Chapter 7
Stigma and Addiction Treatment

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Introduction

Substance use disorders (SUDs) are one of the most stigmatized conditions in the United States, making it exceedingly difficult to adopt solutions rooted in science and human compassion. SUDs are not rare—more than one in six people in the United States meet the clinical criteria for a SUD, and another one in three use addictive substances in a way that threatens their own or others' health and safety. In fact, the number of people with SUDs far surpasses the number suffering from heart disease, cancer, or diabetes [19]. There are numerous government-funded institutes and organizations tasked with researching, preventing, and treating addiction

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and countless nonprofit and grass roots organizations dedicated to doing the same. Stories of addiction and its effects regularly appear in the headlines of news media and in popular songs, books, television shows, and movies. Public officials regularly acknowledge addiction's enormous social, physical, and economic toll. Given its broad reach and obvious public interest, why has it remained so difficult to implement an effective, health-promoting, and compassionate response to this disease?

In one word, the answer is stigma.

Stigma is a social phenomenon whereby individuals who deviate from the accepted norm are perceived by society as less desirable and are judged or punished accordingly [39]. Stigma operates in a manner that exemplifies the exercise of power: labeling a group as different, attaching stereotypes to that group, and separating the labeled group by distinguishing "them" from "us." This process establishes a rationale for those with power to devalue, reject, and exclude those who do not conform to a certain social ideal, leading to loss of status and discrimination for the stigmatized group [52].

Stigma operates on three levels, each of which influences the other. Social (or public) stigma occurs when the public endorses stereotypes about and acts against a stigmatized group. Institutional (or structural) stigma occurs when rules and policies intentionally or unintentionally disempower that socially stigmatized group. Finally, internalized (or self) stigma occurs when people in the stigmatized group anticipate social rejection, endorse the stereotypes, and perceive themselves to be of low value in society [26].

Public Perceptions of Addiction and its Treatment

Although stigmatized attributes vary across contexts and time, substance use and addiction consistently have been at odds with social convention [39], and people with addiction

historically have been perceived as dangerous and blameworthy [53]. The dangerousness stereotype stems from the illicit status of drugs and the loss of self-control and inhibition that results from their intoxicating effects. The blameworthiness stereotype stems from the belief that individuals have a choice in their use of drugs [53]. These stereotypes form the basis for seeing addiction as a marker of personal irresponsibility and for believing that people with addiction are morally weak [33]. Other research on stigma posits that individuals whose distress seems to derive from an uncontrollable cause receive sympathy and assistance while those whose distress seems to derive from a controllable cause are met with hostility [45]. The latter is reflected in the view, deeply entrenched in our society, that addiction is a choice, a moral failing, and an indicator of weakness. These stereotypes around addiction endure despite a significant body of research attesting to a very different picture of how addiction develops, why it persists, and how it can best be managed.

Over the past few centuries, two general models have dominated society's understanding of addiction: the moral model and the disease model [50]. The model that predominates at any given time influences how individuals with SUDs are perceived and treated across the three levels of stigma: social/public, institutional/structural, and internalized/self.

The moral model frames addiction primarily as a failure of morality or personal responsibility [68]. This model attaches blame, creates shame and embarrassment, increases the likelihood of discrimination, and decreases the chances that an individual with SUDs will seek or receive effective treatment. It implies that addiction should be addressed in ways that hold people accountable for their "immoral" behavior, which usually translates into restricting needed social services or inflicting some sort of penalty within the criminal justice system (see Fig. 7.1).

The disease model of addiction, in contrast, emphasizes the role of biology in the development and persistence of addiction, drawing on advances in genetic and neuroscience research [51]. Although this approach tends to be less judg-

mental of people with SUDs, it runs the risk of being reductionistic and of discounting personal responsibility when it comes to substance-related decisions and behaviors. It also can engender feelings of hopelessness regarding the chances of achieving a sustained recovery through treatment.

In contrast to these two models, the biopsychosocial model (see Fig. 7.1) recognizes addiction as a disease, but one that originates from and exists within a larger ecological context in which many interrelated determinants influence substance use initiation and its progression to addiction [77]. This model is the one most deeply steeped in the research evidence and most widely accepted by researchers and public health experts today. Unfortunately, despite its strong empirical support, it is not widely accepted by the public, which largely continues to adhere to the moral model of addiction.

The longstanding stigma associated with addiction pervades not only public attitudes but also the government and health care and justice systems' responses to it.

In addition to the stigma around addiction itself, there also are many misconceptions deeply held by the public, policy makers, health professionals, and criminal justice professionals about its treatment. These are exemplified by prevailing views such as the following: (1) addiction treatment does not fall within the purview of the medical system, (2) an adequate qualification to treat addiction is to have experienced addic-

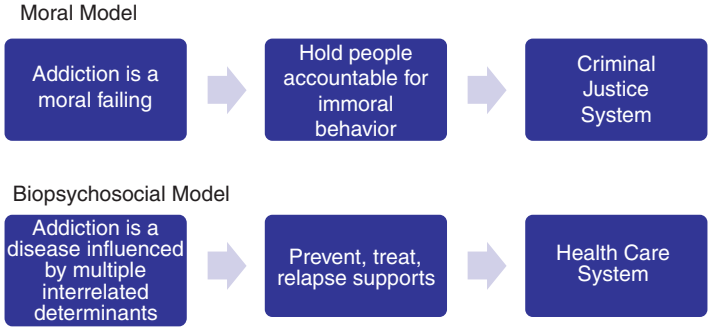

Figure 7.1 Model of Addiction Dictates the Approach to Addiction

tion oneself, (3) complete abstinence is the primary goal of treatment, (4) addiction treatment medications should be avoided because they merely "substitute one addiction for another," (5) if medication to treat addiction is used, the patient should be weaned off it as quickly as possible, and (6) a person needs to "hit rock bottom" for treatment to be successful. Each of these assumptions is patently contradicted by the research evidence, and each reinforces the stigma around the disease.

There also is widespread misunderstanding of what exactly constitutes addiction treatment. For example, detoxification alone is not treatment; rather it is, in some instances, a necessary precursor to treatment. A 28-day stay in a rehabilitation facility is not the optimal treatment model; rather, most cases of addiction can best be treated on an outpatient basis, and most require more than 28 days of treatment to be effective. Finally, the 12-step, mutual support model (e.g., Alcoholics Anonymous, Narcotics Anonymous) is not, on its own, an evidence-based treatment for addiction; rather it is, for many people, a helpful supplement to treatment and relapse reduction efforts.

Despite these misunderstandings, there is hope. Recent history shows us that when a health condition is thought to derive from bad behavior, a character flaw, or a moral deficit, it produces a markedly different public response than when it is thought to derive from a genetic predisposition, a neurological disorder, or a biological impairment. There also is evidence that when a condition is seen as treatable, the stigma surrounding it tends to decrease. Take, for example, our country's shifting perceptions of depression. Until it was understood that many cases of depression could be attributed, at least in part, to neurochemistry rather than a character flaw and until antidepressant medications gained widespread acceptance, depression was highly stigmatized. Once it was shown to be amenable to treatment by medical professionals, the stigma surrounding it declined [12]. This is also exemplified in how the public response to HIV/AIDS—one of the mostly highly stigmatized conditions in recent history—has evolved toward a more tolerant and health-based approach

as evidence accumulated regarding its cause, nature, progression, and responsiveness to medication. Policy changes were made, and payment programs were expanded to increase access to these medications, ultimately resulting in a steep drop in AIDS-related morbidity and mortality [99].

When it comes to addiction, however, 37 percent of adults in the United States still believe that people with opioid use disorder, for example, have a personal weakness rather than an illness, and the majority either think that there is no effective long-term treatment for it (30 percent) or do not know whether such a treatment exists (35 percent) [69]. Because of the lingering view that addiction results from personal weakness, stigma associated with addiction and its treatment is difficult to eradicate. Nevertheless, as new treatments for addiction emerge and as its care increasingly becomes integrated into mainstream medical practice, we can expect a decline in the stigma surrounding addiction, people with SUDs, and treatment for SUDs.

Self-Perceptions of Individuals with Addiction

The widespread misunderstanding about the disease of addiction and its treatment contributes not only to public disapproval and to institutional discrimination against those with addiction but also to how individuals with SUDs perceive themselves. Self-stigma is reflected in the language they use (e.g., referring to themselves as "addicts"), in their sense of failure when they experience relapse, and in some of the basic tenets of the addiction recovery community.

The language used in reference to substance misuse and addiction is fraught with stigma and has been adopted by many who themselves have the disease. Stigmatizing language commonly is used in both popular and clinical parlance in reference to unhealthy substance use—substance or drug "abuse"—and in reference to those who engage in that behavior—"addict" or "drug abuser." Terms such as "abuse" are powerful and villainize those who use addictive substances,

casting them as aggressive or immoral and connoting a deliberate and malevolent action. Likewise, terms such as "getting clean" or having a "dirty" toxicology screen impute derogatory value judgments on normal clinical manifestations of the disease of addiction but nevertheless commonly are used by those who have the disease [72].

The shame and self-recrimination that are so prevalent among those with addiction have very real consequences: they reduce the chances that someone will seek and receive needed support and treatment, jeopardize recovery efforts, and increase the risk of relapse [21]. A national survey found that 29 percent of adults in the US believe that the main reason people with addiction do not get the help they need is a fear of social embarrassment or shame [19]. The fear of disapproval can derive from an individual's own sense of shame, or it can derive from a realistic fear of abandonment by friends or family because of the substance use or the decision to pursue treatment [70, 76]. More than half of those who do manage to begin treatment do not complete their program [81]. Reasons for dropout vary, but it is clear that stigma plays a large role in driving high attrition rates [16].

Self-stigma also occurs on a structural level within the addiction recovery community. A primary intervention recommended for people with SUDs is the 12-step, mutual support model. Three key characteristics of that model are as follows: (1) care is essentially delivered by peers who have addiction and are themselves in recovery; (2) the desired outcome is complete abstinence, and any substance use, even in the form of addiction medication, generally is frowned upon; and (3) the goal of anonymity is paramount. Although mutual support programs undoubtedly help countless people with addiction, these features run counter to a science-based understanding of the disease of addiction and perpetuate the stigma associated with it.

First, best practice for addiction care calls for treatment to be delivered by a qualified health care professional, not a peer (although peer support is extremely valuable to ensure a sustained recovery). The mutual support model does not

embody the goal of treating addiction within the mainstream medical system where all other diseases are treated. This separation of treatment is one of the main driving forces behind the stigmatization of addiction, which has been perpetuated by a system that does not rely on medical facilities or professionals to deliver care for it. Second, holding abstinence up as a primary goal of treatment is an obstacle to one of the most effective forms of treatment for opioid use disorder and, in some cases, alcohol use disorder: addiction treatment medications. These medications save countless lives and give many more a second chance at a productive and rewarding life. Yet stigma has contributed to a misperception that medications to treat addiction are a poor way to manage one's disease, a misperception that does not extend to other medication use, such as insulin for those with diabetes, beta-blockers for those with heart disease, or inhalers for those with asthma. This perspective is held not only by people within the recovery community but also by many treatment providers [71]. Finally, a cornerstone of most mutual support programs is the preservation of participants' anonymity. Clearly, revealing a person's medical condition without consent is unethical within the context of any disease. However, prohibiting public scrutiny and valuing anonymity above all sends a clear message that needing to be in a mutual support program is embarrassing or shameful. In reality, the more people are made aware of individuals in their lives who have SUDs, the better the odds of defeating the stigma that so strongly clings to this disease [49].

How Did We Get Here? The History of Stigma Around Addiction and Its Treatment

The current state of the addiction treatment system is the result of a long and ongoing history of stigmatizing people with addiction, as well as the medical professionals who treat them.

Perceptions of drug use have fluctuated from periods of tolerance to antidrug zealousness [28]. From the mid-nineteenth century through the early twentieth century, there was widespread acceptance of the use of addictive substances, including opium, to treat common ailments [61]. Pure morphine injections became one of the most frequently utilized pain relievers; its fast-acting relief made it seem like a "wonder drug." While some doctors certainly were aware of the potentially addictive properties of these medications, their medicinal properties were believed to outweigh their risks [62]. Prescribers were almost entirely unregulated during this time, and medications were not required to reveal their opioid content, leading to reckless distribution and misuse [62]. Easy accessibility, combined with an influx of Civil War veterans suffering from injuries and trauma, fueled drug consumption during the latter half of the nineteenth century [28, 29].

Most pertinently, people suffering from opioid addiction often were prescribed opioids to ease their withdrawal symptoms, a practice referred to as "maintenance"—a predecessor to the more recent use of medications like methadone to treat addiction [29, 62].

In a series of events reminiscent of the current opioid epidemic, concerns about the use of opioids to treat medical disorders—and, in particular, SUDs—began to take hold by the late 1800s as addiction rates climbed at an alarming rate [27, 62]. The risk of addiction began to be seen as outweighing the medical benefits of opioid medications [62]. Naturally, this led to reduced faith in the prescribing physicians. When it became clear that a significant addiction problem existed, the public swiftly turned against medical professionals for their reckless prescribing habits. The medical community generally suffered from an astoundingly poor reputation during this time; many doctors themselves had addiction and freely prescribed drugs in the absence of training or practice standards [61]. As a result, addiction treatment began its century-long shift away from the field of medicine.

Negative attitudes toward physicians and their patients with addiction contributed to the passage of the Harrison Narcotics Tax Act of 1914. The Act, which regulated and taxed the production, importation, and distribution of opioids and coca products, made it nearly impossible to prescribe opioid medications to patients with addiction [96]. Initially, the Supreme Court treated the Harrison Act with some trepidation as it was wary of the power that the government was attempting to exert over the field of medicine. However, the Court eventually ruled that while physicians could prescribe narcotics to patients for medical treatment, they could not do so for the treatment of addiction since the latter did not constitute a legitimate medical practice [92, 95]. This effectively prohibited the provision of opioid-based medication to treat individuals with addiction [62, 98].

The stringent regulation of opioid-based treatments for addiction propelled the separation of addiction treatment from the mainstream health care system, the trend for medical professionals to distance themselves from caring for people with SUDs, and the shift toward punitive measures to address addiction and its consequences. With the medical community effectively removed from addiction treatment, the Federal Bureau of Narcotics was created in 1930 to handle drug-related issues. People who violated the country's strict narcotic laws were imprisoned, leading to overcrowded jails and high relapse rates [62]. Around this time, "narcotic farms" were established via the 1929 Narcotic Farms Act in place of medical clinics to address addiction. They were based on a withdrawal model, essentially a precursor to today's abstinence-based rehabilitation facilities. Any substances used to ease a patient's withdrawal symptoms were given only on a temporary basis. The farms essentially functioned as barely more than overflow rooms for overcrowded prisons and were largely ineffective, since the vast majority of the participants relapsed post-departure [98].

Stigma's Effect on Addiction Treatment Today

The stigma against doctors and patients with addiction established during the early twentieth century is evident in our current approach to addiction and its treatment. Tragically, this has resulted in the well-documented statistic that only about one in ten individuals in need of addiction treatment receive it, and even fewer receive evidence-based care [83].

Preference for Punitive Approaches

Coupled with the illicit status of drugs, stigma around addiction has contributed to the public and institutional view that the most appropriate means of addressing addiction is through punitive measures rather than through medical interventions. This perspective endures despite evidence that punitive approaches are ineffective and that the criminal justice system is ill-equipped to provide addiction treatment. Policy makers have embraced our nation's aggressive "war on drugs" for more than 50 years, with funding for punitive approaches outpacing efforts to expand treatment [33, 54].

Aside from failing to help those with SUDs and their families, punitive efforts have proven ineffective in reducing drug availability and demand. People with SUDs continue to flood jails and prisons, but the prison system is incapable of accommodating their needs. As of 2015, half of the individuals incarcerated in federal prisons had drug-related offenses [18]. Based on a recent analysis of more than one million arrests for drug law violations in the United States in 2016, most arrests (85 percent) were for possession of a controlled substance; only 15 percent of arrests were for the sale or manufacture of a drug [32].

Drug use and addiction are associated with an increased risk of recidivism [34], and the criminal justice costs associated with drug use and addiction account for a very large portion of total government spending ([88]). Although the justice system is constitutionally mandated to provide inmates with "adequate" medical care [35], only 11 percent of incarcerated

individuals with addiction receive treatment and very few of those receive evidence-based care [89]. The criminal justice system has largely shunned the adoption of evidence-based treatment, including medications to treat addiction. As of August 2018, only Rhode Island offers all three forms of opioid addiction medication to those who are incarcerated; 28 states do not offer any medication to prisoners with opioid use disorders [55]. Failing to provide evidence-based treatment in prison is unethical, contradicts medical guidelines, reduces the chances that an individual will seek treatment postrelease, and increases the odds of postrelease relapse and overdose [37].

The criminalization of addiction only exacerbates its stigma. When individuals with SUDs are incarcerated rather than treated, the perception of addiction as a crime as opposed to a disease is reinforced and public support for improved treatment opportunities is eroded. The failure of the criminal justice system to connect individuals with SUDs to effective treatment is a tremendous missed opportunity.

In recent years, the criminal justice system has attempted to rectify this situation by implementing diversion or "alternative to incarceration" programs, which provide opportunities for individuals in the criminal justice system who have substance use disorders to engage in treatment. These programs have demonstrated promise in reducing recidivism and saving costs [56]. However, they do not always provide effective or evidence-based care. Participants may be jailed for failed drug tests and relapses, outcomes that could have been averted with proper treatment. Historically, drug courts have been reluctant to allow the use of medications for addiction treatment, although they now are required to do so as a condition for federal funding [17].

Poor Access to Quality Addiction Treatment

Stigma against addiction in the health care system is rooted in a historical belief that addiction is not worthy of the attention of medical professionals. This has had a profound impact on creating generations of providers who are unable to identify, treat, or manage a preventable and treatable disease that

is prevalent in their patient population. It also affects the quality of care that patients with addiction do receive since a shadow treatment system has filled the void left by the health care system. This system is not subject to the same rigorous standards as the health care system, does not adhere to evidence-based practices, offers substandard care to patients with a serious medical condition, and increases the risk of avoidable relapse, morbidity, and mortality.

The separation of addiction care from mainstream medicine is evident in the minimal education and training that health care providers receive in relation to addiction. Medical schools and other health professional training programs barely address addiction [19]. As a result, many health care providers do not feel confident in their abilities to treat a patient with a SUD [59] and tend to share many of the same stereotypes and misconceptions about such individuals as those held by the general public [53]. These biases significantly affect the type and quality of care that a patient with addiction receives [58, 67]. As the opioid epidemic has worsened in recent years, professional health care education and training programs have begun to incorporate some addiction training into their curricula [22, 23, 57].

Physicians comprise a small proportion of the addiction treatment workforce. There are few physician role models within the addiction field to mentor and inspire younger physicians [59], and their preparation in medical school and residency training to treat patients with SUD and complex cooccurring conditions is severely limited. Treatment must be comprehensive, and the medications used to treat addiction require close monitoring and follow-up. Addiction treatment providers tend to be paid less than other types of health care providers. The siloed nature of the treatment system means that doctors do not have access to necessary outpatient services such as counseling and support systems to help patients navigate their treatment and recovery [93]. For all these reasons, many doctors consider treating patients with SUDs a disheartening, costly, and futile practice [53].

Given the longstanding absence of an adequate workforce of health care providers to treat people with SUDs, others

have filled the gap. These providers, while typically very well intentioned, are largely unqualified to provide the level of evidence-based clinical treatment needed by most people with a complex disorder like addiction. Those delivering care to people with addiction often are armed primarily with their own lived experience with addiction rather than advanced professional training. Addiction counselors, who comprise the vast majority of the workforce, typically are not required to have an advanced degree, and some states require only a high school degree and practical training [19]. One would be hard-pressed to think of another disease—especially one that overlaps with as many mental and physical health conditions—where the primary qualification for treating it is having experienced the disease itself rather than having medical training. Although there is little doubt that individuals in recovery from addiction are essential for providing treatment supports, clinical treatment involving the provision of medications and psychotherapy is best delivered by trained health care professionals.

States are in charge of licensing and certification requirements for addiction treatment providers and facilities, but the degree of oversight is meager. The requirements typically are set by state agencies that are charged with overseeing addiction services rather than the agencies responsible for regulating health care facilities [19]. Private organizations comprise the majority of treatment facilities in the United States, and a lack of regulation allows many to operate on a profit motive rather than in the best interests of patients with SUDs [98]. As our understanding of addiction has evolved, the treatment system has not kept pace, and many of the current approaches do not reflect the scientific evidence regarding what works best to treat this disease. The lack of medical professionals, practice standards, and oversight in the addiction treatment system not only highlights the continued stigma around addiction and the wide scale misunderstanding of the disease but also makes it exceedingly difficult for patients and their families to find quality, effective, lifesaving care.

Medications for Addiction Treatment

Although there are many ways in which the current addiction treatment system does not adequately meet patients' needs, perhaps the most glaring example of how stigma creates a barrier to effective, evidence-based care is the extreme underutilization of medications to treat opioid addiction. Medications are commonly used to treat other chronic diseases, including HIV/AIDS, heart disease, and diabetes. When medications were developed to alleviate suffering and extend the lives of patients with these diseases, they were heralded as wonder drugs. But medications for addiction, particularly opioid addiction, are viewed very differently.

The use of U.S. Food and Drug Administration (FDA)-approved medications in combination with psychosocial therapy is commonly referred to as medication-assisted treatment (MAT), but even the term "assisted" in this context is stigmatizing as it suggests, contrary to evidence, that these medications on their own are inadequate for alleviating addiction symptoms [36]. There are FDA-approved medications to treat nicotine, alcohol, and opioid use disorders. The medications help control cravings and withdrawal symptoms and allow individuals with addiction to avoid substance use and improve life functioning. FDA-approved medications to treat opioid addiction include methadone, buprenorphine, and naltrexone. Methadone and buprenorphine are opioids but, when taken as prescribed, do not produce the same euphoric rush characteristic of misused opioids. Naltrexone, which is not an opioid, blocks the effects of opioids, helping to prevent opioid misuse and overdose.

The stigma against medications for opioid addiction treatment is rooted in a general misunderstanding that these medications cannot treat addiction because, being opioids themselves, they merely "replace" or "substi-

tute" one addiction for another [75]. Underlying this belief is a conflation of physical dependence and addiction. Physical dependence occurs when the brain adapts to a drug's effects and develops tolerance so that more of the drug is required to achieve the initial positive effect, and continued use may be required to prevent painful and uncomfortable withdrawal. In contrast, addiction is characterized by the compulsion to use substances despite negative consequences, including loss of employment, damage to personal relationships, and even overdose. Many types of medication produce physical dependence without the psychological characteristics of addiction. Medications for treating opioid addiction have proven successful in reducing withdrawal symptoms and cravings and decreasing the risk of overdose, disease transmission, and substance-related crime [24, 80]. The fact that patients are able to regain normal functioning in their lives while on these medications is evidence that their addiction is being effectively managed.

The stigma around these medications is so strong that public opinion has been slow to change despite the growing body of evidence demonstrating their effectiveness. A 2018 poll found that only 33 percent of respondents would consider a friend to have been effectively treated for opioid addiction if the person no longer misused opioids but did use a medication on a long-term basis to control cravings [69]. Even addiction treatment providers view abstinence-based interventions as more appropriate than pharmaceutical treatments [19]. Less than half of addiction treatment facilities provide medications such as buprenorphine to treat opioid addiction [74]. Because of the stigma around these medications, patients often are unwilling to admit that they take them and face pressure from family members to discontinue their use.

Stigma is also reflected in the requirements around how these medications are delivered. While the addiction treatment system is largely unregulated, medications for opioid addiction treatment are subject to a legal and regulatory regime that is wholly unique to these medications and not applicable to any other type of medical treatment. Methadone is the oldest medication for opioid addiction, and despite decades of demonstrated success in alleviating cravings and reducing relapse, it has long been treated with apprehension by the public and policy makers because of the incorrect belief that it perpetuates addiction [31, 98]. As a result, federal law requires that methadone for opioid addiction be prescribed and dispensed in separate, specially-licensed facilities known as opioid treatment programs (OTPs) (unless a patient has been hospitalized for another medical condition), and regulations dictate patient eligibility requirements, initial dosing, counseling requirements, and criteria for take-home medication [3]. States are permitted to impose additional regulations on methadone. The medication is only covered by Medicaid in about one in three states in the United States [43].

Most patients must travel to an OTP daily to receive a supervised dose of the medication. There is a deep shame associated with attending an OTP [94]. Patients in treatment are routinely drug tested and monitored for illicit substance use, making them feel as though they are under surveillance and cannot be trusted with their own medications [67]. OTPs are highly stigmatized, as is reflected in the "not in my backyard" phenomenon, where local residents typically resist having them in their neighborhoods based largely on an unfounded fear of criminal behavior among persons with opioid addiction [14, 38], which further limits patients' access to methadone treatment.

Unlike methadone, buprenorphine can be prescribed in an office-based setting for at-home use. Buprenorphine was intended to free patients from the restrictions and stigma surrounding OTPs and increase access to treatment by allowing patients to receive care more quickly and easily from their primary care or other office-based provider. Nevertheless, buprenorphine is also subject to unique regulatory restrictions that only allow doctors to prescribe the medication under a limited set of conditions [46]. The Drug Addiction Treatment Act (DATA) allows qualified providers to prescribe buprenorphine to a limited number of patients under a "waiver" from the U.S. Drug Enforcement Administration. The number of patients who can be prescribed buprenorphine at a time depends on the prescriber's qualifications and prescribing experience [84]. The maximum number of patients that a single provider can treat is 275, but most providers are permitted to treat only 30 or 100 patients at a time (21 U.S.C § 823; 42 C.F.R. Part 8, Subpart F) [1, 2]. In practice, fewer than five percent of physicians have received the DATA waiver, and of those who have, only about half have ever even prescribed buprenorphine and most prescribe well below the allowed limits [47]. Sixty percent of rural counties and one in four urban counties in the U.S. have no physicians with the DATA waiver [9]. Initially, only physicians were allowed to prescribe buprenorphine, but in recent years, in light of the opioid epidemic, other health professionals have been granted prescribing authority.

Concerns about misuse and diversion serve as the justification for these tight regulations. However, these risks are not unique to or particularly elevated for addiction treatment medications. Methadone and buprenorphine, like any opioid, do have the potential for misuse and diversion, but they rarely are the primary drugs of choice for illicit opioid use. Notably, when

they are diverted or responsible for overdoses, they generally are one of several drugs taken, or they are misused to control opioid cravings and withdrawal symptoms that have not been adequately managed clinically [64]. Indeed, many participants in one study reported self-treating because of the lack of availability and "hassle" of OTPs. None of the individuals surveyed had ever used buprenorphine in an attempt to get high [60]. It also is important to note that the same restrictions do not apply to the prescribing of other opioid medications where there are legitimate concerns about misuse and diversion, such as oxycodone and other opioid pain relievers. Even when methadone is prescribed for the treatment of pain, it is not subject to supervised dosing in an OTP but is dispensed in a pharmacy upon presentation of a prescription. The only difference between these medications and other medications with risks for misuse and diversion is that methadone and buprenorphine are prescribed to patients known to have a SUD. Restrictions, therefore, are based not on the type of medication being prescribed but rather on the type of patient receiving it.

The many restrictions on medications to treat opioid addiction make these medications highly inaccessible to the growing population of people who desperately need effective treatment. The result is that more than one million patients with opioid addiction are unable to access evidence-based care [47]. In light of the current opioid epidemic, it is difficult to argue that the societal risks associated with these medications still outweigh the societal benefits. Stigma and a persistent misunderstanding of these medications and the disease of addiction sustain the current regulatory structure intended to limit access to effective medication treatments because of distrust of the patients who need them and of their doctors.

Room for Improvement

Stigma and misunderstanding of addiction are evident in many of the ways we currently address the disease. First, the addiction treatment system, in its current form, is not designed to treat addiction as a chronic disease. While the high rates of relapse for addiction are comparable to other chronic diseases, inadequate or ineffective treatment interventions may be a contributing factor to many instances of relapse [58]. The usual approach to addiction treatment involves brief, episodic interventions rather than long-term disease management, which is indisputably needed to treat chronic health conditions effectively.

Second, the addiction treatment system largely does not take into account that addiction affects parts of the brain associated with motivation, decision-making, judgment, risk/reward assessment, and impulse control. Lapses in these cognitive abilities are symptoms of the disease itself rather than signs of a moral failing or that an individual with addiction is not interested in treatment or recovery. Still, because of these cognitive and emotional effects, the motivation and energy to seek treatment can be fleeting and unpredictable. Therefore, a "no wrong door approach" is needed to ensure that patients can be engaged in appropriate treatment regardless of the setting or time in which they demonstrate a willingness to pursue and receive care. In the current system, in contrast, patients and their families must find treatment on their own, make countless phone calls, spend months on a waiting list, tolerate the ubiquitous stigma, and, if they do enter treatment, endure the constant threat of involuntary discharge if there is a relapse episode. Likewise, if a person experiences a drug overdose, he or she increasingly will be revived with an overdose reversal drug like naloxone, but it is unlikely that he or she will be connected to treatment despite the obvious indications that the person has a potentially fatal disease. A lack of motivation to get treatment is often cited as an excuse simply to discharge the patient once he or she is stabilized postoverdose, even though the evi-

dence of extreme impairment from the disease could not be starker than in the event of an overdose. None of these practices aligns with how we treat any other chronic, impairing, life-threatening disease.

Third, the addiction treatment system does not adequately address the high rate of cooccurrence of mental health and SUDs. Although best practices call for integrated, simultaneous treatment of cooccurring conditions, the separation of the health care and addiction treatment systems means that they typically are not treated together [66]. A 2016 survey revealed that only half of existing treatment facilities had a special program for patients with cooccurring conditions [82]. Failing to treat a cooccurring mental health disorder increases the risk of relapse and reduces the likelihood of a successful and sustained recovery.

Finally, the addiction treatment system largely takes a "one-size-fits-all" approach, in which the care that a patient receives is largely determined by whatever type of intervention is most readily available. Yet treatment is most effective when it is tailored to the individual needs and characteristics of the patient.

Stigma and Addiction Treatment for Women

Special consideration must be given to the stigma that women face when seeking addiction treatment. Women face gender-specific obstacles that compound the already existing barriers to accessing and attaining addiction treatment [41, 78]. Women often are cast into specific roles that carry restrictive social and cultural expectations, which makes it more difficult for them to acknowledge their addiction and seek help [15, 41, 42]. The punitive approach to addiction is especially pronounced for pregnant or parenting women with SUDs; they are derided as unfit mothers and can face imprisonment on charges of child abuse or neglect and risk losing custody of their children if they admit to using

addictive substances [44, 85]. The stigma surrounding pregnant women with SUDs is especially damaging because it can dissuade them from seeking prenatal care and addiction treatment during a time when women are typically highly motivated to receive help because of concerns about their baby's health [73]. Even women who do seek treatment may not get the most effective care if they are pregnant. The general stigma surrounding the use of medications to treat opioid use disorder is compounded for pregnant women. Most do not receive these medications despite evidence that they are safe and effective and despite the risks to the fetus of long-term exposure to addictive drugs or to the stress associated with unmanaged detoxification and withdrawal [48, 86]. Practical considerations that typically affect women more than men, such as lack of childcare services, are additional obstacles for women who might require long-term treatment [15]. And although the causes, manifestations, course, and consequences of addiction in women differ in many respects from men (e.g., prevalence of cooccurring disorders, history of trauma), most treatment programs do not adequately take into account these gender differences [40, 87].

Lack of Coverage and Funding

In the United States, addiction treatment historically has not been covered by health insurance. While insurers are now expected and, in many cases, legally obligated to cover addiction treatment, vestiges of discriminatory insurance practices persist, making it difficult for patients to receive affordable care. Lack of insurance coverage and high cost frequently are cited as key obstacles to care [79].

Relative to other health care services, addiction treatment is excluded more frequently, covered less adequately, and subjected to more restrictive limits and requirements by insurers. Patients face greater difficulty accessing in-network addiction treatment than other types of medical treatment, leading to higher out-of-pocket costs [20]. Further, insurance determinations often dictate the type and duration of treatment a patient receives, which may not align with best practices for treating addiction [7, 8, 10, 90]. Common insurance practices, such as requiring prior authorization and "fail-first" policies, can be very detrimental to patients with SUDs because they delay access to care, increasing the risks of relapse and overdose [90].

Stigma is evident not only in the way insurers cover or fail to cover addiction treatment but also in how requirements to improve insurance coverage have not been prioritized or enforced. The Mental Health Parity and Addiction Equity Act of 2008 [6] requires coverage for mental health and SUD benefits to be equal to the coverage of other medical conditions. The Patient Protection and Affordable Care Act (ACA) of 2010 required covered plans to offer SUD benefits as an Essential Health Benefit [4, 5]. Together, the parity law and the ACA provide the strongest protections available for patients seeking treatment paid for by their insurance.

While both laws hold great promise, they are not realizing their full potential. Although the ACA's reforms have helped to increase access to mental health treatment, there does not appear to have been a comparable increase in the rate of addiction treatment [30]. The current parity enforcement framework, which relies primarily on traditional regulatory tools and consumer complaints, is insufficient [97]. Stigma is at the root of this lack of enforcement. Patients are often unaware of their rights under the laws, lack the expectation that insurers should cover addiction treatment, and are reluctant to assert their rights in a time of personal crisis. Federal and state governments have not prioritized enforcement of

insurance protections despite recognizing that increasing access to treatment is an important priority in the midst of an unrelenting opioid epidemic.

Federal, state, and local governments have long borne the cost associated with addiction treatment [88, 91]. However, spending on addiction treatment only accounts for a small fraction of the exorbitant costs associated with addiction [88]. Despite the fact that the opioid epidemic has received significant attention from Congress, recent increases in funding have failed to invest adequately in treatment. Federal funding for addiction treatment is not centralized and, therefore, is largely short term and grants based. In 2016, the 21st Century Cures Act provided only $1 billion over two years, and in 2018, Congress allocated $6 billion for fiscal years 2018 and 2019 in its omnibus spending bill [25]. While the increased funding and attention from the federal government are encouraging, these are inadequate and short-term solutions for a large-scale and systemic problem—the commitment of funding for only two years is insufficient to implement programs with the potential to catalyze real change.

How to Reduce the Impact of Stigma on Addiction Treatment

Because of addiction's effects on countless health and social conditions, its reach is broad and wide. Despite its widespread prevalence, addiction and its treatment are stigmatized in a manner unmatched by most other diseases, regardless of their magnitude. It is nearly impossible to imagine a condition other than addiction that has as much scientific proof of a physiological and health basis, and as strong evidence of effective clinical treatments, that continues to be addressed outside the scope of mainstream medical practice. The only real hope for reining in its damage is to prevent its occurrence whenever possible and offer effective and lasting treatment to those for whom it was not successfully prevented.

Unfortunately, our nation has not chosen to take this sensible approach. Instead, we offer blame, shame, and humiliation to those who have the disease; discriminate against them so that they are deprived of the social, emotional, and economic capital and support needed to seek care and achieve a sustained recovery. The farms essentially functioned as barely more than overflow rooms for overcrowded prisons and were largely ineffective, since the vast majority of the participants relapsed post-departure [99] (see Fig. 7.2).

If its pervasiveness, reams of scientific evidence, and well-documented adverse effects are not enough to catalyze an effective repudiation of the stigma associated with the disease of addiction, then what can be done? The only logical response is to remove the stigma itself. Doing so would require a widespread public education campaign aimed at undoing centuries of misunderstanding and bias against individuals whose use of addictive substances has led to pain and suffering. While necessary, this is a costly and time-consuming endeavor, and our current addiction crisis cannot wait until the hearts and minds of millions of people are redirected from bias and disparagement toward science and compassion.

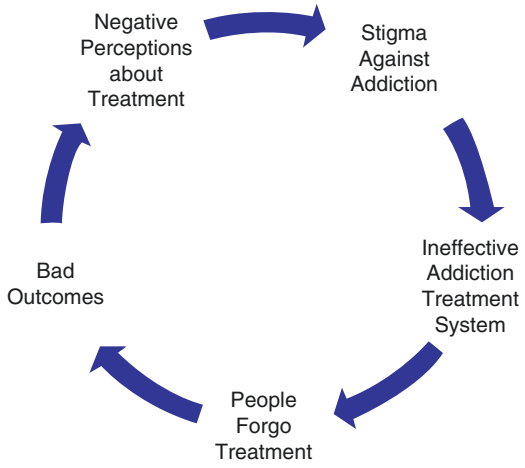

Figure 7.2 Stigma Feedback Loop

In the absence of (or preferably alongside) efforts to eradicate stigma, those with the power to ensure that individuals with addiction receive the treatment they need must be convinced, incentivized, or, if necessary, compelled to do so. It is important to make a clean break with the past, base policy and practice on current science, and stop allowing stigma to dictate our approach to addiction treatment.

Treat Addiction Within the Health Care System

To ensure that people with addiction receive the treatment they need, health care professionals must be trained and remunerated to treat it as they do any other complex disease and should no longer be allowed to dismiss addiction care as being outside of their profession's purview.

This change will not happen overnight. Many seasoned medical professionals who have not been involved in addiction treatment will likely have entrenched views about addiction and their responsibility to treat it. The greatest shift in care will most likely occur once emerging and future health professionals receive the proper education and training to address addiction as the treatable disease that it is. This change will require a commitment on the part of medical training institutions to better integrate addiction care into their curricula, enforceable standards by policy makers, financial incentives from payers, and a paradigm shift in best practices for treatment delivery and in standards of evidence-based care. One thing that perpetuates stigma and the sense of failure around those with addiction is that, when treated improperly as it frequently is, addiction can seem intractable. However, once health care providers routinely render evidence-based services for addiction, there will be higher rates of recovery, lower rates of relapse, and a reduction in the prevailing sense of hopelessness summed up by the popular stigmatizing phrase "once an addict, always an addict."

For too long, our nation has allowed just about anyone to render ill-defined addiction care services, often to the detri-

ment of people struggling with a very real and life-threatening disease. To truly transform how addiction is addressed in the United States and eradicate the effects of stigma on treatment delivery and quality, professional health care training programs must provide comprehensive and ongoing training about addiction prevention and treatment, just as they train health professionals to prevent and treat other complex chronic diseases that affect a significant proportion of the patient population. Policy makers should provide additional resources and incentives as needed to increase substantially the training and availability of addiction medicine specialists to meet the need nationwide. Non-health care professionals, such as educators, law enforcement, and criminal justice personnel, who interact regularly with people at risk for or who have addiction should also be educated about substance use and addiction and trained to respond to it effectively [19].

Policy makers and professional associations must exercise their leverage to ensure that addiction treatment programs and providers are offering evidence-based clinical care. Professional conduct should be monitored and regulated, as it is in relation to the treatment of any other health condition. Standards of care should be developed and adhered to, and there must be consequences for failure to comply with these standards. Health care accrediting organizations should stipulate requirements for all facilities and programs providing addiction treatment with regard to professional staffing, intervention and treatment services, quality assurance, and outcome monitoring. All addiction treatment facilities and programs should be subject to the same mandatory licensing processes as other health care facilities and should be required to have a certified addiction physician specialist on staff to serve as medical director, oversee patient care, and be responsible for treatment services. Providers should be required to collect and report comprehensive quality assessment data, including process and outcome measurements, related to all aspects of addiction care.

The way that the government regulates addiction treatment bears little resemblance to its regulation of other forms

of health care practice. Despite its lax oversight of treatment providers and programs in general, its stringent restrictions on the delivery of FDA-approved medications for opioid use disorder have no parallel in mainstream medical practice. The fact that any person with a medical license can prescribe addictive opioids to treat pain but those who wish to treat people addicted to those opioids with proven medication therapies require extensive government scrutiny is the clearest sign that stigma is deeply entrenched in how addiction treatment is delivered in the United States.

Employer Involvement Is Critical for Reducing Stigma and Expanding Addiction Services

The annual economic toll of substance misuse in the United States exceeds $700 billion, a significant proportion of which is due to lost productivity [63]. Employees with SUDs miss an estimated 50 percent more workdays than their peers, have significantly higher turnover, and incur higher health care costs [65]. Still, addressing addiction barely registers as an important goal for employers. Traditionally, stigma has stood in the way of addressing addiction in the workplace. But employers no longer can afford—morally or financially—to turn a blind eye to the benefits of supporting treatment to allay the tremendous costs of untreated addiction among employees and their families.

Employers should raise awareness and provide support for workers and their family members struggling with addiction, ensure that employee insurance plans offer comprehensive addiction treatment benefits, and have naloxone on site and train employees in overdose reversal. To help reduce stigma, health promoting rather than punitive policies should be implemented, such as offering assistance if an employee fails a drug test or hiring workers in recovery. Investing in employees' addiction treatment is not only the right thing to do; it also increases worker productivity and reduces turnover and health care costs [65].

Change the Way We Talk about About Addiction and Its Treatment

Language strongly influences how addiction is perceived and addressed by the public, health professionals, and policy makers. Words like addict, junkie, abuse, and dirty demean patients who have a real medical disease, deter them from seeking needed care, and dissuade qualified providers from offering treatment. Eliminating imprecise and pejorative terms from our language and instead adopting terms that reflect a health perspective and are consistent with those used to describe other health conditions is necessary to reduce stigma and transform delivery of addiction care [13, 72]. As we face the deadliest addiction crisis in U.S. history, we no longer can afford to debase, ignore, and marginalize individuals with a legitimate and treatable medical condition.

Conclusion

The stigma surrounding addiction and its treatment is its own public health crisis, deterring people with a treatable disease from getting the care they need and deserve to live a healthy and rewarding life [11]. Given what we now know about addiction and how to treat it, it is unethical and cost prohibitive to continue to deny effective care to the millions of Americans with the disease of addiction or to fail to intervene to help the millions more who are at risk.

Unfortunately, because of stigma, too many people do not seek or receive the help they need. Many have a legitimate fear that disclosing their SUD can jeopardize their parental rights, job, housing, personal relationships, or educational prospects. The behaviors most closely associated with addiction in the public's eye—criminality, irresponsibility, unreliability, negligent parenting—and that contribute most to stigma and discrimination rarely are indicative of a person's true nature; rather, they generally are symptoms or behavioral manifestations of the disease itself. Addiction alters the

brain in ways that make obtaining and using the addictive substance rise in importance above all other needs and desires [51]. Rejecting or marginalizing people with addiction will only exacerbate the disease. Instead, we must treat the disease so that healthier and more natural rewards take precedence over drugs in driving behavior.

This can be done, if only we can manage to turn away from a treatment paradigm steeped in stigma and toward one driven by health promotion. A person with addiction should not have to "hit rock bottom" or "submit to a higher power" to get treatment. A person with addiction should not have to travel miles, wait months, or spend his or her family's life savings to get treatment. A person with addiction should not be sent to facilities that lack basic medical, psychiatric, and therapeutic services. A person with addiction should not have to forgo effective treatment because federal requirements have made medications for addiction treatment largely unavailable where they live. A person with addiction should not have to stop using a medication that controls addiction symptoms just because of an unfounded belief that complete abstinence from any type of drug is superior to medication management. A person with addiction should not be arrested for having a disease, nor should a person with addiction feel compelled to get arrested as the only hope of obtaining treatment for that disease. A person with addiction should not be considered a failure if it takes longer than 28 days to recover. And parents in the United States in the twenty-first century should not have to watch their teenage children die because treatment for addiction—recognized for over 60 years as a medical disease—simply is not available.

We do not ask these things of people with diabetes, asthma, heart disease, or cancer. We should not tolerate them for people with the disease of addiction.

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