

## Stigma undermines prevention programs for the opioid crisis

The World Health Organization and the U.S. Commission on Combatting Drug Addiction and the Opioid Crisis, agree that opioid addiction is an epidemic. In the U.S., the Centers of Disease Control and Prevention framed three approaches to prevention: (1) avoiding addiction caused by exposure to opioid pain relievers; (2) identifying opioid addiction early to guide people into treatment; and (3), derailing the progression of addiction into major medical complications. A recent report from the National Academy of Sciences suggests stigma is a significant barrier to engaging people with substance use disorder (SUD) in prevention programs. Diminishing stigma is an essential step in addiction prevention.

There are two types of stigma related to SUDs. Public stigma occurs when the general population endorses stereotypes and discriminates against people labeled with the SUD. For example, health care providers who endorse the stigma of addictions sometimes withhold needed services. Public stigma impacts care seeking of people with behavioral health disorders when it leads to label avoidance. People who endorse the stigma of SUDs are less likely to avail prevention programs in order to avoid the harm of stigmatizing labels.

Anti-stigma interventions meant to promote service engagement and diminish discrimination are driven by two differing agendas. A prevention agenda diminishes label avoidance through education about SUDs. Individuals who better recognize their illness and corresponding treatment options better avail those options. The rights agenda is endorsed by those victimized by stigma -- in the health care clinic or work setting -- and demands replacing discrimination with opportunity. Programs like the San Francisco Drug User's Union have featured fair treatment under the law in its mission statement.

Although the two agendas seek to decrease the egregious impact of stigma, they differ in constituencies and valued outcomes. For example, those who erase stigma to facilitate prevention might be unaware of the equally important goal of challenging the discrimination wrought by prejudice. For example, Australia's *beyondblue* program promotes care seeking for mental illness (MI) by framing common illnesses as treatable diseases. Although framing these illnesses as familiar might decrease stigma, "treatable disease" might also lead to an unintended idea that people with depression are somehow different from everyone else. Perceptions of difference undermine the rights agenda.

The stigma of SUD is unlike that of MI: stigmatizing messages about addiction are socially and legally sanctioned. First, although the justice system is often concerned about the role of MI in criminal guilt, it mostly protects their civil rights. Much less so for people with SUDs. Use of controlled substances are illegal in most jurisdictions. The stigma of SUD also impacts interpretations of civil law. Although reasonable accommodations in the Americans with Disabilities Act (ADA) are guaranteed under the law to help people with psychiatric disabilities complete work-related duties, ADA protections for SUDs are comparatively limited. Employers, for example, are

not violating the ADA when denying promotions to employees currently engaged in illegal drug use.

Second, stigma is purposefully incorporated into health communications to promote substance use prevention. Mothers Against Drunk Driving, for example, pairs alcohol and drug use with horrific scenes of car accidents to promote prevention. Efforts to promote prevention need to consider the legal and social sanctions related to the stigma of SUDs. If one benefit of SUD stigma is to reduce substance use, is it acceptable to use stigma to achieve prevention goals? This kind of decision needs to be weighed against a social justice perspective. Is it really acceptable to use stigma as a public health tool? More importantly, what happens to care of people with opioid addictions in a culture that promotes negative views of them?

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