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Commentary

Stigma and the public health agenda for the opioid crisis in America

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ABSTRACT

The current opioid crisis in the U.S. is unprecedented and calling for a nationwide reorganization of the public health prevention program. Stigma is a persistent barrier to this agenda, unfortunately with a limited body of research on substance use disorder (SUD) available to inform it. We review the broader research literature on the stigma of behavioral health (*i.e.*, mental illness and SUD) to identify strategies to address the opioid crisis and harmful stigma. A major difference between mental illness and SUD stigma is that the latter is legally and socially sanctioned. In making sense of the behavioral strategies for stigma change, we consider three agendas for stigma prevention (prevention, rights, and self-worth). We suggest that incorporating the rights and the self-worth agendas with an *in vivo* focused contact model, might be most effective for an integrative strategy aimed at targeting opioid stigma. Involving people in recovery as key drivers of this agenda and evaluating the detrimental impact of using stigma as a health tool (social sanction), will bring new horizons to solving this deadly epidemic.

Stigma and public health policies for the opioid crisis in America

The World Health Organization (WHO) (2014) has said that opioid addiction is an epidemic challenging health across the globe. Recent lessons from the United States illustrate barriers caused by stigma in trying to implement policies meant to address the crisis. In an interim report released May 2017 by the White House Commission on Combating Drug Addiction and the Opioid Crisis (2017), commission members called on the White House to rally stakeholders to address the epidemic that is overwhelming our country. The report noted opioid prescriptions have quadrupled since 1999 with more than 27 million people admitting current use of illegal opiates or abuse of prescription drugs. Mortality rates quintupled during this time. Since 2015, the Centers of Disease Control and Prevention (CDC) has organized a nationwide public health program to tackle the crisis (Centers for Disease Control and Prevention (CDC) (2017)). Kolodny et al. (2015) outlined the public health agenda in terms of the three levels of prevention: primary, avoiding addiction caused by medical or nonmedical exposure to opioid pain relievers (OPRs); secondary, identifying OPR addiction early and guiding people into treatment; and tertiary, derailing the progression of addiction into medical complications, death, or psychosocial deterioration. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) prioritizes stigma as an essential barrier to these goals, a decision that is echoed by a recent National Academies of Sciences, Engineering, and Medicine (NAS) (2016). According to the NAS, stigma interferes with public health agendas that address challenges of mental illness (MI) and substance use disorder (SUD). In particular, people with behavioral health conditions will avoid prevention programs in order to escape the stigma that occurs when the public knows a person is availing it.

One important finding of the NAS report was the relative lack of research on SUD stigma, compared to MI stigma. In completing the NAS report, its committee sifted through more than 1500 peer reviewed papers on the stigma of MI. Less than 200 papers were found on the stigma of SUD with the quality of this work markedly less (Kulesza, Teachman, Werntz, Gasser, & Lindgren, 2015; Lloyd, 2013). As a result, systematic reviews of the existing literature on SUD stigma were integrated with the much larger literature on MI stigma to proffer a research and intervention paradigm for SUD (Corrigan, Schomerus et al., 2017). In this commentary, we carefully reviewed the research literature finding less than ten empirical studies examining stigma, opioid use, and injectable methods of SUD. The opioid crisis is nigh; strategies for addressing opioid stigma to promote prevention cannot await the incremental progression of research. Hence, one goal of this essay is to extrapolate from the mental illness stigma literature to understanding SUD, with the small research on opioid stigma providing an added heuristic for future research and action. Our post-NAS review of the SUD stigma literature also examined ways to stem the impact of stigma on public health priorities (Corrigan, Schomerus et al., 2017) Hence, a second goal here is to propose anti-stigmas strategies that might be incorporated into public health programs targeting opioid stigma.

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Table 1
A matrix describing the stigma of opioid use.

		Public	Self	Label Avoidance
social cognitive STRUCTURES	Stereotypes and Prejudice	*People who use opioids are: dangerous, immoral, to blame for their disorder, criminal.*	*Because I use opioids, I am dangerous, immoral, and ashamed. These lead to lowered self-esteem and self- efficacy.*	*I perceive the public disrespects and discriminates against people with substance use disorders like opioid use.*
	Discrimination	*Therefore, employers should not hire them, landlords rent to them, primary care providers offer a worse standard of care.*	*Why try: someone like me is not worthy or unable to work, live independently, have good health.*	*I do not want this. I will avoid the label by not seeking out treatment.*

What is stigma?

Modern conceptualizations of stigma as social injustice are traced to Erving Goffman who framed stigma as a mark that leads to "spoiled identity" (Goffman, 1963). He distinguished discredited stigma (marks are obvious such as skin color leading to racism or body characteristics leading to sexism) from discreditable stigma (marks are hidden so that the public cannot tell whether a person belongs to a stigmatized group such as sexual minorities, MI, SUDs or opioid use). The manifest mark of MI and SUD is a label – that person is "schizophrenic" or a "drug addict" – that frequently occurs by association. People seen coming out of the psychiatrist's office are believed to be "crazy." People in the methadone clinic are marked as criminal heroin addicts. Corrigan extrapolated Goffman's work into a matrix useful for understanding the stigma of disease in general and behavioral health disorders more specifically (Corrigan, Schomerus et al., 2017). The matrix (see Table 1) is defined by two dimensions: social cognitive constructs (stereotypes, prejudice, and discrimination) that underlie stigma and types that meaningfully impact the person with illness.

Stereotypes. Social psychologists have distinguished the largely private experience of stigma in general – stereotypes and prejudice – from the more public, behavioral result which is discrimination (Rüsch, Angermeyer, & Corrigan, 2005). Stereotypes are harmful and disrespectful beliefs about a group. Sixteen stereotypes have been identified that describe alcohol use disorder and include unreliable, emotionally unstable, living on other's expenses, and self-pitying (Schomerus et al., 2011). Another study identified stereotypes and prejudices about the generic label of substance use disorders (Nieweglowski et al., 2018). Stereotypes included dangerous, self-destructive, and no job potential. One qualitative study identified possible stereotypes for those who use opioids include shame and guilt (Howard, 2015).

Prejudice and Discrimination. Stereotypes are unavoidable; they are learned as part of growing up in a culture; *e.g.*, many American children learn at a young age that "addicts" are violent (Corrigan & Kosyluk, 2014). Prejudice occurs when agreeing with the stereotype leads to emotional evaluation. The behavioral health stigma research literature suggests three emotional responses mediate stereotypes and subsequent discriminatory behavior (Corrigan & Watson, 2007): (1) fear causing unfair discrimination that undermines personal goals related to work, independent living, and health; (2) blame (believing people caused their addiction) leading to anger and subsequent discrimination, often in the guise of unnecessarily coercive treatments; and (3) and internalized blame ("I caused my substance use disorder because I am weak.") leading to shame (decreased sense of self-esteem and self-efficacy).

Stigma types

The impact of discrimination becomes clear when realizing it varies by type; three types of stigma are summarized in Table 1 that emerged from the mental health and SUD stigma literature. Public stigma occurs when the general population endorses stereotypes and decides to discriminate against people labeled with a behavioral health disorder. Research shows employers are less likely to hire and landlords are less likely to rent to people with these labels (Phelan, Link, & Dovidio, 2008). A particularly concerning form of discrimination has been identified in the health care sector. People labeled with MI receive fewer primary care and specialty health services than those not labeled in this manner (Druss & Rosenheck, 1997) including fewer insurance benefits (Mark & Mueller, 1996). Research shows health care providers admit to the stigma of addictions (Dawson et al., 2005; Keyes et al., 2010), which leads to withholding primary care (Rivera, DeCuir, Crawford, Amesty, & Lewis, 2014) and pharmacy services to people with addictions in need (Anstice, Strike, & Brands, 2009; Simmonds & Coomber, 2009). Health care providers also endorse stigma specifically about people who inject drugs including opioids at a high rate (Brener, von Hippel, Horwitz, & Hamwood, 2015). Stigma undermines support of harm reduction strategies such as safe injection facilities and needle exchange programs (Kulesza et al., 2015; Rivera et al., 2014). Endorsement of opioid stigma corresponds with greater support for punitive polices towards those who use the drug (Kennedy-Hendricks et al., 2017).

Label avoidance. Public stigma impacts care seeking of people with behavioral health disorders when it leads to label avoidance. Epidemiological research shows only about 25% of people with SUDs ever participate in any care (Dawson et al., 2005). People who perceive higher stigma towards peers with SUDs are less likely to use treatment programs for alcoholism (Keyes et al., 2010) and less likely to participate in sterile syringe programs (Rivera et al., 2014). Label avoidance has been shown to be a recurring barrier to engagement in services for opioid use. Adolescents addicted to opioids who endorse the stigma are less likely to seek out care (Wu, Blazer, Li, & Woody, 2011); adults are unlikely to participate in methadone programs (Lan, Lin, Thanh, & Li, 2017; Shah & Diwan, 2010). People addicted to opioids who endorse the stigma are less likely to remain engaged in services for HIV-AIDS (Kiriazova et al., 2017).

Self-stigma. Self-stigma occurs when people with behavioral health challenges internalize corresponding stereotypes and prejudice (Link, 1987; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). A regressive model of self-stigma has four stages (Corrigan & Kosyluk, 2014): people are (1) Aware of the stigma of behavioral health (also called perceived stigma: "The public thinks people with SUDs are dangerous") (Phelan, Link, Stueve, & Pescosolido, 2000), which might lead to (2) Agreeing with the stigma ("Yes; that's right. People with SUDs are dangerous!"), followed by (3) self-Application ("I have an SUD so I must be dangerous.") which (4) negatively Impacts self-esteem ("I am less of a person because I have an SUD and am dangerous.") and self-efficacy ("I am less able to accomplish my goals because I have an SUD."). Self-stigma causes the "Why Try effect" (Corrigan et al., 2015b;