NATIONAL COUNCIL for Mental Wellbeing

Stigma, Biases and Shame: Tobacco Use and Wellbeing Masterclass

Thursday, May 27, 2021

3:00 – 5:00 pm ET

Closed captioning: https://www.streamtext.net/player?event=StigmaBiasesandShame

Welcome!

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Director,
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Project Manager,
Practice Improvement

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Project Coordinator,
Practice Improvement

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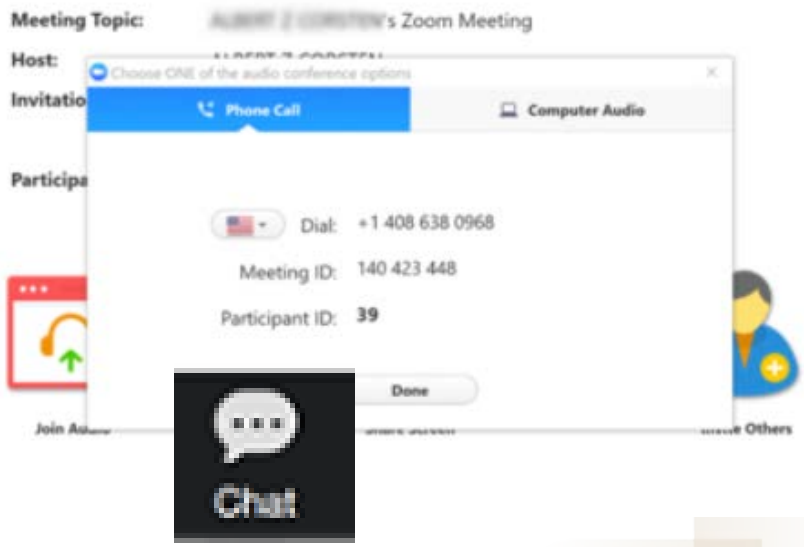
Housekeeping

- This workshop is being recorded. All participants placed in “listen-only” mode.
- For audio access, participants can either dial into the conference line or listen through your computer speakers.
- Submit questions by typing them into the chatbox or using the Q&A panel.
- Access to closed captioning:
  - https://www.streamtext.net/player?event=StigmaBiasesandShame
- Slide handouts and recording will be posted here:
  - https://www.bhthechange.org/resources/resource-type/archived-webinars/



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National Behavioral Health Network for Tobacco & Cancer Control

- Jointly funded by CDC's *Office on Smoking & Health & Division of Cancer Prevention & Control*
- Provides resources and tools to help organizations reduce tobacco use and cancer among individuals experiencing mental health and substance use challenged
- 1 of 8 CDC National Networks to eliminate cancer and tobacco disparities in priority populations

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SMOKING CESSATION LEADERSHIP CENTER

MPHI

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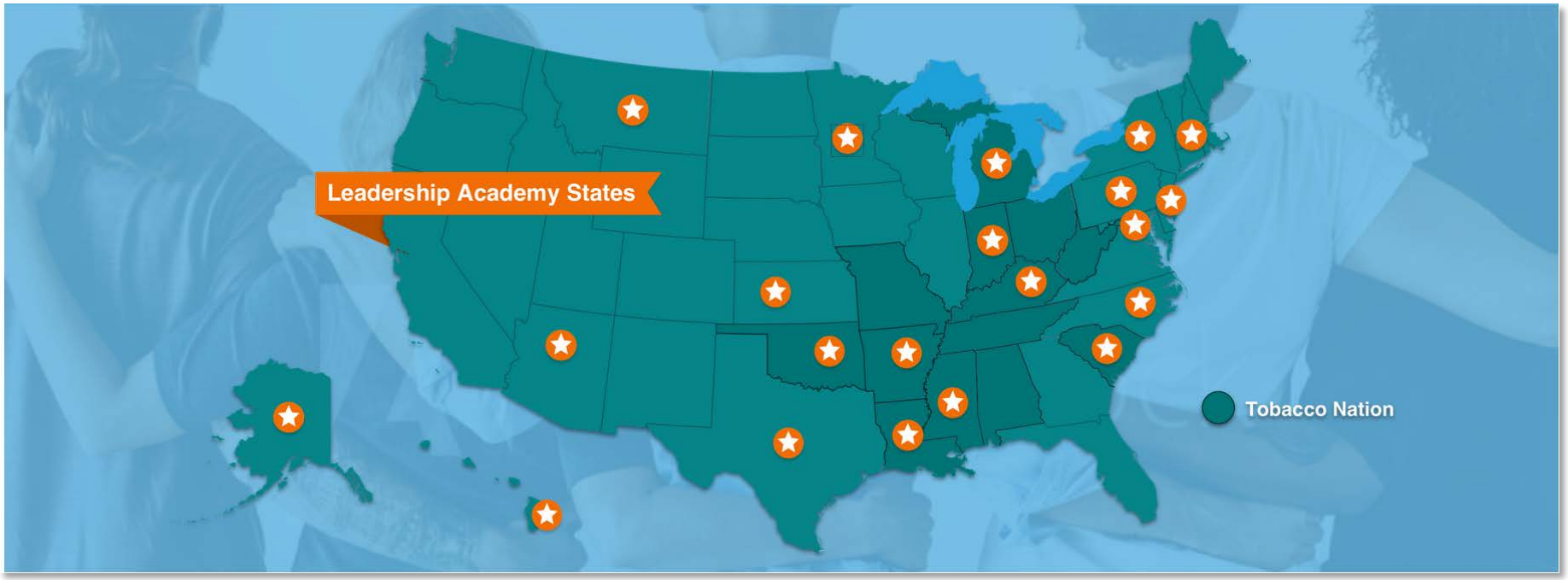
SAMHSA National Center of Excellence for Tobacco-Free Recovery

- The Center of Excellence builds on and expands SAMHSA's efforts to increase awareness, disseminate current research, educate behavioral health providers, and create results-oriented collaborations among stakeholder organizations in an effort to reduce tobacco use among individuals with behavioral health disorders

- Goals of the Center of Excellence are to:
  - **Promote** the adoption of tobacco-free facilities, grounds, and policies
  - **Integrate** evidence-based tobacco cessation treatment practices into behavioral health and primary care settings and programs
  - **Educate** behavioral health and primary care providers on effective evidence-based tobacco cessation interventions

State Leadership Academies



Action Planning Summits to reduce tobacco use and foster tobacco-free living in behavioral health

Visit **TobaccoFreeRecovery.org**
for more opportunities, trainings and resources

Today's Learning Objectives

- Define and discuss the history and impact of shame and stigma on individuals who use tobacco and have a mental health and substance use challenge.
- Understand the social, psychological and cultural processes that create self-stigmatization, social stigma and structural stigma, and how each might influence access to and engagement with high-quality treatment.
- Describe ways health care providers and health systems propagate stigma and shame-mediated health disparities related to mental health and substance use, including tobacco and alcohol dependence.
- Explore and apply methods to reduce stigma through empowerment and systems structure improvements.
- Implement steps to reduce stigma within your organization and communities that will promote smoking cessation and treatment.

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A Note on Language & Terminology

Mental wellbeing: thriving regardless of a mental health or substance use challenge.

Commercial tobacco use/tobacco use: The use of commercial tobacco and nicotine products (including electronic nicotine devices, otherwise known as ENDs).*

***All references to smoking and tobacco use is referring to commercial tobacco and not the sacred and traditional use of tobacco by some American Indian and Alaskan Native communities.**

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Today's Featured Speakers

Jason M. Satterfield, PhD
Academy Endowed Chair,
Innovation in Teaching
Professor of Clinical Medicine
University of California San Francisco

Richard Bottner, DHA, PA-C
Assistant Professor,
Department of Internal Medicine
Physician Assistant, Dell Seton Medical Center
University of Texas at Austin

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Stigma, Biases and Shame: Tobacco Use, Behavioral Health, and SUD

Richard Bottner, DHA, PA-C

Dell Medical School at The University of Texas at Austin

Jason Satterfield, PhD

University of California

Smoking Cessation Leadership Center

Conflicts and Disclosures

- Richard Bottner, DHA, PA-C has no conflicts to disclose. He has received implementation grants from Texas Health and Human Services and an education grant from the Association of American Medical Colleges.
- Jason Satterfield, PhD has no conflicts to disclose. He has received multiple research and educational grants from NIH and SAMHSA.

- Pull up Menti.com on your personal device or browser now.

Objectives

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Roadmap

- The theory and science of stigma
  - Self stigma narratives and intervention exercise
- Smoking, behavioral health, and SUD
  - Why do people do the things they do?
- Stigma in health care and providers
  - Language matters exercise
- Strategies to reduce stigma and promote cessation
- ”Fireside Chat” and Q&A


WHAT'S YOUR
STORY
?

Definition of Stigma

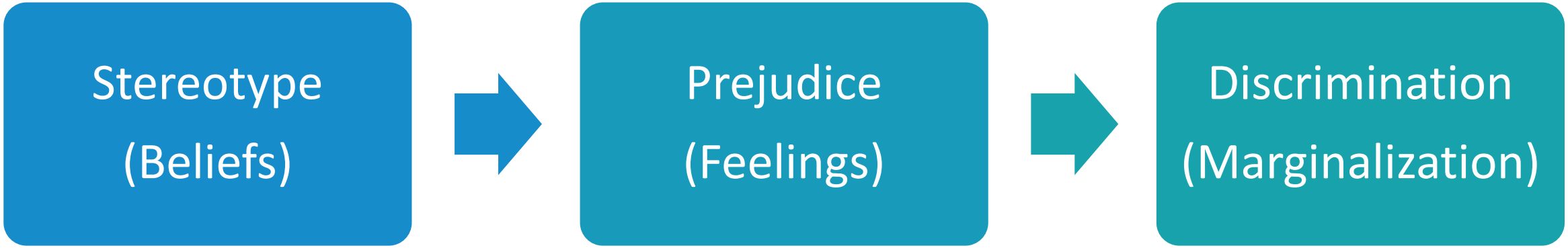
Originates from Greek “stizein”

A mark burned onto the skin of slaves to signify their low place in the social hierarchy in ancient times.[1]

“An attribute that links a person to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one.”[2]

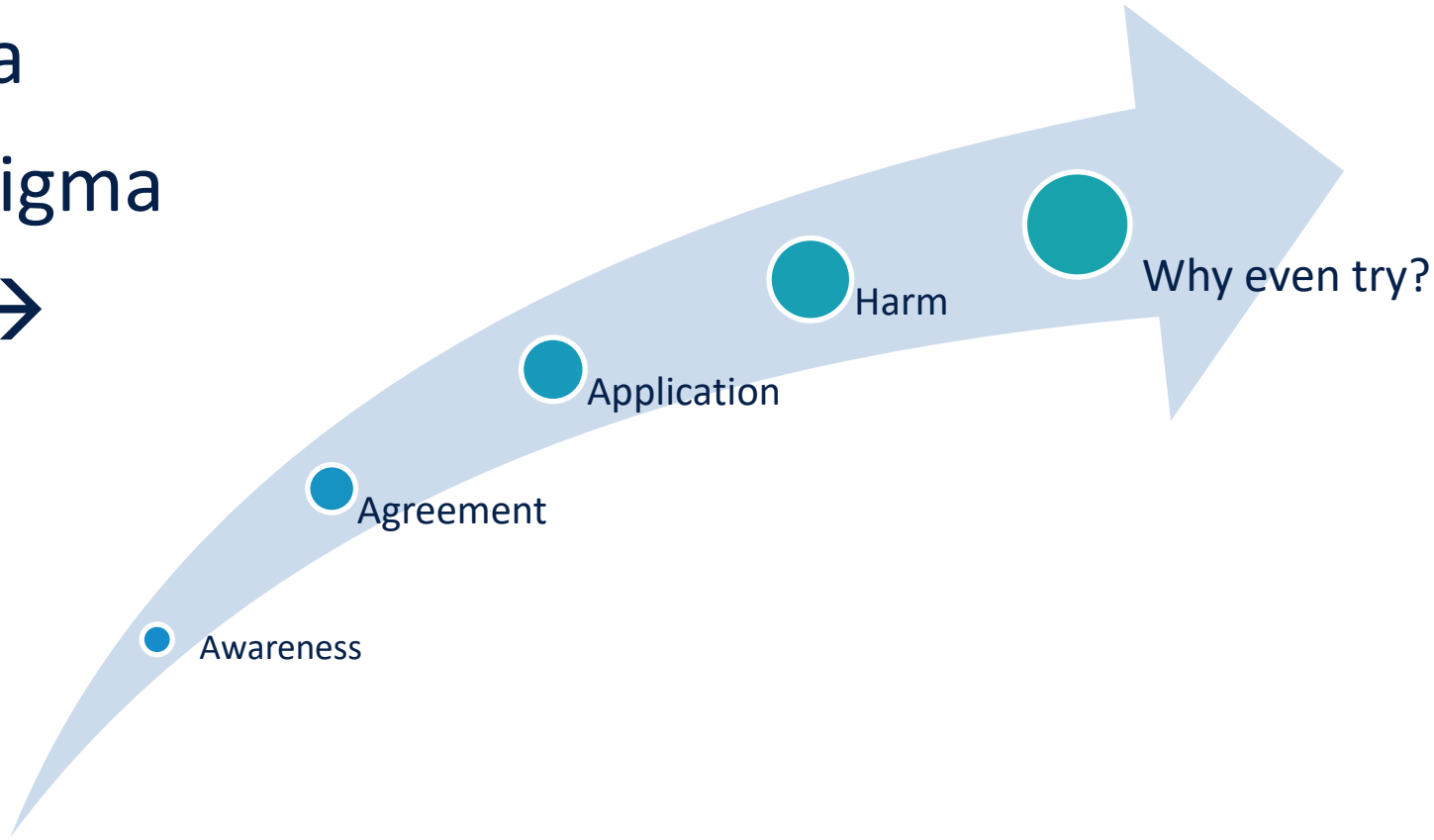
“A social construct whereby a distinguished mark of social disgrace is attached to others in order to identify and to devalue them. Thus, stigma and the process of stigmatization consist of two fundamental elements: the recognition of the differentiating ‘mark’ and the subsequent devaluation of the person.”[3]

What exactly is stigma?



Types of Stigma

- Social Stigma
- Structural Stigma
- Self stigma →



Word Cloud Exercise #1

What are words typically used to describe people with substance use disorders?

Up to two words per entry.

Encouraged to submit multiple entries.

Word Cloud Exercise #2

What are words typically used to describe people with mental illness?

Up to two words per entry.

Encouraged to submit multiple entries.

www.ResetStigma.org

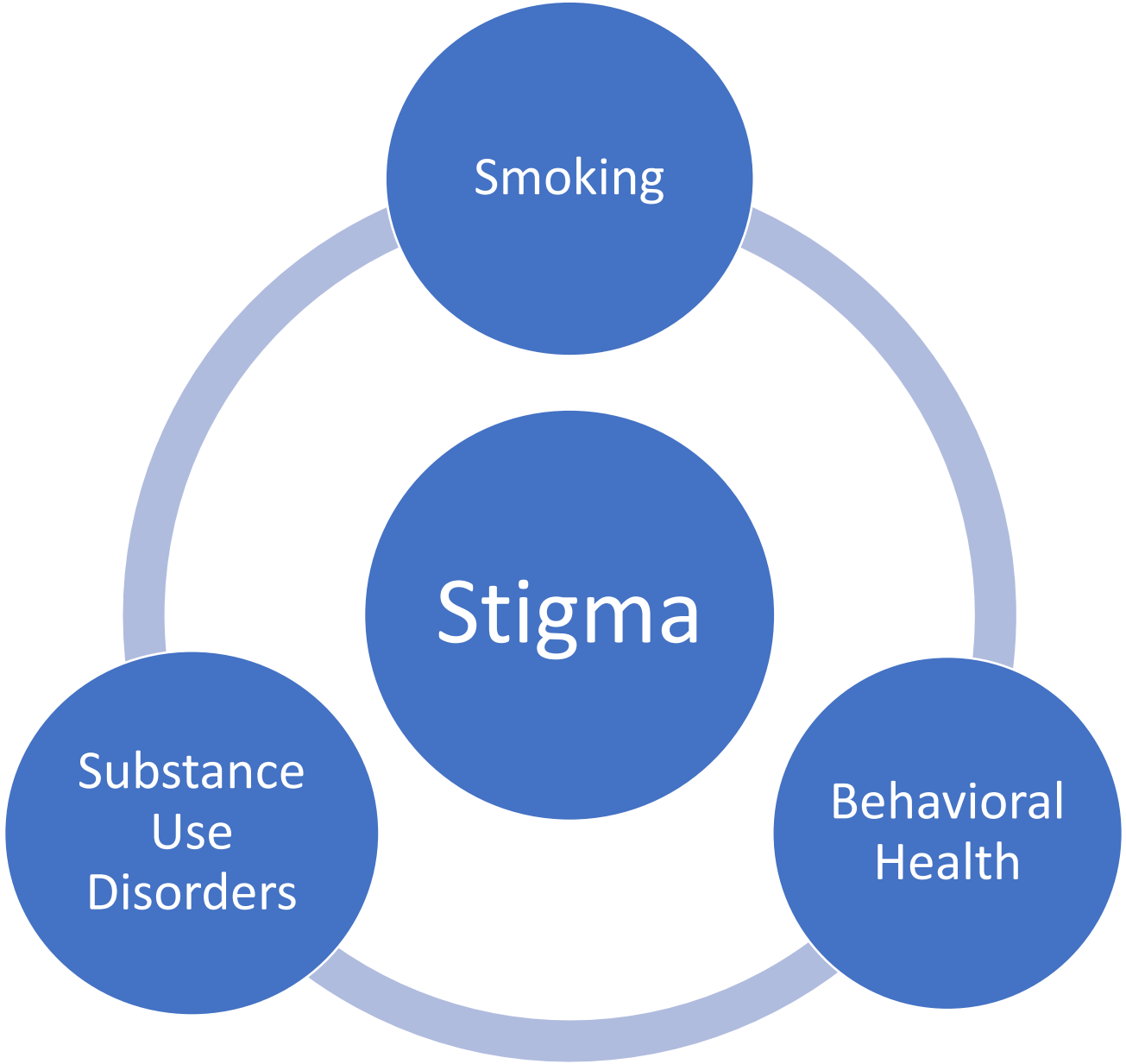
Self-Stigma Interventions

- Recall: Aware -> Agree -> Apply -> Harm
- Interventions can target any step in this pathway
  - Cognitive-behavioral therapy; narrative
  - Lovingkindness and self-compassion meditation
    - Sharon Salzberg – Lovingkindness: The Revolutionary Art of Happiness
    - Includes 3 common meditation elements:
      - Somatic quieting
      - Attention/focus
      - Acceptance

Exercise: Lovingkindness

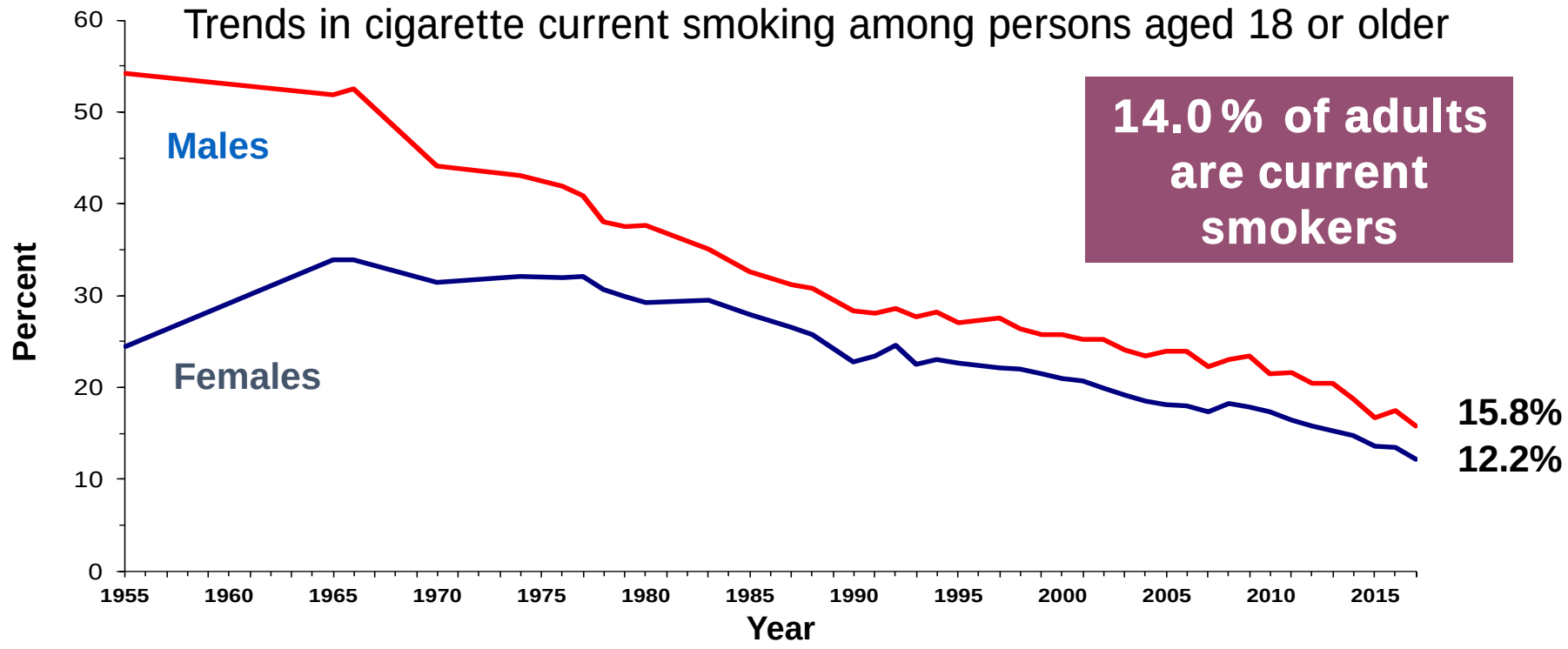
3 min meditation:

- Settle into your breath
- Hold an image of yourself in your mind
- Repeat the mantra
  - May I be free
  - May I find peace
  - May I have grace and courage


Smoking
Stigma
Substance Use Disorders
Behavioral Health

We’ve come a long way baby – have we?

TRENDS in ADULT SMOKING, by SEX—U.S., 1955–2017



68% want to quit
55% tried to quit in the past year

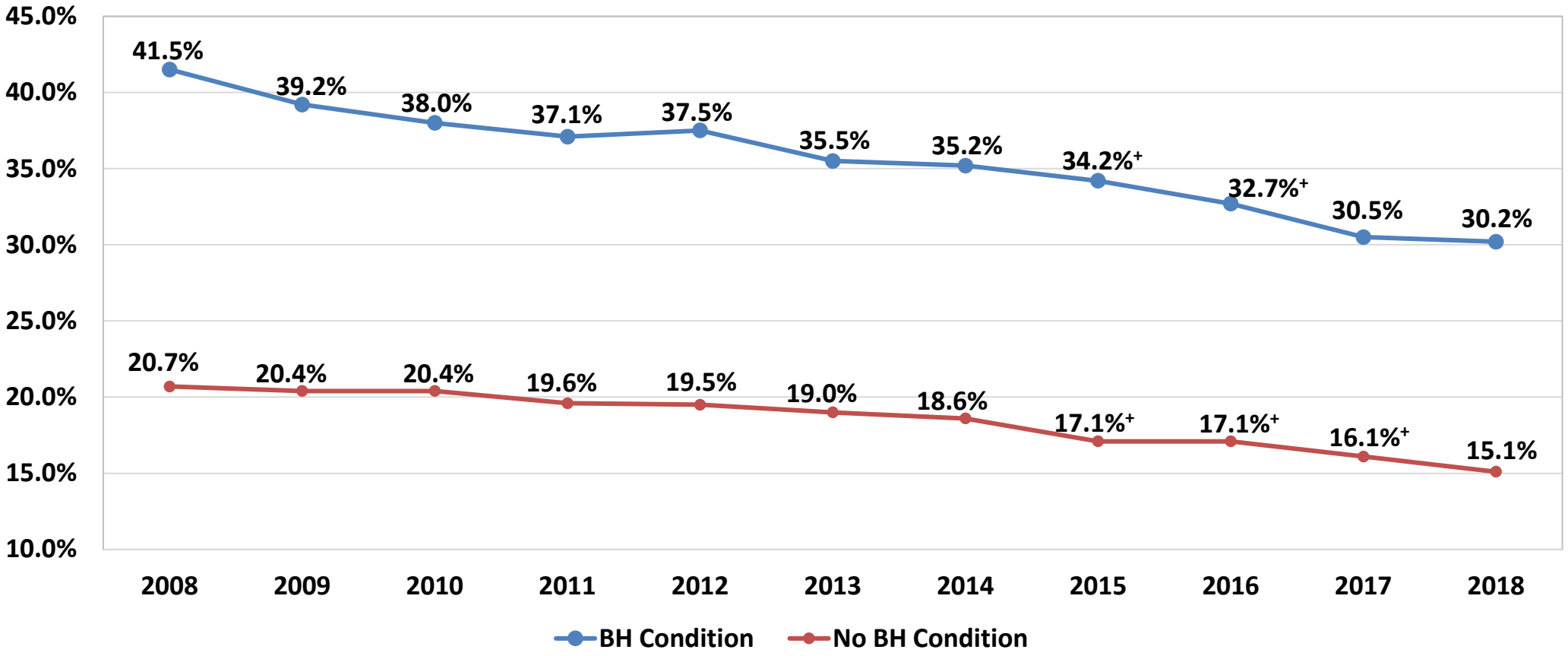
Graph provided by the Centers for Disease Control and Prevention. 1955 Current Population Survey; 1965–2017 NHIS. Estimates since 1992 include some-day smoking.

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Smoking and Special Populations

- Smoking prevalence is 50% higher among LGBT Americans compared with straight Americans.
- In 2013, smoking prevalence was significantly higher among persons living below poverty (29.9%) than those living at or above poverty (20.6%).
- Among adults under age 65, 30 % of Medicaid enrollees and 30% of uninsured individuals smoke, compared to 15 % with private insurance coverage.
- People living at or below the poverty line are less likely to successfully quit smoking (5.1%) than those living at or above poverty (6.5%).
- Those groups most impacted by the tobacco epidemic have consistently been targets of marketing by the tobacco industry.

Current Smoking Among Adults (age> 18) With Past Year Behavioral Health (BH) Condition: NSDUH, 2008-2018



Adults with mental health or substance use disorders
represent **25%** of the population,
but account for **40%** of all cigarettes smoked by U.S. adults

Behavioral Health Condition includes AMI and/or SUD
Due to changes in survey questions regarding substance use disorders in 2015, including new questions on meth and prescription drug misuse, this data is not comparable to prior years
*Difference between this estimate and the 2018 estimate is statistically significant at the .05 level

Smoking Prevalence and Co-morbid SUD

- 53-91% of people in addiction treatment settings use tobacco[1]
- Tobacco use causes more deaths than the alcohol or drug use bringing clients to treatment: death rates among tobacco users is nearly 1.5 times the rate of death from other addiction-related causes
- In 2016, < half (47.4%) of U.S. substance abuse treatment facilities —offered tobacco cessation services

[1]Guydish J, Passalacqua E, Tajima B, et al. Smoking Prevalence in Addition Treatment: A Review. *Nicotine Tob Res*. 2011;13(6):401-11.
[2]Substance Abuse and Mental Health Services Administration, *National Survey of Substance Abuse Treatment Services (N-SSATS): 2013. Data on Substance Abuse Treatment Facilities.* BHSIS Series S-73, HHS Publication No. (SMA) 14-489. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
[3] Marynak K, VanFrank B, Tetlow S, et al. Tobacco Cessation Interventions and Smoke-Free Policies in Mental Health and Substance Abuse Treatment Facilities —

UCSF

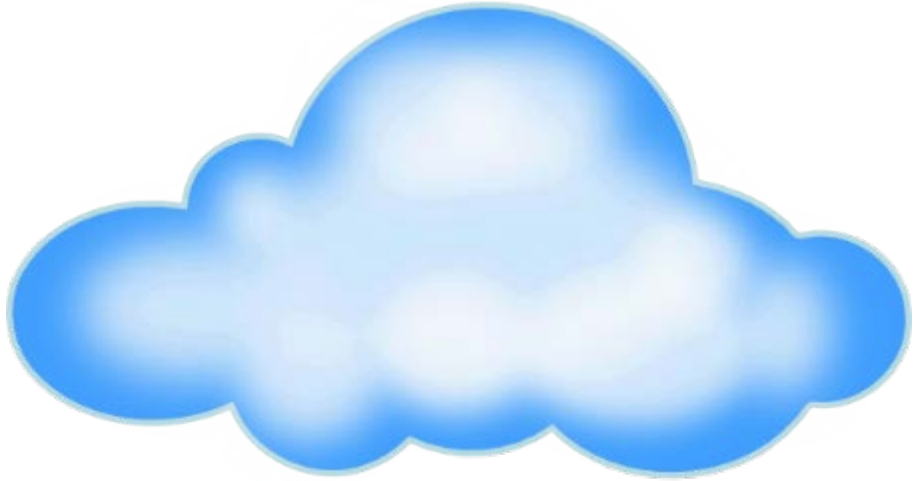
Smoking and Behavioral Health: The Heavy Burden

- 240,000 annual deaths from smoking occur among patients with chronic mental illness and/or substance use disorders
- This population consumes 40% of all cigarettes sold in the United States

  -- higher prevalence, smoke more, smoke down to the butt
- People with serious mental illnesses die earlier than others, and smoking is a large contributor to that early mortality
- Greater risk for nicotine withdrawal
- Social isolation from smoking compounds the social stigma

Word Cloud #3:
Why do people do the things that they do?

- Prompt: Many people continue to smoke tobacco, drink alcohol, and/or use drugs even after they realize their behavior is harmful to themselves or others. In two words or less, explain why they do this.
- Up to two words per entry.
- Encouraged to submit multiple entries.



Why do people do the things that they do….?

- ACE’s and epigenetics
- Social determinants, social risks, social needs
- Social networks
- Self-medication
- Physiology of addiction
- Manipulation by big business and media
- Unintended effects of public health and policies (e.g. vaping/Juul)

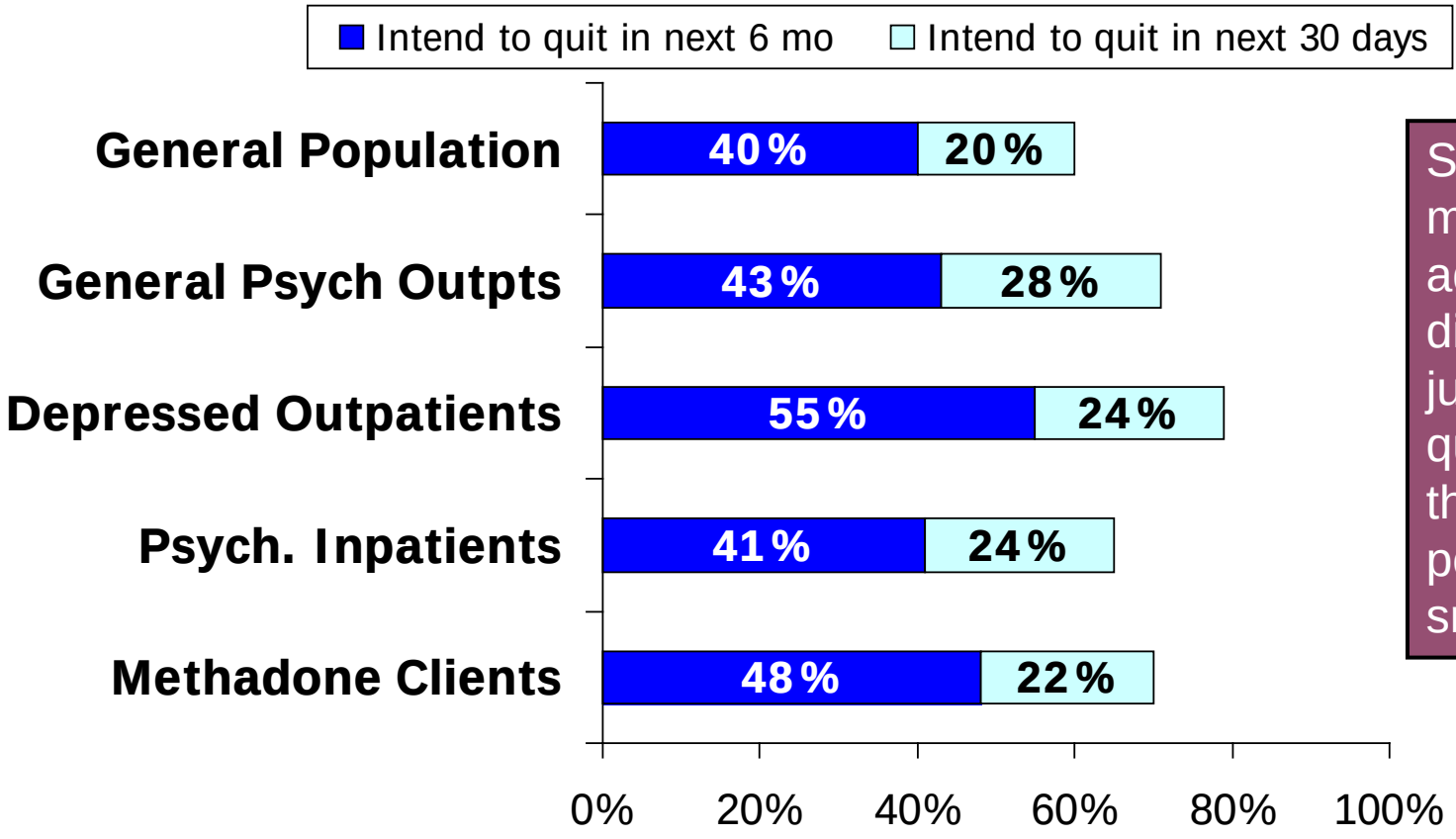
Blame and Shame Are Killing our Clients….

- Both PC and BH Providers are less likely to offer smoking cessation services to patients with BH conditions – despite having access to effective interventions
- Hypothesis: The stigma of having a BH condition biases providers who think cessation will not be wanted, will not be effective, and/or will exacerbate the BH condition.
  - In a sense, these clients are **blamed** for smoking/continuing to smoke
- Hypothesis: Clients who smoke and have a BH condition are **shamed** for having a mental illness and for being a smoker.
  - This lowers self-esteem and self-efficacy and raises stress

Provider Beliefs about Tobacco and BH

- Tobacco is necessary self-medication
- BH consumers are not interested in quitting
- They are unable to quit
- Quitting worsens recovery
- Smoking is a low priority problem
- THESE ARE MYTHS

READINESS to QUIT in SPECIAL POPULATIONS*



Smokers with mental illness or addictive disorders are just as ready to quit smoking as the general population of smokers.

*** No relationship between psychiatric symptom severity and readiness to quit**

Smoking Cessation for Patients with SUD

Studies have shown that as many as **80% of clients** in substance use disorder treatment have **expressed an interest in tobacco cessation**.[8]

Quitting tobacco use during drug addiction treatment is linked to a **25% increase in long-term sobriety**.[8]

Research has shown **substance use disorder treatment attendance did not differ** between the groups receiving smoking cessation treatment and those receiving treatment as usual.

In fact, **85% of participants completed the 10-week active treatment period** concurrent with smoking cessation treatment.[9]

Emotional, Cognitive, and Behavioral Responses from People with BH

- Guilt – “I’ve done something bad or wrong…”
- Shame – “I am something bad or wrong…”
- Hopelessness – “Nothing I do will make a difference…there’s no way out….”
- Distrust – “Medical people don’t respect me and won’t help me….”
- Avoidance; other forms of maladaptive coping (e.g. smoking, drinking)
- Stigma yields 3 kinds of harm that may impede treatment participation:
  - It diminishes self-esteem, lowers self-efficacy and robs people of social opportunities.

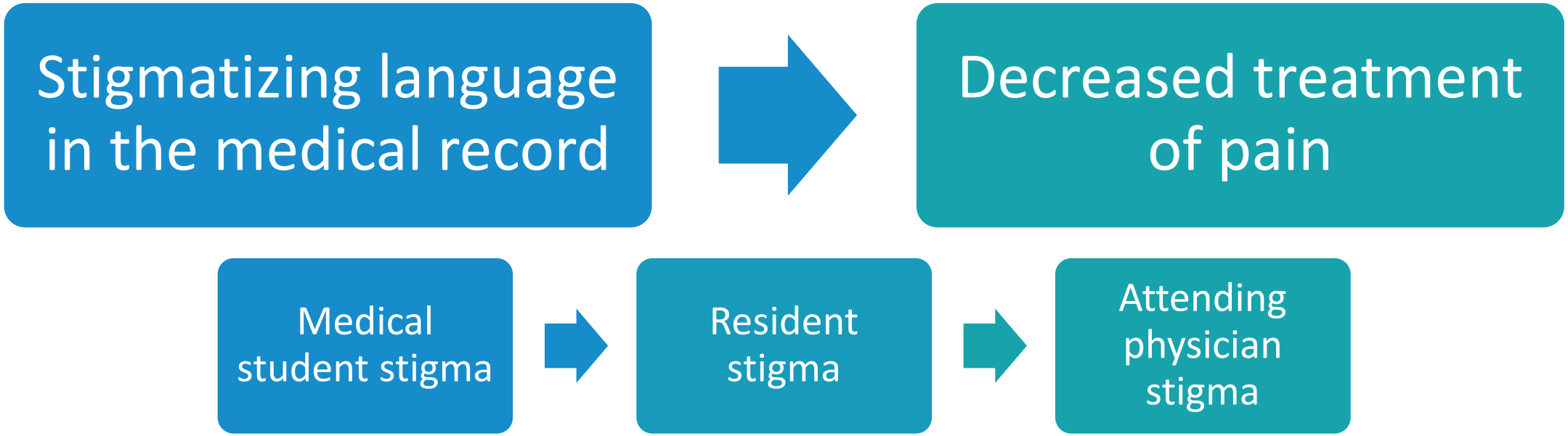
Biobreak – 10min

Reflection

- Take a moment to reflect on what we've covered so far today.

How does stigma manifest in clinical practice?

Health professionals have a negative attitude towards patients with SUDs.



Goddu et al., 2018; Goddu, Anna et al., 2018; van Boekel et al., 2013

How does stigma manifest in clinical practice?

- Discontinuation of life-saving treatment to receive liver transplant.
- Denial of valve repair surgery in endocarditis.
- Shame, prolonged hospitalization, and potential justice-system involvement for pregnant patients.
- Desire to address SUD far less than other chronic medical conditions.
- Hospital self-discharge – as high as 17%

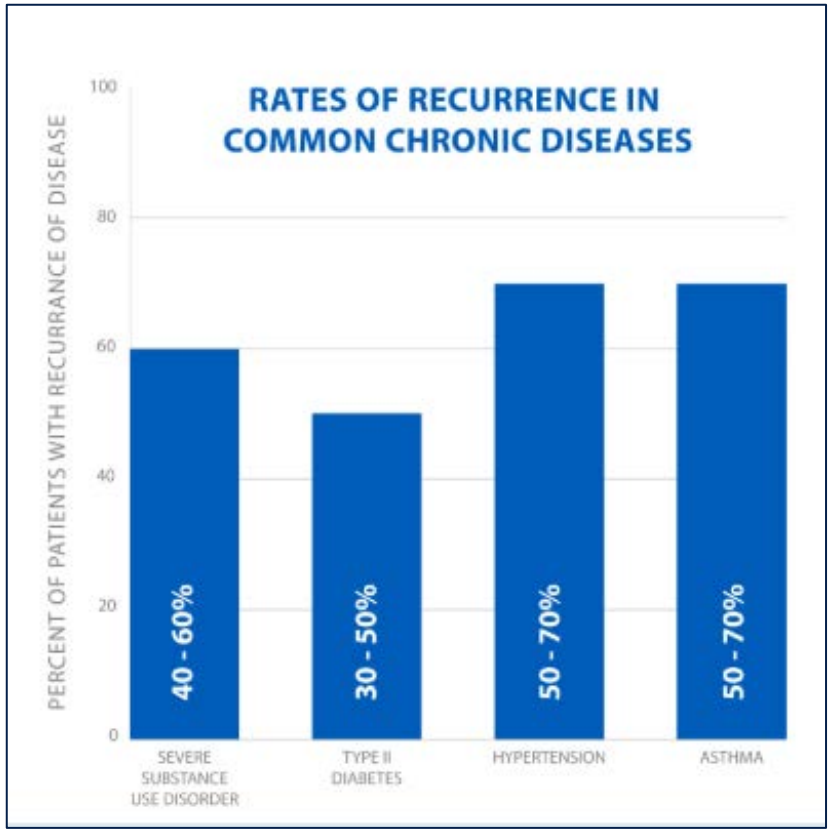
van Boekel et al., 2013; Meisner et al., 2019;

How does stigma manifest in clinical practice?

Substance use disorders are treated as a moral failing.

In reality:

- SUDs are driven by genetic and environmental factors
- Rates of recurrence very similar to other chronic diseases

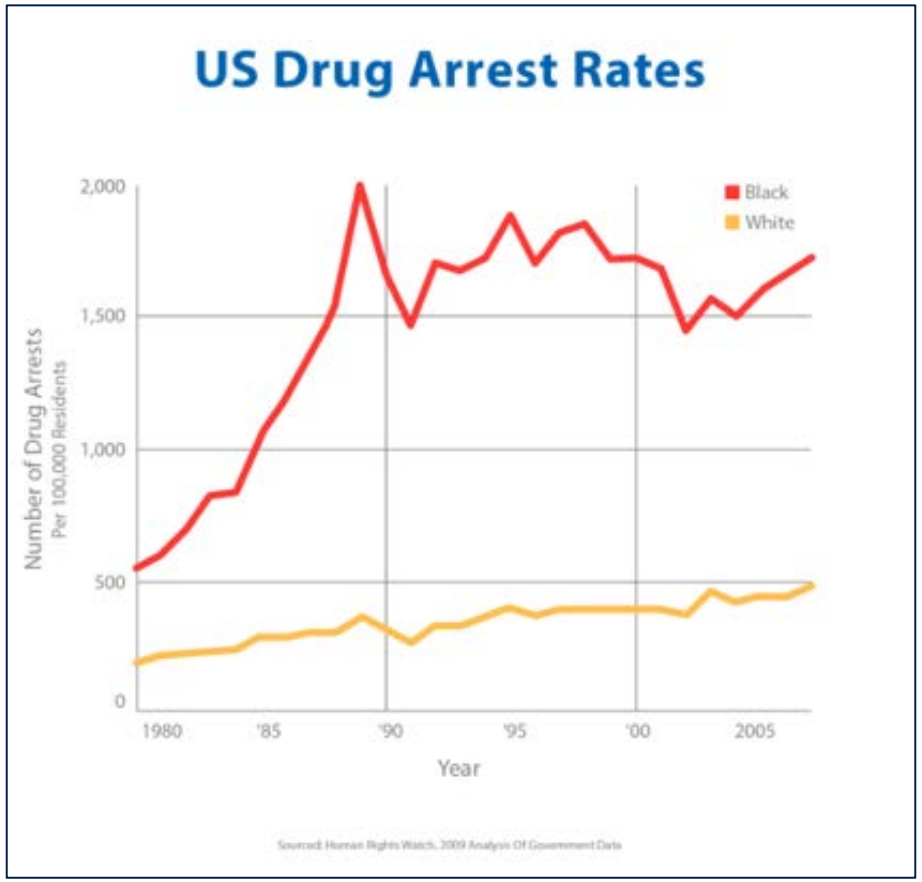


NIDA, 2005

Drug Policy

1970s “War on Drugs”

- Cocaine then, heroin now.
- Responsible for large disparities among individuals of racial minority groups.
- Today, white patients are **35 times more likely** to receive treatment for OUD compared to Black patients. →



Santoro & Santoro, 2018; Lagisetty et al., 2019

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

APRIL 2, 2020

Stigma and the Toll of Addiction

Nora D. Volkow, M.D.

Each day in 2018, an average of 185 people in the United States died from a drug overdose.[1] In fact, recent declines in U.S. life expectancy are being attributed to direct and indirect effects of alcohol and drug use disorders. Expanding the number of people receiving evidence-based addiction treatment is crucial for reversing these trends. But among the many challenges in delivering appropriate care to the nearly 20 million people in the United States with substance use disorders is the chilling effect of stigma. Stigma not only impedes access to treatment and care delivery; it also contributes to the disorder on the individual level.

Stigma associated with many mental health conditions is a well-recognized problem. But whereas considerable progress has been made in recent decades in reducing the stigma associated with

causes beyond those that apply to most other conditions. People who are addicted to drugs sometimes lie or steal and can behave aggressively, especially when experiencing withdrawal or intoxication-triggered paranoia. These behaviors are transgressions of social norms that make it hard even for their loved ones to show them compassion, so it is easy to see why strangers or health care workers may be rejecting or unsympathetic.

Tacit beliefs or assumptions about personal responsibility — and the false belief that willpower should be sufficient to stop drug use — are never entirely absent from most people's thoughts

people with addictions[3] that may even lead them to withhold care. In emergency departments, for instance, health care professionals may be dismissive of someone with an alcohol or drug problem because they don't view it as a medical condition and therefore don't see its treatment as part of their job. People who inject drugs are sometimes denied care in emergency departments and other hospital settings because they are believed to be drug-seeking.

In part, the difficulty reflects continued resistance to the idea that addiction is a disease. Drug use alters brain circuitry that is involved in self-regulation and reward processing, as well as brain circuits that process mood and stress. For a person with a serious substance use disorder, taking drugs is no longer pleasurable or volitional, for the most part, but is instead a means of diminishing

Medical Record Exercise

Identify Stigmatizing Language From This H&P

History

- Mr. Joe Smith is a 24-year-old male with a history of intravenous drug abuse, primarily heroin. He also reports heavy use of cocaine in the past. He's a frequent flyer of our facility and I have met him several times before. He returned several hours ago with general malaise and fatigue, but now with aches all over his body, diaphoresis, and anxiety. He had been clean for about two years but starting using again a few weeks ago because of some stressful issues that he's dealing with.

Review of Systems

- Pan-positive

Allergies

- No Known medication allergies

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Review of Systems

- **Pan-positive**

Allergies

- No Known medication allergies

Identify Stigmatizing Language From This H&P

Past Medical History

- Polysubstance Abuse

Family History

- Says his parents were both addicts. His mom was an abuser of alcohol and his dad was a junkie.

Social History

- Denies tobacco use but reports extensive drug use.

Surgical History

- Previous admissions for abscesses.

Identify Stigmatizing Language From This H&P

Past Medical History

- **Polysubstance Abuse**

Family History

- Says his parents were both **addicts**. His mom was an abuser of alcohol and his dad was a **junkie**.

Social History

- Denies tobacco use but reports extensive drug use.

Surgical History

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Identify Stigmatizing Language From This H&P

Physical

- He is in moderate distress. He is non-cooperative. Appears he's been using a lot. Otherwise his vital signs are normal and the remaining exam is unremarkable.

Assessment

- 24-year-old IV drug user presents with withdrawal vs drug-seeking behavior.

Plan

- 1. He is a chronic relapser and NEEDS TO STOP USING HEROIN.
- 2. Will treat symptomatically.
- 3. May benefit from medication-assisted treatment. Will have social work see him.

Identify Stigmatizing Language From This H&P

Physical

- He is in moderate distress. He is non-cooperative. **Appears he's been using a lot**. Otherwise his vital signs are normal and the remaining exam is unremarkable.

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So where do we go from here?

- Humanize and empathize
- Speak up and speak out; be anti-stigma and anti-bias
- The solution will be multi-dimensional and must involve policies and organizations
  - Examples:
    - Smokefree policies (work, home)
    - NRT becomes over-the-counter (and sometimes free)
    - Free quitlines and counseling
    - Limit “suppliers” and their power to influence
    - Support positive changes


NO SMOKING

What to do about stigma and discrimination

Change strategies for mental illness stigma into three approaches:

- Protest inaccurate and hostile representations of mental illness as a way to challenge the stigmas they represent. These efforts send two messages. To the media: stop reporting inaccurate representations of mental illness. To the public: stop believing negative views about mental illness.
  - This challenges negatives but doesn't really promote any positives.
- Education – about the presence/effects of stigma, correcting misinformation about the stigmatized group. The "messenger" matters!
- Contact – direct contact with members can dramatically change opinions but requires member to "come out" and risk negative consequences

Reducing Provider Bias and Stigma

- Protest, Educate, Contact
- Structural changes
  - Data, data, data – use data to drive decision making. Consider audits and performance reports
  - Adapt workflows to include smoking status and cessation
  - Smokefree workplaces and clinics
    - Assistance for staff who smoke and/or have BH dx
  - Designate people with BH conditions as underserved to increase research, education, and clinical funds/innovations

Program Examples

- UCSF Smoking Cessation Leadership Center and the SAMHSA Center of Excellence for Tobacco Free Recovery
- NAMI –National Alliance on Mental Illness [Peer, family, and provider programs]
  - www.nami.org
- Time to Change (UK); Opening Minds (Canada); Beyondblue (Australia)
- VAMC – Make the Connection, Real Warriors campaigns

Time to Change (UK) - $60 million investment www.time-to-change.org.uk

- Social marketing and mass media activity; library of stories
- Local community events to bring people with and without mental health problems together ("hubs" and "time to talk" events)
- A grant scheme to fund grassroots projects led by people with mental health problems
- A program to empower a network of people with experience of mental health problems to challenge discrimination
- Targeted work with stakeholders to improve practice and policy
- Research and evaluation

- RB: Jason, I've heard you talk about "post traumatic growth" and how to move from darkness into strength in the context of HIV/AIDS. Can you say more about how this works and whether it's relevant to stigma around smoking, SUD, and behavioral health?

- JS: Rich, you and your team at Dell Medical School do not have formal training in caring for people with SUD, yet you setup a clinical program and reduced stigma. Can you say more about the lessons you learned and how this applies to colleagues in the healthcare system who also may not have formal SUD or mental health training?

Summary/Take homes

- Stigma of mental health and substance use disorders including tobacco use disorder is widespread in our health ecosystem and are rooted in stereotypes and prejudices that result in discrimination.
- While social stigma is an important construct to dismantle, structural and self stigmas must also be addressed.
- We ALL have a role to play in reducing and one day eliminating stigma associated with mental health, substance use, and tobacco use so all individuals feel comfortable accessing necessary evidence-based treatment.


?
Q
&
A
!

References and Recommended Readings (update)

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Thank you for joining us!

Please be sure to complete the brief post-webinar evaluation.

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