Practice Brief

A Misunderstanding of Biology: Stigma surrounding MAT and OUD

L. Bailey King, LMSW
COSW Program Manager
UofSC College of Social Work
Columbia, SC

Rebecca L. Christopher, LMSW
Field Education Coordinator
UofSC College of Social Work
Columbia, SC

Melissa C. Reitmeier, PhD, LMSW
Associate Clinical Professor
Director of Field Education
UofSC College of Social Work
Columbia, SC

Aidyn Iachini, PhD, LSW
Associate Professor
UofSC College of Social Work
Columbia, SC

Teri Browne, PhD, LMSW
Associate Dean for Research
Associate Professor
UofSC College of Social Work
Columbia, SC

Corresponding Author:
Melissa C. Reitmeier
mcreitme@mailbox.sc.edu
803-777-5293

Abstract With significant increases in opioid use along with deaths resulting from opioid overdose in recent years, it is important to understand the landscape of the current opioid crisis.[1,2,3] The aim of this practice brief is to discuss the context of stigma, from various perspectives, as it relates to opioid use disorder (OUD) and medication assisted treatment (MAT). Additionally, this brief aims to provide accurate, evidence-based information so that public opinion and health care practice may be better informed when engaging with individuals diagnosed with Opioid Use Disorder (OUD).

Opioids and Opioid Use Disorder (OUD)

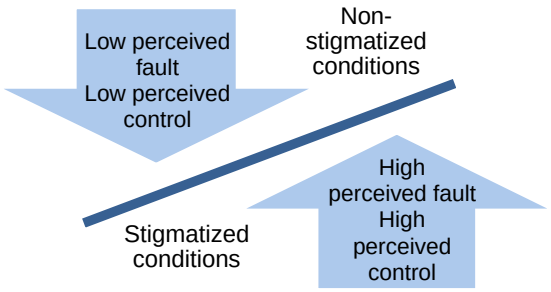
Opioid is a general term that includes the prescription medications used to treat pain (i.e. morphine, codeine, methadone, oxycodone, hydrocodone, fentanyl, hydromorphone, and buprenorphine) and illegal drugs (i.e. heroin and fentanyl analogs).[4] As with most substance use disorders defined in the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM-5), the criteria for a diagnosis of OUD can be clustered into four categories: impaired control, social impairments, risky use, and pharmacological principles (tolerance and withdrawal).[5]

Medication Assisted Treatment (MAT)

MAT is an evidence-based approach to treating individuals diagnosed with OUD that combines pharmacotherapy using FDA-approved medications (i.e. methadone, buprenorphine, and naltrexone) and other psychosocial and/or behavioral therapies in a comprehensive, individualized treatment plan, as recommended by federal health organizations and associated guidelines.[4,6,7,8,9] In 2017, the Health and Human Services Department (HHS) declared the opioid crisis a nationwide public health emergency with a new, five-point opioid strategy that listed improving access to prevention, treatment, and recovery support services as the top priority.[10] Yet, stigma towards individuals diagnosed with OUD, misperceptions regarding the effectiveness of MAT, and misinformation relating to the biology behind OUD and MAT continue to persist, from both the general public, those diagnosed with OUD, and health care professionals, which can limit access to this important evidence-based treatment for those who may be at risk for health complications or overdose.[11,12,13]

Stigma Defined

Stigma is often defined as a mark of disgrace or stain on one's reputation associated with a particular circumstance, quality, or person.[14] In general, stigma regarding a disease or disorder is closely tied to both the perceived control a person has over the condition and the perceived fault in acquiring the condition.[14] For example, stigma is not typically associated with people believed to have little control over the illness or who acquired the illness through no fault of their own, as seen with hard-to-treat cancers.[14] In contrast, substance use disorders



*Modified from Substance Abuse and Mental Health Services Administration[14]

are often still viewed as within a person's control and partially their fault. Therefore, people with substance use disorders, especially those that use or misuse illegal substances or prescription medications, often experience frequent and pointed stigma.[14] Dr. Vivek Murthy, U.S. Surgeon General from 2014 to 2017, emphasized this perspective by stating, "we must help everyone see that addiction is not a character flaw – it is a chronic illness that we must approach with the same skill and compassion with which we approach heart disease, diabetes, and cancer".[15] The added burden of shame and fear of judgement from others makes it less likely for someone struggling with a substance use disorder to seek help and can deter necessary investments for prevention and treatments.[14,15]

What's the Cost?

Some studies have found that starting an opioid agonist medication following an overdose event is associated with up to a 50% reduction in subsequent death, yet the same studies found that less than 5% of those who survive an overdose received any type of pharmacotherapy.[16] Other national studies have found that 7.1% of people who needed substance use treatment reported that they were not aware of a program that offered the "type of treatment" for which they were looking.[16]

Discrepancies in clinical language and misinformation surrounding MAT perpetuates negative biases and harmful stigma. This stigma can impact health outcomes for people who are diagnosed with OUD and their willingness to engage in treatment.[14] Moreover, there is a reciprocal relationship between stigma and providers such that providers play an integral role in changing stigma related to MAT, but providers' personal beliefs and practice may be shaped by stigma as well.[14] While MAT has shown to be an effective treatment for OUD,[4,7,9,17] widespread stigmatization of substance use, opioid use, and MAT has hindered treatment utilization, availability and access, as well as policy and prevention efforts.[18,19]

> We must help everyone see that addiction is not a character flaw – it is a chronic illness that we must approach with the same skill and compassion with

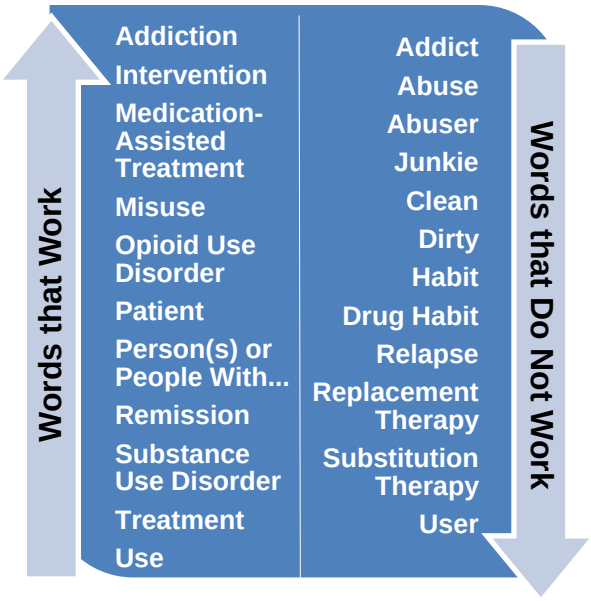
University of South Carolina College of Social Work
South Carolina DAODAS
Department of Alcohol and Other Drug Abuse Services

which we approach heart disease, diabetes, and cancer. - Dr. Vivek Murthy[15]

Language and Labeling

Terminology used to describe substance use, specifically opioid use, OUD, and MAT, is inconsistent with unclear labels derived from outdated concepts of "addiction," such as opioid substitution treatment, opioid replacement therapy, addiction-focused medical management, and so on.[20] Stigmatizing language and labels have been shown to create significant barriers to treatment for both patients and providers.[14,16,20] Much of the research, available data, and policies focusing on OUD and MAT use definitions and criteria outlined in previous editions of DSM-III and DSM-IV.[21] In the DSM-5, "opioid abuse" and "opioid dependence" were combined to create "opioid use disorder". This then leads to a lack of linguistic and labeling consensus when referencing these topics in both research and practice.[5]

More specifically, providers often act as information "gatekeepers", which is a role that can influence patients, other health care providers, and the community.[14] Given their influence, providers must consider the precedence they establish through their own language when referencing substance misuse and the way in which they provide care to people with substance use disorders.[14] Whether discussing substance use in a clinical setting with patients, families, and colleagues, or whether presenting information in prevention and treatment messaging, providers have an obligation to promote pro-health activities and utilize person-centered and person-first language to avoid perpetuating negative stereotypes about people who are affected by substance misuse.[14]



*Modified from the National Alliance of Advocates for Buprenorphine Treatment (NAABT)[22]

How the Brain Works

The stigma towards opioid agonist medications used to treat OUD has a long history.[14,15,16,20,22] Much of the stigma in public discourse is related to a misunderstanding of the way opioids act in the brain and misperception of how the medications used in MAT are only a "substitution" drug, such that people diagnosed with OUD are simply trading one opioid for another opioid while the diagnosis of OUD is being left untreated.[20,23,24,25] The important thing to remember is that even though medications used in MAT may induce euphoria in people who are not dependent on opioids, they do not produce the same effect in people who are dependent on opioids because MAT medications act differently on the brain's receptor sites than other opioids.[7,9] Furthermore, people who become dependent on opioids generally develop a tolerance as their opioid receptor sites become desensitized and downregulated, when then prevents an opioid agonist (i.e. methadone or buprenorphine) from inducing euphoria while simultaneously minimizing withdrawal symptoms and cravings.[7,9]

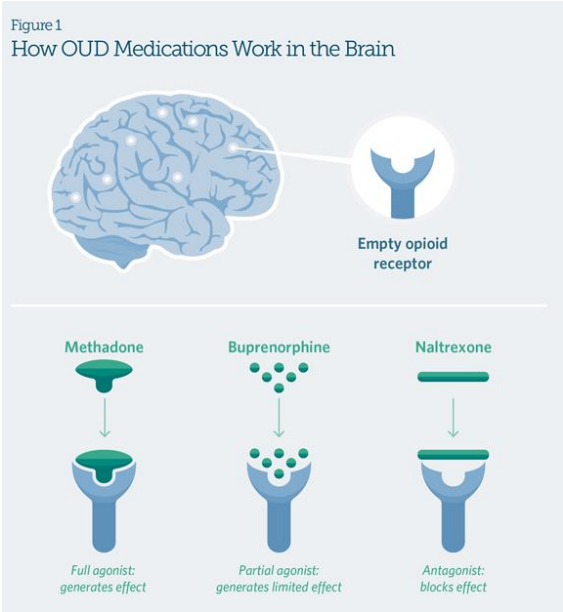


Figure 1 shows the various functions of pharmacotherapy options, from a full agonist to an antagonist, and the mechanism by which they influence the opioid receptor in the brain.[26]

The goal of opioid agonist therapy is to prevent or reduce withdrawal symptoms, prevent or reduce drug craving, prevent relapse to addictive drug use, and restore normalcy of physiological function disrupted by drug abuse.[8]

Health Perspectives and Stigma

Even with the major public health response backed by credentialed groups, such as HHS, Substance Abuse and Mental Health Service Administration (SAMHSA), National Institute on Drug Abuse (NIDA), and Health Resources and Services Administration (HRSA), there is still widespread misinformation and negative perceptions regarding MAT and OUD from both the public and the medical field. Unfortunately, these perceptions have proven to be significant obstacles in reaching as many individuals as possible who misuse opioids and may be at a high risk of opioid overdose.[13,24,27]

Patient Perspectives. There are differences in opinion and preference among patients who are eligible for MAT based on a number of factors, including previous exposure to MAT and participation in other substance use treatments.[28,29] There are also differences in patient perspective with regard to the types of medication used in MAT, such as considering a person using methadone as a "current user/addict" as compared to a person using buprenorphine.[24] These perspectives can be isolating and harmful, as many people are deterred from seeking necessary treatment due to personal beliefs or negative peer judgment.

Provider Perspectives. Provider perspectives are created through training, experience in the field, personal values and biases, and staying informed on current evidence-based methods of treatment. Provider perspectives have a profound impact on substance use stigma as providers' influence may extend through patients, their families and the broader community, so it is important to understand the factors that may shape provider perspectives and the effects of

those perspectives on the stigma related to MAT and OUD.[14,20]

Additionally, providers may be unaware of how their language or biases can negatively impact the patient-provider relationship, which can also influence a patient's willingness to start or maintain treatment.[20,30,31,32] For example, providers may consider a patient as "difficult" or "noncompliant" when they believe the patient has more responsibility over their behaviors when engaging in substance use, rather than considering substance use disorder as a condition much like other medical diagnoses, such as diabetes, which is often viewed as outside of a patient's responsibility or control.[32] Provider beliefs regarding patients and treatment can influence their views on the effectiveness of MAT, their expectations for patient success, and their willingness to prescribe MAT to treat substance use disorder, specifically OUD.[20,30,31,32] For example, providers' past experiences and frequency of interaction with patients diagnosed with OUD can influence their perception of patient success using MAT.[30] There are also outside barriers, cited by providers, that interfere with prescribing practices, including limited provider education, limited insurance reimbursement, regulatory restrictions, and liability fears.[31]

Treatment Settings. Many people in the recovery community continue to view OUD through the lens of abstinence-based treatment where recovery is defined by strict sobriety and, as a consequence, MAT is frequently perceived as a "substitution", or simply replacing, illicit opioids.[20,21,24,31,33,34] In many abstinence-based recovery settings and in the recovery community in general, the stigma against MAT persists such that patients are either not allowed to maintain MAT or are highly discouraged to continue MAT because it is not considered a path of "true recovery".[24] Unfortunately, because providers outside of these recovery settings may not be well informed on which programs are best suited for patients currently utilizing MAT.[24] The landscape of treatment and medical responses are rapidly expanding as naloxone, commonly known as Narcan, is becoming increasingly more available outside a medical setting. Narcan is now available to law enforcement, emergency medical services, and even family members are allowed access to certain formulations at affordable costs.[35]

Documentation. Another important consideration regarding stigma is the type of language used in clinical documentation to describe patients and patient behaviors. Sometimes language used to document a patient interaction, behavior, or appearance can be stigmatizing as it may reflect negative biases or incomplete assumptions from the provider's perspective.[20,23] Medical records and documentation follow a patient beyond the span of a single provider's work; therefore, stigmatizing language in a patient's chart can shape a patient's future experiences in health care. Potential consequences of using stigmatizing language in clinical notes include influencing other providers' judgements and actions towards patients. For example, some patients may be denied acceptance into residential treatment programs based on stigmatizing language or not return to treatment based on the stigmatizing language contained within a provider's clinical notes.

Stigma in the Research

There are significant discrepancies in OUD and MAT literature, not just related to using inconsistent, unclear, and/or stigmatizing language, but within the approaches used to research these topics.[36] In the current research, study samples are disproportionately representative of people who are incarcerated, people who are pregnant and their infants, and people who are living with HIV/AIDS. This limited scope of demographics in MAT and OUD research may lead to erroneous impressions that these are the only populations struggling with substance use disorders. Furthermore, these demographic limitations reveal a gap in knowledge for patients, providers, and the public related to understanding the implications of combining MAT with additional medications or other diagnosable conditions. While there are valid concerns related to the treatment of these vulnerable populations, it is important that researchers examine OUD and MAT in a variety of diverse sub-populations, including individuals with co-occurring mental health and substance use disorders, to develop a more comprehensive framework and approach when treating patients with substance use disorders.

Conclusion

As more attention and resources are focused towards treating OUD and preventing the increasing number of deaths related to opioid overdose, it is imperative that we as a nation confront the societal stigma associated with substance use and substance use treatment. If we fail to identify, address, and alleviate this stigma, our efforts in finding an effective and sustainable treatment for OUD may not be fully realized in practice because people may be too afraid to seek treatment or lack access to necessary treatment services.

Furthermore, it is vitally important for the health care community to be in the forefront of MAT research, as well as utilization and destigmatization efforts so that the public and policy makers may receive accurate and unbiased information regarding evidence-based treatments that offer the best possible outcomes for those affected by opioid use or misuse. Listed in the box below are a few recommendations on ways to reduce stigma in everyday practice so that patients may feel more empowered and supported by their health care provider.

Recommendations to Reduce Stigma

- Use person first language in all communications to all entities, including documentation in health records.
- Encourage consistency in provider language when engaging patients, families, and the public
- Implement evidence-based staff and community trainings that aim to dispel the myths and address misconceptions associated with OUD and MAT
- Acknowledge that there is controversy between abstinence-based recovery treatments and harm reduction treatments (i.e. MAT) and work to incorporate the most beneficial elements of both to improve patient outcomes
- Disseminate accurate, scientific information to the public to address societal stigma associated with OUD and MAT

Article Information
Published Online: June 29, 2018
This project was supported by contract number USC-MED-18 with the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) and SAMHSA Grant number H79TI026428 called Health Occupations Providing Excellence in SBIRT. Points of view in this document are those of the authors and do not necessarily represent the official position or policies of SCDHHS or SAMHSA.
Full Webinar Can Be Accessed:
https://webconnect.sc.edu/opioidsandmat/
Conflict of Interest:
The authors declare that they have no conflict of interest

References

1. Rudd RA, Seth P, David F, Scholl L. (2016). Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. *MMWR: Morb Mortal Wkly Report, 65*, 1445–1452. DOI: http://dx.doi.org/10.15585/mmwr.mm655051e1.
2. Substance Abuse and Mental Health Services Administration. (2017). *Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health* (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/
3. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. Available at http://wonder.cdc.gov
4. Substance Abuse and Mental Health Services Administration. (2018). SAMHSA Opioid Overdose Prevention Toolkit. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/shin/content//SMA18-4742/SMA18-4742.pdf
5. American Psychiatric Association. Opioid Use Disorder. Diagnostic Criteria. http://pcssmat.org/wp-content/uploads/2014/02/5B-DSM-5-Opioid-Use-Disorder-Diagnostic-Criteria.pdf.
6. Health and Human Services. (2017, April 19). Secretary Price Announces HHS Strategy for Fighting Opioid Crisis [Speech]. Retrieved from https://www.hhs.gov/about/leadership/secretary/speeches/2017-speeches/secretary-price-announces-hhs-strategy-for-fighting-opioid-crisis/index.html
7. National Institute on Drug Abuse (NIDA). (2018, June 8). Medications to Treat Opioid Use Disorder. Retrieved from https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-use-disorder
8. Substance Abuse and Mental Health Service Administration. (2015). Medication-Assisted Treatment of Opioid Use Disorder Pocket Guide. Retrieved from https://store.samhsa.gov/shin/content//SMA16-4892PG/SMA16-4892PG.pdf
9. Substance Abuse and Mental Health Services Administration. (2018). Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63, Full Document. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/shin/content//SMA18-5063FULLDOC/SMA18-5063FULLDOC.pdf
10. Health and Human Services. (2017, October 26). HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis [Press release]. Retrieved from https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html
11. Aletraris, L., Edmond, M. B., Paino, M., Fields, D., & Roman, P. M. (2016). Counselor training and attitudes toward pharmacotherapies for opioid use disorder. Substance Abuse, 37(1), 47-53.
12. Uebelacker, L.A., Bailey, G., Herman, D., Anderson, B., & Stein, M. (2016). Patients' beliefs about medications are associated with stated preference for methadone, buprenorphine, naltrexone, or no medication-assisted therapy following inpatient opioid detoxification. Journal of Substance Abuse Treatment, 66, pp. 48-53.
13. Hewell, V.M., Vasquez, A.R., & Rivkin, I.D. (2017). Systemic and individual factors in the buprenorphine treatment-seeking process: A qualitative study. Substance Abuse Treatment, Prevention, and Policy, 12(3), pp. 1-10.
14. Substance Abuse and Mental Health Services Administration. (2017). Words matter: How language choice can reduce stigma. Rockville, MD: Center for the Application of Prevention Technologies. Retrieved from https://www.samhsa.gov/capt/tools-learning-resources/sud-stigma-tool
15. U.S. Department of Health and Human Services (HHS). (2016). Office of the surgeon general, facing addiction in America: The surgeon general's report on alcohol, drugs, and health. Washington, DC: HHS.
16. Wakeman, S. E. (2017). Medications for addiction treatment: Changing language to improve care. Journal of Addiction Medicine, 11(1), 1-2.
17. American Society of Addiction Medicine (ASAM). (2015, June). National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. Retrieved from https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=96df6fc2
18. Stein, B. D., Gordon, A. J., Dick, A. W., Burns, R. M., Pacula, R. L., Farmer, C. M., & ... Sorbero, M. (2015). Supply of buprenorphine waivered physicians: The influence of state policies. *Journal of Substance Abuse Treatment, 48*(1), 104-111.
19. Dineen, K. K. (2016). Addressing prescription opioid abuse concerns in context: Synchronizing policy solutions to multiple complex public health problems. *Law & Psychology Review, 1*.
20. Robinson, S. M., & Adinoff, B. (2018). The mixed message behind "Medication-Assisted Treatment" for substance use disorder. American Journal of Drug and Alcohol Abuse, 44(2), 147-150.
21. Alonso, E.M., Frydrych, V., Lake, J., Gonzales, V., Fiander, M., & LaFleur, J. (2017). Utah Medicaid Pharmacy and Therapeutics Committee drug class review agents for the treatment of opioid use disorder: Final report. Retrieved from https://medicaid.utah.gov/pharmacy/ptcommittee/files/Criteria%20Review%20Documents/2017/2017.09%20Agents%20for%20Opioid%20Use%20Disorder_Updated.pdf
22. National Alliance of Advocates for Buprenorphine Treatment (NAABT). (2017). The words we use matter. Reducing stigma through language. Retrieved from http://naabt.org/documents/NAABT_Language.pdf.
23. Salsitz, E., & Wiegand, T. (2016). Pharmacotherapy of opioid addiction: 'Putting a real face on a false demon'. Journal of Medical Toxicology, (1). 58.
24. Majer, J.M., Beasley, C., Stecker, E., Bobak, T.J., Norris, J., Jason, L.A. (2017). Oxford House Residents' Attitudes Toward Medication Assisted Treatment Use in Fellow Residents. Community Mental Health Journal, 1-7.
25. Thomas, C.P., Doyle, E., Kreiner, P.W., Jones, C.M., Dubenitz, J., Horan, A., & Stein, B.D. (2017). Prescribing patterns of buprenorphine waivered physicians. Drug and Alcohol Dependence, 181, pp. 213-218.
26. PEW Charitable Trust. (November 2016). *Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder* [Fact Sheet]. Retrieved from http://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder#1-background
27. Friedmann, P., Wilson, D., Knudsen H., Ducharme L., Welsh W., Frisman L., Knight K., Lin H., James, A., Albizu-Garcia C., Pankow J, Hall EA, Urbine T., Abdel-Salam, S., Duvall, J., and Vocci, F. (2015). Effect of an organizational linkage intervention on staff perceptions of medication-assisted treatment and referral intentions in community corrections. *Journal of Substance Abuse Treatment*. doi: 10.1016/j.jsat.2014.10.001
28. Maradiaga, J.A., Nahvi, S., Cunningham, C.O., Sanchez, J., Fox, A.D. (2016). "I Kicked the Hard Way. I Got Incarcerated." Withdrawal from Methadone During Incarceration and Subsequent Aversion to Medication Assisted Treatments. Journal of Substance Abuse Treatment, 62, pp. 49-54.
29. Stein, M. D., Flori, J. N., Risi, M. M., Conti, M. T., Anderson, B. J., & Bailey, G. L. (2017). Overdose history is associated with post detoxification treatment preference for persons with opioid use disorder. Substance Abuse, 38(4), 389-393.
30. Lin, C., Tuan, N. A., & Li, L. (2018). Commune health workers' methadone maintenance treatment (MMT) knowledge and perceived difficulties providing decentralized MMT services in Vietnam. Substance Use & Misuse, 53(2), 194-199.
31. Andraka-Christou, B. & Capone, M.J. (2018). A qualitative study comparing physician-reported barriers to treating addiction using buprenorphine and extended-release naltrexone in U.S. office-based practices. International Journal of Drug Policy,54, pp. 9-17.
32. Johnson, R.A., Lukens, J.M., Kole, J.W., & Sisti, D.A. (2015). Views about responsibility for alcohol addiction and negative evaluations of naltrexone. Substance Abuse Treatment, Prevention, and Policy, 10(10), 1-13
33. Uebelacker, L.A., Bailey, G., Herman, D., Anderson, B., & Stein, M. (2016). Patients' beliefs about medications are associated with stated preference for methadone, buprenorphine, naltrexone, or no medication-assisted therapy following inpatient opioid detoxification. Journal of Substance Abuse Treatment, 66, pp. 48-53.
34. Huhn, A. S., Tompkins, D. A., & Dunn, K. E. (2017). The relationship between treatment accessibility and preference amongst out-of-treatment individuals who engage in non-medical prescription opioid use. Drug and Alcohol Dependence, 180279-285.
35. South Carolina Department of Health and Environmental Control. (2018). Opioid Statistics. Retrieved from https://www.scdhec.gov/Health/Opioids/OpioidStatistics/
36. Reitmeier, M.C., Iachini, A.L., Christopher, R.L., King, L.B. & Browne, T. (2018). The Opioid Epidemic: A Systematic Literature Review of Opioids and Medication Assisted Treatment (MAT). Unpublished. College of Social Work, University of South Carolina.