

## POLICY AND MANAGEMENT DEPARTMENT

## Dismantling Structural Addiction Stigma in Law: Policies for Systematic Change

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Stigma is an under-recognized health malady that is both rampant for vulnerable communities and difficult to measure for researchers. Stigma has enormous and compounding negative health impacts, associated with lower education levels, employment and income, and poorer control of chronic conditions and illness. When stigma is embedded in the systems that govern daily life, it is considered structural stigma. Structural stigma in law has a particularly potent impact on the health and recovery of patients with substance use disorder (SUD) and addiction. Stigmatizing laws against individuals with addiction have a powerful role in downstream health, including opportunities for employment, access to health insurance, self-stereotyping, and reduced willingness to access recovery resources. Understanding and dismantling structural stigma in law, therefore, is a necessary component in comprehensively addressing SUD and addiction in collaboration with other evidence-based interventions.

**Public Significance Statement**

Stigma is a ubiquitous and damaging experience for vulnerable populations with significant consequences, classifying it as a social determinant of health. By better understanding how stigma is preserved and promoted in the structures and organizations that govern daily life, we can meaningfully uproot structural health inequalities at the source.

*Keywords:* stigma, social determinants of health, policy and law, substance use disorder

Although health care providers and staff recognize stigma as an uncomfortable experience for individuals, the health care system is broadly unaware of the expansive and negative impact that stigma and its counterpart “structural stigma” have on individual and community health for vulnerable populations. As both an upstream social determinant of health (SDOH) and as a direct health harming experience, structural and interpersonal stigma must be better understood and addressed for individuals with

substance use disorder and addiction. There are multiple steps to be taken to reduce the impact of stigma beginning with a better understanding of what constitutes this complex social construct.

**What Is Stigma?**

Stigma is complex, evasive, and difficult to detect or measure by third parties and researchers, while at the same time omnipresent and consuming for those that experience it. Defined as “a mark of disgrace or infamy; a stain or reproach, as on one’s reputation” ([Dictionary.com, 1995](#)), stigma demotes health and wellbeing far beyond its impact on access and utilization. Stigma can be internalized, showing up in the familiar forms of shame and self-stereotyping. The consequences of

This work was supported by Well Being Trust. The authors acknowledge Lina Brou, MPH.

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stigma are far-reaching and dynamic, leading researchers to classify stigma as a social determinant of health (SDOH). Whether it's avoiding picking up the phone to make an appointment, or dreading going to work every day with a visible health condition, stigma impedes patients' ability to become healthier every day.

Time and time again, research has shown that stigma has significant negative effects on mental health, willingness to seek treatment, and even acquisition of education and income—key components of SDOH (Major & O'Brien, 2005). Although historical studies have best documented the detrimental impact of stigma on mental health and substance use, a growing body of evidence demonstrates stigma's influence on other health conditions such as treatment of HIV/AIDS, epilepsy, cancer, and diabetes (Brown et al., 2003; Conner et al., 2010; Corrigan, 1998; Jacoby et al., 2005; Lebel et al., 2013). Stigma and self-stereotyping has even been shown to influence physical cardiac recovery after myocardial infarction (Levy et al., 2006). The public health and disease-specific literature demonstrate repeatedly that stigmatized communities have worsened self-image, decreased motivation to seek health-improving resources, and even when resources are used they have worsened health outcomes.

Modern stigma scientists describe stigma in its duality as both a *process* and an *outcome* (Link & Phelan, 2001). The components below occur sequentially, 1 leading to 2, and so on. Additionally, each step of the sequence independently contributes to stigma as an *outcome*, therefore all four steps are not required to intensify stigma. Ultimately, stigma promotes power differentials between in-groups and out-groups by exploiting, controlling, or excluding vulnerable communities (Link & Phelan, 2014).

**Process of stigma as defined by Link and Phelan (2001):**

1. Labeling of human difference
2. Ascription of deviance to characteristics that mark difference
3. Separation of out-groups from in-groups
4. Out-groups experience status loss and discrimination

### What Is Structural Stigma?

When stigma operates on a systematic scale, rooted in systems such as the education, housing, and judicial systems, it is termed “structural stigma.” One of the most powerful vectors of structural

stigma is through laws and policies. The key mechanism is the language itself, as the law can be an expressive function of the bias held by the law's authors. Laws with stigmatizing language can actually promote and protect discriminatory, health-harming actions, cloaked as socially acceptable legal recourse. There is abundant documentation of structural stigma against individuals with conditions such as chronic pain, obesity, substance use disorder (SUD), mental health conditions, and many more (De Ruddere & Craig, 2016; Goldberg, 2017; Greene-Shorridge et al., 2007).

Structural stigma against individuals who live with SUD and addiction surface in almost all aspects of their daily lives. Stigmatizing laws and policies against individuals with SUD begin early with punitive rather than rehabilitative policies in the education system. School suspension has been proven to have detrimental and lasting effects on access to higher education, future employment, and earning potential (Belzil, 1995; Martin, 2010). Perhaps more illustrative of their health impact, stigmatizing laws often determine which communities are excluded from important resources, making them a corrosive and powerful SDOH (Hatzenbuehler et al., 2013).

As an example of this, Sacramento County municipal codes abound, restricting where assisted living facilities and recovery centers can be located through the use of nuisance law (Safety, 2010). These geographic limitations directly impact accessibility and can make recovery logistically challenging, derailing the recovery attempt altogether. Another example of laws which stigmatize individuals with SUD is from San Francisco County, where an employer can terminate their employee for historical substance use even if it is no longer current (License, 2004; Denial of License, 2004). These legally protected and enduring repercussions on social wellbeing have exponential health impacts including food insecurity, loss of health insurance status, and homelessness.

### Solutions for Structural Stigma Against SUD and Addiction

Each sector represented in the SDOH is governed and detailed in existing municipal, city, or state law. It is, therefore, not sufficient to simply write new laws and policies free of stigmatizing language. Evaluation of historically operative laws for stigmatizing language against individuals with SUD is a high-yield opportunity for primary prevention of downstream health inequities.

Policymakers must be educated on the impact of structural stigma in law, specifically laws that target individuals battling SUD and addiction, as a critical step to improve recovery rates. Combating structural stigma through the revision of local laws and policies is a potentially powerful tool to provide primary prevention of the most detrimental downstream effects of stigma: worsened mental health, overdose, and suicide. Equipped with a better understanding, policymakers can work to revise and eliminate laws and policies that fuel addiction stigma which challenges recovery and rehabilitation.

Certainly, effective interventions in the public health battle against SUD and addiction must include financial support and growth of existing evidence-based interventions such as peer supports, addiction counselors, and community-based rehabilitation programs. However, these traditional interventions may not be sufficient unless the upstream legal determinants of health contributing to structural stigma against SUD are addressed and corrected. Structural stigma in law has the pervasive capacity to impact all aspects of life, from interpersonal interactions to the systems we live, work, and play in, making it a necessary target if we hope to achieve lasting change in the battle against SUD and addiction for healthier communities of tomorrow.

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Received April 6, 2022

Accepted April 8, 2022 ■