There needs to be more than a change in language if our care of people who use drugs is to improve

Ian Hamilton, Lecturer, Area 4, Seebohm Rowntree Building, University of York and Chris Ford, Clinical Director IDHDP

Treating symptoms can sometimes can be an effective way to deal with a health problem. However, this isn't always the case, particularly when the same symptoms keep re-appearing due to the underlying cause of the problem having not been addressed. So, could the stigmatising language often used to describe people who use drugs or develop problems with drugs simply be the symptom of a belief that is wrong?

The new report from the Global Commission on Drug Policy calls for politicians, journalists, celebrities and religious leaders to set an example in the language they use to describe people who use drugs (1). The report suggests they should stop using descriptions like "junkie" or "crackhead," and instead use terms such as "person with drug dependence" or "person with substance use disorder." Few of us would disagree, but if people only learn what is acceptable terms to say without altering what they actually believe then there is a real danger that this will be no more than lip service and the much needed real change will not take place.

The report identifies doctors and healthcare staff as the ones who can champion this change in language, recommending they take the lead in challenging misperceptions of this patient group -

"*Putting health and safety first requires the medical community and healthcare professionals to be vocal in promoting evidence-based prevention, treatment, and harm reduction services, and to urgently address perception-based stigma in healthcare settings. Doctors, nurses, and other healthcare workers who are in contact with people who use drugs have a major role to play in changing the perceptions on drugs.*"

However, the report fails to recognise that negative views about such patients are rife amongst health professionals too. Health workers who avoid patients that use drugs or who have minimal contact with them are more likely to hold negative and stigmatising views (2, 3).

It is no coincidence that as exposure to such patients yields the varied personal stories that underpin the reason why an individual takes drugs or has developed a problem drugs. Why would a health worker choose to come into contact with a group of people you perceived to be "manipulative, potentially violent, unmotivated and hard to treat?"

Ninety percent of people who use drugs do so with little or no problem. The other 10% who do get into problems are often people with a difficult background, with high rates of trauma,

especially physical and/or sexual abuse as children. In our experience if PUDs are treated well they respond well. A good number will relapse and of course there may be a few who are more challenging than others. But they all have the capacity to change, as should the clinicians who hold negative views about them.

Case story: Siobhan 32 years had presented several times for help with her drug problem to various drug services. Each time she requested and got a detoxification and each time she relapsed.

When she relapsed again, a friend told her to go and see her GP. Her physical and mental health was beginning to deteriorate and when she presented she looked awful. Again she requested a detoxification but her GP asked if she would try a different way and try maintenance for a few months to allow her health to improve. After 3 months her physical health improved but she was still low in mood. Her GP started to explore her background very carefully. Soon a terrible history of physical and sexual abuse was revealed and she agreed to further in-depth counselling. She stayed on maintenance whilst this happened and after a few months began to blossom.

After 2 years on maintenance, Siobhan went to see her GP and said “thank-you now I’m ready to stop drugs”.

Pretending to care at the same time as concealing your real view is of little value as this group of patients can be well tuned into non-verbal signs of disgust. Without a change in attitude some workers will continue to covertly discriminate by making all manner of assumptions, such as “can’t be helped”, “waster”, “self-induced condition”, “why don’t they pull their socks up”. These assumptions are usually based on distorted truths and myths and lead the clinician to limit the amount of time they make available and the degree of engagement they are prepared to offer.

This can also happen in related fields such as HCV. Some hepatologists, who have had little or no exposure to people who use drugs in their training can be extremely judgemental of them, “brought it on themselves” “why waste good money” on “these’ people”, show little empathy and withhold life-saving medication.

Case story: Ruby aged 70 years, had been a patient of ours for many years. She was well, had worked all her life, raised 2 children and lived with the love of her life until he died 2 years ago. Investigations of bleeding from her bowel had shown a potentially curable bowel cancer. When we discussed referral for surgery, Ruby became very agitated. She wasn’t concerned about the surgery, which she understood would be fairly straightforward, but of the attitudes of the doctors on the way. She had been on injectable methadone for over 30 years and had relapsed each time she had tried to stop. Many years ago she had accepted that this was the best option for her and she was going to stay on it.

Sadly we were unable to reassure her, having come across this type of attitude at the local hospital before. However, we didn’t expect them to be as appalling as they turned out to be. She reported back that the Professor of Surgery changed completely as he read further down the referral letter, with comments like “you don’t need to be on that dirty stuff”; “at your age you should know better and stop”; “we won’t give you that poison in hospital”: etc, etc. We were livid yet respected Ruby’s request not to complain until after surgery, which we did. Sadly the arrogant professor did not change his position but thankfully did get a warning from the hospital board.

There are many papers worldwide that show many health professionals appear to ascribe lower status to working with people who use substances than helping other patient groups, particularly in primary care; the effect is larger in some countries than others (2, 3, 4).

Many medical schools failing to include addiction in their curriculum which sends a clear message early in a medical career that this group doesn't matter. We know from numerous papers that the right training in medical and other health professional's schools can help prevent the development of negative attitudes towards people who use drugs. We also know that early exposure to people who use drugs to gain experience in accepting that people who use drugs receive services in their entirety can help health professional to provide a non-judgemental service (5, 6).

Recognising the importance of understanding drug use at this stage of their education has the potential to equip these doctors of the future in supporting the people they will inevitably encounter. A recent US paper showed that better medical schools have lower levels of prejudice in their students (5)

In the UK an obvious resource that could provide training is addiction psychiatry, but this speciality has been decimated in recent years as the competitive bidding process to provide cheaper drug treatment has reduced the funding available to employ an 'expensive' speciality (8). This is clearly a false economy as having removed this pool of expertise it is not just medical students who are disadvantaged but all health professionals who are unable to call on their experience and ability of addiction psychiatrists to help with particular approaches to treatment.

It is also worth remembering that of all professions it is doctors who are most likely to develop substance use problems and other healthcare workers are not immune from developing problems with drugs themselves. Although this should improve acceptance of patients who have similar problems we have some way to go, as those courageous enough to share their experience will testify. The stigma and prejudice they are exposed too is felt most sharply from their peers and professional bodies at a time when they needed support and acceptance.

Language matters enormously but the danger of simply adopting a new vocabulary while retaining many of the same values and attitudes is that we might sound more accepting but really nothing has changes from the patient's point of view. To quote a prominent person who uses drugs "I don't really care what you call me but I do care how you treat me!"

References

1. Global Commission on Drug Policy. The world drug perception problem—countering prejudices about people who use drugs: 2017 report. Jan 2018. www.globalcommissionondrugs.org/wp-content/uploads/2018/01/GCDP-Report-2017_Perceptions-ENGLISH.pdf.
2. Boekel L., Brouwers ., Weeghel J., Garretsen H,. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review Drug and Alcohol Dependence Volume 131, Issues 1–2, 1 July 2013, Pages 23-35 https://www.sciencedirect.com/science/article/pii/S0376871613000677
3. Lloyd C, The stigmatization of problem drug users: A narrative literature review Pages 85-95 Published online: 29 Nov 2012 Drugs: Education, Prevention and Policy Volume 20, 2013 - Issue 2 https://doi.org/10.3109/09687637.2012.743506
4. Gilchrist G, Moskalewicz J, Slezakova S, Okruhlica L, Torrens M, Vajd R, Baldacchino A. Addiction. Staff regard towards working with substance users: a

European multi-centre study 2011 Jun;106(6):1114-25. doi: 10.1111/j.1360-0443.2011.03407.x. Epub 2011 Apr 28.
5. Klimas, J.,Training in addiction medicine should be standardised and scaled up *BMJ* 2015; 351 doi: https://doi.org/10.1136/bmj.h4027 (Published 28 July 2015)Cite this as: BMJ 2015;351:h4027
6. Gotay A., Health Professionals attitudes towards Substance Abusers: A part of the Health Professionals' value and beliefs system which prevail in society (2014 Master in Public Administration Theses Paper 15
7. Colin Drummond Cuts to addiction services are a false economy May 25, 2017 BMJ opinion http://blogs.bmj.com/bmj/2017/05/25/colin-drummond-cuts-to-addiction-services-in-england-are-a-false-economy