

Confronting the Stigma of Opioid Use Disorder—and Its Treatment

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The death of Philip Seymour Hoffman from a heroin overdose tragically adds another name to the list of celebrities who have lost their lives to addiction. Increasing numbers of overdoses from prescription opioids and a more recent increase in heroin-associated fatalities have caused heartbreak in communities across the country. More than 30 000 deaths from unintentional drug overdose were reported in the United States in 2010, the most recent year for which data are available.¹

Given the severity of this national epidemic, it is time to confront the stigma associated with opioid use disorder and its treatment with medications. By limiting the availability of care and by discouraging people who use opioids from seeking effective services, this stigma is impeding progress in reducing the toll of overdose.

According to the National Institute on Drug Abuse (NIDA), the long-acting medications methadone and buprenorphine are “a critical component of opioid addiction treatment” because “scientific research has established that medication-assisted treatment of opioid addiction increases patient retention and decreases drug use, infectious disease transmission, and criminal activity.”² Researchers have documented that treatment with these medications is life-extending for individuals with opioid use disorder.³

Medication-assisted treatment of opioid use disorder is also supported by the Substance Abuse and Mental Health Services Administration, the Institute of Medicine, and the World Health Organization. Major expansions in access to care with buprenorphine have been associated with declines in overdose deaths from heroin of more than 50% in France⁴ and 37% in Baltimore, Maryland.⁵

Opioid use disorder, like all substance use disorders, is a chronic illness for which there is no cure. The goal is holistic recovery that allows affected individuals to live productive, fulfilled lives as they effectively manage the symptoms of their illness. Extended treatment that includes medications is a proven path to recovery and is associated with a lower risk of relapse. Such care is not only effective, but there is no other treatment approach supported by the same level of evidence.

Nonetheless, there is significant resistance to the treatment of opioid use disorder with medications. For instance, some communities have opposed having medication-assisted treatment services located in their neighborhoods, some local officials have proposed legislation in violation of the Americans with Disabilities Act that would change zoning codes to exclude medication-assisted treatment centers, some health insurers have imposed arbitrary limits on the duration of treatment of opioid use disorder with medications, and even some clinicians have acted as though patients taking methadone or buprenorphine are still using illicit drugs, missing the critical distinction between addiction and the treatment of addiction.⁶

Four factors contribute to the stigma associated with opioid use disorder and its treatment with medications.

First, the understanding of opioid use disorder as a medical illness is still overshadowed by its misconception as a moral weakness or a willful choice.⁶ This misconception has historically separated this illness and its treatment from the rest of health care. Within the substance use treatment community, many still believe that recovery depends solely on willpower to abstain from all opioids, including methadone and buprenorphine. As a result, many who provide residential services force patients receiving methadone or buprenorphine to taper off of medication as a condition of initial or continued treatment, and many counselors consider taking medication a character weakness.

People effectively managing their illness with medications for years may even be scared to mention methadone or buprenorphine in mutual support groups for fear of being ostracized. Narcotics Anonymous, for example, has historically seen medication-assisted treatment as contrary to its philosophy, and chapters may exclude people taking methadone or buprenorphine from holding leadership positions or attending meetings.⁷

Second, the separation of opioid use disorder treatment from the rest of health care has meant that clinicians who treat these patients have not always paid sufficient attention to other substance use, mental health, and physical health conditions. Methadone and buprenorphine effectively treat opioid use disorder, but not cocaine, sedative, cannabis, nicotine, or alcohol use disorder, and not depression, diabetes, hypertension, asthma, schizophrenia, bipolar disorder, or HIV infection. Regulation and oversight of medication-assisted treatment has historically focused primarily on the medication and narrow aspects related to opioid use disorder. Reimbursement for treatment may cover only the most basic services, including medication delivery and a weekly professional encounter. Patients with complex conditions, however, may need more counseling, care

management, and different pharmacologic therapy. In the meantime, other health care practitioners, family members, and the public may attribute the signs and symptoms of these nonopioid disorders to methadone and buprenorphine, adding to the stigma.

Third, language mirrors and perpetuates the stigma related to treatment of opioid use disorder with medications. The health care system, and therefore the public, does not routinely talk about opioid use disorder and its treatment as medical care, but rather often may assign judgmental, pejorative terms. Urine test results are called “clean” or “dirty” rather than “positive,” “expected,” “negative,” or “unexpected.” Medically indicated situations in which patients receiving methadone or buprenorphine are tapering or decreasing their doses are described as “detoxification,” as though the medications are toxins poisonous to the body. Patients with opioid use disorder are referred to as “clean” when they are in recovery or managing symptoms and are referred to as “dirty” if they are still demonstrating symptoms of their illness. Within the substance use treatment sector, therapy that does not involve a medication is known as “drug-free” with the implication that by taking a medication such as methadone or buprenorphine, a person cannot be in recovery. Health care practitioners, and many lay people, refer to people with opioid use disorder as “junkies.” While the term “junkie” originated because of the heroin individuals were using, it now is broadly associated particularly with the people who use illicit opioids. Who would use similar terms about a patient with diabetes and an elevated hemoglobin A_{1C} level?

Fourth, the criminal justice system often fails to defer to medical judgment in the treatment of opioid use disorders.⁸ Some judges have prohibited participation in medication-assisted treatment from satisfying a condition of probation requiring treatment for opioid use disorder. If incarcerated, people taking methadone or buprenorphine as part of treatment rarely are allowed to continue to receive their medications as they would insulin or other prescription medications. They are left to deal with the discomfort of the withdrawal syndrome that occurs with all opioids. Because the body acclimates to the lower intake of opioids, this practice may significantly increase the risk of fatal overdose if the individual relapses after release from incarceration. Physicians working in jails and prisons are seldom allowed to prescribe buprenorphine or methadone.

The stigma associated with opioid use disorder and its treatment is unhealthy, but it is not inevitable. Health care practitioners can counter stigma by adopting accurate, nonjudgmental language to describe this disorder, those it affects, and its therapy with medications. States can promote the provision of comprehensive health services in opioid treatment programs and expand access to effective therapies in the criminal justice system. The public can fight back against the rising threat of overdose by supporting broad access to effective treatment with medications.

Affected neighbors, colleagues, family members, friends, and children, as well as celebrities, need care—and they all deserve the best care available. Their lives may well depend on it.

ARTICLE INFORMATION

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