

# ***Human First: Recognizing Bias and Reclaiming the Recovery Narrative***

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## **I. Understanding the Foundation: Bias**

### **Defining the Terms**

- **Implicit Bias:** Unconscious associations or stereotypes that affect our actions and decisions without our realization.
- **Explicit Bias:** Conscious prejudices where a person is aware of their feelings and attitudes and acts upon them with intent.

### **How Bias Presents Itself**

- **In Society:** Through microaggressions, hiring disparities, and media portrayals that reinforce negative stereotypes.
- **In Addiction & Recovery:** Assuming a person is "unmotivated," "resistant," or "frequent flyers" based on their appearance, history, or background.
- **In Policy:** Zoning laws that block recovery housing (NIMOBY) or laws that prioritize incarceration over treatment for specific substances.
- **In Your Community:** Lack of transportation to clinics, limited multilingual services, or "invisible" barriers that make certain neighborhoods feel unwelcome in local recovery spaces.

**Self-Reflection:** *Think of a time you had a "gut reaction" or snap judgment about someone in your community. Looking back, what unconscious stereotype might have triggered that?*

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## **II. Recognizing and Addressing Explicit Bias**

### **Indicators of Explicit Bias:**

- Use of derogatory language or slurs.
- Openly stating that certain groups are "beyond help" or don't deserve resources.
- Actively excluding specific individuals from services or community spaces.

## Your Responsibility:

We have an ethical mandate to interrupt harm. Remaining silent can be interpreted as agreement.

## How to Address It:

1. **Call In (for education):** "I noticed you used [term]; in this space, we use [human-first term] because it respects the individual's dignity. Can we try that?"
2. **Call Out (for harm):** "That comment is discriminatory and is not aligned with our values of trauma-informed care."

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## III. The Impact of Shame and Inequity

### The Weight of Shame

Shame is the "silent killer" in treatment. It presents as:

- **Avoidance:** Not showing up for appointments to avoid being judged.
- **Dishonesty:** Hiding a recurrence of use (relapse) for fear of "failing" the counselor.
- **Isolation:** Believing one is fundamentally "broken" rather than having a treatable health condition.

### Inequitable Access

Inequity isn't just a lack of clinics; it's a lack of **relevant** care. It looks like:

- Treatment hours that don't accommodate working-class families.
- Programs that aren't culturally responsive or trauma-informed.
- Digital divides that prevent people from accessing life-saving telehealth services.

**Self-Reflection:** *In what ways might our current systems (or my own practice) unintentionally make a person feel shame or create a barrier to entry?*

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#### IV. Shifting the Narrative: Words to Actions

##### Stigma & Deficit-Based Language

Context	Stigma / Deficit-Based	Human-First / Asset-Based
Spoken	"They are a dirty/clean drug screen."	"The screen was positive/negative for [substance]."
Written	"Patient is non-compliant and resistant."	"Patient is facing barriers to [task] and needs support."
Action	Discharging someone for "relapsing."	Adjusting the treatment plan because more care is needed.

##### Changing the Narrative

We change the narrative by moving from "**What is wrong with you?**" to "**What happened to you?**" and "**What do you need to thrive?**"

##### Our Responsibility:

- **Educate:** Lead by example with person-first language in every email, note, and conversation.
- **Advocate:** Push for policies that treat substance use as a public health issue, not a moral failing.
- **Empower:** Center the voices of those with lived experience in leadership and decision-making.

**Final Reflection:** *What is one specific change in my language or my daily actions that I can commit to today to help dismantle stigma?*