Pharmacists' Role in Reducing Stigma Surrounding Opioid Use Disorder (OUD)

This resource is intended to provide pharmacists with an overview of the stigma surrounding OUD and provide effective strategies to mitigate stigma in clinical practice.

OUD [1, 2]	• A problematic pattern of opioid use that causes significant impairment or distress • Highly stigmatized yet treatable chronic health condition • Changes in brain pathology develop over time • Often co-occurs with other substance use disorders/mental health disorders such as depression/anxiety • Common risk factors: past medical history or family history of substance use, comorbid psychiatric illness
Stigma [2]	**Complex social process of labeling, stereotyping, devaluing, and discriminating** • Use of "junkie" or "addict," believing people with OUD are aggressive, seeking drugs, or criminals • The idea that people "choose to use drugs and bring consequences upon themselves" • Discriminatory laws related to group characteristics or behaviors increasing social isolation
Impact of Stigma [2, 3]	• Barriers to care, limited access to medications for OUD (MOUD), loss of trust with provider • Reduced willingness to seek treatment and increased risk of mental health disorders from untreated OUD • Legal, housing, employment, and social disparities

Approaches to Reducing Stigma – Modifying Attitudes Through Education and Practice [2-4]

Recognize Stigma	• Despite proven effectiveness and being FDA-approved, medications for OUD are being overly restricted, under-prescribed, and underutilized
Use Non-Judgmental Language	• Use person-first language to put the person before the chronic health condition (e.g., "person with opioid use disorder") • Avoid slang and idioms, opting for language that promotes recovery • Listen without judgment and treat with dignity, respect, and compassion • Ask permission before giving unsolicited advice • Counter misinformation/disinformation with evidence and facts
Build Positive Relationships	• Invite people to openly share their lived experiences; observe and hear what they are saying • Be optimistic and supportive, encouraging individuals to be involved in their treatment plan
Implement Relevant Practices and Policies	• Support harm reduction and stigma-reducing strategies, such as needle exchange programs, naloxone training and distribution, and requirement of relevant continuing education for employees
Support Access Through Pharmacist-led Services	• Serve as care coordinators to better connect patients with community resources • Provide education on proper medication disposal or place a take-back box in the pharmacy • Use Prescription Drug Monitoring Program (PDMP) to engage in conversation/not to create barriers to treatment • Invest in telehealth to reach at-risk patients for follow-up monitoring • Advocate for pharmacist authority to prescribe and manage buprenorphine under collaborative practice agreements

Language Matters [2, 4, 5]

Instead of saying...	Say...	*Instead of staying...*	Say...
Junkie, addict, drug abuser	Person with substance use disorder	***Drug addicted infant, addicted baby, born addicted***	Baby with neonatal abstinence syndrome; newborn exposed to substances in utero
Drug habit	Substance use disorder	***Drug of choice or abuse***	Use of [X substance]
Abuse	Use other than prescribed	***Treatment is the goal***	Treatment is one path to recovery
Dirty drug screen	Positive for substances other than those prescribed	***Clean***	Abstinent; tested negative for [X substance]
Detox	Withdrawal management	***Medication as a crutch for recovery***	Medication to aid in recovery
Ex-addict	Person in remission or recovery	***Drug offender***	Person arrested for substance use violation; person with criminal legal involvement due to substance use
Relapsed	Had a setback	***Relapse prevention***	Recovery management
Risky patients	At-risk medications	***Opioid replacement or substitution***	Medication for opioid use disorder (MOUD)
Clean needles/dirty needles	Sterile syringes/used syringes	***Stayed clean***	Maintained recovery

Bust the Myths on OUD Pharmacotherapy

Chemical and physical changes in the brain can impact a person for life; therefore, individuals with OUD need treatment similarly to other chronic conditions, such as hypertension and diabetes. For evidence-based pharmacotherapy for OUD, reference *APhA - Opioid Use Disorder Pharmacotherapy*

	Myth	Reality
Medications for Opioid Use Disorder (MOUD) [2, 6, 7]	There is no proof that MOUD is better than abstinence-based treatment.	• MOUD is evidence-based and is first-line therapy for OUD by various health care organizations and agencies involved in the treatment of substance use disorders. • The current medications used to treat OUD are buprenorphine, methadone, and naltrexone.
	Pharmacotherapy for OUD is only for the short term.	• No evidence exists demonstrating a specific time period after which MOUD should be stopped. • Follow-up studies have shown longer-term use of MOUD is associated with improved outcomes.
Buprenorphine [2, 6, 8]	Buprenorphine is more difficult to manage compared with other pharmacotherapies.	• Buprenorphine has a lower risk of respiratory depression than other commonly prescribed opioids (hydrocodone, oxycodone, morphine). • Buprenorphine is a relatively safe medication when compared to other medications that most individuals consider safe (insulin, warfarin).
	Use of buprenorphine is simply a "replacement addiction".	• Patients taking buprenorphine do not demonstrate negative symptoms of OUD (e.g., drug-seeking behaviors, cravings, withdrawals) and they have lower risk of relapse compared with those in abstinence-based treatment programs.
Methadone [2, 6, 9]	Methadone clinics are just a legal way for people to get high.	• Methadone does not cause euphoria if prescribed and monitored correctly. • Per Federal Opioid Treatment Program Standards, when used for OUD, methadone can only be dispensed from a federally licensed facility to prevent diversion and inappropriate use. • Methadone used for pain management can be dispensed at a local pharmacy.
	The lower the dose of methadone, the better.	• Methadone dose, frequency, and duration is dependent on the amount needed to decrease cravings, minimize withdrawal symptoms, and prevent the use of opioids.
Naloxone [2, 10-12]	Naloxone is a medication that is exclusive to those with OUD.	• Naloxone reverses opioid-related respiratory depression, restores breathing, and saves lives. • Respiratory depression is an adverse effect of any opioid; therefore, naloxone should be provided to patients taking opioid therapy, even those for chronic pain (with or without the presence of OUD). • All individuals should carry naloxone since opioid-induced respiratory depression is unpredictable.
	Naloxone access results in "Narcan parties".	• There is no evidence that "Narcan parties" exist.
	Naloxone enables or condones drug use.	• Research has shown that naloxone does not lead to greater or riskier opioid use. In fact, some studies have shown that naloxone decreases opioid use. • There is evidence that naloxone reduces opioid-related deaths. In communities with widespread naloxone access, there was a 63% reduction in opioid-related emergency department visits, with more lives saved.

References:

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