



Summer 8-5-2021

The Cost of Stigma

Jeremy Kourvelas

University of Tennessee Knoxville, jperki22@vols.utk.edu

Carole R. Myers Dr.

University of Tennessee Knoxville, cmyers9@utk.edu

Katie Cahill

University of Tennessee Knoxville, kcahill3@utk.edu

Karen J. Derefinko PhD

University of Tennessee Health Science Center, kderefin@uthsc.edu

Robert Pack PhD

East Tennessee State University, PACKR@mail.etsu.edu

See next page for additional authors

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Recommended Citation

Kourvelas, Jeremy; Myers, Carole R. Dr.; Cahill, Katie; Derefinko, Karen J. PhD; Pack, Robert PhD; Moore, Kelly E. PhD; and Tourville, Jennifer, "The Cost of Stigma" (2021). *SMART Policy Briefs*.
https://trace.tennessee.edu/spn_briefs/4

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Authors

Jeremy Kourvelas, Carole R. Myers Dr., Katie Cahill, Karen J. Derefinko PhD, Robert Pack PhD, Kelly E. Moore PhD, and Jennifer Tourville

The Cost of Stigma

Key Points

- Substance Use Disorder (SUD), formerly known as addiction or substance abuse, is a treatable medical condition, but [fewer than 1 in 10 Tennesseans with SUD receive treatment](#).
- Stigma can lead to a view of those with SUD as weak-willed, unmotivated, and unlikely to recover. However, the reality is that [about 60% of people with SUD experience full remission](#).
- Treatment is also fiscally sound: [every \\$1 spent on evidence-based treatment for SUD saves \\$12](#) in healthcare and criminal justice costs.
- How we talk about SUD is the beginning of reducing stigma. Using person-first language such as “people with substance use disorder” as opposed to harmful words like “addict” or “junkie” is a start.
- The Recovery Research Institute’s ["Addictionary"](#) is an excellent resource for clinicians, policymakers, judicial authorities, and other stakeholders to refer to when seeking to destigmatize their vocabulary.

Background

The Centers for Disease Control and Prevention [defines stigma](#) as devaluing or discriminating against an identifiable group of people, a place, or a nation. [Stigma can be viewed as a process of social selection](#), wherein “us” and “them” dynamics are systematically defined in a self-reinforcing cycle:

- First, differences between groups are identified and stereotypes form.
- Second, negative labels based on these stereotypes are applied.
- Third, the labeling creates an “us” and a “them” partition.
- Fourth, the labeled individuals go on to face discrimination and lose social status.
- Finally, this creates a tangible power differential that propagates the cycle.

In the case of SUD, observations are made about individuals with SUD, negative labels like “junkie” are used, these individuals come to be seen as “less than” and are thus denied opportunities and resources, and finally, the denial of these resources create worse life conditions, which reinforces the continued use of drugs. The cycle of substance use is thus perpetuated by stigma.

Further, due to the experience of exclusion, rejection, and blame associated with substance use, stigma can significantly decrease the likelihood that people with SUD will seek help.

For example, [one experiment](#) found that physicians primed with the phrase “substance abuser” were more likely to blame the patient for having the condition and recommend punishment rather than treatment, compared to physicians primed with the phrase “having a substance use disorder.” Clearly, our language can impact multiple aspects of how individuals with SUD are treated.

Stigma in Healthcare

Stigma is prevalent across many different systems in our society. [Despite the long-established consensus that addiction is a complex neurological and psychological disorder, many people - even healthcare professionals - still view substance use disorder as a moral failing or a weakness of character.](#) These pervasive beliefs have inhibited the development of evidence-based policy. For example, only a few years ago, Medicaid did not cover medication assisted treatment (MAT), [the “gold standard” of treatment for opioid use disorder.](#) MAT is now covered by TennCare, and [the Tennessee Department of Mental Health and Substance Abuse Services offers additional services and coverage](#) for those of low income. However, [stigma still prevents people from enrolling](#), even if their needs are severe.

One of the reasons for this is that the treatment itself is stigmatized. Despite the evidence that medications to treat opioid use disorder (MOUD) [reduce overdose deaths](#) and [improve remission rates](#), MOUDs are often criticized as [“substituting one drug for another,”](#) even by the very healthcare providers that offer them. This leads to [demonstrably lower quality of treatment.](#) Importantly, MOUDs such as buprenorphine [do not produce the same euphoric effect as heroin or other opioids.](#) When used in combination with a receptor blocker, such as [naloxone](#) or naltrexone (one of the most common products of this type is called Suboxone), the treatment staves off withdrawal symptoms while simultaneously preventing the patient from experiencing euphoria, or “getting high.” In other words, MOUDs allow the patient’s brain chemistry to stabilize without causing intense highs and lows, creating a psychological stability that makes behavioral therapy much more effective.

The key point is that every patient’s SUD is different, and some individuals have better outcomes with different MOUDs. Buprenorphine is the most common, but still some patients benefit from methadone or naltrexone. Whichever drug is prescribed depends significantly on the patient and what their physician feels comfortable with as a treatment program. The duration of treatment is also variable. One of the most common forms of stigma lobbied against patients with SUD is the criticism that they take MOUDs for “too long.” Some clinicians believe that if the course of MOUDs lasts longer than six months, there has been some sort of failure in treatment. In fact, [there is no agreed-upon duration for MOUDs.](#) As with choice of MOUD, the duration of treatment varies by patient and circumstance. One size does not fit all.

Stigma in Policy

It has been observed that the [“spoiled addict persona” is treated by society very similarly to that of the “felon.”](#) This is true especially within treatment contexts. For example, patient contracts with clinics that provide MOUDs [frequently contain language and stipulations that are just as punitive as parole agreements.](#) For example, patients are expected to maintain inflexible appointment times with stiff penalties for tardiness or absences. Furthermore, patients face the constant threat of unannounced monitoring, and strictly enforced confirmation of participation, such as frequent urinalyses. This can be painful and humiliating for patients, leading to attrition.

These strict, one-sided dynamics wherein clinicians are cast as wardens and not healers have real consequences in practice. [Clinicians with punitive attitudes that come from such a dynamic have been observed to engage in punitive prescribing practices,](#) such as administering too low a dose of the patient’s MOUD, which can cause painful withdrawal symptoms. If patients face discrimination at the hands of those who are supposed to be helping them, it makes sense if they feel inclined to simply stop coming in for treatment.

Clinicians should do their best to make their patients feel welcomed, especially since patients with SUD already face stigma at the community level. [The stereotype of rehabilitation clinics as sources of local crime lead to not-in-my-back-yard, or “NIMBY” attitudes](#) that reduce access to care, either by defunding clinics or preventing the opening of new facilities. Additionally, such hostility can make it very painful to present at these locations. [Telehealth has provided a way for patients to obtain treatment in the safety of their own homes,](#) but this does not solve the issue of systemic stigma. It merely hides treatment from view.

Moving Forward

- Research shows the importance of embracing substance use disorder as a **chronic illness**. Overall, the conversation about substance use must change from exclusively punishing bad behaviors to reinforcing good behaviors.
 - Encouraging the use of treatment for SUD, rather than relying on punishment via the criminal justice system, will reduce the fear of reprisal and encourage patients to seek help.
 - Stipulations pertaining to denying student, housing and employment aid to people with SUD present challenges for recovering from SUD and should be considered for removal.

- Community-level intervention in instructing the use of non-stigmatizing language has the potential to change our public dialogue. Those in positions of power - such as landlords, employers, and clinicians - might be encouraged to reconsider their perspective of SUD. [Studies show that simply providing fact sheets is not enough; campaigns of positive messages should be targeted at these key groups.](#)
 - [Churches and other religious organizations can play a major role in positive outreach](#) and community-level intervention. Healthcare providers would have to [ensure coordination](#) with local religious leaders.
- By highlighting and humanizing stories of recovery, stigma reduction efforts reduce the shame/judgement associated with the diagnosis, treatment, and recovery of substance use disorder.
- Cultural competence should be demonstrated. Stigma reduction efforts should take into consideration how stigma affects people differently because some groups suffer from certain unique stereotypes. These specific contexts must be accounted for.
- Healthcare providers should have expanded knowledge of and access to prescribing privileges of MOUDs. This could improve treatment access and uptake.
- Policies should include non-stigmatizing, medically accurate language.
 - The Recovery Research Institute has produced an ["Addictionary"](#) to describe and clarify non-stigmatizing terms associated with substance use disorder.
- Medicaid itself must be destigmatized. TennCare now pays for MAT and MOUDs, but utilization remains low because people feel shame in applying for Medicaid, let alone the rehabilitation programs themselves.

Expert Opinion: Stephen Loyd, MD

The two main MOUDs, buprenorphine and methadone, have been found to reduce overdose risk by 50-70%, but despite this incredible benefit there is still significant resistance to their use, and MOUDs are perceived as replacing one drug for another. "It's just incredible that this is what people get hung up on," says Dr. Loyd of Cedar Recovery. "If I had a drug that cut mortality for heart disease by 50% but I didn't have my patient on it, I would be sued for malpractice."

The unique issue with MOUDs is that "people with little to no medical training" are essentially making medical decisions by making MOUDs less available. "We're not talking about the decision about whether or not to put alcohol or peroxide on a scrape, we're talking about a medication that has the

potential to save someone's life." Dr. Loyd's goal is to help people "feel better, get better and stay better," and he says the first step is making sure his patients stay alive. "I've never figured out a way to treat dead people."

"I can't believe the fight that goes on around this," he says. "So many people believe that the only path to recovery is the one that worked for them or the one they were trained in." MOUDs work. They reduce overdose risk and improve recovery rates, but despite the evidence they are still stigmatized, and there are significant political and cultural barriers to expanding access.

A major part of the stigma involves a disagreement over the length of treatment. Even among those who see the benefit of MOUDs, there is an assumption that the treatment should not last for more than a few weeks. "'Let me go to this 28-day treatment program, I go in, I come out, and I'm fixed.' We don't have that for hypertension. We don't have that diabetes. We don't have that for any disease that I can think of, and yet we expect that in addiction medicine." For Dr. Loyd, "compassionate care is meeting hurting people where they are no matter what, no matter how many times it takes." He discussed programs such as those that isolate patients in the wilderness with a Bible, saying that "if that worked for them, I love that. That's the path that works for them. My problem is when those same folks say 'that's the only path.' I'm not OK with that."

"We put a lot of our resources into this battle about the role of medication, 'switching one drug for another,' 'if you're on this drug you aren't in recovery,' all of that. But medication is such a tiny part of recovery. It's a necessary part because I've got to be able to keep people alive, but I would like us to focus all of this passion and energy on more important things like social determinants of health. What if we had that same fervor for making sure that people had safe housing?"

Policy Brief Authors:

Jeremy Kourvelas, UT Master of Public Health Student

Carole Myers, PhD, Professor, UT Knoxville College of Nursing

Katie Cahill, PhD, Associate Director, UT Howard H. Baker Jr. Center for Public Policy

Karen Derefinko, PhD, Assistant Professor, UT Health Science Center College of Medicine

Rob Pack, PhD, Associate Dean for Academic Affairs, East TN State University College of Public Health

Kelly Moore, PhD, Assistant Professor, East TN State University

Jennifer Tourville, DNP, UT Director of Substance Misuse Outreach and Initiatives

Secondary Authors:

SMART Policy Network Steering Committee