MOUD—buprenorphine, methadone, naltrexone—as well as individual and/or group counseling and support groups.

Person-centered care.
- Perspective includes the whole life of a person.

Choice of language.

Use language that is…	*Instead of…*
- Clinical	
- Neutral	
○ Expected or unexpected results	○ Dirty/clean results
○ Substances detected or not detected	
- Person first	
○ Person with a SUD	○ Junkie, addict, abuser, crackhead
○ Person with an OUD	○ IV drug user, druggie
○ Person with an AUD	○ Alcoholic, drunk
- Medically appropriate	
○ [Name of drug] use	○ Abuse
○ Addiction, disease	○ Habit, behavior, choice
- Focused on recovery	
○ Recovery, long-term recovery, substance-free, previously used [name of drug]	○ Sober, clean, former/reformed addict

Implicit bias.
- Take the Implicit Association Test: https://implicit.harvard.edu/implicit/education.html.
- Common identity formation: Ask questions about interests and activities; focus on a shared, common identity, such as hobbies, likes, dislikes.
- Perspective taking: Take the perspective of the other person; that is, put yourself in their shoes. What is it like to have a SUD?
- Consider the opposite: When data seem to point to one conclusion, look for data supporting the opposite conclusion before deciding.
- Exposure to counter-stereotypical exemplars: Spend time with or focus on individuals or celebrities you admire who have a history of addiction.
- Partnership building and removing power differentials: Reframe/collaborate with individuals so your relationship is level and equal.
- Individuation: See the person as an individual instead of as the stereotype of a substance user; that is, learn about them.
- Perform reflection exercises—the practice of looking inward to reveal your own biases.
- Time out: pause and take time to consider how you may be contributing to the problem.

AUD = alcohol use disorder; MOUD = medication for opioid use disorder; OUD = opioid use disorder; SUD = substance use disorder.

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the whole life of a person.[31] Patient- and person-centered care have many similarities, such as empathy, engagement, coordination of care, and shared decision-making.[31] Acknowledging that a patient with a SUD is a person is a good first step; moreover, the goal is to recognize them as separate from the disease of addiction and acknowledge their individual circumstances. The mother to be in our case scenario, Ms. Harper, is more than someone with a history of addiction; she is a young woman who is pregnant with her first child and experiencing labor, who also possesses individual strengths and has personal goals.

Choice of language. The old adage that sticks and stones may break bones but words will cause no harm is not true, as words can in fact be hurtful.[36] Language and word choice have a profound impact, influencing how people think, feel, and act, and thereby affect patient care. Importantly, words impact both the likelihood that someone will seek help and the quality of the help they receive.[9] Language can reflect attitudes, and word choice can reinforce stigma. Stigmatizing language, such as when the staff referred to Ms. Harper as a "junkie" or "addict," is dehumanizing, deflating, and disempowering. It creates feelings of loneliness and isolation, hurt, shame, and failure, and fosters low self-esteem.[37] By contrast, nonstigmatizing language (referring to the patient as "a person in recovery," for example, or as having a history of an OUD) conveys encouragement and contributes to a collaborative patient–nurse relationship that promotes engagement and adherence to treatment.[37] Although language is not the only manifestation of stigma, using nonstigmatizing language creates an opportunity to improve care for people with SUDs.

Person-first language. Providing person-centered care starts with selecting person-first language. Person-first language emphasizes the person over the medical condition, acknowledging the whole individual and recognizing that a disease does not define the person.[9] This applies to all areas of health care; for example, describing someone as "a person with diabetes" is preferred to calling them a "diabetic" and "a person with cancer" is preferred to a "cancer patient." In the case of addiction, "a person with an alcohol use disorder" is preferred to an "alcoholic." Referring to a "person with a substance use disorder" instead of saying "junkie" or "addict" demonstrates that the person *has* a problem, rather than *is* the problem. Like medically appropriate terminology, person-first language is more clinically accurate and nonjudgmental. It avoids negative associations, punitive attitudes, and the assigning of blame that comes with labeling someone by their disease. Person-first language results in improved quality of care and ultimately better patient outcomes. It values the person as a human being and a dignified member of the greater community.

Medically appropriate terminology. Use of medically appropriate terminology, which is more accurate, neutral, and nonjudgmental language, is an easy way for nurses to counter stigma that can be incorporated into everyday routines. Precise language is more scientifically correct, conveying the understanding that SUDs are chronic yet treatable health conditions.[12] In our case scenario, the nurse says that her patient is "sober" instead of using less stigmatizing words like "in recovery" or "in long-term recovery."

Language can suggest value or worth, and a nurse's word choice can promote or undermine a sense of mutuality and inclusion. Words influence the way people feel,[37] and nurses should be careful to avoid words that imply a negative value judgment.[9] For example, the word "habit" inaccurately implies that substance use is a choice, and if people really wanted to, they could choose to stop. Use of the word "habit" may also minimize the seriousness of the disease. Similarly, the word "abuse" has been found to have an association with negative judgments and punishment.[37] Using medically appropriate terminology also applies to reviewing laboratory results. For example, with toxicology screens, instead of referring to samples as "clean" or "dirty," a better choice is to report them as "positive" or "negative," and the best option is to say, "There were no unexpected (or expected) findings" or "Substance X was present or absent."

Addressing implicit bias. Bias positively or negatively influences a person's attitudes, perceptions, and actions toward another individual or group. Everyone, including health care professionals like nurses, has implicit biases or prejudices they are unaware of.[35] These unconscious biases occur automatically, resulting from stored associations influenced by attitudes and stereotypes, and can ultimately affect clinical decision-making. Stigmatizing language can precipitate explicit and implicit biases that negatively affect quality of care and patient outcomes, contributing to barriers to people with SUDs seeking health care.[37] Not only does implicit bias negatively affect the therapeutic relationships nurses have with their patients, but it can also affect treatment and interfere with potentially lifesaving decisions.[38] In the case scenario, when Ms. Harper begins experiencing labor-related pain, the nurse labels her as "drug seeking" and does not further evaluate her pain. She could be experiencing a complication related to childbirth. Her concerns need to be validated to avoid poor clinical decision-making and serious medical errors.[39]

The first step to reducing implicit bias is identification and self-awareness. Recognition of implicit bias may be uncomfortable; however, self-awareness is necessary for implementing management approaches.[34, 35, 40, 41] The most readily available tool used to measure a person's attitudes, which is widely used in research, is the Implicit Association Test (IAT). Implicit bias is measured indirectly. For example, the IAT measures the strength of associations between certain designations (fat, thin) and judg-

ments (good, bad) or stereotypes (athletic, clumsy) to determine a person's attitudes.[42] Results may produce potentially emotional reactions—such as defensiveness or skepticism—so establishing a judgment- and blame-free environment beforehand is essential.[34] Criticism of the IAT does exist and primarily focuses on construct validity (that is, does the IAT truly measure implicit bias?), psychometrics (does the IAT predict discriminatory behavior?), and external validity (is the IAT applicable in real-word contexts?), and it is important to recognize the potential limitations of this approach.[34]

Ground rules, such as respect and confidentiality, create a nonthreatening space to foster vulnerability and learning.[43-45] This atmosphere enables sensitive discussions to take place among nurses and colleagues and encourages growth. Implicit bias is part of being human; however, overcoming one's misconceptions is necessary to prevent harmful clinical decisions.[43] Awareness alone is not enough, and the IAT is most useful when paired with other techniques, such as facilitated discussions and reflection.[35] Managing unconscious bias requires a multidimensional approach and may take time to achieve.[46] In their systematic review, FitzGerald and colleagues identified 47 antibias interventions and classified them into eight categories, including strategies such as finding commonalities, perspective taking, alternative narratives (considering the opposite view), and counterstereotypical exemplars.[32]

There has not been much research on the long-term effects of stigma and bias interventions on behavior. A commitment to implicit bias training is essential for nurses to ensure that they provide equitable care. Recognizing the interconnectedness of different biases and identities (based on gender, age, sexual orientation, race, and socioeconomic status) is critical.[32, 35] Using clinically appropriate terminology and person-first language are effective ways nurses can reduce stigma by modifying the types of implicit and explicit bias individuals might otherwise experience.[47]

Case scenario: missed opportunities. The case scenario highlights several opportunities to improve care. A lack of understanding of the pathophysiology of addiction is apparent throughout. The nurse asks, "How could any mother do that to their baby," implying that addiction is a choice. Her remark that now the patient "is addicted to buprenorphine," suggests that administering buprenorphine, a medication approved by the Food and Drug Administration for the treatment of OUD, is replacing one addiction with another. The nurse fails to recognize her patient's complaints of pain as a potential symptom of active labor, instead labeling her as "drug seeking." A lack of formal education on addiction combined with limited exposure promotes the common misperception that addiction is a choice. The nurse might be emulating behaviors and language used by her role mod-

els (attending physicians or nurse peers, for example) who openly express dislike for caring for people with SUDs. Past experiences of misunderstanding and mistreatment likely led to this example of mutual mistrust between nurse and patient.

In this case, Ms. Carter could have approached patient care in a more compassionate and supportive manner by expressing a nonjudgmental attitude, empathy, and hope for a healthy future. Knowledge of OUDs and the evidence-based medications used to treat them may have precluded her from equating buprenorphine with substituting one addiction for another. Active listening could have been used to validate her patient's concerns about pain and to foster trust, self-esteem, and self-efficacy. A first step toward meaningful change is to replace pejorative language with neutral alternatives and to avoid documentation in the chart that perpetuates stigma (see Table 1).

NURSING IMPLICATIONS

Nursing integrity is a complex concept, as it is associated not only with direct patient care but also with ethical conduct and actions.[48] Nurses are recognized as both formal and informal leaders in health care and are critically important in taking the necessary steps to combat addiction stigma.

Academic curriculum. Addressing the unwritten or unofficial messages, also known as the "hidden curricula," in addition to the implicit, explicit, and null curricula in nursing education is key to transforming nursing education and sustaining meaningful change.[28] The impact of stigmatizing language—an example of hidden or null curricula—is often not taught.[28] Limited coursework related to SUDs and little or no contact with people with SUDs compounds this problem. Instead, students often draw lessons from the implicit messages about values, norms, and attitudes conveyed by the behavior of role models or influential groups, such as nursing professors, preceptors, and other nurses.[28]

Attitudes of first-year nursing students toward people with SUDs can be changed with educational interventions such as teaching the disease model of addiction and hearing firsthand accounts from people in recovery.[30] Role modeling or demonstrating skills such as screening, assessing, and providing medication for SUDs can improve nursing students' knowledge and provide opportunities to approach instances of discomfort as moments to discuss evidence and therapeutic interventions. Implementing stigma training in the nursing curricula is critical to improving quality care.

Continuing education. Nurses are well positioned to champion strategies to combat stigma given their largely patient-facing role throughout health care settings. Continuing education for practicing nurses to identify their own implicit biases, participate in addiction stigma training, and incorporate stigma mitigation strategies into their daily practice is critical to improving care for people with SUDs.

Table 1. The Case Scenario: Biased vs. Neutral Language

Stigmatizing or Biased Language	Neutral Alternative	Rationale
At the nurse's station: "These junkies are so annoying."	"I find caring for people with SUDs challenging." Ask a peer: "What have you found that helps improve your care?"	Identify implicit biases and use this experience as an opportunity to address them.
During report, calling patient an "addict" and her unborn child a "crack baby." In progress notes: She is a "drug abuser" . . . "she chose to stop using drugs when she found out she was pregnant" . . . "found with dirty urine."	Person with an OUD, now in recovery . . . baby at risk for developing neonatal abstinence syndrome . . . last use on X date . . . urine results showed presence of buprenorphine, which is an expected finding	She is a person first. Her disease does not define her. She did not choose to become addicted, and she can't just choose to stop using substances. Addiction is a chronic brain disease. Recovery is multifactorial and a lifelong process.
On the unit: Patient displays "drug-seeking" behavior, "claims to be in pain"	Demonstrating signs and symptoms of pain	Listen to and seriously consider the concerns and symptoms reported by people with SUDs; assumptions could lead to serious diagnostic errors and poor clinical decision-making.
In the EHR: "27-year-old drug abuser" . . . "claims that she is in pain" . . . "she is reportedly clean"	27-year-old female with a history of substance use. She reports X/10 pain, localizes pain to X, describes pain as X, worst at X, improves with X. She has been in recovery since X date.	Avoid using terms like she "claims" and "reportedly," which imply judgment and suggest doubt.

EHR = electronic health record; OUD = opioid use disorder; SUD = substance use disorder.

Positive interactions between nurses and people with SUDs can facilitate introduction to treatment, retention in treatment, and lifelong recovery.[18] People with SUDs have expressed the importance of non-judgmental staff who understand addiction and how to treat withdrawal as crucial to securing trust, essential to engagement in care, and key to their decision to stay in the hospital and not leave against medical advice.[16] For women like Ms. Harper who are undergoing labor, stigma can be a significant barrier to facilitating healthy mother–baby attachment and to growing confidence in providing care for their babies.

Addiction stigma training is a continuing professional development opportunity that allows clinicians to enhance their knowledge and skills, promoting high-level effective patient care. Workshops can introduce evidence-based strategies to reduce bias toward people with SUDs by creating a safe and nonthreatening learning environment. They provide a platform for nurses to increase their confidence in challenging encounters, to learn mitigation techniques, and to brainstorm solutions for improving care with real-life examples.[49]

Nurses can help shift organizational culture by securing leadership support and collaborating with their interdisciplinary colleagues to reduce stigma. Areas to focus on include removing punitive structures such as restricting patients with SUDs from receiving visitors or leaving nursing units; revising policies that include stigmatizing, pejorative language; and encouraging the adoption of standardized protocols and addiction consult teams.

Beyond health care. As members of the most trusted profession, nurses are uniquely positioned to educate their surrounding communities on the brain disease model of addiction and the appropriate language to use when discussing SUDs and the people these disorders may impact. Stigma reinforced by nurses only perpetuates a misunderstanding of SUDs by the lay public. Language used by people in the community can significantly impact attitudes and beliefs toward people with SUDs. Evidence indicates that people who consider SUDs a medical illness are more likely to support evidence-based treatment, be less biased against people with SUDs, and show support for naloxone distribution and harm reduction strategies.[5] This may facilitate access to more SUD providers and treatment facilities, which remain disproportionately low in rural settings, and increase distribution of naloxone, sterile syringes, fentanyl test strips, and other harm reduction interventions.

Case scenario: conclusion. Ms. Harper delivers a healthy baby boy. She and her baby are transferred to the postpartum unit where she meets her nurse, Sue Winston, a veteran nurse with more than 30 years of experience, who warmly welcomes the young mother and baby. Ms. Winston has a son with a SUD in recovery

and is keenly aware of the negative effects of health care–related stigma and the tremendous impact positive interactions between nurses and people with SUDs can have on engagement in care and patient outcomes. She encourages the new mom to have the baby room in with her. She spends time with her, sitting next to her while she navigates breastfeeding, and provides reassurance when the young mother questions whether she can do it all. Ms. Harper begins to trust this nurse and expresses hope that there are more people like her outside the hospital. Meanwhile, having reviewed her patient's chart, Ms. Winston reaches out to Ms. Harper's previous nurses to share with them her confidence in the new mom. She also shares her experiences with people in recovery and what she has learned over the years about the importance of language choice, including how labeling and stereotyping can interfere with proper diagnosis and treatment and lead to negative health outcomes. She offers to share resources with the nurses on the science of addiction and the impact of health care–related stigma and invites them to a workshop she is leading on stigma mitigation strategies.

CONCLUSION

Addressing systemic health and social inequities requires a shift toward human caring and a more authentic, value-driven health care environment. Addiction is not a choice, but the language that is used to describe it and the people affected by it is. The first steps in stopping addiction stigma are using person-first language and medically appropriate terminology in all interactions, conversations, and clinical documentation. Adopting these strategies will help improve quality of care, decrease barriers to accessing care, and ultimately result in better patient outcomes.

Reducing the stigma surrounding addiction among health care personnel is a priority for future research.[50] Nurses need to confront addiction stigma by developing innovative training programs for nursing students, while also creating and promoting continuing interprofessional education opportunities throughout health care organizations.[51] Nurses are not only leaders in health care but also role models throughout the community; therefore, nursing's support is key to ending addiction stigma. ▼

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