# Combatting the Stigma of Addiction - The Need for a Comprehensive Health System Approach

**Jennifer Atkins, MBA,** Blue Cross Blue Shield Association; **Anna Legreid Dopp, PharmD, CPHQ,** American Society of Health-System Pharmacists; and **Edna Boone Temaner,** health information technology subject matter expert

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The opioid epidemic is raging within the COVID-19 pandemic, with more than 40 states reporting increases in opioid-related overdoses and deaths. COVID-19 has disrupted health care services, disproportionately affecting already marginalized populations. Prior to the COVID-19 pandemic, individuals with substance use disorders (SUDs), particularly persons of color, faced significant barriers to care, largely due to the prevalence of systemic issues like stigma. Stigma is a pervasive force alienating those who experience addiction from medical care and recovery support. The added stress of the COVID-19 pandemic on the health system has sharply exposed these barriers, separating patients with addiction from their care teams and in-person recovery groups. Pre-COVID-19, only 10 percent of those with SUDs received treatment, contributing to the 70,000 annual deaths from drug overdose, of which more than two-thirds are opioid-related. In the current context, the opioid crisis is being acutely aggravated. The pandemic has exacerbated the weaknesses of an already fragile system—a system rife with both individual and structural stigma against patients and medications for treatment—that many individuals with opioid use disorder (OUD) found difficult to enter and navigate. The need to address stigma has never been more pressing.

Stigma materializes as discrimination arising from the institutionalization and individual practice of negative attitudes, beliefs, and actions. Stigma against OUD and other SUDs is rooted in the historic separation of addiction treatment and financing from "mainstream" health care. Structural stigma is perpetuated by the inequities of this siloed structure and reinforced by clinician biases. The history of systemic stigma toward OUD dates back to 1972 when restrictive regulations were established for treatment, requiring specialized prescribing clinics, observed dosing, and close behavior monitoring. These regulations have isolated addiction treatment from primary care and integrated treatment practices. Today, additional regulatory and reimbursement barriers to accessing medications for OUD (MOUD), the gold standard for treatment, further amplify this deep-rooted stigma.

Addressing structural stigma requires an understanding of how stigma permeates across the health system. Barriers at the system level present as restrictive requirements limiting access, coverage, and reimbursement for OUD treatment. Health care policies and payer structures have not been built to treat OUD as a chronic disease, perpetuating gaps in access to and provision of affordable, evidence-based treatment. Complex requirements for practitioner waivers and pre-authorizations can serve as additional barriers, reinforcing continued isolation and stigmatization of treatment. Further, reimbursement may be lower when compared to other common conditions, disincentivizing health care systems and providers to prioritize individualized, quality OUD treatment. Although the Mental Health Parity and Addiction Equity Act of 2008 and individual payer initiatives have facilitated important changes across the health system to improve coverage for the treatment of SUDs, including MOUD, there continue to be disparities in its implementation, demonstrating the need for increased state and national support.

The historic isolation of the addiction treatment system has also sustained individual-level stigma held by health care providers towards people with OUD and the life-saving medications available for treatment. Despite the evidence for MOUD, use remains limited, in part because of negative beliefs held by many providers. The risk factors that can cause clinician bias include negative attitudes, fear, lack of awareness of the health condition, and uncertainty as to how to treat it [1]. Studies indicate that among clinicians, negative attitudes toward individuals with SUDs far exceed those

reported for other medical conditions [2,3]. Clinician-harbored stigma manifests as lower empathy, limited patient engagement, sub-standard or disrupted care, denial of care, and limited competency to manage addiction as a disease [1]. Taken together, these challenges magnify the risks of patient harm by compromising access to necessary addiction treatment, reducing patient empowerment, lowering adherence to treatment plans, and diminishing treatment outcomes. There is a clear opportunity to reorient provider education and practices to reduce stigma.

Creating robust efforts to call attention to stigma and build individual and structural competency within health care can be the stimulus that drives change. Historical precedence for national campaigns has profoundly reduced stigma. For example, initiatives targeted at improving care for patients with HIV/AIDS, mental health challenges, and sexually transmitted diseases have not only improved health outcomes but also addressed all levels of stigma [1]. Leveraging the learnings from these and other effective, stigma-reducing campaigns present a critical opportunity to address stigma against OUD. Currently, several ongoing individual initiatives use patient-centered strategies and advocate for transformative change in health systems and across the nation; however, these efforts should be systematically evaluated to strengthen the evidence base for stigma-reducing approaches:

- Shatterproof [4] is embarking on a national campaign to reduce stigma against addiction, including educating the public on redefining OUD as a chronic brain disease. Shatterproof identifies key drivers of the epidemic, critical gaps in our national response, and evidence-based factors for success. The organization's plan includes stakeholder maps for six high-impact systems: employers, health care, government, local communities and those in recovery, criminal justice, and media and entertainment. Shatterproof also delivers evidence-informed action plans with tailored strategies and tools for sustainable change.
- Dell Medical School has developed the Reducing Stigma Education Tools (ReSET) [5] modules, which feature education-based strategies to address stigma against OUD across health care settings. Each module contains curated evidence-based content designed by health communication researchers. The modules promote interprofessional collaboration and target trainees and practicing health professionals, providing interactive learning assessments with research-informed best practices, communication tools, and resources to address stigma. A key feature is the inclusion of persons with lived experience who share their stories about dealing with stigma.
- The American Medical Association's Opioid Task Force [6] is leading a comprehensive, policy-focused effort prioritizing the systematic removal of stigma across the health system. The Task Force is comprised of more than 25 nationwide medical societies that recommend, in part, confronting stigma by improving access to MOUD and mental health services, removing barriers to pain care, supporting maternal and child health, and advancing civil and criminal legal system reforms.
- The American Nurses Association [7], American Society of Health-System Pharmacists [8], and other professional organizations have made similar commitments to addressing stigma through their respective task forces.

While independent efforts are underway, a comprehensive, evidence-based, cross-health system strategy is needed to effectively address entrenched stigma. The impact of stigma across health care has led to the marginalization of patients with OUD, marked by significant barriers in access to evidence-based treatment and care. The COVID-19 pandemic highlights these inequities and has exacerbated the existing OUD epidemic, demanding the need for action.

To help stem persisting stigma, the health care community should consider engaging in anti-stigma initiatives. The authors of this manuscript call for Medicare, state Medicaid, federal health programs, and professional societies to adopt anti-stigma framing language, vocabulary, and frameworks. The authors of this manuscript also ask the greater health care community to collectively incorporate the following research-supported principles in their practices and organizations:

- Commit to universal use of person-first and recovery-centered language.
- Establish regular communication on addiction topics with staff and peers.
- Use evidence-based educational efforts and tools to address stigma.


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- Engage and employ people with lived experience, and trained, licensed, and skilled addiction specialists.
- Expand equitable access to MOUD and prevention, treatment, and recovery services through enhanced provider training, integrated care, and inclusive reimbursement policies and incentives.

It is time for every health care provider and organization in the health system to commit to a cohesive, evidence-driven effort to lead the way in eliminating stigma against OUD, to better meet the needs of those with SUDs and turn the tide of the opioid crisis.

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## Author Information

**Jennifer Atkins** is Vice President, Network Solutions at Blue Cross Blue Shield Association. **Anna Legreid Dopp** is Senior Director, Clinical Guidelines and Quality Improvement at the American Society of Health-System Pharmacists. **Edna Boone Temaner** is a self-employed health information technology subject matter expert, formerly with the Office of the National Coordinator for Health Information Technology and HIMSS.

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