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Stigma Toward People With Opioid Use Disorder in Southwest Michigan

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
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Abstract

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by

Kathy A. Carruthers

MSW, Grand Valley State University, 2012

BA, Grand Canyon University, 2009

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

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February 2022

Abstract

The opioid epidemic is one of the largest health problems in America. In one Southwest Michigan county, opioid overdose deaths increased from 36 deaths in 2008 to 104 deaths in 2017. In the same county, stigma was identified as the highest-ranked reason people do not seek opioid use disorder (OUD) treatment. The purpose of this study was to examine knowledge that social work practitioners have regarding stigma toward people who inject drugs with OUD in Southwest Michigan. The purpose aligned with social work values as people with OUD are marginalized and cannot advocate for themselves. The theoretical framework that guided this study was stigma theory. This qualitative action research included two Zoom focus groups with five social work practitioners licensed and certified in the state of Michigan to treat people with OUD. The findings included the participants' knowledge regarding stigma toward people with OUD. Data were organized and analyzed using the elemental method and three themes were identified: (a) internalized stigma, (b) provider stigma, and (c) social stigma. From the three themes, the data indicated four sources for the origination of the stigma: (a) providers (both medical and behavioral health), (b) policy, (c) society, and (d) the recovery community. The findings of this study can contribute to positive social change when used to design education about how stigma develops and how stigma impacts people's ability to seek treatment for providers, friends, and family members of people with OUD and policy makers.

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Dedication

I dedicate this research to several people. My husband, Pat Carruthers, and our two sons, Aaron and Steven. They provided me with many hours of uninterrupted research time and supported me in ways that proved they are Godly people. I have been blessed with many amazing colleagues in my years, and Cassandra Patterson, Stacey Williamson-Nichols, Bob Stephans, Jacqueline Gerlofs, and Kurt Hulst are the ones whose words and experiences taught me more than I can explain about addiction and recovery. Also, I dedicate this research to the millions of people who struggle with addiction and strive to live a life of recovery.

Acknowledgments

I want to acknowledge my doctoral chair, Dr. Debora Rice, and my committee member, Dr. Jaegoo Lee. Together, they offered invaluable encouragement and direction throughout this project.

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Section 1: Foundation of the Study and Literature Review

Introduction

The opioid epidemic is a significant national health problem (Bohnert et al., 2018; Cioe et al., 2020; Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). In 2017, Michigan’s opioid death rate was statistically higher than the national average (Hedegaard et al., 2019). In Southwest Michigan, yearly opioid overdose deaths increased from 36 in 2008 to 104 in 2017 (County Administration, 2020). According to a manager at a local department of community health, more knowledge is needed regarding the disease of addiction, symptomology, and chances for recovery in Southwest Michigan. The opioid overdose death rate is a social work practice problem. Social worker practitioners may have the knowledge and experience to explain how stigma impacts people with opioid use disorder (OUD; A. Tarantowski, system manager for Department of Community Mental Health in Southwest Michigan, personal communication, April 7, 2020).

On a national level, stigma delays and stops people from seeking treatment for OUD (Allen et al., 2019; Cornford et al., 2019; Ezell et al., 2021), and people who inject drugs (PWID) receive more stigma than other people with OUD (Behar et al., 2019; Shelby, Smith, & Mancoski, 2004; Linas, 2018). In Southwest Michigan, a study identified stigma as the leading reason people with OUD do not seek treatment (Calvin University Center for Social Research, 2020). In this qualitative study, I aimed to gather knowledge from social workers to identify possible strategies for decreasing stigma toward people who inject drugs (PWID) with OUD to increase treatment access and slow the death rate. In this study, I investigated how stigma impacts people with OUD in one Southwest Michigan county.

The first section of this document includes the problem statement, the purpose of this study, how this study connects to social work, the theoretical basis, ethics, and an exhaustive literature review. For this qualitative study, I conducted two focus groups with five social workers and gathered knowledge regarding stigma toward PWID with OUD in Southwest Michigan. The literature review provides an overview of research into the opioid epidemic nationally and in Michigan and identifies current national, state, and county prevention and treatment strategies for OUD. The research findings can guide social workers in helping to reduce stigma toward people with OUD and may help reduce the opioid overdose death rate. The first section is focused on identifying the foundation for the study.

Problem Statement

The opioid epidemic is one of America's most significant national health problems (Bohnert et al., 2018; Cioe et al., 2020; SAMHSA, 2020). In 1999–2018, 446,032 people died from an opioid-related overdose (Wilson et al., 2020). Nationally, there was a 9.6% increase in opioid overdose deaths from 2016 to 2017 (Centers for Disease Control and Prevention [CDC], 2019). In that same period, Hedegaard et al. (2019) noted that overdose deaths involving synthetic opioids (fentanyl, fentanyl analogs, and tramadol) increased by 45%. In 2018, opioid overdose deaths were 2% less than in 2017, and prescription opioid overdose deaths had the most significant decline, with 13.5% (Wilson et al., 2020). One area for concern in 2018 data was synthetic opioid overdose deaths, and those deaths increased 10% compared with 2017 (Wilson et al., 2020). McCance-Katz (2020), the Assistant Secretary for Mental Health and Substance Use at SAMHSA, described the COVID-19 effect as a specific phenomenon that led to increased stress and domestic violence. McCance-Katz (2020) reported a warning that 2019 data did not include this COVID-19 effect that will likely have a higher number of opioid overdose deaths due to the increased risk factors of stress and domestic violence. McCance-Katz (2020) provided preliminary data for April and May 2020 that indicated a substantial increase in opioid overdose deaths–with as much as a 25–50% increase compared with 2019.

When looking at the epidemic from a state perspective, Michigan had a statistically significant (13.9%) increase in opioid overdose deaths in 2017 compared with 2016 data (CDC, 2019; Hedegaard et al., 2019). In 2017, Michigan's opioid death rate was among 20 states that reported statistically higher rates than the national average (Hedegaard et al., 2019). From 2017 to 2018, the opioid overdose death rate was statistically the same (Hedegaard et al., 2020), with only a 1.1% decrease (Wilson et al., 2020).

From a local perspective, the yearly opioid overdose deaths increased from 36 in 2008 to 104 in 2017 in Southwest Michigan (County Administration, 2020). Southwest Michigan established the County Opioid Task Force (COTF) to decrease overdose deaths and collaborate to prevent OUD (County Administration, 2020). COTF is an interdisciplinary team with community stakeholders (social work practitioners, psychologists, medical health providers, criminal justice representatives, and county health department staff). COTF studies prevention strategies, overdose reversal interventions, and treatments for OUD in Southwest Michigan (County Administration, 2020).

When considering the COVID-19 effect, R. Jantz, a public health epidemiologist for Southwest Michigan (personal communication, September 9, 2020) provided preliminary data for April and May 2020, indicating a 68.2% increase in opioid overdose deaths over 2019 data. A. Tarantowski is the team co-leader for COTF's treatment team and is the substance use disorder (SUD) system manager for a Southwest Michigan's Department of Community Mental Health. A. Tarantowski (personal communication, April 7, 2020) reported that more knowledge is needed regarding the disease of addiction, symptomology, and chances for recovery in Southwest Michigan. The additional knowledge can help reduce the high opioid overdose death rate (A. Tarantowski, personal communication, April 7, 2020).

At Calvin University Center for Social Research (2020) a quantitative study was conducted in Southwest Michigan that identified the highest-ranked reason that people do not seek treatment for OUD was stigma. According to Ravitch and Carl (2016), the qualitative methodology can gather more knowledge about a problem and identify possible strategies to alleviate it. In this qualitative study, I aimed to gather knowledge regarding stigma toward PWID with OUD in Southwest Michigan.

Social work practitioners can have knowledge and experience to help understand the biopsychosocial factors that impact people's decision making and prevent them from seeking OUD treatment (A. Tarantowski, personal communication, April 7, 2020). As one of the largest behavioral health providers (Council on Social Worker Education [CSWE], 2018), social workers are essential in the treatment of people who struggle with a SUD (Shelby, Smith, & Mancoski, 2004; Strasussner, 2001) and guide addiction treatment policy (Strasussner, 2001).

Purpose Statement and Research Question

Stigma can create a lower perception of oneself and can include feelings of unworthiness and shame (Akdağ et al., 2018), can cause a hostile environment within social support networks (Henderson & Dressler, 2017), and can come from healthcare professionals (Scott et al., 2020). PWID experience increased stigma from peers who do not use opioids intravenously (Weeks & Stenstrom, 2020). The purpose of this study was to gather knowledge from social workers regarding stigma toward PWID with OUD in Southwest Michigan.

On a national level, stigma delays and stops people from seeking treatment for OUD (Allen et al., 2019; Cornford et al., 2019; Ezell et al., 2021), and PWID receive more stigma than other people with OUD (Behar et al., 2019; Shelby, Smith, & Mancoski, 2004; Linas, 2018). In Southwest Michigan, one study identified stigma as the leading reason people with OUD do not seek treatment (Calvin University Center for Social Research, 2020). The goal of this action research study was to conduct two focus groups with five social work practitioners and gather knowledge regarding stigma toward PWID with OUD in Southwest Michigan. I used the following research question to guide this study:

RQ: What knowledge do social work practitioners have regarding stigma toward PWID with OUD in Southwest Michigan?

Definitions

The following definitions and key terms are provided for clarification and context:

Medication-assisted treatment (MAT): Medications used in treating OUD that can include methadone, buprenorphine, naloxone, and naltrexone (Bride et al., 2016).

Opioids: Prescription medications and illicit substances. Examples are hydrocodone, oxycodone, codeine, tramadol, buprenorphine, morphine, methadone, fentanyl, and carfentanil (SAMHSA, 2018). Opioids bind to opioid receptors in the brain, diminish the brain's perception of physical and emotional pain, and cause a euphoric high (Levounis et al., 2016; SAMHSA, 2018).

Opioid use disorder (OUD): Pattern of opioid use that leads to clinically significant impairment as noted with manifesting at two of 11 different criteria listed in the Diagnostic and Statistical Manual of Mental Disorders (5th ed., DSM-5, American Psychological Association [APA], 2013).

Overdose reversal medications: Naloxone is an opiate antagonist that can rapidly restore the ability to breathe to a person experiencing an active opioid overdose (Compton et al., 2015).

Polysubstance abuse: Nonmedical use of more than one drug in more than one of the following classes: nicotine, marijuana, more than four alcoholic drinks per day, antidepressants, muscle relaxants, sedatives, stimulants, hallucinogens, opioids (Cicero et al., 2020).

Substance use disorder (SUD): Pattern of nonmedical use of mind-altering substances leading to clinically significant impairment as noted with manifesting at least two of 11 different criteria identified in the DSM-5 (APA, 2013).

Synthetic opioids: Fentanyl, tramadol, and methadone

Nature of the Doctoral Project

The purpose of this study was to gather knowledge among social workers regarding stigma toward PWID with OUD in Southwest Michigan. Action research was appropriate as the principles of action research focus on experience, developed in partnership with the stakeholders, addressing significant problems and developing new ways of seeing the problem (Bradbury & Reason, 2003). Huang (2010) noted that action researchers use knowledge, understanding, and action to theorize a deeper meaning of the problem. In this study, I focused on social work practitioners' experiences, addressed the opioid overdose death rate, and identified new ways of seeing stigma. This study met the criteria for action research as the research question targets developing a deeper understanding of a current problem in Southwest Michigan. This study added practice knowledge from stakeholders regarding stigma toward PWID with OUD.

Significance of the Study

This action research project contributes to social work by gathering knowledge regarding stigma toward PWID with OUD in Southwest Michigan. This study's findings increased knowledge regarding stigma and may reduce the opioid overdose death rate in

Southwest Michigan. This study’s findings can impact how social practitioners speak with and and about people OUD, and these practioners can share this information with other professionals, people in their community, and policy makers.

In this study, I focused on these three values listed in the social work discipline’s Code of Ethics (National Association of Social Workers [NASW], 2021, pp. 5–6): (a) social justice, (b) dignity and worth of a person, and (c) the importance of human relationships. For social justice, I focused on PWID with OUD who are vulnerable and oppressed (Shelby, Smith, & Mancoski, 2004; Howard, 2015; Lundgren & Krull, 2014). For the dignity and worth of a person, I sought to resolve conflicts related to the stigma that prevents people from accessing treatment. For the value of the importance of human relationships, I gathered knowledge regarding stigma with the hope of strengthening relationships among people with OUD and others in Southwest Michigan.

Theoretical/Conceptual Framework

In this study, I gathered social workers’ knowledge regarding stigma toward PWID with OUD in Southwest Michigan. Using one formal theory ensured that the study relied on theoretical assumptions previously investigated (Ravitch & Carl, 2016). The theory that guided this study was stigma theory. Stigma theory guides the understanding of stigma and how stigma impacts people’s access to treatment and guides understanding stigma toward people PWID with OUD. Calvin University Center for Social Research (2020) conducted a quantitative study in which stigma was identified as the highest-ranking reason people with OUD do not seek treatment in Southwest Michigan. Increasing access to treatment is vital as treatment provides medically necessary education to prevent overdose deaths and results in healthy behaviors with abstinence or harm reduction (Shelby, Smith, & Mancoski, 2004).

Stigma theory guided understanding stigma and how stigma impacts behaviors. Stigma theory has been a valid theory since the mid-1930s and notes that stigma can minimize a person’s value (Türedi, 2018) through identifying a discrediting attribute (Yang et al., 2007). Stigma theory provides a framework for understanding the prejudices or defects that a person or group has, the visibility of stigma, and the internalization of stigma (Türedi, 2018). Stigma is linked with poorer physical health and behavioral health outcomes and might be linked to lack of treatment access (Smith et al., 2016). Stigma can be enacted in various ways with people who have OUD, including the perception of past treatment, prediction of future treatment, and negative self-perception. Stigma theory links directly to the stigma that was the highest-rated reason people do not access OUD treatment in Southwest Michigan (Calvin University Center for Social Research, 2020).

Values and Ethics

This action research study aligned with social work values and ethics. The NASW (2021) created a code of ethics that provides values and ethical standards that drive social work practice in the United States. Three values that align with this study are social justice, dignity and worth of the person, and the importance of human relationships (NASW, 2021). For social justice, I focused on people with OUD who are a vulnerable and oppressed population (Howard, 2015; Lundgren & Krull, 2014). For the dignity and worth of the person, I sought to resolve conflicts between cultural beliefs or norms and the practices of people with OUD. For the value of the importance of human relationships, I identified stigma with the hope of strengthening relationships among people with OUD and others in Southwest Michigan.

Social workers strive to identify and resolve social injustice and understand the contexts that create injustice. Illicit drug use policies are examples of social injustice that lowers the public's view of people's value and worth (Eversman & Bird, 2017). When social injustice occurs toward a social group, inaccurate stereotypes develop. Social workers need to debunk stereotypes to increase the probability of being accepted and building and maintaining relationships with people in other groups (Eversman & Bird, 2017). The findings of this study can increase knowledge regarding stigma in Southwest Michigan. People with OUD experience social injustice, lack of worth, and lack of human relationships with other social groups.

Review of the Professional and Academic Literature

Selected articles relating to SUDs, opioid overdose death rates, and sociodemographic data for Southwest Michigan, are described here. The publication date range searched was 2015–2020. The keywords searched were *addiction, integrated behavioral model, intravenous, injection, heroin, substance abuse, disease, death, drug abuse, opioid(s), opiate(s), overdose, epidemic, social work, stigma, stigma theory, discrimination, Michigan, substance use disorder,* and *opioid use disorder* in PsycINFO, Social Work Abstracts, SocINDEX, Thoreau multidatabase, Google Scholar, SAMHSA, CDC, Mission Insite, and Google.

Opioid Epidemic General Information

The opioid epidemic is one of America’s most significant national health problems (Bohnert et al., 2018; Cioe et al., 2020; SAMHSA, 2020). Many people do not understand what opioids are and how they work in the body, and education is a valuable tool in the opioid epidemic (SAMHSA, 2018). Opioids are prescription medications and illicit drugs that include hydrocodone, oxycodone, codeine, tramadol, buprenorphine, morphine, methadone, fentanyl, and carfentanil (SAMHSA, 2018). Opioids bind to opioid receptors in the brain and diminish the brain’s perception of physical and emotional pain and may cause a euphoric high (Levounis et al., 2016; SAMHSA, 2018). The euphoric high is due to the opioids and causes a burst of dopamine in the brain that is common to drug use (Levounis et al., 2016). Opioid intoxication symptoms include euphoria followed by apathy, constricted pupils, drowsiness, slurred speech, and memory impairment (Levounis et al., 2016). Sometimes, people who experience opioid intoxication may develop OUD, which is a mental health disorder listed in the DSM-5. DSM-5 (APA, 2013) identified 11 criteria for OUD, and the number of criteria that a person has determines the severity of their disorder. A person who meets two to three criteria is diagnosed with mild OUD; four to five criteria is moderate; six or more criteria is severe (APA, 2013). Following are the 11 criteria: (a) opioids are taken in larger amounts or over a more extended period; (b) a person has a persistent desire to use opioids or unsuccessful efforts to control use; (c) a person spends a great deal of time locating, using, or recovering from opioid use; (d) a person experiences cravings, desire, or urges to use opioids; (e) recurring opioid use results in a person not performing obligations at work, school, or home; (f) opioid use continues and results in recurrent social or interpersonal problems; (g) a person avoids or reduces recreational, social, or occupational opportunities; (h) repetitive opioid use results in dangerous situations; (i) ongoing opioid use negatively impacts a person’s physical or psychological health; (j) a person has a tolerance due to their need to use more opioids to achieve the desired effect or avoid withdrawal symptoms; and (k) a person has opioid withdrawal disorder when they abstain from use. Symptoms of withdrawal may include restlessness, insomnia, yawning, dilated pupils, abdominal pain, fever, diarrhea, vomiting, dehydration, hyperglycemia, or hypotension (APA, 2013).

Not all opioid use leads to OUD (SAMHSA, 2018). Many people receive opioid pain prescriptions yearly for acute and chronic pain management (SAMHSA, 2018). Acute pain can include tooth pain, broken bones, postoperative pain management, and chronic pain, including back pain, arthritis, or migraines (SAMHSA, 2018). Opioids reduce pain as they bind to opioid receptors in the brain that reduce the brain’s pain perception (SAMHSA, 2018). Opioids impact multiple systems in the body, such as the respiratory system, the gastrointestinal system, and the brain’s ability to manage moods (SAMHSA, 2018). These systems work together to block the brain’s perception of pain and create the euphoria or the high that many people with an OUD crave (SAMHSA, 2018).

Opioid overdoses occur for many reasons and result in slowing or stopping the heartbeat or respirations (SAMHSA, 2018). Symptoms of opioid overdose include decreased level of consciousness, decreased respiration, pinpoint pupils, slurred speech, and behavioral changes (Levounis et al., 2016). SAMHSA (2018) created a list of possible high-risk situations for opioid overdose: (a) a prescriber miscalculated the dose; (b) a person misinterpreted the prescription instructions; (c) the pharmacist filled the prescription incorrectly; (d) the pharmacy and prescriber did not know about other contraindicated medications for opioid prescriptions; (e) a person took more than the prescribed opioid dose; (f) a person used opioids illicitly; (g) a person used an opioid contaminated with another drug; and (h) a person practiced polysubstance use and mixed opioids with another drug (i.e., alcohol, sedatives, stimulants, or hallucinogens).

Any person who uses opioids is at risk for overdose whether the person took the opioid as prescribed or illicitly (SAMHSA, 2018). The good news is not all opioid overdoses end in death. Naloxone is an opioid antagonist used to restore respirations to people in active opioid overdose (Compton et al., 2015) and has a half-life of 30–80 minutes (Levounis et al., 2016). Once a person receives naloxone, recommendations are for the person to seek medical treatment. The half-life for naloxone is shorter than the half-life for opioids, and overdose may return once the naloxone reaches its half-life (Levounis et al., 2016). Stigma prevents some communities from having naloxone access programs because community members believe that increased naloxone access would increase illicit opioid use (McClellan, 2019). However, no data indicate that naloxone access programs increase illicit opioid use (McClellan et al., 2018). Data suggest that communities with naloxone access programs experience fewer opioid overdose deaths (McClellan, 2019).

Naloxone is an example of one type of MAT as it is a medication used to reverse opioid overdoses. OUD is a treatable disease that may require long-term treatment, and MAT is the gold standard treatment that reduces opioid overdoses and increases treatment retention (SAMHSA, 2020). In clinical trials, methadone, buprenorphine, and long-lasting injectable naltrexone effectively reduced illicit opioid use (SAMHSA, 2020). Methadone and buprenorphine reduced the risk of opioid overdoses.

While MAT is the gold standard treatment for OUD treatment, not all OUD medical and behavioral health providers want to refer a person to MAT. A study of social work practitioners in Ohio found that some practitioners did not offer MAT to people due to fears this would lead to ongoing opioid use and that people would begin using their MAT medication illicitly (Toler, 2019). A danger exists that people might use their MAT illicitly. The U.S. Drug Enforcement Administration (DEA, 2019) reported illicit buprenorphine use dramatically increased from 2013 to 2017. Illicit buprenorphine can lead to overdoses, and typically, these overdoses result from polysubstance use, when people mix buprenorphine with another drug (Velander, 2018).

Long-lasting naltrexone is another MAT medication proven to be equally effective as buprenorphine (Velander, 2018). While the medication is equally effective, not all people with OUD select this MAT due to long-term withdrawal symptoms. A study found that people prescribed long-lasting naltrexone experienced withdrawal symptoms for weeks after their last use of opioids (Velander, 2018). The withdrawal symptoms are painful and accounted for their rationale for relapse (Velander, 2018). A longitudinal study showed that people who use long-acting naltrexone were eight times more likely to relapse than buprenorphine for MAT (Velander, 2018).

Opioid Epidemic in the United States

The opioid epidemic began in 1980 when the Carter administration warned that a large number of drug-related injuries might result from misued legal prescriptions (Dasgupta et al., 2018). Since 2013, the national opioid overdose deaths exceeded the number of yearly vehicle accidents (Bohnert et al., 2018; Califf et al., 2016; Jones et al., 2015; Vashishtha et al., 2017). Many root factors for the epidemic exist, including the economy erosion in 2008 as the Great Recession began, increased opioid use for pain management, and limited access to SUD treatment (Dasgupta et al., 2018).

Development of the Opioid Epidemic

The opioid epidemic developed in three phases. The first phase of the opioid epidemic began in 1980 when the Carter administration warned that seven out 10 drug-related injuries or deaths might result from legal prescriptions that were misused (Dasgupta et al., 2018). At this same time, the World Health Organization (WHO) encouraged opioid pain medications for pain and published data stating opioids had a minimal addiction risk (Borsari & Read, 2019). In the 1990s, chronic pain cases increased due to obesity, people living through injuries or severe illnesses, population aging, and increased expectations for pain relief (Borsari & Read, 2019; Dasgupta et al., 2018).

Additionally, data reported that Oxycontin lasted for 12 hours, and people began inadvertently overusing the medication due to breakthrough pain caused when the medication stopped reducing pain after 3–4 hours (Borsari & Read, 2019). In addition, insurance companies began limiting funding for pain-related cognitive behavior therapy (CBT), and previously, CBT was the treatment choice for chronic pain (Dasgupta et al., 2018). In addition, the Great Recession impacted the opioid epidemic. Brown and Wehby (2019) posited that median house prices fell $70,000, and the loss of wealth linked with nearly a 25% increase in opioid overdose deaths.

The second phase of the epidemic began around 2010 when concern began surrounding opioid and heroin use, and opioid prescriptions became monitored (Borsari & Read, 2019; Dasgupta et al., 2018). While reducing prescription opioid access was well-intentioned, this led to increased illicit opioid use as people with canceled prescriptions did not want to experience opioid withdrawal (Borsari & Read, 2019). Wilson et al. (2020) noted that opioid prescriptions peaked in 2012 and have been steadily declining since that time. Dart et al. (2015) conducted a study investigating the correlation between opioid prescription misuse and heroin-related overdose deaths. The researchers found that when prescription opioid availability decreased, heroin mortality increased (Dart et al., 2015).

The third phase of the epidemic began in 2013 with fentanyl, a synthetic opioid supply produced globally, smaller and more potent (Borsari & Read, 2019; Dasgupta et al., 2018). Between 2013 and 2016, fentanyl-related deaths increased 540% nationally as people knowingly and unknowingly mixed fentanyl with illicit opioids (Arendt, 2020; Dasgupta et al., 2018; Unick & Ciccarone, 2017). With the increased use of illicit opioids, opioid overdose deaths dramatically increased (Borsari & Read, 2019). People added fentanyl to illicit opioids that increased the potency, and people using the opioids were not aware of the increased strength (Borsari & Read, 2019).

Perhaps another phase of the opioid epidemic is nearing as increased polysubstance use mixed with opioids causes overdoses (Cicero et al., 2020). Glick et al. (2018) noted that mixing opioids with stimulants has been practiced for years and involved mixing opioids with cocaine. The trend of mixing opioids with cocaine morphed into people mixing opioids with methamphetamine to achieve a roller coaster effect with the highs from these two different substance-induced experiences (Cicero et al., 2020). The practice of mixing opioids with methamphetamine increased illicit opioid use as people searched for the roller coaster effect (Al-Tayyib et al., 2017).

The danger of opioid and methamphetamine use includes overdose and people practicing higher risk use behaviors, including sexual behaviors, intravenous use, substance misuse, and avoiding HIV testing (Al-Tayyib et al., 2017). According to a study in Denver, Colorado, people who reported injecting heroin and methamphetamine were more likely to inject more than one time per day and reported higher overdosing occurrences than people who misused only an opioid (Al-Tayyib et al., 2017). A study in King County, Washington, indicated that people who injected methamphetamine and heroin attributed to an increase in HIV infection rates (Cicero et al., 2020; Clinton et al., 2019). The trend is that people with OUD endorse polysubstance use, and polysubstance use needs further study with OUD prevention and treatment strategies (Cicero et al., 2020).

Another root cause of the epidemic is pain management. One hundred million people in the United States experience pain, which has led to increased opioid pain medication prescriptions (Califf et al., 2016). Many people believe the opioid epidemic was caused by doctors overprescribing pain medications that pharmaceutical companies pushed (Compton et al., 2015; Dasgupta et al., 2018); however, the opioid epidemic is more complex and has multiple causes. Between 2012 and 2015, opioid prescriptions were reduced by 13% nationally, and opioid overdose deaths increased by 38% (Dasgupta et al., 2018).

Demographics

Knowing the demographics is a vital piece of understanding the epidemic. Szalavitz and Rigg (2017) reported that White people account for 90% of new heroin users and that prescription opioid misuse was prevalent among White people. White people had increased access to health care and pain management treatment, and the increased pain management treatment might explain the higher increase of White people's use of heroin (Dasgupta et al., 2018). Once a physician stops prescribing an opioid for pain management, the patient may seek illicit opioid options because they fear opioid withdrawal (Borsari & Read, 2019). When considering race or ethnicity, a study in Flint, Michigan, reported that women and Black people were less likely to overdose (Bohnert et al., 2018). Age is another demographic consideration. The Flint, Michigan, study reported nonfatal overdoses peaked around ages 40–55 (Bohnert et al., 2018). Nationally, the age group that experiences the highest increase with overdose death rates is adults ages 55–64, and the rate for this age group increased from 4.2 per 100,000 in 1999 to 28.0 per 100,000 in 2017 (Hedegaard et al., 2019).

Opioid Prescriptions' Impact

In 2019, 9.7 million people misused prescription pain medications, and 96.6% of these people abused opioid pain medications (McCance-Katz, 2020), and 14%–19% of opioid prescribed pain patients met the criteria for OUD (Compton et al., 2015). From 2016–2019, prescription pain reliever misuse decreased from 11.5 million to 9.7 million, and prescription pain reliever misuse initiates dropped from 2.1 million to 1.6 million (McCance-Katz, 2020). In that same period, heroin use reduced from 948,000 to 745,000, and heroin initiates dropped from 170,000 to 50,000 (McCance-Katz, 2020). These data indicate progress in the fight to end the opioid epidemic.

Opioid Epidemic in Michigan

Since 2000, the opioid overdose death rate grew ten-fold in Michigan (State of Michigan, 2020). In 2017, Michigan had a statistically significant (13.9%) increase in opioid overdose deaths (CDC, 2019). From 2016 to 2017, Southwest Michigan had one of the largest opioid overdose death rate increases in the state, with a 59.4% increase (SAMHSA, 2019). In 2018, there were 2,036 opioid overdose deaths in Michigan, with 1,556 deaths from synthetic opioids and 639 from heroin (State of Michigan, 2020). In 2018, Michigan experienced a 1.2% decline in opioid overdoses, and the state believed that the decrease was in response to prescription opioid and heroin overdose deaths declining (State of Michigan, 2020). The 2018 data was not all positive; Michigan reported that deaths from synthetic opioids, such as fentanyl, continued to increase (State of Michigan, 2020).

Michigan Overdose Data

In 2017, Michigan experienced a statistically significant increase in opioid overdose deaths (CDC, 2019; Hedegaard et al., 2019). One possible problem was that Michigan prescribers wrote more opioid pain prescriptions than the national average (Lister et al., 2019). Compton et al. (2015) reported that 14%–19% of opioid-prescribed patients meet the criteria for OUD. The overdose death rate was above the national average, with increased deaths in rural and urban areas (Lister et al., 2019). One study in Michigan identified an increase in overdose death rates for urban counties than rural counties (Lister et al., 2019). Lister et al. (2019) encouraged Michigan policymakers to expand community access to MAT, behavioral health treatments, and syringe exchange programs in rural areas of the state (Lister et al., 2019). One limitation of this study is that counties were considered either urban or rural without considering that some counties have urban and rural populations (Lister et al., 2019).

Bohnert et al. (2018) conducted a study in a trauma center located in Flint, Michigan, and reported that 12.1% of non-fatal opioid overdoses were people who experienced a previous overdose. Once people overdose, they are at a higher risk of overdosing again (Bohnert et al., 2018). Bohnert et al. (2018) noted that emergency departments are environments suitable for interventions for at-risk OUD populations. This study’s limitations included that the samples were all from one emergency department and that quantitative data from a limited population sample may not generalize to other areas (Bohnert et al., 2018). In addition, overdoses' historical data did not identify if the previous overdoses occurred weeks or years before their current overdose (Bohnert et al., 2018).

Southwest Michigan Overdose Data

From 2016 to 2017, the opioid overdose death rate increased by 59.4% in Southwest Michigan (SAMHSA, 2019). COTF reported that they could not prevent enough opioid overdose deaths due to lack of access to overdose-reversing medication, lack of education regarding OUD, and stigma from community and healthcare providers (County Administration, 2020). When looking at demographics for 2017 overdose deaths, there were 125 deaths (County Administration, 2020). Of those who died, 81.5% were between the ages 25–44; 78.4% were White; and 65.5% were men (County Administration, 2020). In 2018, there were 66 opioid overdose deaths (County Administration, 2020). Of those who died, 60.5% were between the ages 25–44; 81.8% were White; and 65.2% were women (County Administration, 2020).

Calvin University Center for Social Research (2020) conducted a study of local OUD treatment stakeholders in Southwest Michigan, comprised of MAT prescribers, behavioral health treatment providers, and members from the health department and the department of community mental health. The study identified that 93% of the respondents believed that treatment accessibility was a barrier to people accessing OUD treatment in one Southwest Michigan county, and 80% indicated that stigma was a problem. A physician, who specializes in addiction medicine from one of Southwest Michigan's largest hospitals, stated stigma impacts treatment accessibility and people's desire to seek treatment (C. Poland, personal communication, September 18, 2020). C. Poland noted that stigma prevents providers from seeking the waiver to prescribe MAT and from using their waiver (C. Poland, personal communication, September 18, 2020). Providers fear that MAT patients will require extra time and will not be cost-effective for their profitability (personal communication, September 18, 2020).

Early data for 2020 indicated that the COVID-19 effect was problematic for Southwest Michigan. In April and May 2020, there was a 68.2% increase in opioid overdose deaths than 2019 data (Rachel et al., September 9, 2020). In May 2020, the death rate increased from 22 people in 2019 to 46 people in 2020, which is more than double (Rachel et al., September 9, 2020).

National Treatment Strategies

When discussing prevention and treatment, stigma is a significant part of the discussion (C. Poland, personal communication, September 18, 2020). Stigma is a barrier to OUD treatment (Akdağ et al., 2018; Allen et al., 2019; Compton et al., 2015; Cornford et al., 2019; Ezell et al., 2021; Pacher, 2019; Pollini, 2019; Vashishtha et al., 2017; Young et al., 2015). People who use opioids intravenously experience more stigma (Behar et al., 2019; Shelby, Smith, & Mancoski, 2004; Linas, 2018).

Several types of stigma impact people with OUD. Social stigma is when a social group disapproves of substance use and misuse and creates a hostile environment within social support networks (Henderson & Dressler, 2017). Another form of stigma is internalized stigma, which is when a person perceives themselves because of societal stereotypes (Akdağ et al., 2018). In a worldwide internet-based study, intravenous heroin users reported that they experience stigma from others in their peer groups of people with OUD (Behar et al., 2019; Shelby, Smith, & Mancoski, 2004; Weeks & Stenstrom, 2020). Stigma links with the type of OUD treatment. For example, peer support groups may stigmatize MAT, the gold standard OUD treatment (Cioe et al., 2020; Jones et al., 2015; SAMHSA, 2020; Vashishtha et al., 2017). Sadly, people with OUD experience stigma in some healthcare facilities with some healthcare providers. Healthcare providers may use stigmatizing language such as abuser, addict, or clean urine screen (Scott et al., 2020). Healthcare providers might believe that treating somebody for OUD might become a long, laborious treatment episode and avoid treating this populations a result (Magidson et al., 2019; Young et al., 2015). In the following sections, I discuss each of these types of stigma in greater detail.

Social Stigma

Social stigma is when a social group disapproves of substance use and misuse and creates a hostile environment within social support networks (Henderson & Dressler, 2017). Social stigma creates a cycle of fear that people who practice the disapproved behavior will no longer feel accepted in a social circle (Weeks & Stenstrom, 2020). One study focused on college students’ judgments about causality for people with SUD (Henderson & Dressler, 2017). The results indicated five themes for judgments that included genetic predisposition, self-medication, familial dysfunction, peer group, and pleasure-seeking for understanding the causality for SUD (Henderson & Dressler, 2017). Willpower was a theme that did not arise as a significant judgment due to participants’ differing understanding of willpower. Some participants reported that some people were either born with or without willpower. Other participants noted that willpower is a personal decision, and people can choose to have it. One limitation of this study was that participants were college students and from a younger and educated age group, which likely impacted results that may not generalize.

Friends, families, religious leaders, and peers can enact social stigma (Ezell et al., 2021). When people live in rural communities, social stigma can be highly problematic. People with OUD reported a lack of access to specialty meetings for men, women, lesbians, gays, and other languages (Young et al., 2015). People with OUD feared that presenting to a peer support meeting might result in social and community groups learning about their SUD due to the high level of social stigma in their area (Young et al., 2015). As peer support groups are an integral part of recovery, more meetings are needed within close driving proximity and confidentiality of meeting information.

Internalized Stigma

Internalized stigma is when a person’s perception of themselves changes because of societal stereotypes and can include feelings of unworthiness and shame (Akdağ et al., 2018). Akdağ et al. (2018) aimed to identify how internalized stigma impacted treatment motivation, social support, and co-occurring mental health disorders. Akdağ et al. (2018) reported that internalized stigma was highest among men with OUD and heightened internal stigma levels resulted in poorer treatment outcomes. Poorer outcomes included people who relapsed more frequently, lower treatment retention, and increased anxiety and depression (Akdağ et al., 2018). People with SUD experience a higher level of stigma than any other mental health disorder (Akdağ et al., 2018; Henderson & Dressler, 2017). Akdağ et al. (2018) posited that increased internalized stigma might result from societal beliefs that their disease is a consequence of poor choices. A study limitation was that the study included 166 men and was from only one treatment center (Akdağ et al., 2018). Due to the limited sampling, it is unclear if these results are generalizable to other populations.

Stigma is a significant barrier that prevents people from seeking and continuing with treatment. Bride et al. (2016) conducted a study focusing on assessing treatment outcomes for people with OUD. The study identified that people with OUD who presented for treatment had higher impairment levels and more social limitations than people with other SUDs (Bride et al., 2016). The study reported that treatment outcomes for people with OUD were as successful as outcomes for people with other substance use disorders (Bride et al., 2016). The study included 1,972 enrolled in a private, for-profit, residential treatment center (Bride et al., 2016). The study limitation was that the population chosen was from a for-profit treatment center, and the results may not be generalizable to people with limited resources (Bride et al., 2016). While the population included people with financial resources, the study indicated that people with OUD experienced similar treatment outcomes to people with other SUDs (Bride et al., 2016).

Stigma Among People With OUD

Two types of stigma exist among people with OUD. PWID with OUD experience more stigma than other people with OUD (Behar et al., 2019; Shelby, Smith, & Mancoski, 2004; Linas, 2018), and peer support groups may stigmatize those who use MAT (Weeks & Stenstrom, 2020). Weeks and Stenstrom (2020) conducted a study to understand whether stigma related to different opioids. The global study of 4,300 respondents via the internet determined that the level of stigmatization corresponded with whether a physician prescribed the opioid. Results indicated less stigma for people whose OUD developed because of prescribed medications and more stigma for people whose OUD developed because of illicit opioids. The groups with the highest levels of stigma were people whose OUD developed because of intravenous heroin use. Another factor of stigma were age and gender as young men with OUD received the highest marks for stigmatization. One limitation of this study is that the study was on the internet and open to any person, and respondents may have responded multiple times. However, the use of the internet increased the breadth of the regions from where responses originated.

Stigma From Healthcare Providers

People with OUD experience stigma from many people in their lives, including their healthcare providers. Scott et al. (2020) conducted a qualitative study of 43 healthcare providers that explored barriers to the use of contingency management (CM). CM includes providing people in treatment with rewards for progress in recovery and is an evidence-based and effective treatment (Scott et al., 2020). One common theme was the stigma. Scott et al. (2020) identified four distinct subthemes of stigma, including the providers' distrust of people with OUD, beliefs that people with OUD had low maturity, ideas that people with OUD do not deserve rewards, and internalized stigma and community-based stigma toward people with OUD. Scott et al. (2020) noted that 86% of the providers used stigmatizing language during the interviews through labeling people with OUD as abuser, addict, and discussing clean or dirty urine screens. One limitation of this study is that the study occurred in Rhode Island, and it is unclear if these results are generalizable beyond the northeastern U.S.

Another study conducted in a residential facility noted that staff in a treatment facility added stigma using stigmatizing words such as addict versus identifying the person as somebody who struggles with a SUD (Edwards & Palmer, 2020). A possible remedy is when staff used inclusive language, stigma among the people in treatment reduced, and treatment was more successful (Edwards & Palmer, 2020).

Stigma Related to MAT

Stigma exists among people in the substance use disorder recovery community. Addiction is a medical disease, and MAT is the gold standard treatment for OUD (Cioe et al., 2020; Jones et al., 2015; SAMHSA, 2020; Vashishtha et al., 2017). One example was that some people in recovery considered somebody who used MAT as not in recovery because they use medication (Velander, 2018). Stigma pressured people into prematurely ending MAT due to wanting acceptance from peers in recovery (Dasgupta et al., 2018; Velander, 2018).

One challenge with MAT is provider access. Velander (2018) conducted a study that reported over 50% of U.S. counties do not have MAT prescribers and that most physicians who prescribe MAT treat far fewer patients than their MAT waivers allowed. About 44%–66% of waivered physicians prescribed MAT (Jones et al., 2015). Providers reported that they avoid prescribing MAT due to lack of institutional support, inadequate Medicaid reimbursement, staff stigma, and insufficient training (Cioe et al., 2020). SAMHSA took steps to increase the number of available MAT prescribers by allowing physician’s assistants and nurse practitioners the ability to prescribe buprenorphine (Vashishtha et al., 2017). However, prescribers have many misconceptions about MAT and continue to avoid prescribing (Cioe et al., 2020), and there is a shortage of MAT and behavioral health providers (Magidson et al., 2019).

Stigmatizing misconceptions exist around the use of MAT include a belief that MAT indicated a person’s failure at self-control and that people can become intoxicated from buprenorphine (Velander, 2018). Intoxication from buprenorphine can occur and only occurs when people mix the medication with another drug (Velander, 2018). The DEA (2019) reported that illicit buprenorphine reports increased dramatically from 2013 to 2017. However, the reported increase was not as dramatic of an increase compared with other illicit opioids (DEA, 2019).

MAT

MAT is the gold standard treatment for OUD (Cioe et al., 2020; Jones et al., 2015; SAMHSA, 2020; Vashishtha et al., 2017). Examples of MAT medications include buprenorphine, methadone, and naltrexone (SAMHSA, 2020). From 2016–2019, the total number of people receiving MAT increased from 912,000 to 1.5 million (McCance-Katz, 2020). MAT’s benefits are that MAT increased OUD treatment retention, reduced overdose deaths, and reduced infectious disease transmission (Cioe et al., 2020; Jones et al., 2015; SAMHSA, 2020). SAMHSA (2020) encouraged all providers to offer MAT and added that MAT is not a stand-alone treatment. Most patients using MAT benefit from counseling as part of their treatment as counselors helped people address the challenges and consequences of addiction and recovery (SAMHSA, 2020).

D’Onofrio et al. (2015) conducted a study to identify whether MAT as a stand-alone treatment was more effective than treatment with behavioral health interventions. Their study reported that people with OUD responded better with only a buprenorphine prescription. The study was a randomized clinical trial of 329 people with OUD who sought treatment through emergency rooms (D’Onofrio et al., 2015). The study reported 78% of people who received only buprenorphine remained in treatment after 30 days (D’Onofrio et al., 2015). Only 37% of those who received a brief intervention with referral remained in treatment, and only 45% who received buprenorphine with a brief intervention remained in treatment (D’Onofrio et al., 2015). One limitation of the study is that the participants did not have relationships with primary care physicians (D’Onofrio et al., 2015). The study results may not generalize to populations that include people with existing primary care physician relationships.

In another study, Kim et al. (2017) aimed to identify the efficacy of two types of brief mental health interventions versus no intervention when a patient screened positive for illicit substances. Kim et al. (2017) identified that even with motivational interviewing strategies, the brief intervention did not significantly increase SUD treatment involvement. This study had limitations including that data was only available from state-funded sources (Kim et al., 2017). If a participant followed through with treatment, the information was not available for the study. The study did not track whether a participant began treatment with peer support groups (Kim et al., 2017). Both D’Onofrio et al. (2015) and (Kim et al., 2017) conducted studies that included people with limited resources who did not have ongoing relationships with physicians.

Young et al. (2015) and Magidson et al. (2019) noted a shortage of trained OUD providers to meet people’s behavioral health needs. Additionally, some behavioral health and medical providers fear that initiating MAT will lead to a long and laborious treatment episode (Cioe et al., 2020). In one qualitative study in Texas, social work practitioners shared that they lacked training and support for treating people with SUD, which led them to experience compassion fatigue and burnout (Unegbu, 2020). While social workers reported problematic conditions, they noted one strength that their professional discipline brought to SUD treatment was their focus on individualizing treatment (Unegbu, 2020). SAMHSA (2020) and Regan (2019) reported that the best treatment outcomes occur when OUD treatment is individualized (Cioe et al., 2020; Regan, 2019; SAMHSA, 2020). Examples of individualized treatment can include different treatment duration, intensity, with or without MAT, or treatment through peer support groups (SAMHSA, 2020).

Increasing access to treatment may include educating people about MAT and withdrawal medications. People with OUD reported one reason for not seeking treatment is the fear of going through painful withdrawals (Compton et al., 2015). They did not know about withdrawal medications that lessen the pain during withdrawal (Compton et al., 2015). The neurobiological aspect of addiction is another reason people do not seek treatment (Compton et al., 2019; Volkow et al., 2016). People feared a lack of euphoria and feared the flat effect when they abstain from opioids (Compton et al., 2019; Volkow et al., 2016). When people are in active addiction, opioids drive the brain’s reward and motivational systems (Volkow et al., 2016). As people begin abstinence from opioids, their brains' reward and motivational systems do not produce the typical dopamine amount, and people experience dysphoria or a flat affect (Volkow et al., 2016).

People who live in rural settings have additional barriers to treatment. People with OUD noted that distance to treatment was a barrier, and people mandated to treatment typically presented with a driving violation, which led to increased transportation barriers as they did not have a driver's license (Young et al., 2015). Once a person in a rural area finds a meeting time, they need to find a sponsor, and in rural areas, meetings included fewer people for sponsorship options (Young et al., 2015). Some people benefit from specialty meetings, and in rural areas, there is a lack of access to specialty meetings for men, women, lesbians, gays, and other languages (Young et al., 2015). They fear that presenting to a peer support meeting might result in social and community groups learning about their SUD due to the high social stigma level in their area (Young et al., 2015).

Chronic Pain and OUD

The use of opioid pain prescriptions for chronic pain requires further study (Kang et al., 2019). In 2018–2018, 5.7% of adults used at least one prescription pain medication, and 10.7% of adults used pain medication prescriptions in the last 30 days (Craig M. Hales et al., 2020). Of the 5.7% who used at least one prescription, 14%–19% of them met the criteria for OUD (Compton et al., 2015). Physicians are the part of system where chronic pain is most likely to receive treatment (Wandner et al., 2020). Pharmacists and physicians wanted to collaborate and mitigate risks, and both disciplines reported a lack of personnel and funding (Kang et al., 2019).

A potential strategy is abuse-deterrent opioid formulations for pain management. Litman et al. (2018) reported that abuse-deterrent opioid formulations were in the early stages and required additional study to prove efficacy. The hope was that these abuse-deterrent formations would reduce the likelihood of people developing OUD, and no evidence existed to support or deny these hopes (Califf et al., 2016; Litman et al., 2018).

Stigma Reduction Strategies

One crucial component for reducing stigma is education regarding addiction's disease model (Edwards & Palmer, 2020; Sapp & Hooten, 2019). When people identify OUD as a medical disease versus a moral failing, stigma reduces, and treatment retention increases (Pacher, 2019). Social workers are a valuable tool for lowering stigma (Edwards & Palmer, 2020; Lee & O'Malley, 2018).

Another tool for reducing stigma is for treatment providers to create a solid therapeutic alliance with the people that they serve (Lee & O'Malley, 2018). A stable therapeutic alliance may help people increase their understanding of addiction and help build esteem and promote healthy lifestyle changes for the people they serve (Lee & O'Malley, 2018). The therapeutic alliance benefits people when they can explain truths about their use and recovery and receive unconditional acceptance from providers (Lee & O'Malley, 2018).

Call to Action for Social Work Practitioners

Social work practitioners are one of the largest SUD providers in the U.S. and practice in settings where people with OUD live, work, and seek other services (CSWE, 2018). Social work practitioners need evidence-based training and education to improve treatment efficacy for people with OUD (Pacher, 2019). Lack of training and education in addiction treatment leads to negative attitudes toward the SUD population (Pacher, 2019). The CSWE (2018) supports principles that focus on advocacy and support for impacted people, interdisciplinary cooperation, evidence-based practices, and education and training programs for future SUD providers.

Michigan's Treatment Strategies

Michigan's treatment strategies are numerous. COTF reported that they could not save people from opioid overdose deaths due to lack of access to overdose-reversing medication, lack of education regarding OUD, and stigma from the community and healthcare providers (County Administration, 2020). A study of local OUD stakeholders in Southwest Michigan identified that 93% of the respondents believed that treatment accessibility was a barrier to people accessing OUD treatment in the Southwest Michigan county, and 80% indicated that stigma was a problem (Calvin University Center for Social Research, 2020). According to a physician in Southwest Michigan, specializing in addiction, stigma prevents providers from using their waivers to prescribe MAT due to fears related to a lack of understanding of OUD treatment.

Michigan identified that the opioid overdose death rate was a problem and took the following steps. In August 2019, Executive Order 2019-18 created the Michigan Opioids Task Force that brings together different governmental departments to fight the epidemic (State of Michigan, 2020). The state of Michigan also applied for and received two SAMHSA grants to assist with the financial cost of prevention and treatment efforts (State of Michigan, 2020). The grants' three goals were to increase MAT access, improve treatment access, and reduce opioid overdose deaths through prevention, treatment, and recovery activities for OUDs (State of Michigan, 2020).

Each regional CMH could choose two youth or family-oriented evidence-based or new and promising programs to fund (State of Michigan, 2020). Southwest Michigan decided to invest in Botvin LifeSkills Training, an evidence-based program focusing on educating middle school to high school-aged students about SUD and violence prevention (State of Michigan, 2020). The other program funded for the Southwest Michigan county was Prime for Life, and this program focused on prevention and intervention for youth and adults ages 13–20 (State of Michigan, 2020).

Statewide, the grant funds supported addiction medicine training and education programs for physicians (State of Michigan, 2020). An investment was made into evidence-based prevention for older adults to assist them with seeking alternatives to opioids for pain management (State of Michigan, 2020). Some of the funds went to training physicians on prescribing opioids following a medical procedure and focusing on short-term and low quantity prescriptions (State of Michigan, 2020). MDHHS used funds to create an anti-stigma media campaign that targeted education for people ages 25–44 (State of Michigan, 2020). The campaign included radio advertisements, transit marketing, and social media (State of Michigan, 2020).

Michigan worked to reduce opioid overdose deaths that occurred once a person leaves jail by developing a program to provide MAT while people with OUD are incarcerated (State of Michigan, 2020). The overdoses happened because the person withdraws and tolerance returns to zero, and when released, they seek out opioids and use at the same levels before incarceration (SAMHSA, 2020). Michigan expanded its jail-based MAT program, and Southwest Michigan began a program that allowed incarcerated people access to MAT (State of Michigan, 2020).

Grants helped fund over 35 case management services and increased the number of peer recovery coaches (State of Michigan, 2020). Funds provided support for facilitators to ensure that people leaving jail received a guide for OUD treatment and increased access for incarcerated people to seek naltrexone injections upon release (State of Michigan, 2020).

Southwest Michigan created the MiRecovery.org website that lists treatment agencies in the area (Michigan Recovery, 2020). The site lists two sub-acute detox units, eight residential treatment centers, six agencies that provide intensive outpatient programs (IOP), and over 50 resources that offer outpatient programs (Michigan Recovery, 2020). One community resource provides free and anonymous syringe access, HIV testing, and naloxone for reversing overdoses (Grand Rapids Red Project, 2020). Another resource provides free residential treatment for men with SUD (Guiding Light, 2020). Several resources focus on people with OUD who are pregnant and parenting, and the local CMH hired numerous recovery coaches in the urban parts of the community (County Administration, 2020). Southwest Michigan hired an educator who educates youth in high schools to prevent OUD from developing (County Administration, 2020).

Southwest Michigan has a federally qualified health center (FQHC) with a methadone program, IOP, long-term case management for families and individuals who struggle with OUD, and physicians who prescribe buprenorphine (County

Administration, 2020). The FQHC is located in the heart of an urban area and provides medical, dental, vision, medical, and behavioral health services for people with Medicaid or on a sliding-fee scale (County Administration, 2020). Southwest Michigan has a drug court program that serves felony and misdemeanor offenders and boasted a 61% graduation rate from 2004 to 2019 (County Administration, 2020). Another grant-funded program created in the county was Hope Not Handcuffs which diverted people from arrest and into treatment (State of Michigan, 2020). Diverted people are assigned an Angel who connects them with free treatment (State of Michigan, 2020).

The opioid overdose epidemic is a significant problem in Michigan and Southwest Michigan, and stigma is a reason that prevents people from accessing treatment. COTF reported that more education, increased naloxone access, and reduced stigma may be part of the solution (County Administration, 2020). The overdose death rate continues to grow. Increasing understanding of stigma and lack of treatment access is a gap that may provide additional social work intervention opportunities into this problem.

Summary

The opioid epidemic is one of America’s most significant national health problems (Bohnert et al., 2018; Cioe et al., 2020; SAMHSA, 2020). Section One provided an overview of the problem related to the opioid overdose death rate in America and Southwest Michigan. The literature review reported historical and current data regarding the opioid epidemic and documented studies that reported the epidemic from different country and Michigan areas. A quantitative study in one Southwest Michigan county reported that stigma is the highest-ranked reason for people with OUD not seeking treatment (Calvin University Center for Social Research, 2020). A gap existed with social workers' knowledge regarding how people in Southwest Michigan with OUD experience stigma. In this study, I focused on this gap and facilitated two focus groups of social work practitioners who shared knowledge gained from their practice experiences with people they serve in Southwest Michigan who have OUD. In the following section, I include the research design, methodology, data analysis procedures, and ethical procedures used for this study.

Section 2: Research Design and Data Collection

Introduction

The opioid crisis is one of America’s most significant national health problems (Bohnert et al., 2018; SAMHSA, 2020). Nationally, there was a 9.6% increase in opioid overdose deaths from 2016 to 2017 (CDC, 2019). In 2017, Michigan had a statistically significant (13.9%) increase in opioid overdose deaths compared to 2016 data (CDC, 2019; Hedegaard et al., 2019). The Calvin University Center for Social Research (2020) identified stigma as the highest-ranked reason people with OUD do not seek treatment. In this study, I gathered knowledge regarding stigma toward PWID with OUD in Southwest Michigan. This research question that guided this study was: What knowledge do social work practitioners have regarding stigma toward PWID with OUD in Southwest Michigan?

In the following section, I identify the research design, the research method, and data analysis strategies used in this qualitative action research study. The methodology section includes characteristics of participants in this study and the process for the study. In the data analysis section, I explain the qualitative data analysis strategies used to ensure validity for this study. The last area is about the ethical procedures that ensured participant protections during the study.

Research Design

The purpose of this study was to gather knowledge among social workers regarding stigma toward PWID with OUD in Southwest Michigan. This action research study was focused on experience developed in partnership with the stakeholders, addressed significant problems, and developed new ways of seeing the problem (Bradbury & Reason, 2003). This study met the criteria for action research as the research question targets increasing knowledge regarding stigma toward PWID with OUD in Southwest Michigan. Practice knowledge was added from participants regarding strategies to increase participation in treatment. The participants were social work practitioners credentialed as a licensed master of social work (LMSW) and certified alcohol and addiction direct counselors (CAADC) and treat people with OUD in Southwest Michigan. The two focus groups included five social work practitioners with more than 2 years of OUD practice experience.

Methodology

Prospective Data

The data were gathered from two virtual focus groups using the Zoom virtual platform that were audio recorded. Participants used Google’s Jamboard program as the electronic whiteboard, which increased participants’ ability to provide feedback in an interactive environment. Participants were social work practitioners with at least 2 years of OUD treatment and experience, are credentialed LMSWs and CAADCs, and practice in Southwest Michigan. The questions (Appendix A) were focused on how people with OUD can experience stigma. Rubin and Rubin (2012) reported that experience, existing literature, and existing research are the three basic approaches for deciding which main questions to ask. The development of the focus group questions (Appendix A) followed examples from knowledge gained in my professional practice and during the literature review. The order of the main questions is an important consideration. Rubin and Rubin

(2012) noted that the questions need to join ideas and ensure that earlier questions do not limit participants’ responses to later questions. The principles of Rubin and Rubin (2012) guided the development of the main questions.

According to Rubin and Rubin (2012), clarifying questions are asked to search for clarity in responses and an opportunity to review the final information to ensure the integrity of the meaning in their responses. Clarifying questions belong to three categories. Reflective listening probes let the participants know that the interviewer is actively listening (Rubin & Rubin, 2012). Conversational probes keep the conversation focused on the research topic and regulate the depth of discussions (Rubin & Rubin, 2012). Credibility probes assess the level of solid evidence or bias behind participants’ comments (Rubin & Rubin, 2012). During the interview process, I used clarifying questions for these purposes.

Focus groups were selected to create a less threatening atmosphere for collecting qualitative data from multiple participants simultaneously (Onwuegbuzie et al., 2009). Focus groups provide benefits to a researcher, including creating a social environment that allows for more spontaneous responses and opportunities to discuss possible solutions (Onwuegbuzie et al., 2009). Another benefit of focus groups is that participants learn more about the problem, and their attitudes may change toward the studied problem due to the dynamics of a group (Zeleeva, 2019).

Participants

Participants in this study were social work practitioners who met several criteria, including at least 2 years of practice experience; LMSW and CAADC credentials;

experience with treating people with OUD in Southwest Michigan; ability to understand and speak English; willing and able to participate in a 90-minute focus group; willing to sign the consent; and willing to be audio recorded for this virtual focus group.

Participants were identified with chain sampling and started with social work practitioners known to me at OUD treatment agencies that provide outpatient counseling services in Southwest Michigan. Chain sampling begins with one or a few participants, and then participants ask others who may provide input (Ravitch & Carl, 2016). Ravitch and Carl (2016) noted that chain sampling is appropriate when understanding relationships and experiences from a specific population.

The recruitment phone call script protocol (Appendix B) was used for people who met the criteria or did not meet the criteria. Sampling began with phone calls to my past colleagues to ask them to identify current social work practitioners who met the identified qualifications. Phone calls were made to these practitioners, and they were asked if they were willing to participate in a study. In this phone call, they were asked if they met the qualifications. If they met the qualifications, they received a summary of information regarding the topic, their time commitment, and the information in the informed consent form. Another recruitment plan added during recruitment was the use of social media, and I posted the social media recruitment flyer on Facebook, LinkedIn, and on a local university’s listserv.

All participants received a copy of the informed consent form via email and returned them via email. Whether they met the qualifications or were willing or unwilling to participate, they were asked to provide names of other practitioners who met the qualifications. The new practitioners were called, and the same protocol was used with the newly identified practitioners. The plan was for recruitment to continue until at least 10 social work practitioners were identified. However, recruitment attained only five practitioners. Peek and Fothergill (2007) noted that group size is an important consideration with focus groups, and effective focus groups can occur with 4–6 participants.

Data Analysis

Data analysis began as the focus group began and continued throughout the research process (Beeman, 1995; Ravitch & Carl, 2016). Qualitative data analysis strategies were used to ensure study validity (Belotto, 2018). While analyzing data, I ensured fidelity to participants and their information by identifying what participants said and how they said it and identifying the contexts for their comments (Ravitch & Carl, 2016). The focus groups were audio recorded and transcribed to increase fidelity to participants’ experiences (Ravitch & Carl, 2016). Once the transcription was complete, the manual coding process began.

Throughout the coding process, I used a structured reflexivity process to question how my bias might be impacting the data, what other ways the data may be interpreted, and balancing my interpretations with data gained from the literature review (Ravitch & Carl, 2016). In the transcript review, I identified words and phrases that convey similar meanings, and similar meanings received a code to interpret the text in new ways (Belotto, 2018). I reviewed these codes to identify categories, and these categories assisted with identifying themes in the data (Saldana, 2016). Upon identification of themes, knowledge gained from these themes was used to identify the assertions (Saldana, 2016).

Qualitative research requires the establishment of validity (Ravitch & Carl, 2016). Data triangulation ensured validity and included the use of stigma theory and data from the literature review. The goal was for the theory and the literature review to assist with grounding and identifications of themes in data analysis (Ravitch & Carl, 2016). The purpose of using data triangulation for validity is to seek a balance between data and established theories (Ravitch & Carl, 2016).

Another tool for validity is understanding the importance of reducing researcher bias as researcher bias is present in qualitative research (Ravitch & Carl, 2016). The strategy I used to reduce my bias was to write a researcher identity memo before the data gathering phase began and to continue with the researcher identity memo until the final analyses were completed. Ravitch and Carl (2016) noted that using a research identity memo reduces researcher bias by identifying a researcher’s experiences, biases, and beliefs that shape the creation, interpretation, and approach to the study. Transparency with processes and biases is necessary to achieve validity throughout the research process (Ravitch & Carl, 2016). An additional step completed to ensure rigor included participation validation. Each participant read a written summary of the findings generated from their focus group participation and had the opportunity to provide open-ended replies (Ravitch & Carl, 2016). Each participant validated their findings and provided a response message indicating agreement.

Ethical Procedures

In section 5.02 on research and evaluation, the NASW Code of Ethics (NASW, 2021) noted that when social workers engage in research, they should consult institutional review boards (IRB) to protect research participants. I sent this study's proposal to Walden University's IRB to ensure that participants' autonomy, privacy, dignity, and safety are protected throughout the process. A significant part of the process to provide participants protection was the informed consent form. The informed consent form must be easily understood without technical jargon, explain that participation is voluntary, and identify any possible risks (DeVine, 2019). Appendix B includes a copy of the informed consent form that went to each participant. Each participant read the form and replied to an email message with "I consent" before being accepted as a research participant.

After the focus group, all audio recordings and electronic data were saved on my password-protected computer. All written data placed in a locked file located in my office. Pseudonyms replaced participant names, their agencies, and any identifying to ensure confidentiality. Pseudonyms replaced any information that might be used to identify a participant to reduce the risks of disclosing a participant's identity. Information regarding confidentiality was in the informed consent form (Appendix B) and was discussed at the beginning of the focus groups.

Summary

Section 2 identified the research design, methodology, data analysis process, and ethical procedures. In this study, I aim to align with the principles of action research as this study focused on experiences, developing partnerships with the stakeholders, addressed a significant problem, and developed new ways of seeing the problem (Bradbury & Reason, 2003). Regarding methodology, the participants were social workers who practiced in Southwest Michigan and had at least 2 years of experience treating people with OUD. Transcription of the audio recordings increased fidelity to participants' experiences (Ravitch & Carl, 2016). Two tools for validity were data triangulation and creation of a researcher identity memo. I received IRB approval for this study to ensure ethical procedures, and all participants completed an informed consent form. Together these practices ensured that this study protected the participants while seeking increased understanding regarding the context and sociopolitical situations that prevent people with OUD from seeking treatment in Southwest Michigan. The presentation of findings section reports the completed data analysis steps and findings for this study.

Section 3: Presentation of the Findings

Introduction

The purpose of this qualitative action research study was to gather knowledge among social work practitioners regarding stigma toward PWID with OUD in Southwest Michigan. Using an action research design to study this topic, I conducted two focus groups to collect data from social work practitioners. The social work practitioners were LMSWs, CAADCs, and had at least 2 years of experience treating people with OUD. I facilitated two 90-minute focus groups with five social work practitioners for data collection. The two focus groups included the same five participants, were audio recorded, and transcribed verbatim. In this section, I outline the data analysis techniques used and the findings. The research question was:

RQ: What knowledge do social work practitioners have regarding stigma toward PWID with OUD in Southwest Michigan?

Data Analysis Techniques

I collected the data for this study in November 2021, following IRB approval (Approval No. 07-06-21-0739679). After receiving IRB approval in June 2021, I began the chain sampling recruitment process and was unsuccessful with my original plan to recruit participants with phone calls. I called 26 social workers and secured only one participant. In September, I asked for and received IRB approval to use social media for recruitment and began using social media. After posting to Facebook, LinkedIn, and a university’s listserv, I recruited five participants. All five participants had full licensure in

Michigan (LMSW), had certification to treat people with SUD (CAADC), and had at least 2 years of experience treating people with OUD in Southwest Michigan.

The two 90-minute Zoom focus groups occurred on November 5, 2021, and November 12, 2021. After both groups concluded, I transcribed the data into a Microsoft Word document. I checked the accuracy of the transcription by listening to the recording and comparing it with the transcription several times. I added information received from the Zoom chat function and the Jamboard. Next, I searched the transcript to identify any texts, phrases, or topics related to the research question. I highlighted these data and copied them into a Microsoft Excel spreadsheet. Once the data were in the spreadsheet, I began the first cycle coding process with the elemental method.

Saldana (2016) reported that the elemental methods include various coding cycles, and I selected descriptive coding and concept coding for this study. Descriptive coding guided me to create labels to provide an inventory of topics discussed, and concept coding guided me to extract labels for big picture ideas the data suggested (see Saldana, 2016). Following the first coding cycle, I identified themes in the data to draw out the codes' meaning (see Saldana, 2016). With these two coding cycles, I identified several key codes that identified a couple of themes in the data. Data analysis took four weeks to complete.

Validation procedures occurred throughout the process. Audio recording and transcribing the data increased fidelity to the participants' words and intonation of these words. During the coding process, I used a structured reflexivity process to question how my bias impacted the data and what other ways the data may be interpreted and to balance my interpretations with data gained from the literature review (see Ravitch & Carl, 2016). Analytical data triangulation ensured validity with comparison of data from stigma theory, the literature review, and the focus groups. I used analytical data triangulation to assist me with rounding out and challenging my understanding of the participants' experiences (see Ravitch & Carl, 2016). When I analyzed participants' responses, I compared their responses with data from stigma theory and the literature review and used data from stigma theory and the literature review to challenge my understanding of their responses. An additional step completed to ensure rigor was participant validation; each participant read a written summary of the findings generated from their participation and had the opportunity to provide open-ended replies (see Ravitch & Carl, 2016). All participants agreed with the findings.

Researcher bias needs to be minimized as researcher bias is present in qualitative research (Ravitch & Carl, 2016). Throughout the data collection and analysis process, I created entries in a researcher identity memo to identify and reduce my bias. Ravitch and Carl (2016) noted that using a research identity memo reduces researcher bias by identifying a researcher's experiences, biases, and beliefs that shaped the study's creation, interpretation, and approach.

This study had a few limitations. One limitation was the participants' demographics were similar as all participants were White women. Another limitation was that the focus groups were conducted via Zoom rather than in person. The third limitation was the lower than desired number of focus group participants. Initially, my goal was to have 6–12 participants, which was unattainable. Peek and Fothergill (2007) noted effective focus groups can include 4–6 participants and noted when there were 6–15 participants, researchers have concerns about whether each person's view is shared.

Findings

The purpose of this qualitative action research study was to gather knowledge among social work practitioners regarding stigma toward PWID with OUD in Southwest Michigan. Two focus groups with the same five participants met to discuss their experiences with PWID with OUD. Participants responded to questions that targeted the identification of stigma and the type of stigma that people with OUD may encounter.

Participants

The names of participants were replaced with pseudonyms to protect their identities. All participants were White women, ages 30–60, and their social work experience varied greatly. Amanda's employment history included working as a case manager with advancement to utilization management. Kimberly's employment history included working as a case manager and a health coach on an integrated team with medical and behavioral health providers. Lilly worked in the criminal justice system as a case manager and supervisor for a community-based program that seeks integration with medical and behavioral health providers. Marsha worked as a case manager and in private practice. Vivene worked as a case manager and therapist and provided telephone support for people with SUD. Vivene is a person in long-term recovery and shared some information gained through her local recovery support meetings. None of the participants worked in the same agency when the focus groups occurred. Agency demographics are not included to protect the identity of the participants.

Themes

Three themes identified in the data included internalized stigma, provider stigma, and social stigma. From the three themes, the data indicate four sources for the origination of the stigma: providers (both medical and behavioral health), policy, society, and the recovery community. Table 1 outlines the type of stigma identified and the sources of the stigma. The numbers in the table represent the number of times a participant noted the types and sources of stigma.

Table 1

Stigma Types Impacting People With OUD

Stigma type	Providers	Policy	Society	Recovery community	Total
Internalized	4	2	16	2	24
Provider	26	11	1	0	38
Social	0	18	24	2	44
Total	30	31	41	4	

Three themes emerged from the data: (a) internalized stigma, (b) provider stigma, and (c) social stigma. These themes were the types of stigma that people with OUD experience. From these themes, four sources of stigma emerged: (a) providers, (b) policy, (c) society, and (d) the recovery community. For example, people with OUD may experience internalized stigma that originated from one or more sources. People with OUD hear a provider make derogatory statements about people with OUD. The provider’s statement can feed their internalized stigma and negatively affect how people with OUD perceive themselves.

Internalized Stigma

Internalized stigma is when a person negatively perceives themselves because of societal stereotypes (Akdağ et al., 2018; Smith et al., 2016). In this study, internalized stigma originated mainly from society, which included family members, friends, and views from the public. Marsha shared a story of a person who had frequent relapses, and each time they returned, Marsha noticed "an additional layer" of shame impacting them. Marsha reported that the shame originated from comments they heard or inferences they garnered from friends, family, and the public. Alice noted that people with OUD have a constant "fear of rejection from their friends and family." Kimberly stated that people with OUD seem to have "shame, unworthiness, powerlessness…. So, the clients themselves have those core beliefs of unworthiness, broken, and unable to change."

When considering internalized stigma that originated from providers, participants included medical and behavioral health providers. Vivene noted that their past trauma impacted their experience of trauma and how providers treated them; providers treated some people as if they were "drug-seeking." Vivene added, "They become in tuned with their stigma radar, and it influences their perception." The stigma radar shines a light on others' glances, voices, or facial expressions. People use this radar to infer how their providers treat them.

Lilly identified internalized stigma from policy when Lilly spoke of a person with OUD who is a licensed medical professional. Lilly heard people share "If I'm a clinical person, is this going to impact my license? My profession? My work?" Lilly noted this fear prevented the professional from seeking treatment when their use first became problematic. Lilly noted that if the policy was more prevention and treatment focused versus punitive, the medical professional might have sought treatment earlier in their disease.

People with OUD experience stigma from the recovery community. Marsha identified internalized stigma from the recovery community. Marsha reported a change in spirit with PWID with OUD and described this as a belief that they were “too far gone.” Marsha noted this perception appeared to originate from peers who used opioids orally. Marsha’s comments align with Weeks and Stenstrom (2020) who reported that PWID experience increased stigma from peers who do not use opioids intravenously. Another area of stigmatization in the recovery community is MAT use. Vivene shared how many in the recovery community do not view people who use MAT as being active in recovery. Vivene stated, “If you are on Suboxone, and you go into the recovery community, you are not abstinent.” Vivene noted that this stigma prevents people from seeking MAT due to fears of stigmatization: “A gentleman who came into my [Alcoholics Anonymous] meeting who was on Suboxone comes to my mind because he couldn’t come to another meeting because it’s not a safe place for him.” Vivene added that some recovery meetings support and encourage MAT, but these meetings are not the majority in Southwest Michigan.

The internalized stigma findings align with stigma theory. Stigma theory posits that once a person experiences a felt sense of stigma, they carry this knowledge throughout their life (Türedi, 2018). Typically, people who experience stigma respond in one of three ways: rejection, acceptance (Türedi, 2018), or counterstigma; counterstigma might explain why the recovery community can stigmatize people who use MAT.

Provider Stigma

People with OUD experienced stigma in some healthcare facilities with some healthcare providers. Healthcare providers may use stigmatizing labels such as abuser, addict, or clean urine screen (Scott et al., 2020), and stigma theory links labeling with an early stage of stigmatization (Türedi, 2018). Scott et al. (2020) identified four distinct subthemes of stigma: the providers' distrust of people with OUD, beliefs that people with OUD had low maturity, ideas that people with OUD do not deserve rewards, and internalized stigma and community-based stigma toward people with OUD. Scott et al. (2020) noted that 86% of the providers used stigmatizing language during the interviews by labeling people with OUD as abuser, addict, and discussing clean or dirty urine screens. Healthcare providers might believe that treating somebody for OUD might become a long, laborious treatment episode and avoid treating this population as a result (Magidson et al., 2019; Young et al., 2015). Smith et al. (2016) posited that stigma from healthcare providers may act as a barrier to SUD treatment.

In this study, provider stigma originated from providers and included both medical and behavioral health providers. When considering medical providers, Kimberly spoke of a young provider who treated patients with their "own ideas," and these stigmatizing ideas increased stigmatization that people with OUD felt. Kimberly said, "One provider came in with his own ideas right away, and I think I understand with his sense of liability, but I feel that he worsened stigma." Alice stated, "Sometimes, they feel like they're beyond hope or they don't mention things to providers 'cause they feel like the doctor's not going to listen to them." Alice noted that people with OUD are fearful of discussing pain or anxiety with medical providers and stated, "I think they feel like even the providers might not treat them as a whole person." This finding aligned with Smith et al. (2016) who reported that people with SUD can be denied services as providers may believe that the people are pill shopping.

Lilly and Vivene spoke about how medical and behavioral health providers use the phrase dirty screen to report a positive drug screen. Lilly questioned, "How often is that pejorative language expressed in the providers themselves who are not skilled or knowledgeable or really maybe even do not even know about addiction?" When considering behavioral health providers, Marsha commented that providers minimized the use of the people who they treated. Marsha said, "How often do we try to get somebody into a higher level of care?" According to Marsha, medical and behavioral health providers might not identify the depth of OUD or minimize a person's use to align with a lower level of care to avoid the complexity or expense of referring them to a higher level of care.

Policy developers may adopt beliefs consistent with socially acceptable beliefs and can create policies based on stigmatized beliefs (Türedi, 2018). Consider the liability Kimberly noted regarding the medical provider's own ideas that led to stigmatization. Lilly stated, "Some of those MATs, there are limits from the federal government on who is able to prescribe. There are a limited number of addiction specialists such as psychiatrists trained and educated in addiction. Those limits add to stigma too." With the limited availability of prescribers, people with OUD infer that they are too high acuity for most providers to treat. Kimberly stated, “A tired emergency department physician who had been there for 12 hours or more, and she put her defenses up.” The emergency department physician might be too tired to take the time to understand and treat a person with OUD. Marsha supported the physicians and stated, “The doctors who are not educated or do not have a connection with addiction. It’s their internal beliefs that they hold, and that is the damaging part.” Marsha believed those providers do not have the time to connect with a person to grasp their needs, and this aligned with the policy that allowed and created the long shift hours and shorter time with patients.

Vivene provided an example of how policy stigma originated with funding. Vivene shared a story about a physically injured person while intoxicated and could not receive funding for their SUD. The person was funded and treated for the physical injury and was denied funding for their SUD. Alice sums up the policy problem with provider stigma, “I think it is a systems’ issue of people really struggling to get people the services they.” Policies from limited availability of MAT prescribers to long shift hours to struggles with funding add to provider stigma.

Social Stigma

Social stigma is when a social group disapproves of substance use and misuse and creates a hostile environment within social support networks (Henderson & Dressler, 2017). PWID with OUD experience more stigma than other people with OUD (Behar et al., 2019; Shelby, Smith, & Mancoski, 2004; Linas, 2018). Peer support groups may stigmatize those who use MAT (Weeks & Stenstrom, 2020).

Social stigma was the most experienced stigma type and originated from policies, society, and the recovery community. Social stigma mainly originated from society and included family, friends, and the public. All participants nodded in agreement when Lilly stated that some believe “You have substance abuse or addiction, and they get what they deserve.” Lilly referred to a discussion heard in public recently, and the people stated, “if they decide to do it, that basically, they should die.” Lilly added that some people ask why people use naloxone, and Lilly appreciated their questions and educated them. Kimberly stated, “people who use intravenously have more stigma, more of a negative. Other people in society look down on them, and they’re weak and have no ability to turn away from those patterns.” Marsha heard people with OUD say, “I would have come a lot sooner had I known it was going this way.” Marsha’s felt sense was that the people received education from the society that taught them people who require treatment are unworthy. Vivene stated, “There is a great deal of stigma associated with syringe service programs. All this about co-prescribing or adding to the problem – enabling use.” The consensus was the public does not understand how naloxone, buprenorphine, and methadone assist people with OUD.

When considering social stigma from society, the stigma comes from family and friends. All participants noted that people with OUD fear stigma from their families. Lilly noted that many people with OUD fear losing their families if they seek treatment or acknowledge their use’s severity. Marsha shared another example of stigma from family, “I’ve heard from families where it’s a family member who has had someone who was using intravenously, and how they’re okay because they’re only using pills.” Families identify that intravenous use is higher acuity and minimize use when a person changes from intravenous to oral use. People with OUD believe that their families accept them when they use orally and not when they use intravenously. Kimberly shared one person report their, “fear of losing class and how his family would be affected.” Kimberly shared a story of a person with OUD who sought treatment in another state as they feared the impact of their use on their extended family. They did not want their family’s name to be tarnished due to their need for OUD treatment.

Policies were the second most common experience of social stigma. Policies included funding, the criminal justice system, and education. When considering funding, Lilly stated, “There are not a lot of treatment options for long-term residential, and that is probably part of that stigma-not seeing it as a medical issue with the crisis that it is.” Lilly reported that Southwest Michigan does not have enough residential treatment options for people with Medicaid, and this is due to the low reimbursement rates. All participants spoke about their sadness with the waitlists for long-term treatment facilities. Lilly and Vivene reported that funding ties directly into stigma. Lilly stated, “If you look at the state budget, we spend the largest part of our budget in corrections…. I mean, we are not getting people where we want them to be, which is productive members of society.”

The criminal justice system and its policies were examples of social stigma. According to Lilly, probation and parole officers determine whether a person with OUD returned to incarceration or received OUD treatment. Lilly stated people experience, “Not only we have a substance use disorder, but there could be felony probation or parole. Definitely, there’s a huge spectrum in parole office and probation officers and how they view substance use disorders.” Lilly noted that the criminal justice system acts out of the beliefs taught and trained during the war on drugs. Lilly stated, “The war on drugs never addressed the root causes. I mean it was a perpetuation of certain systems of oppression, and it almost made it worse.” Lilly noted not all people are aware of the criminal justice’s policies on SUD, and most people consider people with OUD as practicing criminal behaviors. Lilly believed these policies created an environment that taught society to stigmatize people with SUD. Marsha shared employer policies were another example of policies and social stigma that focused on punishment versus treatment without any room for a lapse. Marsha shared a story of a man whose employer called weekly for updates on whether the employee reported substance use. Marsha stated, “It’s not about the person’s recovery. It’s about the liability that he might pose to his company. I know that he has to jump through hoops to continue employment, and this brings a lot of shame.”

When considering social stigma from the recovery community, Vivene said, “There’s stigma about some people who aren’t at a place where they want to stop. There’s the users union who formed their own group.” Vivene shared how people in the users’ union can use (oral or intravenously) and have someone available to ensure their safety. The users union allowed people a safe place for connection and community with others who wanted to use safely. Vivene noted that most people in the recovery community stigmatize people who wish to use safely and do not allow them in recovery meetings.

Unexpected Findings

In the literature review, data supported that PWID with OUD experienced internalized stigma, provider stigma, and social stigma. The unexpected finding in this study was the amount of provider stigma. Provider stigma ranked second after social stigma, indicating that providers drove a significant amount of the stigma people with OUD experience. Scott et al. (2020) identified four distinct subthemes of stigma: the providers’ distrust of people with OUD, beliefs that people with OUD had low maturity, ideas that people with OUD do not deserve rewards, and internalized stigma and community-based stigma toward people with OUD. If PWID with OUD cannot get their medical and behavioral needs met, their needs intensify.

Summary

The research question focused on gathering knowledge from social work practitioners regarding stigma toward PWID with OUD in Southwest Michigan. Social work participants shared their knowledge and experiences with the community and with PWID with OUD.

Participants identified stigma, and three themes emerged from the data: (a) internalized stigma, (b) provider stigma, and (c) social stigma. These themes were the types of stigma that people with OUD experience. From these themes, four sources of stigma emerged: (a) providers, (b) policy, (c) society, and (d) the recovery community. All participants provided input and shared some of their knowledge regarding stigma toward PWID with OUD in Southwest Michigan.

In the next section, I discuss how the findings from this study apply to professional ethics in social work practice, recommendations for social work practice, implications for social change, recommendations for future research, and conclusions derived from this study.

Section 4: Application to Professional Practice and Implications for Social Change

Introduction

The purpose of this study was to gather knowledge among social workers regarding stigma toward PWID with OUD in Southwest Michigan. Action research was appropriate as the principles of action research focus on experience, developed in partnership with the stakeholders, addressing significant problems, and developing new ways of seeing the problem (Bradbury & Reason, 2003). Huang (2010) noted that action researchers use knowledge, understanding, and action to theorize a deeper meaning of the problem. This study was focused on social work practitioners' experiences to identify new ways of seeing stigma. The findings of this study can increase stigma knowledge and may help identify strategies to reduce stigma.

Participants responded to questions that targeted the identification of stigma and the stigma types that people with OUD experience. Three themes identified in the data were (a) internalized stigma, (b) provider stigma, and (c) social stigma. From the three themes, the data indicated four sources for the origination of the stigma: (a) providers (both medical and behavioral health), (b) policy, (c) society, and (d) the recovery community. The findings can extend social work knowledge if used to improve knowledge and training surrounding stigma and OUD, improve care practices with people who have OUD, and enhance overall experiences with people with OUD with the hope of guiding them to treatment earlier in their disease.

In this section, I discuss the study's findings and how these findings apply to social work practices. I begin with an explanation of how the findings can be applied to professional ethics in social work practice and concludes with recommendations for social work practice and implications for social change.

Application to Professional Ethics in Social Work Practice

This action research study aligns with three social work values and ethics. The NASW (2021) created a code of ethics that provides values and ethical standards that drive social work practice in the United States. Three values that aligned with this study were (a) social justice, (b) dignity and worth of the person, and (c) the importance of human relationships (NASW, 2021). For social justice, I focused on people with OUD who are a vulnerable and oppressed population (Howard, 2015; Lundgren & Krull, 2014). Participants discussed their experiences with people with OUD and society and discussed how stigmatization oppresses the people’s ability to treat their OUD. Participants identified areas of oppression that included treatment from providers, policy, society, and the recovery community.

For the dignity and worth of the person social work value, I sought to understand conflicts between cultural beliefs or norms and the practices of people with OUD. Participants identified conflicts between beliefs and practices and discussed how these beliefs and practices stigmatize people with OUD. Participants discussed how internalized stigma, provider stigma, and social stigma limited people’s perceived value and worth of people with OUD. For the value of the importance of human relationships, I identified stigma with the hope of strengthening relationships among people with OUD and others in Southwest Michigan. Participants acknowledged stigma people with OUD experience and how stigma diminishes people’s ability to strengthen relationships with providers, policy, society, and the recovery community. Participants believed when the stigmatization is acknowledged and diminished, people with OUD may seek treatment earlier in their disease.

Recommendations for Social Work Practice

Based on the findings, I recommend three actions steps for social work practitioners. First, social work practitioners can seek to better understand people with OUD and their internalized stigma and practice acceptance. Increased insight into internalized stigma can increase social work practitioners’ awareness of the feelings of shame and unworthiness that people with OUD experience (Akdağ et al., 2018). Social workers can begin to understand the stigma radar that people with OUD have and address stigma by expressing hope that OUD is treatable and encouraging people with OUD to use multiple treatment options that might include MAT and a supportive recovery community. With increased insight, the findings of this study can guide social work practitioners as they engage people with OUD and practice unconditional acceptance toward people who struggle with the disease (SAMHSA, 2020).

Next, social work practitioners could challenge stigmatizing policies on a micro and macro level. When speaking with an individual, social work practitioners can listen for stigmatizing language and can advocate for increasing acceptance toward OUD people. Practitioners can incorporate this into their professional and personal lives as they speak with friends, family members, and people they serve. On a macro level, social work practitioners can advocate for policies that focus on prevention and treatments that include MAT and work to overcome policies that lead to labeling people with OUD as criminals. When policies focus on treatment and prevention, people with OUD can experience less stigma because the focus is not on the criminal implications of their use (Weeks & Stenstrom, 2020).

The last action step is to advocate for people with OUD when social work practitioners are with other providers. The findings from this study can help social work practitioners identify stigmatizing beliefs and practices, such as labeling or believing that people with OUD are immature and cannot be trusted (Scott et al., 2020). Social work practitioners can provide education that OUD is a disease and MAT is the gold-standard treatment that reduces opioid overdoses and increases treatment retention (SAMHSA, 2020). Social workers can inform other providers that stigma is a barrier to OUD treatment, and reducing stigma might help more people access treatment (Akdağ et al., 2018; Allen et al., 2019; Compton et al., 2015; Cornford et al., 2019; Ezell et al., 2021; Pacher, 2019; Pollini, 2019; Vashishtha et al., 2017; Young et al., 2015).

The findings of this study will guide my interactions with the people I serve, providers, the recovery community, and the public. I will practice intentional awareness of my words and avoid pejorative language that triggers stigmatizing beliefs toward people with OUD. When I hear others use pejorative language, such as abuser, addict, and discussing clean or dirty urine screens, I will explain the potential harm that those words may cause (see Scott et al., 2020). I will manage my biases, encourage people with OUD to seek MAT or abstinence, and support their desire to join a users' union to practice safe OUD use. I will focus on acceptance.

I will actively listen for stigmatizing language or practices when working with other providers. If I identify stigma, I will take the time to educate about OUD and the stigma that people with OUD experience. I will educate providers about the stigma that people with OUD experience and their high sensitivity to stigma. I will encourage providers to consider their language and practices and ways to reduce stigma. Part of this education will include sharing that stigma is a barrier to OUD treatment (Akdağ et al., 2018; Allen et al., 2019; Compton et al., 2015; Cornford et al., 2019; Ezell et al., 2021; Pacher, 2019; Pollini, 2019; Vashishtha et al., 2017; Young et al., 2015). Reducing the stigma experience may minimize it as a treatment barrier.

I will share the findings with the COTF stakeholders (social work practitioners, psychologists, medical health providers, criminal justice representatives, and county health department staff). These findings can help them identify stigmatizing practices, such as the externalization of beliefs that OUD treatment episodes are not likely to be successful (Magidson et al., 2019; Young et al., 2015) and people with OUD cannot be trusted and are immature (Scott et al., 2020). When the stakeholders begin to identify and challenge these beliefs, they can increase acceptance toward people with OUD. Also, I will offer to share these findings with the stakeholders’ colleagues to target increasing acceptance and decreasing stigmatizing practices. Also, I will look for opportunities to share this information in panel discussions about stigma and OUD. When more people learn about people’s stigmatizing experiences, stigma can be reduced, and more people may access treatment.

Transferability and Usefulness

The transferability of a qualitative study is how the study may apply to broader contexts (Ravitch & Carl, 2016). This study included five participants who practiced in Southwest Michigan, and the participants’ views cannot be applied to all populations. However, the findings can be transferable to other contexts when researchers compare them with their contexts (Ravitch & Carl, 2016). For example, the findings can be useful to social workers who serve people stigmatized for other reasons, such as other forms of SUD, mental illness, or medical illness.

Usefulness of Findings

The findings of this study helped identify some ways that social work practitioners can identify stigma toward people with OUD. The findings of this study can be used to help social worker practitioners identify and manage their biases and can help practitioners identify language or behaviors to reduce stigma toward people with OUD. The findings can be used to help educational institutions develop curricula around the importance of understanding stigma and identifying practices that target unconditional acceptance. The findings can be used to aid policy developers from the institutional and governmental levels. If the policy developers can understand stigma, they may be better able to create policies that focus on acceptance and treatment versus punishment.

Limitations

This study had three limitations. The first limitation was the participants’ demographics were limited as all participants were White women. The second limitation was the focus group was conducted via Zoom. Due to COVID-19 restrictions, the chosen platform was virtual. Pocock et al. (2021) reported virtual platforms are an alternative to traditional focus groups and can help researchers complete research. The third limitation was my initial goal was to have 10 participants, and recruitment struggles caused me to reduce the number of participants to five social work practitioners. Peek and Fothergill (2007) support using a focus with 4–6 participants, and Onwuegbuzie et al. (2009) support the use of 6–12 participants.

Recommendations for Further Research

In this study, I gathered knowledge among social work practitioners regarding stigma toward PWID with OUD in Southwest Michigan. The findings of this study identified the different stigma types that people with OUD experience in Southwest Michigan. Further research could gather knowledge directly from people with OUD who are in recovery and in active use to identify how they manage stigmatization. Such research could target which stigma type is the most problematic for them.

Dissemination Recommendations

I plan to disseminate this research in a presentation for the COTF during a monthly meeting. Community stakeholders attend these meetings, and their attendance will increase the number of people the data impacts. Also, I plan to disseminate this to key stakeholders at local agencies who treat people with OUD. Together, these opportunities will impact professionals who treat people with public and commercial insurances.

Implications for Social Change

Micro Level

This findings of this study can impact how providers speak with and about people with OUD. Providers can use this information to adjust their language to decrease stigma derived from pejorative language. Alice shared that people with OUD felt hopeless and feared that the medical providers would not listen to them. Providers can begin to understand the stigma people with OUD experience before starting treatment. Providers can work to identify the depth of a person’s struggle with OUD to avoid minimizing a person’s use and seek to determine a level of treatment aligned with the person’s reported use.

Mezzo Level

The findings of this study can impact how providers educate families and communities about stigma and OUD. The findings can be used to educate families and friends of people with OUD to increase their understanding of the disease of addiction and OUD. The education can target stigmatizing beliefs and language to train people to practice acceptance. Another benefit of the education is to help people understand the importance of treating OUD early to reduce the occurrences of what Marsha reported people with OUD said, “I would have come a lot sooner had I known it was going this way.”

Macro Level

The findings of this study can impact policy and how educational institutions train providers in the future. For example, universities that train medical doctors could use these findings to educate their students on the importance of guiding people to treatment earlier in their opioid misuse. Policy developers can use these findings to create policies that focus on prevention and treatment versus punishment. The medical community could use these findings to increase the amount of time a provider spends with their patients. Marsha believed the current policy allowed and created long shift hours and shorter time with patients, and this policy does not allow enough time to connect with patients.

Summary

The opioid epidemic is one of America’s most significant national health problems (Bohnert et al., 2018; Cioe et al., 2020; SAMHSA, 2020). Yearly opioid overdose deaths increased from 36 in 2008 to 104 in 2017 in Southwest Michigan (County Administration, 2020). In this action research study, I aimed to gather knowledge from social work practitioners regarding stigma toward people with OUD. The findings included three themes from the data: (a) internalized stigma, (b) provider stigma, and (c) social stigma. These themes were the types of stigma that people with OUD experience. From these themes, four sources of stigma emerged: (a) providers, (b) policy, (c) society, and (d) the recovery community.

Calvin University Center for Social Research (2020) identified stigma as the leading reason people with OUD do not seek treatment in Southwest Michigan. Increasing access to treatment is vital as treatment provides medically necessary education to prevent overdose deaths (Shelby, Smith, & Mancoski, 2004). Identifying and reducing stigma toward people with OUD may help them seek treatment and may help slow the opioid overdose death rate.

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Appendix A: Focus Group Research Questions

The following questions will be asked during the two focus groups.

1. What is your understanding regarding the stigma that a person with OUD might experience?
2. What is your understanding regarding stigma for PWID with OUD?
3. Please describe examples of the stigma that people with OUD shared with you.
4. What sources of stigma have you witnessed from other people against people with OUD?
5. For people with OUD, what events triggered the health behavior of seeking treatment?
6. When working with people with OUD, please share some reasons why they did not seek treatment when they first identified opioid use as a problem.

Appendix B: Recruitment Phone Call Script

Hello, this is Kathy Carruthers. I am completing a study for my dissertation and am looking for participants for my study.

1. Do you have time to talk now? If yes, move to number 2. If no, schedule a time to speak.
2. If they are a past colleague who worked under the same supervisor simultaneously as I worked under that supervisor, they cannot participate in the study. If this does not rule them out for participation, I will move to number 3. If this rules them out, I will move to number 4.
3. I will share and ask the following:
    a. Are you licensed with an LMSW?
    b. How many years have you been in practice?
    c. Do you have a current CAADC?
    d. Do you practice in Southwest Michigan?
    e. Do you have experience with treating people with OUD in Southwest Michigan?
    f. Are you willing to participate in a voluntary focus group that will meet twice for 90-minute sessions? The focus group will focus on gathering knowledge from social workers regarding stigma toward PWID with OUD and strategies for increasing treatment access in Southwest Michigan. The focus group will meet twice for 90-minutes each session, and the groups will be audio and video recorded. Is this an opportunity that you are

willing to consider? Please remember that your participation is voluntary. If yes, I need you to sign an informed consent (Appendix D).

        i. If they agree, I will email them a copy of the informed consent and ask them to print, scan, sign, and return it to me via email.
        ii. If they disagree, I will move to number 4.

4. I am in the recruitment phase of this study. Are you aware of other practitioners that meet the qualification criteria?
    a. If no, I will thank them for their time.
    b. If yes, I will for the practitioner’s contact information? These practitioners will be contacted with this protocol starting at number 1.