



The role of stigma in referrals for medication for opioid use disorder: Three case studies in Montana

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REPORT INFORMATION AND ACKNOWLEDGEMENTS

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STUDY SUMMARY

This study consists of in-depth studies of three rural Montana communities to examine both how community attitudes may shape the composition of the care system and how stigma is shaping use of existing treatment resources for opioid-use disorder. Stigma remains a concern across the three communities that were the focus of this study. There is marked variation across sites in how interviewees perceive the shifts in attitudes among community members about substance use disorders and the pursuit of treatment services. In all locations the interaction between access to treatment services, literacy about behavioral health, and stigma produce different local dynamics.

In each community, four types of stigma were examined—associative, internal, received, and perceived. These different aspects of stigma help to clarify how negative attitudes and beliefs about substance use disorders (SUDs), opioid use disorders (OUDs), and medication-assisted treatment (MAT) interact within each place to impact treatment utilization and referral practices. One clear and consistent finding across all communities is the low level of stigma being expressed by referral sources toward those individuals who are experiencing addiction. Rather than expressing stigma, interviewees expressed a sympathetic and caring orientation toward those whom they meet and attempt to support as they work to address an OUD or SUD.

Attitudes among interviewees varied by type of medication-assisted treatment, and they were often bifurcated by opioid agonist medications (specifically, buprenorphine) and opioid antagonist medications (such as naltrexone). A number of interviewees had negative views of agonist medications; no interviewees expressed negative views about opioid antagonist medications. The other common point of difference across interviewees was in their attitudes about the expansion of community-based harm reduction services—specifically, needle exchanges and drug disposal locations. Interviewees shared their beliefs about community attitudes toward these services, noting that in two of the three study communities, perceptions of community attitudes and the associative stigma they convey may be limiting interested providers who might otherwise develop or implement these programs.

Direct service providers tended to express very little stigma or negative attitudes toward individual users, instead expressing stigma and negative attitudes more broadly about people with addictions overall or the destructive impacts of substances, specifically methamphetamines, alcohol, and marijuana. The most important finding related to direct service providers, most of whom do not work directly in behavioral health services, was a low level of literacy about behavioral health conditions. The majority of interviewees were aware of multiple waived providers for MAT treatment within their communities. Almost universally, interviewees spoke highly of sites that are providing services through State Opioid Response (SOR) funding.

BACKGROUND

During the State Targeted Response (STR) process evaluation, both patients and medication-assisted treatment (MAT) site staff mentioned their concern about the negative impacts of stigma on both treatment seeking and referral practices. Based upon information learned during the STR study and interest from staff at the Addictive and Mental Disorders Division (AMDD), this special study was completed as an element of the State Opioid Response (SOR) grant program evaluation. The primary goals of the study were to (1) better understand community perceptions of the experience of stigma among potential and current MAT clients, and (2) clarify whether potential referral sources hold stigma that may decrease their willingness to link clients with MAT providers.

To achieve the primary goals of this study, researchers completed in-depth case studies in three Montana communities with SOR-funded MAT provider sites—Hamilton, Havre, and Miles City. These three communities were selected because they vary in characteristics that were believed to be related to stigma in the community and among referral sources, including the amount of outreach done by the MAT site, proximity to tribal communities, and degree of rurality. Each MAT site was newly created under the STR program, and they have been active for the same length of time.

Studying stigma can be a challenge, as “stigma” is often used as an umbrella term that includes the expression of knowledge, attitudes, beliefs, and stereotypes (Webel 2015). In this analysis, knowledge (factual and accurate information or experience) is delineated and separated from attitudes (including beliefs, stereotypes, and prejudices). Attitudes are then expressed through different types of stigma. Distinguishing between knowledge and attitudes about substance use disorder (SUD), opioid use disorder (OUD), and MAT can help clarify how these two elements interact within three Montana communities to shape or impact referral and treatment-seeking behavior for MAT for OUD.

Stigma has been shown to have a negative impact on substance use treatment-seeking behavior (Georgakakou-Koutsonikou & Williams, 2017). The reason stigma has a negative impact on treatment-seeking is that individuals may avoid pursuing substance use treatment if they think they will experience a social cost for receiving that treatment. Stigma is written about as a broad concept with multiple components or ways of being expressed. In this study, researchers focus on attitudes expressed as associative, internal, received, and perceived stigma.

- Received stigma is the direct expression of negative views toward an individual, as heard by that individual.
- Internal stigma is a negative view within the individual who may be experiencing addiction or be in need of treatment services.
- Perceived stigma is the perception of an individual of how other members of a community think about an individual with OUD or SUD.
- Associative stigma takes place when people make negative inferences about specific components of a treatment program (rather than about individuals in the program).

This study focuses specifically on trying to understand the varied impacts of stigma on treatment seeking and on the referral behavior of potential referral sources within each community. Referral sources examined in this work include a broad set of potential referral sources, including individuals working in social services, the medical system, the criminal justice system, and community-based nonprofits. Each of these actors reflects opportunities for the identification of OUD and a formal or informal referral to the MAT clinic. Understanding the relationship between stigma and referral practices requires the development of a careful and thorough model to analyze the interactions among community context and the knowledge and attitudes of referral agency staff as well as of clients. Each of

these sets of variables may shape how stigma is expressed and the impact stigma has on treatment seeking and referral behavior. For each community, researchers completed approximately 20 interviews with staff from potential referral sources, including social service agencies, medical providers, law enforcement, and political leaders. During the course of these interviews, respondents were asked to describe the context of their community as related to SUD, OUD, and MAT treatment access; their knowledge about SUD; their own attitudes about SUD, OUD, and MAT; and their beliefs about the presence and impact of stigma.

METHODS

Research Questions

Two key research questions informed this study:

1. What are the perceptions of potential referral sources and staff at community-based organizations about the stigma being experienced among potential and current MAT clients?
2. Do potential referral sources express stigma in a way that may influence their willingness to link clients with MAT providers?

Study Design

Data gathering

The primary means of data collection for this study included in-depth interviews with a cross-section of providers and staff within organizations that are potential referral sources to local SOR-funded MAT sites in three separate Montana communities. Researchers initially targeted staff from the following five organizational categories to interview: criminal justice, medical care, social services, recovery support services, and coalitions/task forces. Once researchers had identified potential participants in a community, they contacted participants using a formal recruitment email and followed up by phone when necessary. In addition to the formal recruitment email from the research team, AMDD staff provided a letter of support for the study. When the respondent did not reply to any of these efforts, they were marked as “no response.” Additionally, the study used “snowball” recruitment—that is, asking for participants who participated in an interview to identify other organizations and contacts who would be ideal participants. Because of this process and the unique qualities of each community, additional interviews across additional organizational categories occurred in some communities. Researchers obtained verbal consent for each interview before proceeding with the interview process. Owing to COVID-19, interviews were conducted over the phone with each participant’s consent, audio recorded, and transcribed verbatim. All interviews were conducted confidentially, and all data in this report is reported anonymously. Interviews were conducted in each community until saturation was reached and similar information was being consistently repeated across interviewees.

The types of respondents interviewed for this project are listed in Table 1.

Data analysis

The interview transcripts for this study were transcribed verbatim and analyzed in NVivo Qualitative Software (QSR International Pty Ltd., 2020). An iterative coding process was used, in which first a deductive coding guide was created by two researchers familiar with the themes raised during the interviews. The researchers then expanded the coding guide to encompass more specific details and patterns. Each transcript was coded for overarching themes within each respondent category.

High literacy was defined as “Speaking about treatment with confidence and accuracy. Able to articulate specific program elements and how best to pair patient need with a treatment program.” Medium literacy was defined as “Speaking about treatment with some uncertainty and in general terms. When discussing the approach, misrepresents at least one program characteristic.” Low literacy was defined as “Speaking about treatment with uncertainty and is inaccurate across multiple elements of the program.”

Limitations

The main challenge associated with this study is ensuring consistency in data collection and analysis across sites. Given the comparative nature of this set of case studies, there was variation in the composition of interviewees, as well as slight variation in the interview procedures. Three separate researchers completed three separate studies, which inherently creates differences. To mitigate these differences, researchers used the same interview guide, recruitment materials, and list of potential interviewee types. Recruitment was further hindered by disruptions brought about by COVID-19. The final limitation is related to the subject matter, as having individuals share their attitudes, beliefs, and potentially stigmatizing views about those who are experiencing addiction is a challenge. Interviewees may be reluctant to express stigmatizing views out of concern that these views may be seen as offensive or socially undesirable. To address this concern, researchers would ideally have met with interviewees in person to build rapport and trust as a way to decrease increase the likelihood that they would feel vulnerable and increase the likelihood of being honest about sensitive subjects and views. The questionnaire was designed to prompt interviewees to share their perspectives on SUD as well as on OUD and MAT, with the idea that researchers could prompt the honest expression of views by asking about these topics in multiple ways. One strategy employed by the research team was to ask interviewees what “other people thought about [a given topic],” with the idea that this could depersonalize the response and create space for the expression of stigmatizing attitudes, should they be present.

Profile of Respondents

A total of 63 interviews were completed for this study, with 27 stakeholders interviewed in the greater Hamilton area, 20 in Miles City, and 16 in Havre. In each community, interviewees included medical care providers, social service providers, criminal justice stakeholders, recovery support staff, and coalition/task force members. In Hamilton and Havre, interviews were also completed with members of the local faith community. In Hamilton and Miles City, interviews were also conducted with prevention specialists. Hamilton interviews also included early care and education providers.

Table 1. Interviewees by location

Provider type	Hamilton	Miles City	Havre
Medical care provider	10	5	5
Social services provider	6	4	4
Criminal justice stakeholder	3	5	4
Recovery specialist	2	3	
Coalition/task force member	2	2	2
Prevention specialist	2	1	
Early care and education provider	1		
Faith community member	1		1
Totals	27	20	16

RESULTS

Interviewees were asked a set of questions to clarify their general perspectives about SUD and treatment for SUD. At the outset of the study, it was expected that differences would be found across sites around levels of knowledge and attitudes, expressed through types of stigma, about SUD and treatment for SUD. However, instead of differences, researchers observed fairly consistent patterns across sites in respondents' perspectives on substance use. This section first summarizes common knowledge and attitudes about substance use and its treatment from interviewees across all three communities, with differences noted when they existed. Researchers then explored knowledge and expressions of stigma associated directly with OUD/MAT within each of the three study communities.

Common Perspectives on Substance Use

Knowledge, attitudes, and expressions of stigma about SUD and treatment for SUD generally provide a backdrop for understanding specific expressions of stigma about OUD and MAT programs. This study focused on understanding how stigma impacts OUD and MAT referral practices and treatment-seeking behavior. Therefore, it is important to delineate between general attitudes and stigma held by interviewees about SUD broadly and attitudes and stigma about OUD and MAT specifically. The following section discusses knowledge and attitudes, expressed as specific types of stigma, about SUD broadly across all three sites.

Knowledge about SUD and Treatment

SUD

Interviewees across healthcare, social services, education, and criminal justice had a generally high level of knowledge about addiction or SUD. When asked how they learned about addiction or substance use disorders, interviewees cited a wide range of methods, most of which can be divided into two categories: job-related learning and personal learning. Most interviewees had some formal education or training on the topic, with many connected to ongoing professional development opportunities.

We always had to go through some type of yearly training on opioid use, marijuana use, alcohol, etc. (prevention specialist).

There's some pretty good trainings that we do just at the VA, and they're not super, super detailed, but it's a really good overview of, "Here's some of the stuff that you could be looking at. And this is, here's some impacts of drug use on kids. And here's some things that you could look for." And again, we'll sometimes have law enforcement come in and do things. We'll have a LAC [Licensed Addiction Counselor] sometimes come in and say, "Here are some things to look for" (social services provider).

Some interviewees said they learned about addiction through self-teaching and personal experiences with family or friends.

Basically, a relative or two, like that. And maybe one other [friend], besides that, just trying to advise them and help them out. Pray for them, too. Of course, pray for them (coalition member).

Although most interviewees expressed comfort with the topic, others shared that they could have used more education. Interviewees who shared this perspective had often learned about SUD only through personal experiences, news, or media campaigns.

As an officer, you deal with them out on the calls, and you see them every day, and you see them at gas stations when they're messed up. I wished that I would've known more when I was in law enforcement (criminal justice stakeholder).

Treatment

Overall, most interviewees understood that having a substance use disorder was a medical issue requiring specialized medical treatment, but most did not distinguish between the different modalities used to treat addiction to different substances. Some interviewees demonstrated awareness of other ways to support and treat persons with addictions outside of medical treatment. They commonly shared opinions about the importance of integrating mental health and SUD treatment for success, commenting on the importance of treating the underlying issues (mental illness and/or trauma) to relieve the symptoms of SUD.

I truly think that integrating mental health, making sure that mental health is integrated into addictions work, is vital. Just because, again, it goes back to traumas, and hurts, and things that have happened to people over time. I think a lot of times people get into recovery and the mental health piece and that history that's behind it is forgotten. And so, people start to get into recovery, and they start doing well, and then something in life triggers them and they go back to their coping skills. And so, I think the mental health piece is so vital (medical care provider).

Attitudes and stigma related to SUD and SUD treatment

Attitudes are informed by knowledge, but attitudes may differ from person to person even when people have similar amounts of knowledge on a subject. During the analysis process, attitudes were coded as being distinctive from knowledge. As an example of this distinction, two people may know the same information (have the same knowledge) about healthy alcohol consumption levels but have different attitudes about whether or not they want to adhere to these consumption patterns or about why others do or do not limit their consumption. These attitudes are expressed as specific types of stigma: received, internal, perceived, and associative.

Received stigma and attitudes about SUD

Received stigma is stigma expressed directly toward an individual by another individual. In this study, the stigmatized group is those experiencing SUD or seeking treatment for SUD. Interviewees expressed few clear attitudes of stigma; they described a myriad of complex factors that they believed might cause addiction, most of which did not include people's moral failing. Almost all interviewees mentioned more than one factor being responsible for an addiction, including substance use for self-medication, intergenerational cycles of substance use, trauma, and access to substances. While self-medication could be seen as a choice, it was often cited as a response to trauma and expressed in sympathetic manner. In addition, interviewees explained addiction and SUD as resulting from mental health issues, lack of treatment or support, genetic predisposition, stress of poverty, and social or cultural norms.

A few interviewees shared stories of stigma expressed by referral sources toward people with SUD. For example, the desire for SUD recovery to be straightforward and seamless can lead to frustration on the part of the interviewee and their colleagues. In addition, interviewees talked about other health and social services providers or referral sources wanting to see people be fixed or make better choices.

What I'm seeing, and this is all anecdotal, is that unfortunately, I'm seeing from mental health and substance misuse providers is that they're wanting harsh,

harsh responses from the courts when people are messing up. They're wanting short-term detention stays, and they're wanting long-term detention (criminal justice stakeholder).

This is going to sound really bad, but the people I work with, they show a lot of frustration about the people, especially the ones that come in over and over and over again. They show frustration that they're not making better choices for themselves. And the comments can get quite derogatory (medical care provider).

But I think that down here there's just so much stigma and judgment, and that hurts because then we don't want to help those people. Or we decide that they're not deserving. Or we decide that, "Why are you getting help from the food bank? If you're a user, why don't you just stop buying drugs? And then you could afford to buy food" (social services provider).

One provider discussed their own challenges having compassion for people with SUD who have higher socioeconomic status.

I think it's easier for me personally to have empathy for those [low-income] families than it is for an upper-middle-class family, parents who are a doctor and an attorney. And we get a report on them, and all you hear from them is, "Well, my kids have iPhones and they've got clothes from American Eagle or the Gap or wherever kids are shopping these days. So how are my kids being neglected?" Those are the families that I personally struggle with and really have to remind myself that obviously there's a reason for that as well. So I guess it's easier for me to have empathy for families who've had to struggle more and who are more underrepresented (social services provider).

Many other interviewees voiced broad-based support for people seeking out treatment and understanding that people tend to not seek treatment and recovery in a straight, orderly path.

Everybody's in sort of a different spot on their journey. Sometimes when they're telling me, they're telling me because they're starting, they're in the recovery, they're in that process already. Sometimes they're looking for help and sometimes it's just where they're at. At that point, I just let them know that I'm there for them to support them if they're ready to take the next step (early care and education provider).

Interviewees shared that they also considered the broader social determinants of health as the context within which successful treatment and recovery occur. One factor influencing someone's substance use was the person's surrounding environment. A disruptive, traumatic, unsupportive, unstructured, or otherwise unhealthy environment was frequently mentioned as a cause or trigger for substance use. In this explanation, the user likely has little control over the situations that create their current environment.

I think when you deal with trauma and then even when you're considering [...] If we looked at Maslow's hierarchy of needs, and if you can't have just the basic security, shelter, things like that, it kind of creates the perfect storm (medical care provider).

Some interviewees talked about poverty and other daily life stressors as types of trauma, which are specifically exacerbated by the economic context of rural Montana.

Living in Montana is stressful because your expenses are high and your wages are usually low. You're trying to figure out how you're going to pay the rent every month and just to escape from all of that stress (medical care provider).

There are some populations toward which higher rates of stigma in connection with substance use are directed. These include parents, people with mental health diagnoses, people who have a criminal record, and Native people. Stigma against Native people is also discussed in the Culture and Community Norms section of this report. This pattern was more present in Havre than in Miles City or Hamilton, largely because Havre is adjacent to tribal communities.

I mean, there's a lot of stigma and I think a lot of just historical issues with alcohol use, and now alcohol has turned into drugs, alcohol and drug use. I do feel like Natives are kind of treated differently because of historically, like, "There's a drunk Indian," or whatever. Those stigmatizing phrases or things you've seen on TV, or heard, or whatever. Those things kind of stick in your brain. Then you have somebody walk into the ER and it's like, "Yep, see, I told you that's how they are." But then you don't think that when you see just a random Caucasian male walk into the ER and he's drunk. You don't have that stigmatizing thing in your head because you never saw the racist comments before for that race (medical care provider).

I do feel though, that probably as far as just seeing the disproportionate amount of Native people that come through our court system, that yeah, maybe they're more likely to receive a citation for something that maybe if they weren't Native, they'd say, "Well, don't be doing that, go on your way" (coalition/task force member).

Some interviewees attempted to express realities about SUD that are difficult to discuss but are not necessarily stigmatizing. These types of comments were mainly made by healthcare providers on the topic of patients manipulating providers. An example includes the following statement made by an interviewee in the mental health field:

She cannot believe [...] all the calls for medication. And they're just doctor hopping or whatever to get the meds that they want (prevention specialist).

Whether intentionally or not, some interviewees directly expressed stigmatizing beliefs or stereotypes about individuals with SUD that could negatively affect these individuals and their potential for successful treatment. It is important to recognize the role that language plays in normalizing stigma and to try to steer clear of phrases that stereotype and may lead to an increase in public stigmatization of those with SUD. Language like "doctor-hopping" serves to distinguish socially deviant or manipulative behavior that falls outside of social norms. Also noted was the perception of users as liars who will "tell you anything" and in desperation will "try anything" to get high. This reflects the common stigma of people with SUD as "dangerous" (Corrigan & Nieweglowski, 2018).

To many, people with SUD do not fit into the socially agreed-upon definition of success and are therefore seen as failures or useless to society. Determining someone's worth based on productivity is a keenly Western mindset, which fits closely with rural notions of "bootstrap" success. Parents are seen as key players in determining whether someone achieves success, and it is perceived that when parents do not instill notions of hard work and success in their children, the children fail. By failing to meet so many rural community norms, people with SUD are "living in a different universe." (social service provider)

Most of what I know is what I see and read and hear, and it's kind of my opinion that a lot of these people in the first place, they don't want help. They seem to be

happy the way they are, I don't know. Or possibly it is bad that they can't, that they can't find a way to quit (social services provider).

While the stigmatizing views expressed here must be addressed to ensure that individuals with SUD in each community are able to access treatment without fear of stigmatization, these views were expressed by a small portion of those interviewed and do not represent the majority opinion.

Across all three communities, interviewees expressed high levels of compassion for people experiencing SUD. The overwhelming majority of interviewees shared comments of support about people with SUD, including recognition of the difficult lives they have led, the factors out of their control that led them to use substances, and the importance of treating others with compassion.

Going through recovery is not easy work for anyone for sure (social services provider).

Interviewees also shared their personal willingness to support those with SUD.

I would be more than happy to help somebody. I would give as much help as I could, if somebody did come up to me and say, "I need help with meth. I got a meth addiction or opiate problem." I'd definitely get them on the right track to get help, what I could do, I guess as much as I could do (criminal justice stakeholder).

I wish it wasn't so stigmatized and shameful of an experience for people. I think we are all in some level of recovery in our lives. And so, whether it be drugs or whatever. So, I wish that we embraced our communities in a more loving, supportive way. Because that makes a huge difference (medical care provider).

Interviewees were also able to sympathize with experiences of addiction by sharing their personal struggles. This included an expanded understanding of addiction that included non-drug-related issues. By relating to people with SUD on a personal level, interviewees may be demonstrating the ways in which they dissolve the "otherness" that surrounds people experiencing SUD and OUD, realizing that they themselves are not far removed from the opioid epidemic or adverse impacts from substance use, whether through their own struggles or the experiences of their neighbors, friends, and family.

I've always said, well, I think we all have an addiction. We all have an addiction to something, whether it's be shoes or purses or chocolate, or [...] we all have an addiction. And if you thought for a minute, if you ever ate chocolate again, you would lose your kids, would you ever eat chocolate again? Jeez. It might happen (prevention specialist).

Internalized stigma about SUD

Internalized stigma, or self-stigma, is generated from the negative impacts upon individuals who are receivers of public stigma (Bos et al., 2013). This internalization affects how members of stigmatized groups make decisions and interact within their environment. Despite expressing general empathy toward individuals with SUD, interviewees said that individuals with SUD can worry about how their friends and family would react if they knew about their SUD, and this worry creates a barrier to seeking treatment.

It's such a small community that people don't want to go to things like AA or NA [Alcoholics Anonymous or Narcotics Anonymous], because people around here don't keep things quiet. I'm not saying the professionals necessarily, but the people that go to the groups (medical care provider).

A few providers said that individuals with SUD generally have low self-esteem and carry shame with them because of their SUD and potential associated negative actions.

With stigma with adults and substance abuse, they've done so many bad despicable things. The list goes on and on, and they know this and the community knows this. We start with that. When you're actively using you have a different mindset. Your priorities are different. People can't be trusted. It's not safe to be around them. They're not safe in the community. They're going to harm people depending on what their method of getting money is. They might knock you over the head and take your money so they can go score. They might sell drugs to your child because they have no morals or values about it. They just want to make their money. People have done these things so all of that is true. They know it. Other people know it, and that shame is the baggage. That's what they carry (social services provider).

In each community, interviewees expressed the view that internalized stigma closely aligns with rural community norms: reputation, social isolation, Western mentality, and avoidance. People are concerned about failing to uphold their rural community norms and therefore about being stigmatized for seeking help, which can impact treatment access.

I still see it all the time where people tell people to just deal with it, just deal with it, just deal with it. They're embarrassed when they have to admit that they're not tough enough to just deal with it (medical care provider).

As is clearly seen, concerns about one's reputation can be heightened in rural communities. Furthermore, individuals are concerned about how others will perceive not only them, but also their family.

As an addict, when you're a newcomer to the meetings, a lot of times it's really hard. As addicts, we aren't always the first-class citizens that everybody wants us to be. And so we've done a lot of things that have hurt our families, or hurt other people, or we've gotten a criminal record out of our addiction. And so a lot of times, it's hard for people to find a way to see that there's something inside of them that can be loved (recovery specialist).

Perceived stigma about SUD

Less pronounced than received stigma, perceived stigma is the belief that others have negative thoughts about a certain group. The majority of interviewees perceived that stigma in each community comes primarily from the general public rather than specific individuals or professions. There is a sense that “they” (the community) judge people with SUD harshly, use harmful labels, support punitive rather than harm reduction methods, and have a generally poor opinion of people with SUD, a group of people “they” believe has chosen to experience addiction.

I think the general perception is that addiction is a choice, not a disease. So I think they feel like people should be able to just not do it and be fine, and I don't think they kind of understand that it should be treated like an illness, like any other sort of disease and needing that support and everything (medical care provider).

Many interviewees shared their thoughts about their perception of others' beliefs about individuals with SUD.

I think that the belief that those who use drugs have a character flaw has been in our society for many, many, many generations. I'm not sure that's something that I've seen a shift in (medical care provider).

Others noted that individuals with SUD might be hesitant to seek out treatment because of their concerns over others' perceptions of what treatment means.

I think in trying to send some people to treatment, even for overdose or suicide attempt by different modalities, I feel like they genuinely want the help, but they feel like people are going to think that they're crazy (medical care provider).

Some interviewees also spoke specifically about stigma on the part of criminal justice stakeholders toward people with SUD.

That's one of the struggles is that either you have a prosecuting attorney's office that sees a diagnosis and then sees that there's a supposed answer to that diagnosis [in SUD treatment] and then that kid should be fixed or that family should be fixed after a short 28 days, then come back and they expect that child and that family to be responding smoothly, and then all of a sudden that kid's goofing up again and then they want much harsher punishments. Or, you know, it's the same thing for a judge that sees the kid and the family in over and over again, and they want an answer and they want something put in a cookie cutter response, and you just can't (criminal justice stakeholder).

Just from my own involvement in different forums and different circles, I think the stigma is incredible against folks in the criminal justice system and with substance abuse issues. We need to not only find ways to bring more education and skill-building into their life but we need the people in charge, the judges and the police. It's kind of the luck of the draw, and some [criminal justice] people have educated themselves or they have a certain background, or they have a certain attitude where they have a little more compassion (social services provider).

Associative stigma and attitudes about SUD treatment

Associative stigma, also known as stigma by association, is defined as the stigmatization of people or places that are associated with stigmatized individuals (Bos et al., 2013). Associative stigma takes place when people indirectly make negative inferences about something because of the individuals' association with the thing in question. In the case of this study, the associative stigma is applied to services and treatment modalities used in SUD treatment and prevention. This type of stigma can be placed on SUD treatment in general, places that offer treatment, or specific elements of a treatment program. It can also be extended to social support programs or staff that assist people experiencing SUD. This extension of stigma can affect the way people seek treatment, as they may want to avoid being associated with the treatment element.

Several interviewees cited instances in which certain treatment types or the implementation of harm reduction interventions were disliked or dismissed because of the stigma attached to the people who use those services and treatments. On the subject of needle exchange, it was apparent that there was stigma associated with this evidence-based practice used to reduce transmission of viral diseases such as HIV and hepatitis C.

For law enforcement, [needle exchange programs are] a catch-22 I guess. You'd rather see people exchange their needles and not find them laying on the streets, the parks, or anything like that. I don't know. You also don't want to see someone that thinks it's okay to do it now because of that [an exchange program]. I don't know. That's just one thought that law enforcement might have. It may increase someone using if they're switching to that (criminal justice stakeholder).

Well, I just know that when we had like a training, that was one of the things they asked do you [...] just kind of like had you move to one side of the room or the other about whether you felt that needle exchange was enabling or whether you felt it was treatment or whether you felt it was prevention, and it was just interesting to see how the whole room just split (coalition/task force member)

There was a tension among interviewees, who varied in their perspectives on the value of treatment and other harm reduction approaches versus punitive approaches across criminal justice, health, and human services systems.

I think where I've seen the most change is within the law enforcement and the legal, and also within the CFS [Child and Family Services] system. When I think about like in the CFS system, I work pretty closely now with the CFS caseworkers, and they really seem to have a pretty good understanding of what's happening with families, and they're pretty willing to be supportive. I've seen a lot of change in how they're writing treatment plans for families (early care and education provider).

That's where prosecutors and that's where district court judges need to, frankly, stay out of thinking that they're able to provide treatment and programming for kids, and allow the professionals to help them navigate that that are on the ground, and when they make that recommendation, do not hold this kid in jail because they need the programming in the community (criminal justice stakeholder).

The stigma expressed by professionals in the legal system seems to lead law enforcement to support more punitive measures than do participants from other sectors in each community. Only interviewees in the legal and criminal justice systems expressed support for legally punitive treatment as a treatment modality. Some of these legally punitive suggestions included threatening to use criminal prosecution and jail time, the use of restraints, removal of children from families, and “get[ting] them in the system” as motivators to change and necessary for the initiation or sustainability of SUD treatment. While proponents of both harm reduction and punitive methods are genuinely attempting to assist people with SUD, a punitive approach is widely debated and generally not accepted by the medical, mental health, and public health sectors (HHS, 2016). It is important to note that this pattern was observed only in Havre and Miles City. Hamilton interviewees in the criminal justice category reported a positive view of treatment and did not see punitive approaches as essential to treatment success for some individuals.

When I was a prosecutor I believed in prosecuting, certainly, the criminal distribution of dangerous drugs, because those folks are the ones that are going to go burglarize and commit partner family member assaults as well, when they have those serious addictions. You need to get them into the system and try to get them help (criminal justice stakeholder)

Interviewees spoke to the myriad of reasons why people struggle to be successful in their treatment programs. Their concerns centered on the attitudes of treatment providers, programs that are too punitive or are not willing to meet the client in their stage of change, or programs with expectations so high that clients simply cannot meet them. Additionally, the interviewees pointed out certain characteristics of the clients that prevent treatment completion, including manipulation of the program, lack of support for pursuing treatment from family and friends, and insufficient social support in their lives more broadly.

So, if you tell me you're not going to do this and you're not going to do this—and you do, then I will eventually sever the relationship, because I can't treat you if you're not honest with me (medical care provider).

You almost never ever saw just the cycle of violence and poverty and continued drug usage. It's so hard to break when it's in their home. They go to treatment and come back, and they're offered a needle or a bottle or a bong the day they get out of treatment—in the parking lot! (recovery specialist).

Support was by far the most commonly mentioned reason for success in treatment. Essentially, being able to surround oneself with a supportive environment seems to be highly indicative of “recovery” in each community.

You have to have good support when they come out, whether it be family, friends, church, AA, NA, whatever. They have to have that support in order to stay sober (recovery specialist).

Following behind support was self-determination, in which the individual made the decision to “get better” rather than having an external force make that decision for them. This idea was expressed across multiple sectors, including law enforcement and treatment court, two areas that also espoused support for more punitive treatment measures. Acceptance and accountability, or willingness to admit one has a “problem,” were also mentioned across sectors and align closely with the previous category of self-determination.

In addition, interviewees expressed the importance of having a positive sense of self in order to achieve success in treatment. Those who saw this as a source of success were frequently also those who felt that people with SUD needed to be held accountable, often in punitive ways, and who expressed received stigma about the sources of SUD. In fact, many of the stated reasons for success in treatment are mirrored in the reasons for unsuccessful treatment. These included a lack of support, forced entry into treatment, and lack of accountability or denial of having a “problem.” Many also noticed that continuing to surround oneself with the same social group or other users frequently has a negative impact on treatment. Others believed that people had to truly hit “rock bottom” in order to successfully recover. Support for treatment seeking was often framed around a question of readiness on the part of the individual in need of SUD treatment. There was a shared perspective among interviewees across all three communities that success is often driven by desperation when one’s life is crumbling as a result of substance use.

And you hear the phrase, "I hit rock bottom, and I had nowhere to go but up," I think those people are more receptive to the treatment and to work the program and work their treatment and be successful at it. Because, I mean, they've got nothing else to lose except for their life, period. They've destroyed pretty much every relationship they have, they're broke, they have nowhere to go, they don't have any money, they can't support themselves. And, I think the ones that have been successful are those ones that, that have finally reached that point (criminal justice stakeholder).

Others supported a more individualistic, or Western mentality, believing that people should be able to “pull themselves up by their bootstraps.”

You can do it by yourself. And I think that's a lot of where people get discouraged. Okay, well, so basically, you're saying because I can get clean and sober by myself, that I'm not an addict (recovery specialist).

Employment was often seen as pivotal in successful treatment, potentially as tangible, visible proof that something has changed. The tendency to connect employment or employability to self or social worth was noted by multiple interviewees.

I know that sounds funny to base it all on being able to have meaningful employment but that is hugely important to me to hear them say (medical care provider).

Interviewees spoke about the importance of leadership in creating a culture of support for people seeking treatment.

When I was working in the Missoula office, I would go a lot of times to the Family Treatment Court that Judge Larson does in Missoula. And I think that his court really encouraged the use of medication-assisted treatment. And I think that was a really positive thing. I think sometimes when you have somebody that's a judge or a medical doctor or someone like that who says this is good, I think people are more likely to get on board with things like that (social services provider).

One key area where leadership is needed, beyond the symbolic impact derived from community leaders' support for treatment, is the need to develop a more robust continuum of SUD services to assist individuals through their treatment and recovery journey in each community.

There needs to be places for people to go that are struggling because you go to the hospital. I mean, a person that doesn't have SDMI [Serious Disabling Mental Illness], is not suicidal or homicidal or greatly disabled goes to the hospital, they give them some medication, they get through withdrawal, but if you're not in a program and you're not continuing to get that care, what are you going to do? You're going to go back to use again in order to stop that feeling that's really horrible (medical care provider).

Common perspectives on substance use conclusion

Across all three communities, interviewees demonstrated knowledge about SUD and treatment for SUD. There were negative attitudes expressed as all types of stigma, as well as consistent, empathetic attitudes toward sources of addiction and the importance of treatment access. Received stigma about those experiencing SUD, or who engage in substance use, continues to be present and was expressed in contrast to the ideal of a person who is hard-working, individualistic, and committed to their family. It should be noted that negative views were expressed by only a subset of interviewees. Negative views were most prominently expressed as a perception that a stigma is held by other members of the community about those with a SUD, and as associative stigma about various forms of treatment and strategies associated with harm reduction.

As will be further explored in the case study sections, stigma regarding OUD and MAT varied between sites. Specifically, interviewees in Hamilton shared the view that stigma reduction efforts within their community have been increasing and have been effective at reducing stigma; this phenomenon was not observed in Miles City or Havre during this research.

Case Study 1: Hamilton

General characteristics of the community

Hamilton is located in western Montana's Ravalli County. Hamilton is a growing community with an estimated 4,898 residents and an annual growth rate of over 12% (US Census Bureau, 2019 estimate). "One thing that has changed a lot in the Bitterroot Valley is growth. Ravalli County is not anything like it was when I was in high school" (criminal justice stakeholder).

Hamilton's SOR provider is Western Montana Mental Health Center (WMMHC), and its federally qualified health center (FQHC) is Sapphire Community Health. Both provide MAT services to clients. The WMMHC MAT program is funded in part by the State of Montana

through the STR and SOR grants under the SAMHSA to provide substance use treatment for people with opioid use disorders.

Rurality

Many interviewees discussed challenges associated with Hamilton's and Ravalli County's rurality, including service availability and people's willingness to access services. Hamilton's proximity to Missoula provides community members with increased access to SUD services across the continuum of care, particularly for people with more acute treatment needs. Nonetheless, the distance creates a myriad of access barriers, including limited transportation resources, more time required to travel, and the need for supportive services like child care.

All the services are in Missoula. A lot of people can't travel to Missoula (criminal justice stakeholder).

Culture and community norms

Interviewees talked about an evolving culture, from one that normalizes alcohol and broader substance use as part of a legacy cowboy culture to one that increasingly sees and understands the negative impact of SUD on its citizens and community.

Interviewees commonly mentioned that substance use, particularly alcohol consumption, has been a part of Hamilton's and Montana's culture. This culture of use is based on learned behaviors passed from one generation to the next.

Alcohol has always been a prevalent issue in Montana in rural communities and is normalized in society (medical care provider).

I think especially with the alcohol, it's kind of a learned behavior. Their parents have done it, their uncles, their aunts, their grandparents, so it's kind of a cultural learned behavior, especially with alcohol (medical care provider).

People's willingness to acknowledge the need for help to address a SUD and/or seek it is purportedly impacted by a culture of self-reliance.

From my experience, what I've seen is that sense of "I can do it myself." What they would title that as cowboy mentality (prevention specialist).

However, multiple interviewees discuss a noticeable shift in the local culture, from substance use as a rite of passage to concern about SUD and addiction. A few interviewees cited local youth deaths related to opioid overdoses as an inflection point for some community members.

You got the cowboy, you got this old school, good old boy club type atmosphere with a lot of these guys that used to drink out in the mountains and fist fight and shoot guns. And my kid ain't doing this, but yet their kid dies the next week of a pill overdose, because he went to a party high on four Oxycontins or whatever the hell. And then they're like, "Oh, we need to educate our kids." It takes some type of dramatic event to finally see the need (prevention specialist).

Interviewees also reflected on the influence of Rocky Mountain Laboratories on local behavioral health and community culture. One lab staff member lost a family member to suicide, which led to the founding of the MIKA (Mental Illness Knowledge and Awareness) community coalition, which focuses on community education around mental illness and SUD. MIKA was founded around the same time as a community-wide SUD conference, which reportedly played a part in enhancing cross-system collaboration around SUD.

We did a big community conference a year ago. It was a strategic planning session about substance use disorders, and it was kind of a neat coalition. It was held at Bitterroot College, and we had folks from the local hospital, from local mental medical care providers. We had the juvenile system there, we also had the sheriff's department and the county attorney. It's kind of this odd group. You have a couple of the old ranchers and farmers and Bitterrooters who are sitting in a room saying, "Hey, we're really worried about people with addictions and how to support them" (early care and education provider).

Primary substances of concern

Interviewees discussed concerns about a range of substances used in their community, most commonly citing methamphetamines, prescription medications or opioids, alcohol, and marijuana.

We see pretty much the whole spectrum, from illicit drugs to abuse of prescribed medications as well. Meth, opiates, those are actually the two big things we see a lot (criminal justice stakeholder).

I think the truth of the matter is, is it's a lot easier for people to get ahold of meth or other things right now than it is using an opioid classification (early care and education provider).

We're seeing, of course, a lot of alcohol. That's really the main thing. We see a lot of marijuana, a lot of pot use. Some for medicinal purchases, some recreational. We don't really see those so much in the CFS cases because that doesn't tend to impact parenting as much, but we have a lot of parents who are just self-reporting to us that they are using a lot of marijuana. We see, unfortunately, that the big one that I work with a lot is meth (early care and education provider).

The opioids we see occasionally, but not anywhere near what we see currently there is kind of a cross addiction trend between opioids and methamphetamine. It's that upper, downer high that people seek. I think alcohol has always been a prevalent issue in Montana in rural communities and normalized in society again (medical care provider).

Awareness about SUD treatment services

Most interviewees felt Hamilton had a relatively robust infrastructure of SUD treatment and recovery services, particularly for outpatient services. Cited weaknesses in the continuum of care included waiting lists for outpatient services, access challenges related to the health care delivery system (i.e., screening, navigation, and funding), and disconnection between outpatient and inpatient care. Interviewees were generally knowledgeable about the treatment resources available in the community for addiction and mental illness. Most interviewees were able to name the community's SUD provider resources. The SUD continuum of care also includes other counselors, a mental health crisis facility, and recovery services (e.g., Alcoholics Anonymous and Narcotics Anonymous).

There are several licensed addiction counselors, and there are some groups (social services provider).

We actually have a crisis facility here for mental health through Western Montana Mental Health. West House is a mental health crisis facility. It has several beds that on the involuntary side and several beds of voluntary (criminal justice stakeholder).

Hamilton does not have inpatient SUD treatment options. The nearest such facilities are in Missoula. Hamilton provides primarily outpatient SUD care. “If a patient is recommended to do anything other than that level one once-a-week outpatient treatment, they have to go out of the area” (social services provider). Several interviewees commented on the challenges people face getting access to outpatient SUD services and the lack of interconnection between local outpatient and distanced inpatient services.

We don't have that inpatient to outpatient cohesiveness that I think we're always going to have a hard time with because of our size, to be perfectly honest. Because we're not going to have a facility here. So that's always going to be challenging (medical care provider).

A few interviewees who function as referral sources for behavioral health services noted a waiting time of a few weeks to see a counselor. Providers speculated that the wait times can cause some individuals seeking care to fall through the cracks. Interviewees discussed how some people who do not connect to treatment services end up involved with the criminal justice system, where they receive court-ordered treatment, which may also entail a significant wait time.

The wait to get into services is sometimes long enough that they just stop [...] You're making me think of families that I just know didn't get the help they needed, and I have no idea where they are, and that's over a few years of, oh, yeah, that mom I know, and oh yeah, this mom (social services provider).

One issue at the core of the wait for services is a workforce shortage. Interviewees noted a particular shortage of dual-licensed individuals able to treat co-occurring mental health and substance use disorder needs. Some expressed frustration with screenings, assessments, and referrals made or needed for resources that do not exist in Hamilton, arguing it would be better to focus on how to best use resources in place that are proven to work.

We do way too much hospital-based detox and things while waiting for good placement. Hospitalizing people with mental health or addiction needs does not help them that much. You know what I mean? (medical care provider).

Hamilton's criminal justice system includes a 24/7 program, jail diversion, district courts, youth and adult probation, and parole. Hamilton and Ravalli County do not have a drug treatment court, but, according to interviewees, Hamilton will have a drug court in the near future. From a broader perspective, interviewees described a strong continuum of services and supports for individuals and families across the social determinants of health. Interviewees discussed nutrition and food security programs; housing supports; safety resources including three local shelters for children, women, and men; child and family services; workforce support; and public health programs. One identified gap is the lack of a home visiting program.

Knowledge about OUD and MAT

Interviewees generally had less knowledge about MAT and OUD than they did SUD and SUD treatment options in general. This was particularly true for stakeholders working with individuals to provide services and supports not directly linked to OUD screening, treatment, and recovery.

My limited experience is just being present for when the nurse hands a survivor, a pill to take. And that's kind of the extent of my understanding is that it's a controlled substance to prevent an addict from being able to use or abuse another controlled substance.[...] And just how much power there was in that locked box and signatures required and two hands. And ultimately this

particular person relapsed because she was tired of checking in with the professional and saying, "I need this, and I need that." And, "Okay, I'll come by and I'll give you this." And ultimately this person threw up her middle fingers at the program and said, "I don't want to deal with this anymore. It's just easier for me to use" (social services provider).

However, healthcare providers, criminal justice stakeholders, Child and Family Services providers, a subset of other social services providers, and the early care and education provider were extremely knowledgeable about OUD and MAT options.

Head Start last year really took this on as a national talking point, a national crisis. So, they really provided a lot of resources and a lot of training (early care and education provider).

This was a 2019 statistic, that 13% of high school students in Montana have reported either taking a prescription medication that was not prescribed to them or used it differently than was prescribed (medical care provider).

Many interviewees were clear in their opinions that addiction, resulting in OUD, stemmed from local medical care provider prescribing practices.

I think the availability of drugs and how that was rolled out through providers for a long time was pretty dysfunctional in that we certainly participated in causing more addiction—using older prescribing practices, that were really narcotic friendly, right. Because that was just the way that they were trained, and that's just the way that it was for a long time. That's how we started this whole problem (medical care provider).

I know in Ravalli County, people are recognizing a lot of things have occurred because our hospital system, our doctors were oblivious to the effects. The opioids were never meant to be used past a prime period, and so many were being prescribed. I mean, when they came out with that one to ten system, you know, how's your pain? And as soon as you said eight or nine, they were like, "Here, take this." A lot of our opioid addictions were created by the system. Not all of them, but certainly some of it (medical care provider).

A few interviewees talked about the Ravalli County doctor convicted of overprescribing opioids.

Ravalli County was in the hot seat of opioid distribution by the doctor in Florence (social services provider).

There was a prescriber [Christiansen] that you maybe have come across, who was kind of the poster child prescriber for illicit prescriptions of opioids. And there certainly hasn't been anybody that even holds a candle to his sort of gross neglect or his gross misuse of his prescribing privileges. But there is certainly a fairly wide spectrum of, I think, providers' comfort level of providers' willingness to prescribe opioids, commonly, heavily, chronically. And that's difficult. That creates waves of difficulty, because not only then do those patients become very physiologically and psychologically dependent on the medications that they're on, those are the patients that we're seeing in the emergency department for issues related to substance abuse, prescription abuse (medical care provider).

Impact of stigma and attitudes on OUD treatment utilization and MAT

Received stigma and attitudes about OUD

Interviewees shared stories of stigma by referral sources toward people with SUD. Stakeholders expressed how the desire to see the recovery journey of individuals with SUD to be straight and seamless can lead to frustration on their part or the part of their colleagues. Interviewees talked about other health and social services providers or referral sources wanting to see people “fixed” or make better choices.

What I'm seeing, and this is all anecdotal, is that unfortunately, I'm seeing from mental health and substance misuse providers is that they're wanting harsh, harsh responses from the courts when people are messing up. They're wanting short-term detention stays, and they're wanting long-term detention (criminal justice stakeholder).

Many interviewees remarked on how challenging it is for people to overcome OUD and how, for some, opioids are a gateway to other SUDs.

Opioid use in that capacity of what I've seen as far as addiction, the experience that I've had, I have rarely seen the success of an individual actually kick that habit full. The cravings, the desires to use opioids, it just seems like it's this forever grip (medical care provider).

I have known a few people who were heavy opioid users. One was a young mom of three who was in a car accident and had some crushed vertebrae in her lower back. That was where she started and became hooked before she knew it and that led to a myriad of other street drugs (social services provider).

Interviewees also spoke about stigma toward people with OUD or in a MAT program by referral sources, by other health and human services providers, and within the criminal justice system.

I do think there's still questions about, there are certain treatment services that do not allow somebody in if they're on medication-assisted treatment. I had a question come up today if a patient was able to do MAT while he's on parole. And so, I think there's still some stigma associated with it (medical care provider).

I've seen the ER docs and staff try to weigh their compassion with their judgment when a chronic repeater is in one of their beds moaning, whimpering, crying, shouting for help because the same pain that brought them in last week is plaguing them again this Friday night and they want another shot of a Class 1 pain killer. The ER staff all the while knowing that after they have received it, they will leave quietly and shortly or they and all the other patients will have to endure the same act next week. Same time, same station.[...] Those would be some very difficult calls to make (social services provider).

One person discussed the types of professional experiences that have caused increased stigma toward individuals on MAT.

I had a lady that came in and took advantage of me for six months because she'd come in and wear a cast and after the doctor's office were closed down and she was forging prescriptions, she had a prescription pad from a doctor's office. And I really thought she was in pain because she'd sit out there with the cast on her arm and sway back and forth, like she was in a lot of pain, and I was like, “Oh man, she just broke her arm or had surgery, whatever.” And I sat there and tried

to get her pain meds as quick as I could, every time she'd come in and found out later on, they were forged prescriptions. Then the next person comes in that's actually in pain, I'm like, "Oh they're full of it." And I try to check myself, but some days my emotions get ahold of me too (medical care provider).

Internalized stigma about OUD

Interviewees discussed how the small size of the community makes it hard to access SUD services anonymously. One interviewee talked about perceived stigma related to someone seeking treatment having her or his car seen at a treatment facility.

I know from my perception, if I had become addicted, I don't know if I would want to go there. I would want to go out of the community. I would be worried about the community perception of my car down at a treatment facility (coalition member).

Another individual discussed worries about recovery group attendees talking about others in attendance.

It's such a small community that people don't want to go to things like AA or NA, because people around here don't keep things quiet. I'm not saying the professionals necessarily, but the people that go to the groups (medical care provider).

Concerns about lack of privacy and the potential for negative experiences related to associated stigma may limit people's willingness to access services.

This area was formed by people who didn't want necessarily, anybody involved in their lives, like the government or people telling them what they need to do and not do. That's kind of still very prevalent here. It's not a good community for people to do a lot of change without feeling like they're being judged (medical care provider).

It would definitely be a better level of confidentiality. It's really hard to maintain that confidentiality when you have one mental health agency and one substance abuse agency, and they're run by the same company (medical care provider).

Perceived stigma about OUD

In Hamilton, a number of interviewees shared how they perceived others' perceptions of individuals with SUD.

I think that the belief that those who use drugs have a character flaw has been in our society for many, many, many generations. I'm not sure that's something that I've seen a shift in (medical care provider).

Two communities singled out for their perceptions of SUD treatment and recovery were the faith and AA-connected recovery communities. Interviewees felt these communities perceived sobriety as the only true recovery, and MAT as a different form of addiction.

In Missoula, I've seen there be some people in the NA groups that are against it [MAT], or they don't think that people are really clean, but that's not a part of the requirements for being a member of NA. The only requirement for membership is the desire to stop using, and so there is some controversy within, just how people perceive it (recovery specialist).

But, unfortunately, a lot of times people approach it as some sort of deliverance. Just go and pray over him and poof, they'll be fine, but that's not usually the way it works.[...] But absolutely there's a stigma attached, and there shouldn't be, especially in the church.[...] There are a lot of people unfortunately in the Christian realm that think that it's just a matter of prayer. You don't need to do that stuff [MAT] (faith community stakeholder).

However, as shared earlier, some community members cite a change in the local culture toward SUD.

Ravalli County is on their way. Hamilton is on the up and up. I see more and more people wanting to learn more about prevention, learn more about substance abuse disorder (prevention specialist).

Associative stigma about OUD

Some interviewees expressed negative attitudes about SUD treatment in general and MAT specifically.

It's hard to convince a community that it is a positive treatment modality when there are certainly cases of it not being (medical care provider).

Several providers expressed associative stigma about the medication aspect of some SUD treatment, including but not limited to MAT.

I have a little bit of an issue with always throwing Ativan at people who are obviously alcoholics. That's pretty much alcohol in a pill. Now, it's not as much as Xanax or Klonopin, but I know that some folks have been using Gabapentin and Klonopin together instead of using that, the benzo, to do that stuff (medical care provider).

It's not truly sober, but it [buprenorphine] does save peoples' lives. I think the bottom line is that it's saving lives (medical care provider).

Most interviewees felt that opioid-agonist MAT is a good treatment modality for a provider's OUD treatment options.

I think MAT is a pretty widely accepted possibility for some folks. It's not a one-size-fits-all fit for sure, but it's kind of another tool in the arsenal (early care and education provider).

I especially think it's helpful for folks that have a mental health diagnosis as well (medical care provider).

It's nice to see the people that do get help, and I've seen people that have chronic pain that have been on opioids forever be able to get off the heavy stuff and be able to manage it with some of the medication-assisted stuff (recovery specialist).

Some discussed how individuals can remain on MAT for a long time, and how it is not clear if this is a failure or a better alternative to remaining addicted to opioids.

Sometimes I think it's just another crutch that they have to deal with, and it's not really helping towards their sobriety (criminal justice provider).

I do think there is that danger of overstaying on Suboxone. I don't know that that's a danger. I'm not sure because I don't do all that much research that shows

how harmful that might be. It also includes a lot of opportunities, and honestly, if you're on Suboxone and you start feeling better, then you get a job and then you start interacting with people, then your likelihood to be able to get off Suboxone increases with everything that you do (medical care provider).

Some interviewees shared concerns about MAT misuse, which they did not think negated its importance in the continuum of OUD care.

I definitely see two sides to medication-assisted treatment. I think that I have seen incredible recovery stories of people with the use of MAT. And then I have certainly seen the other side of it that is kind of misused. I think in terms of the success stories, I think it's incredibly important at a harm reduction level. And then also there's a maintenance level as well. So, there's lots of things to consider, but I think it's a really important piece to the continuum of care. And we're happy to have that in our facility (medical care provider).

I can tell you that there's a lot of people in my community that take medications for opioid abuse. That's a really a tough thing because I think there's people that are really struggling and really need the help. And I think there's people that take advantage of it too, but it's hard to identify, you don't want to not help somebody. But I think more focus on weaning people off of, after they've been put on like the Suboxone or buprenorphine. It seems like they just increase the dose and increase the dose. I've yet to see somebody come off of Suboxone after they've started on it.[...] It's tough because pain management is subjective, it's not an objective thing and that's what makes it difficult. People go in and say they have pain, what do you do? Continue to believe them? (medical care provider).

Another discussed concerns about people reselling their MAT drugs.

So some of the concerns that I've heard other people talk about and concerns myself, some of the people, the patients that come in and get Suboxone, it's paid for by state funds, like Montana Medicaid and they pick it up, and I'm making some assumptions here and I don't know for sure, but it's being paid for by state funds and then they're turning around and selling it to people on the street after it's being paid for by state funds (medical care provider).

Many interviewees felt that MAT should be paired with mental health counseling, particularly at the outset of their recovery journey, to be most effective.

Just getting medicine doesn't necessarily treat them (medical care provider).

I think you can really use things like the medication-assisted treatment to really help them through that rough part where they are really ready to make those life changes (social services provider).

What I have observed is most useful is when people can start when they're on medication into counseling so that it helps them to focus. It helps them to feel okay, to calm down. It gives them that soothing, it takes the edge off. At some point they need to be consciously dealing with their emotions. If you're on medications that have you so euphoric or so away from the reality of what those emotions are that are really elevating you or helping you to feel better, that's an assist but only for so long. Then it can become a lifelong thing and it does (social services provider).

Reducing stigma

Many interviewees described a general reduction in stigma toward SUD and OUD, people with SUD or OUD, and treatment.

I think on a nationwide level and also even here, I think the stigma is much better than it used to be. Even folks that you wouldn't expect to be supportive are like, yes. I think it's a lot better, but there are still ways to go [...] overall, it's significantly better. Treatment is looked at as something that helps (medical care provider).

I would be shocked to see stigma there around it because it's very much accepted as a disease, as a mental health disorder. I think that that's widely accepted (early care and education provider).

Several interviewees noted that they support further reducing stigma and that the community would benefit from reducing stigma as well.

As a medical provider I would like to see it that people recognize it for the diagnosis it is and treat it medically and with compassion just like everything else, and that, that kind of spreads out into the greater community. But I think we still have a long way to go from that standpoint (medical care provider).

Most provided input on how they and their organizations are striving to reduce stigma.

We treat everybody equally. We try not to make any judgments on anyone. We try to help everyone that comes into our office and that is eligible for our programs (social services provider).

And that becomes I think the number-one responsibility of the leadership of the church is to create an atmosphere where there isn't a shame factor or a stigma, because if you do that, you're going to bury people. They just won't come forward (faith community member).

Case study 1 conclusion

The community of Hamilton is small, and interviewees shared concerns about how a lack of anonymity can discourage individuals from pursuing treatment. The community stakeholders who participated in this study felt that the general capacity for SUD treatment was adequate, minus inpatient treatment and particular expertise in treating co-occurring disorders. Stigma among potential referral sources was minor, with the majority of interviewees expressing compassion and a desire to support those with SUD or OUD. There was mention of associative stigma toward harm reduction or elements of a MAT program. The main barrier identified by interviewees was a lasting orientation toward punitive treatment approaches among a subset of law enforcement and criminal justice stakeholders—notably, not including the interviewees who participated in this analysis. One key finding was the observation that stigma has been decreasing in the community, as has been the cultural norm of being a Western tough guy—changes brought about in part by public community tragedies. The legacy of overprescribing of opioids and the ways in which inappropriate actions by medical providers contributed to the opioid crisis in the Bitterroot County.

Case Study 2: Miles City

General characteristics of the community

With a population of under 10,000, Miles City is the seat of Custer County and one of the largest communities in southeastern Montana. Miles City is situated nearly 100 miles west of North Dakota, 145 miles north of Billings (the largest city in Montana and the nearest large population area for hundreds of miles), 70 miles north of the Northern Cheyenne Indian Reservation, and 150 miles south of the Fort Peck Indian Reservation.

While Miles City is considered a population and economic hub of southeastern Montana, it is quite small and has limited economic resources. If they are unable to find the services needed in Miles City, most residents will drive the 145 miles to Billings in their personal vehicles. The top employment industries in the area continue to be railroad and ranching.

OneHealth, the main healthcare provider in Miles City, offers an array of healthcare services, including a program funded in part by the State of Montana through the SOR grant under SAMHSA to provide substance use treatment for people with opioid use disorders.

Rurality

The negative effects of rurality on health, including behavioral health, are well known. These effects are often related to limited access to healthcare, which many Miles City interviewees referenced. Rural life can be both geographically and psycho-socially isolating. The concern for maintaining privacy, a good reputation, and the appearance of self-sufficiency also lend themselves to isolating behaviors. This is compounded by the fact that behavioral health services are often many miles away or hard to reach.

With the rural nature of business out here, we have people that drive 40 miles one way to come for a group in Miles City (medical care provider).

Geographical isolation is also a factor in a chronically poor economy where there is a resulting lack of opportunity. This lack of opportunity can create a sense of hopelessness and stress, a commonly recognized trigger for substance use or unhealthy coping skills.

I think a lot of it is just—it's life is stressful, and there's a lot of stress put on people in a rural community, and there's not much hope, and there's not very many opportunities. You can work at one of a couple places for good jobs and that's it, otherwise you're just bored and you don't want to think about how hard it is (coalition/task force member).

Another function of Miles City's geography is its proximity to coal and oil fields. The cyclical nature of these economies, with booms and busts, can create additional hardships, including loss of employment or the presence of "outsiders" that can introduce an actual or perceived sense of danger.

Listening to others mainly just with the flow of folks coming through the pipelines, you see an increase in sex trade workers in different drugs that tapered off a little when the Bakken slowed down. But as things vacillate up and down, I think we do see different drugs coming through different activities (medical care provider).

Culture and community norms

Residents of Miles City expressed identification with a rural identity, effectively labeling themselves as "other" or "separate" from urban or less rural communities. Many interviewees also expressed the perception that their community does not want to address difficult topics

like substance use disorder or opioid use disorder, preferring to avoid discussing these issues altogether.

It just seems like addiction is a closed-door issue here, where people are struggling so low and there's just not very much that you ever hear in the community of mental health or addiction (medical care provider).

Interviewees also stressed the important role of reputation in a small town where people's families have lived for generations and where family status continues to impact how individuals interact with their social environment. As one coalition/task force member put it while talking about job opportunities:

If your family has a bad name, you can't overcome it. And if you have a good name and you have the pressure of don't screw it up, because everybody's going to look at you and everybody's held to that reputation and hired or not hired because of [it] (coalition/task force member).

Identity management intersects uniquely within rural areas through the expression of “cowboy” or “Western” mentalities. This mentality is characterized by a rugged sense of individualism and a “bootstrap” attitude toward mental health that can prevent people from accessing available resources. This identity is not only expressed as a barrier to care but is also manifested as a general way of life, one that often includes normalizing or even romanticizing a hard-drinking lifestyle, bringing rural identity and substance use into close contact. This then brings the relationship full circle: rugged individualism and normalized substance use come together to create barriers to care for substance use treatment.

Because we have a population of very hardy ranchers who are tough and weather out the storms and that's their way of life, and that's truly how everybody. Everybody is generally hardworking, gritty, and feel like people should be able to tackle their own problems, and so I think it's just sort of the perception of how people were raised (medical care provider).

I think the perception that substances are a normal part of life, that you're kind of viewed as what's wrong with you if you don't drink, especially drink in Montana. And to change that culture and mindset it's difficult, and to ask for help, it's no different than the suicide rates or anything else. We live in a strong Western culture where people don't generally like to ask for help, there's shame involved, embarrassment (medical care provider).

When asked generally what they thought of substance use or people experiencing substance use disorders, respondents again reported avoidance of the topic or a general unwillingness to recognize substance use as a problem in their community. This was expressed across sectors, showing wide acknowledgment of “ostrich” behavior (the concept of putting one's head in the sand, as an ostrich might do when sensing danger), as one respondent called it.

“I think some people are just oblivious to drugs. They're like ostriches. They just don't get it. I think there's a generational gap. I live in rural Montana, I don't even think people who don't deal in this work even know that that even exists other than if they saw it on Dateline or something (social services provider).

Among those who are aware of substance use issues, many recognized that it is probably a bigger problem than has been acknowledged, but overall felt that substance use is a negative behavior that requires external assistance in order to alter actions or behaviors toward a more “acceptable” notion of social norm adherence, a perspective that has been identified in prior research (Bos et al., 2013).

I think it's more widespread than what we think, probably (criminal justice stakeholder).

Primary substance of concern

When asked to identify which substances were most often misused in the area or are emerging illicit substances, respondents focused on methamphetamines, opiates, and alcohol. Marijuana was also identified as a substance of concern but to a lower degree than these three. Interviewees also discussed how drug use patterns in their community have changed over time. This was explained in terms of geographical spread (new drugs coming in from other areas) and changes in accessibility of certain drugs or drug components.

Awareness about SUD treatment services

Overall, interviewees did not feel there has been a large shift in the awareness of or attitudes about OUD or MAT since the establishment of MAT programs in the community. However, incremental changes have started to take place, including a slight shift in awareness and acceptance of MAT.

Right now, we are just barely, barely, barely even talking about it (medical care provider).

Residents have access to a number of additional non-faith-based community resources that provide a wider array of services, but there was inconsistent awareness of the resources available in Miles City, Custer County, and throughout Montana, as well as misperceptions about local resource availability.

I think small communities probably have less knowledge of those sort of availabilities. I guess I would consider Miles City to be more like a hub. Just in eastern Montana, it's kind of a healthcare hub, and so we have things that smaller, rural communities probably have never heard of (medical provider).

All five types of interviewees had at least some level of awareness about resources in their community. Interestingly, social service providers appeared to be least aware of services available, especially those related to substance use treatment.

I think it's just, it's one of those things until you need it, you don't really know what's there (medical care provider).

Many interviewees indicated keen awareness of which resources are not available in their community, namely inpatient or residential treatment facilities, sober living or recovery housing for women or families, and waived providers who prescribe opioid-agonist medications. Similarly, when asked about resource availability, interviewees readily mentioned insufficiencies.

Interviewees observed that patients are frequently unable to access appropriate care because of lack of availability, inaccessibility, or service providers' inability to meet patients' constraints or needs. For example, regulations restrict certain individuals from accessing services based on their gender, sobriety, or perceived ability to self-treat. These restrictions were most frequently mentioned in association with treatment court and in-patient treatment services.

We do require, I think two clean patches to get in, too. I should have mentioned that. We want them sober at the outset (criminal justice stakeholder).

Of note, even when people were aware of services available, they often did not know the current name of the services. The use of screenings for substance use and mental health issues was not consistent among interviewees. Some used thorough, evidence-based

screening processes while others screened informally and would send referrals to familiar referral sources. Overall, it seems that even those playing important roles at potential referral sources are only generally aware of what services are available in their area for substance use and mental health care and treatment. This could make an effective referral difficult to achieve.

Yeah, I don't know if there's any specific programs for that. I guess I'm not sure. I'm sure One Health does that. That's the public health clinic. I'm sure. I have not actually ever even stepped foot in their building, so I don't really know (medical care provider).

There are a few experts on local resources, namely directors of mental health centers and those involved in the treatment court. Some of these experts are expanding services through telehealth as a strategy to increase access to care. Similarly, local coalitions could represent a key opportunity for stigma reduction campaigns; in Miles City the coalitions appear to be in a reorganization phase, which could be good timing for new projects.

Knowledge about OUD and MAT

Literacy about MAT for OUD varied widely across interviewees, with no consistent pattern in who is well informed about treatment. This aligns closely with the wide variation in knowledge about addiction. Those involved in the legal and medical professions appeared to have higher literacy overall, but with variation in what was known.

We have the medically assisted treatment. I try to stay up on that. I was just reading the other day—there's two or three—I think I knew two of the drugs. We have a provider in Miles City that is now doing medically assisted treatment (criminal justice stakeholder).

Interestingly, interviewees involved in recovery support services, but not direct treatment, seemed to have a low level of literacy. Many were unable to use specific treatment terminology and readily admitted a lack of experience with treatment.

I've heard of them. I've never been through it myself. I don't really know anybody that has. I don't think there's much of that out here at the mental health. There might be. They might prescribe something out there. When I was going out there, this has been seven, eight, ten years ago, I never heard of anybody being prescribed medications from out there. So I don't know anything about that myself (recovery specialist).

Law enforcement and elected officials also knew very little about OUD treatment options.

I haven't heard of [MAT, or medication-assisted treatment for opioid use], no, but it makes sense (coalition/task force member).

Interviewer: *Are you familiar at all with medication-assisted treatment, the use of prescription drugs to help treat opioid addiction?*

Interviewee: *Yeah, what is it called?*

Interviewer: *There's a couple of them. There's buprenorphine, or Suboxone, or Methadone.*

Interviewee: *Yeah, I've heard of Suboxone. That's the one I hear most of the time. I've heard of those (criminal justice stakeholder).*

Generally, opinions about the efficacy of MAT were positively associated with literacy rates. Those who were aware of MAT generally felt it to be an effective treatment approach.

They see what the difference makes. I mean, they know it's needed (social services provider).

I know this is what they tell me: I don't have to worry about being sick. I don't have to worry about looking for my next fix. The one gal that I just started on it [MAT], she said, "You know, I'd wake up in the morning. The first thing I'd have to do is pull out my phone and start figuring out where am I going to get my stuff today? Because I'm going to be sick if I don't. And then I spend all day looking for the next one. I can't do anything or I don't feel like I can do anything productive because all I'm doing is trying to get my next fix so I'm not sick (medical care provider).

Impact of stigma and attitudes on OUD treatment use and MAT

Received stigma

There was a clear difference in opinion toward users that had substance use disorders with legal versus illegal substances. Opioids were largely included in the legal category, as "pills" or MAT pharmaceuticals can be obtained legally. Many interviewees suggested that people initially become addicted to opioids through a physician-provided prescription. This is in stark contrast to opinions about methamphetamine, to which users are perceived as being unable to have become addicted through legal access. This distinction suggests a view that OUD may have arisen unintentionally, whereas methamphetamine use can come about only through intentional acquisition and use.

Alcohol's a legal drug, and meth is an illegal drug. As for a prescription drug, I think people look down more on you if you're a meth addict than if you have opiate problems (criminal justice stakeholder).

I think that there is, I don't know, maybe I think that there's a little bit more sympathy to an addicted opiate user in some way, because it's something they most likely started in a reasonable way and weren't able to overcome that addiction piece of it. Whereas someone who chooses to start meth and that just has a different feeling about it, generally, in the hospital, I think (medical care provider).

Some interviewees directly expressed stigmatizing beliefs or stereotypes about individuals with SUD. These stereotypes included viewing those with SUD as "blue collar" or "in poverty," again identifying gainful employment as a standard of self-control and adherence to cultural norms.

I'd rather have somebody productive in the community than not, and we do. They are required to get a job (criminal justice stakeholder).

I think that if there weren't anybody who had problems with chemical dependency, whether it was alcohol or drug addiction, then I just think there would be more attentive parents, more attentive community members, more attentive people in just society in general. My magic wand would say, "There's no such thing as drug addiction" (social services provider).

Better families. Not that they can't come from good families, but it's horrible when I have people that are addicts and they start telling me the story, I mean

they don't have a mom and a dad, and they were never made to get up in the morning. And that's been one of my challenges, is they won't get up and come to testing. They have no structure growing up. It just sounds like chaos to me (criminal justice stakeholder).

Others focused on the harsh environment substance use can create, which is an attempt to mark certain behaviors as unacceptable because of their potential to introduce “disease” or poor health to the community. While this may be true for some substance users, there is a risk that by using definitive, assumptive, generalizing terminology, well-meaning providers may be further “othering” those with SUD. By talking about life with SUD as being wholly “other,” they may be defining the problem by life circumstances rather than by clinical definitions of SUD. In doing so, they may be unintentionally excluding community members who have stable lives and an SUD from accessing services with less concern for stigma.

I always ask them if they want to go back to their old life, and the response is, “No.” I say, “Why not?” He says, “That was miserable. I don't want to go back to that.” So to a person, they don't want to go back to that misery (criminal justice stakeholder).

Related to disease avoidance is the stigmatizing perception that users are “dirty,” as evidenced by language such as “get clean” (successfully undergo treatment) or differentiating appearances between those who are “clean” (non-users) and those who are “dirty” (users).

Because you can't get yourself clean, and our court isn't going to help you do that (criminal justice stakeholder).

The role of medical providers who provided prescriptions for opiates in the opioid epidemic is well known and was mentioned as a concern by both medical professionals and non-medical professionals. Providers themselves noted that there is stigma around MAT, and drug use in general, in the medical profession, including pharmacies. One provider noted that local pharmacies sometimes treat MAT patients poorly or even refuse to fill MAT prescriptions. This behavior not only promulgates stigma on public and individual levels, but also affects treatment success—which in turn could feed stigmatizing beliefs about the ability of people with SUD to succeed. One interviewee, a person in recovery, noted that providers in Miles City treat people with SUD with “apathy” and that “if you walk into the hospital, they treat you like you're just a piece of junk” (recovery specialist). This person noted that this reaction is likely a result of fear and lack of knowledge about how best to help people suffering from SUD.

While the stigmatizing views expressed here must be addressed to ensure individuals with SUD in Miles City are able to access treatment without fear of stigmatization, it is important to note that the majority of these direct expressions of stigma were voiced by a small portion of those interviewed and do not represent the majority opinion.

Internalized stigma

Many interviewees expressed the view that stigma is an issue that deeply affects people with SUD and OUD, including their ability to access treatment.

Interviewer: What do you think the other barriers are that prevent people from accessing services that they need for substance use issues?

Interviewee: Obviously cost is another one, and I think the stigma is a huge one (medical care provider).

In Miles City, internalized stigma closely aligns with rural community norms: reputation, social isolation, Western mentality, and avoidance. People in Miles City are concerned about

failing to uphold their rural community norms and therefore being stigmatized for seeking help; all of these concerns affect treatment access.

I still see it all the time where people tell people to just deal with it, just deal with it, just deal with it. They're embarrassed when they have to admit that they're not tough enough to just deal with it (medical care provider).

Clearly, people's concerns about their reputation can be heightened in rural communities. Individuals are concerned about how others will perceive not only them, but also their family.

To me, that's basically the bottom line of it, that they don't want other people to see them get help, because they feel like they could handle it. Don't want to embarrass their self or their family. Like my family hasn't done enough to help me, so I'm taking this drug (coalition/task force member).

The concern about reputation can also affect self-esteem, which in turn can cause reticence to seek treatment or support. The negative effects of stigmatization are well known.

As an addict, when you're a newcomer to the meetings, a lot of times it's really hard. As addicts, we aren't always the first-class citizens that everybody wants us to be. And so we've done a lot of things that have hurt our families, or hurt other people, or we've gotten a criminal record out of our addiction. And so a lot of times, it's hard for people to find a way to see that there's something inside of them that can be loved (recovery specialist).

Oftentimes being unable to uphold the cultural norms of a “Western mentality” and reputation impinges on people's ability to hold gainful employment. As mentioned in the section on attitudes about substance use, employment is seen as a positive attribute over which individuals have control, tying into beliefs about what constitutes adverse use of substances. However, the perception of being in control as symbolized by being a good worker could be undermined if the person were known to be involved in treatment.

Most people feel like they can make it. I think, I would say that. I've felt that for years, that most people feel like they can handle the problems. They don't want to be embarrassed by going somewhere that would give them help, because they may be perceived as weak. Maybe, people begin to look at them more closely and to say, look at them when they're on the job and how are they going to act? “Are you on drugs, now, or something?” Wouldn't say it to them, but watch after (coalition/task force member).

These concerns extended beyond treatment for OUD to mental health treatment, illustrating the co-occurring role of stigma toward mental health. As many people with OUD or SUD also experience mental health issues, they are at risk of being doubly stigmatized in their community.

I think in trying to send some people to treatment, even for overdose or suicide attempt by different modalities, I feel like they genuinely want the help, but they feel like people are going to think that they're crazy (medical care provider).

Perceived stigma

Interviewees in Miles City as a group expressed a small amount of received stigma compared with perceived stigma, suggesting that there may be fewer direct expressions of stigma toward OUD than is assumed. One interviewee brought up a unique insight into the progression a community moves through when handling stigma:

It's been my experience that rural populations that are whiter have more labeling language, and so it seems like sometimes they have a little bit harder time getting over what they're thinking about people who are struggling with addiction usually until they have an experience with someone they know (coalition/task force member).

The majority of interviewees perceived that stigma in Miles City comes primarily from the general public rather than from specific individuals or professions. Many of these judgments were perceived to arise from a lack of education on the topic as well as the religious and conservative worldviews held by many Miles City residents.

Yeah, people have a terrible view on the users. I think in this town, very judgmental. Maybe a lower class of society that's using [...] there's just a lot of conservative, not really forward thinking, want things to be like they were 50 years ago. Good old boy (medical care provider).

While this perception is certainly valid, it was not borne out in the interviews among those who work with people with SUD. Rather than expressing stigma, most interviewees expressed an empathetic understanding of what may cause SUD and an interest in helping their fellow community members.

One specific segment of the community that was perceived to have stigma about substance use was those working in the criminal justice system. Law enforcement was generally seen to hold negative beliefs about substance users and to be uninterested in helping people with OUD. In interviews, members of law enforcement did not exhibit this stigma. However, interviewees identified the treatment court as playing a role in perpetuating stigmatizing attitudes, a perception that did play out in interviews with treatment court staff.

By law enforcement, I'm lumping whether that's treatment court judges whatnot into that, that they perceive MAT as just a substitute drug. Like, "Okay, well, you're not doing this, but then what's the difference now it's legal and you're doing it." It's kind of that shame based (medical care provider).

Associative stigma and attitudes

Miles City interviewees expressed general discomfort with harm reduction methods. Many felt these methods, such as needle exchanges, would not align well with community norms, though harm reduction methods have already been implemented in Miles City through the OneHealth MAT program. However, associative stigma presented most commonly when interviewees discussed MAT, which may be an extension of their misgivings around the perceived misalignment of harm reduction with rural community norms.

I know from my time spent in corrections, there's kind of that, "Well, no, you need to be abstinent. That's the only way you're sober." It's hard for them to understand that the concept of harm reduction versus abstinence (medical care provider).

Low levels of knowledge were associated with more stigma around the impacts of MAT. Those who were less familiar with MAT indicated uncertainty about its effectiveness and expressed the most concerns about the negative effects MAT may have on their community. Many interviewees also expressed concern that MAT is not truly effective as a stand-alone treatment option. This stigma centered on common concerns with, or misunderstandings of, the MAT concept. Given the previously discussed low levels of literacy and knowledge around treatment, many of these concerns likely sprang from a lack of understanding about how MAT works.

As far as using treatment with another opiate, I think people are uneducated and feel like that doesn't make any sense to do—why would we give an opiate to

an opiate abuser, you know? I just think there's a lot of, even the education that goes out, I think there's a lot of people that just don't believe it. They think they know more than the researchers (medical care provider).

The concern about drug substitution was echoed by others, from social service providers to the treatment court.

Because what we're working on is addiction and you can't just take one drug and then substitute another and still not treat the addiction part of it (criminal justice stakeholder).

A large majority of stigma around MAT focused specifically on opioid-agonist medications such as buprenorphine (brand name, Suboxone). Interviewees in Miles City were uncomfortable with Suboxone for a variety of reasons, ranging from concerns about substitution and diversion, to a preference for abstinence, to actual misunderstandings about the usability of Suboxone as a treatment therapy. Although highly literate about substance use treatment options, treatment court staff held multiple negative attitudes about MAT. These attitudes were expressed specifically about buprenorphine, a therapy that is not allowed for participants in the Miles City treatment court. Negative beliefs about buprenorphine in the form of Suboxone included mentions of abuse, diversion, doctor shopping, substituting one drug for another, and a treatment goal of eliminating all medications.

We don't take clients that are on Suboxone because of the problem that we have with them selling them and abusing them. That's the only drug that we don't take because they take Naltrexone or all those (criminal justice stakeholder).

It appears there is also a misunderstanding about how to properly monitor for illicit substances while a person is on buprenorphine.

They can't be on any sort of prescription that'll show up as an illegal drug. Methamphetamine, amphetamine, or any of those, we have to be able to monitor them (criminal justice stakeholder).

If you get on Suboxone, we really can't accept you into our court, because it's going to be a positive, so I've got someone that right now, if they can get to where they're stable and get off of Suboxone, then I will allow them to come in (criminal justice stakeholder).

These stigmatizations and misunderstandings limit the number of people in treatment court that could be successful if they were allowed to utilize buprenorphine. It would be beneficial to remove this barrier given the many other existing barriers to receiving adequate treatment in the area.

Overall, however, MAT and the efficacy of MAT drugs other than buprenorphine were readily recognized as efficacious, and even humane, by treatment court interviewees. The discrepancy between the beliefs of healthcare providers and those of treatment court staff around MAT was a clear pattern in these interviews and may be a characteristic of the local referral system that has an impact on both treatment initiation and referral practices in Miles City.

Oh yes. I mean, I have some people that are on Naltrexone and other stuff, and it does help them get through it. Some of them don't, they change their drugs and ended up through the program where they're not on them, but I think that it does help (criminal justice stakeholder).

Reducing stigma

The overwhelming majority of interviewees shared comments of support about people with SUD, including recognition of the difficult lives they have led, the factors out of their control that led them to use substances, and the importance of treating others with compassion. Interviewees also shared their personal willingness to support those with SUD.

So we just show people that recovery is possible, and sometimes life throws you curveballs, and we're just here to help you every step of the way (recovery specialist).

I guess I enjoy treatment court because I get to talk to these people every two weeks and see how they're doing, and the best thing I can do is give them an "attaboy" and tell them they're really doing good. That's, and at the end of it, when we say such and such has been clean and sober for 270 days, everybody claps. I mean, that's the kind of support system and I'm very proud of the ones that are doing good. And are very proud when we do the graduations (criminal justice stakeholder).

A majority of interviewees also expressed support for harm reduction methods, emphasizing the inefficiency of incarceration. Healthcare providers stressed the importance of safe prescribing, patient-centered care, and holistic, wraparound services. Social services noted the importance of acceptance and support of people in recovery.

I hate the idea of somebody becoming a convicted felon, because they're addicted, you know? (criminal justice stakeholder).

It's amazing, because the people that I work with, they're so just very accepting of the fact that I'm in recovery, and they're very supportive (recovery specialist).

It's just, you're real. You want them to be successful. You recognize that, you know what, you might relapse, but we're not here to punish you for it. Why did that happen, and what can we do to move forward? That's part of that peer support, and when you don't have it, your social worker needs to do that (social services provider).

Interviewees were able to sympathize with experiences of addiction by sharing their personal struggles. This expanded understanding of addiction to include non-drug-related issues reduces the stigma associated with addiction.

I've always said, well, I think we all have an addiction. We all have an addiction to something, whether it's be shoes or purses or chocolate, or, we all have an addiction. And if you thought for a minute, if you ever ate chocolate again, you would lose your kids, would you ever eat chocolate again? Jeez. It might happen (medical provider).

Changing perceptions parallel pointed efforts within the community to make change. This is a reiterative process that is more cyclical than linear and depends largely on maintaining momentum. According to interviewees, Miles City is working to increase the number of MAT providers and peer supporters. Advocacy and awareness on SUD are being furthered through the growth of prevention and community coalitions and expansion of the treatment court. Interviewees were supportive of the treatment court program, and treatment court staff suggested increasing the length of the program to provide individuals with more time to succeed, holding virtual court proceedings, and expanding to other counties. Many of these community-based efforts have been halted due to COVID-19.

So there might be a bit more of a power shift. And if we had ideas or there was a desire to do more, or there was opportunities to do more, I think people might be willing to do that. I think at least on the city council, there's people that I think are compassionate that would hear an argument in favor of starting a program to help people, and I think if there was something like that, people would be in support of it. I think a lot of the people here have, have good hearts to try to want to help people, but they just don't know how sometimes (coalition/task force member).

I wanted to do something about the meth addiction other than incarcerate people (criminal justice stakeholder).

Case study 2 conclusion

The majority of interviewees perceived that stigma in Miles City comes primarily from the general public rather than specific individuals or professions. There is a sense that “they” (the community) judge people with SUD harshly, use harmful labels, support punitive rather than harm reduction methods, and have a generally poor opinion of people with SUD, a group of people they believe has chosen to experience addiction. Many of these judgments were perceived to arise from a lack of education on the topic as well as from the religious and conservative worldviews held by many Miles City residents. While this perception is certainly valid, it was not borne out in the interviews.

More than expressing stigma, most interviewees expressed an understanding of what may cause substance use disorders and an interest in helping their fellow community members. There remain tensions in Miles City as to the efficacy of buprenorphine and the role it can play in a treatment plan for those who enter the treatment court.

This duality is difficult to pin down. It is possible that Miles City as a whole holds more stigmatizing views than its individual residents, through a sort of crowd mentality that holds antiquated beliefs on substance use. It is also possible that Miles City is in a period of change, where individual beliefs are progressing but not yet those of most residents. Furthermore, it is difficult to separate this issue from the current political tension in the United States, where conservatism and liberalism are at extreme odds, and any benignly intended comment can be construed to have political meaning. Perhaps Miles City is changing in a slow, covert way that avoids direct conflict with the overarching conservatism of rural America.

Case Study 3: Havre

General characteristics of the community

With a population of approximately 9,791 people in 2019, Havre is the seat of Hill County and one of the largest population centers along the Hi-Line of north-central Montana. The Canadian border is located 36 miles to the north of Havre, the Rocky Boy Indian Reservation seat at Rocky Boy Agency is 33 miles to the south, and the Fort Belknap Indian Reservation border is approximately 47 miles to the east. Given its proximity to the Rocky Boy Indian Reservation, the town is known as a “border town,” as a significant number of Native people reside in Havre or travel to Havre from Rocky Boy to conduct business and access services. Many people living in Havre drive 112 miles south to Great Falls for services that are not available in the area. Unlike many rural communities in Montana, which have seen decreasing populations over the past decade, the population of Havre increased approximately 3.1% from 2010 to 2019. Havre is an economic hub for smaller communities in the area, which is reflected in the top employment industries, including railroad, healthcare,

education (including the community college Montana State University–Northern), retail (Walmart, various grocery stores), and county and municipality governments.

As part of a robust healthcare portfolio, the Bullhook Community Health Center is an outpatient medical clinic that offers a full range of medical services including a program funded in part by the State of Montana through the STR and SOR grants under the SAMHSA to provide substance use treatment for people with opioid use disorders.

Rurality and geography

Havre's circumstances as a small town that is geographically isolated from larger cities play a significant role in how substance use treatment is delivered and accessed. The people interviewed were aware of the unique barrier created by rural isolation and the need to create programming for SUD treatment that can address that barrier.

I thought I knew where rural was until I moved here and realized really it's just very different than what I was imagining or what I had known rural to be. And the lack of resources that come with that and all the other difficulties that come from being in a rural setting has been an interesting setting and environment to adapt to and to do programming in (coalition/task force member).

We are a small town, but we actually are a larger town than some of the other small towns around us. And so we get a lot of patients from everywhere, and we need to be as big and as a full service as possible, because the next option is so far away (medical care provider).

The theme of “everyone knows everyone—and all of their business,” common to rural small-town life throughout Montana, was prevalent in conversations around substance use treatment. Interviewees found that knowing their clients and colleagues on a personal level came with both benefits and challenges. Knowing someone—and in many cases, having grown up with someone and understanding the context of that person's family and social life—can change how care is provided or accessed. From the perspectives of both the provider and the client, having previous knowledge of the people in the service relationship can either improve service access or create a barrier to it.

One example of how previous relationships, or the lack of anonymity in small towns, affect access to SUD treatment was provided by an interviewee who noted how difficult it is for potential attendees to decide to begin attending Alcoholics Anonymous (AA) meetings, where they are likely to know others there:

You walk into this building, and you don't know who's in there. You might know some people because we are a small community, but it's so hard to make that first initial step to get into that recovery meeting (criminal justice stakeholder).

Simply having grown up in the community and being well connected to the people being served can elicit different feelings for providers in treatment or support situations.

I know pretty much the Hi-Line, and that's kind of bad for me because I know who does drugs up here and who doesn't and it's like, “Oh Lord” (social services provider).

Culture and community norms

Havre shares with other rural Montana communities a number of factors that either facilitate or impede substance use treatment programming and access. However, interviewees brought up several unique aspects of life in Havre that also affect programming and access, including the influence of Native culture and a lack of community and individual financial resources.

Havre's proximity to two Native communities was the cultural aspect most commonly mentioned by interviewees. While some interviewees stated that they did not believe providers treat Native people any differently when providing care, others both directly and indirectly reported that racism affects local programming and access to medical and substance use treatment.

Havre is what we would call a border town because we border Rocky Boy Reservation and Fort Belknap Reservation. I'm Native American. I'm from Fort Belknap. And I myself have encountered racial discrimination at the emergency room because I am Native American, I believe (medical care provider).

So, I personally would say that I think that our healthcare workers and our officers that I deal with are pretty open to whether they're Native or not [...] that they're welcome to seek services, so as far as that aspect. But I definitely think there's a perception that most of those people are in a position of power or a position of controlling those services are white, and they don't look like them and they may not understand their culture, and they may not understand even basic things like not looking straight at them isn't rude, that's a cultural trait, or intonations. So I do feel like there's some disparity there (coalition/task force member).

There needs to be a level of trust I think, both ways. I don't think we're there yet. I think we're working on it. We work quite a bit with the prevention specialists on the Rocky Boy Reservation, and it's an open conversation that we have. Like how can we better serve your people? How can your people be better served on the reservation? And are they receiving the amount of services they need?(coalition/task force member).

Another issue affecting many rural communities is the lack of financial resources compared with larger cities. Interviewees cited this issue as creating barriers to both access to and use of substance use treatment at the community and individual levels.

I think that we have, believe it or not, a high poverty rate. And I haven't looked at my numbers. I know one of our specialists did a report two, three years ago, specifically on poverty. It's almost an unspoken topic here. Like we know we have poverty, but we don't want to talk about it. And so that's, I think, also a really hard thing for people that might be already stigmatized from using something. But also when there's a lack of resources, there's a lack of support as a whole, as a community. I think that makes it more, it makes it harder. People struggle more (coalition/task force member).

Primary substances of concern

Interviewees were clear that substance use is an issue in the community and cited a wide range of substances that were common in the area. Methamphetamines, various types of opioids, and alcohol abuse were the top concerns of most people interviewed. Many acknowledged marijuana as a problem, but considered it less of a problem than other substances. Other substances mentioned less commonly included bath salts, spice, LSD, kratom, and ecstasy.

Interviewees noted that the types of substances used in the area have changed consistently over time as availability and cost for the various substances change. It appears that heroin is becoming more available and is less expensive than prescription opioid pills such as hydrocodone, oxycodone, and percocet, and that heroin use is on the rise as a result.

Additionally, more substances of all kinds are being laced with fentanyl, and law enforcement in particular indicated a growing concern about the associated consequences.

They moved toward the heroin. They can't afford the \$100 pills and having to use four or five of those a day. Where they can buy a gram or half a gram of heroin, and that should hold them over for as much time and be less (criminal justice stakeholder).

I do a lot of investigative things, search warrants and that type of thing, and I'm starting to see probably in the last four months more black tar heroin, and the officers, it appears to me, are even reluctant to touch it or test it because it's commonly laced with fentanyl (criminal justice stakeholder).

Methamphetamine is easily accessible within the county and sometimes used instead of other substances that are harder or more expensive to obtain.

I would say a good portion, probably more than 90%, are dealing with meth. I don't know if, if you know or have heard kind of what's going on with the cartels and stuff here lately. But they're trying to get heroin and cocaine back on the market by throwing in six, five, six grams of heroin and stuff like that on top of the order. Just free off the top to try to get that back on the market. But I would say 90% if not more is dealing with meth (criminal justice stakeholder).

And as people have found that [opioids] harder to get to, [there's] now been an increase in methamphetamines in our area that's pretty severe. I think that's been pretty well known. And right along with that, of course, alcohol remains pretty prevalent all the way through all of that (medical care provider).

And I've interviewed people who were crankers from back in the 90s, and they would have to hunt a day or two to get their fix, but the problem that they have now is that it's so readily available. They can't get away from it (criminal justice stakeholder).

Awareness about OUD treatment services

Substance use treatment and support require the interdisciplinary work of many different professionals and organizations. Generally, treatment connections are made through a robust referral network, ensuring that patients are able to navigate and access various services. In general, each interviewee had a different approach as far as when and how they generated referrals. Many said they worked with other organizations but did not specifically mention providing referrals for clients, which may mean that there are few formal avenues for referral-like relationships among organizations.

The main variables that affected referrals were interviewees' knowledge of available resources and their trust in the organization to which they were referring. People who indicated a lack of trust in the organization or skepticism about its effectiveness were less likely to generate referrals to or work with the organization. Interviewees who professed trust in the referral source seemed much more likely refer or work closely with those other resources.

If there's anything they need, I know how to refer them to any place that I can get them to, to get them the help they need (criminal justice stakeholder).

I do know that I'm pretty lucky in a sense that I have pretty good partners and community relationships that if I did have people ask me [for help with

substance use disorder treatment], I would more than likely refer them to somebody else (coalition/task force member).

Some interviewees specified why they did not collaborate or generate referrals to certain organizations, saying that it simply takes too long for a patient to be able to access resources or that the barriers of cost or transportation would be too great for the patient. In some cases those perceived barriers stopped the interviewee from even starting the referral or collaboration process.

And it's just the time it takes. I don't think I'm the only one that feels that it takes a long period of time, or much longer than it should, probably, to get the help to these individuals when it's needed. I guess, as an example, someone could get the felony charge, okay, and it's going to take them, let's say six months to get into treatment (criminal justice stakeholder).

I also think lack of resources here of the mental health and substance abuse disorders. When people admit to it, I don't have a lot of referrals of where I can send them unless they can travel hundreds of miles away, which a lot of those people we see cannot do that (social services provider).

Some interviewees seemed to understand the importance of referrals but indicated that they were simply unfamiliar with the process of actually sending a referral.

Well, there's no way to send one. During the day, Monday through Friday, we do have a substance abuse counselor here at hospital, which we used to not have. This morning I saw a guy who at six o'clock in the morning still was intoxicated (medical care provider).

To determine whether a referral is needed, organizations sometimes conduct screenings to better assess a client's needs, but screening for substance use, mental health issues, and social determinants was not consistent among interviewees. Some had thorough, evidence-based screening processes. Others screened informally through conversations and would send referrals for issues for which they personally had referral sources. Urine drug screening was a common screening mechanism in the hospital, courts, and law enforcement.

On the court side, we're not professionals as far as chemical usage, and mental health, and we send them to the treatment providers to do the majority of the screenings. We screen on our end, because we see who's in jail and what they're in jail for and think, "Now, this person is really going downhill fast. Maybe we can intervene" (criminal justice stakeholder).

One important aspect of a healthy referral system is knowledge about the availability of local and regional resources. In general, interviewees seemed to exist on two ends of a spectrum: they were either well connected and knew many different places to send clients for additional services, or they knew little about the availability of local resources.

I know somewhat about [MAT treatment] but not a whole lot. It's not something that we can refer someone to. Typically, we just refer to the drug court, and then the drug court has their addiction counselors and their mental health people that could help them out with that (criminal justice stakeholder).

If an interviewee worked for an organization where referral to a specific place in a specific situation was required, then that referral was commonly made. Conversely, if there was not a requirement or clear referral process, then the individual interviewee's knowledge and relationships seemed to determine whether a referral was made. Interviewees seemed to be aware of certain substance use treatment resources, whether they regularly referred people

to them or not. Those well-known resources included the Bullhook Community Health Center, the Salvation Army, and the treatment court.

Knowledge about OUD and MAT

In part because of a general lack of knowledge about the scientific mechanics of addiction, many interviewees referred people for treatment of a substance use disorder without a solid grasp of various treatment types or modalities. Unsurprisingly, interviewees with medical backgrounds were best able to accurately distinguish opioids from stimulants and were most likely to recommend MAT for OUD.

Whether an interviewee thought that MAT worked well for the treatment of OUD depended on their previous interactions with people who had used this treatment and whether or not the use of an opioid-agonist medication fit into their understanding of addiction and treatment for addiction. Interviewees seemed to lack experience working with people who had participated in a MAT program with an opioid-agonist medication. Most who had worked with someone who was treated using MAT (whether it was an opioid agonist or antagonist medication) thought that the treatment worked well and helped their clients. Almost all of the participants with some understanding of MAT believed that coming off of all medications was the end goal of addiction treatment. Most of the time, interviewees stated that they supported anything that helped their clients.

Well, I worked with a gal, and she was just beginning her addiction with opioids, and then she became a member of the MAT program. It changed her life, and she was honest about everything. She did not have any charges. She was never in our court. So she applied for this voluntarily. She did it. It was great. To see her name on things and making the honor roll and stuff, I'm so proud of her. That MAT program is a big deal because she spiraled downward so far, and now, she picked herself up, got herself back where she needed to be (criminal justice stakeholder).

I think a lot of us would rather not do it [prescribe opioid-agonist medications for OUD], but we're glad someone is willing to (medical care provider).

Because the treatment court allows only for the use of opioid-antagonist medications such as naloxone/Vivitrol and does not allow for opioid-agonist medications such as buprenorphine (brand name, Suboxone) among participants, it was sometimes difficult to tell what kinds of “MAT” were supported for OUD among those who work with or closely with the treatment court. They also used medications to assist with addictions to substances other than opioids, complicating our ability to fully understand how they perceived the use of MAT for OUD.

We do medically assisted treatment. The National Association of Drug Court Professionals pretty much mandates that you have to do a medically-assisted treatment. We use naltrexone for alcohol trainings, and have had, used it off-label and had some success with methamphetamine (criminal justice stakeholder).

I know Bullhook also has a Suboxone program for the opioid use, and to my knowledge, none of the treatment court professionals, or personnel at this time are on the Suboxone program. I would certainly be open and willing to use it if I had a person that seriously needed it. But we look at everybody on a case-by-case, individualized treatment plan, and so far, none of them have ended up having to need the Suboxone regimen (criminal justice stakeholder).

Impact of stigma on OUD treatment utilization and MAT

Received stigma and attitudes about OUD

Many of the interviewees were able to speak to the stigma they have received and the stigma they have seen placed on the people they serve. Stigma inhibits people's willingness to admit they may have a SUD or need treatment or support services.

It makes it hard, people that are trying to recover, hard to recover. Just if somebody knows that they have had that problem or are seeking treatment for that problem, I feel like they're treated differently than everybody else. I feel like that would make the entire situation better, and I feel like more people would seek treatment if it was more socially accepted, I guess, might be a good term for that (medical care provider).

I think we have a lack of support. We have a lot of people that as a community, I don't think we embrace people as much as they're suffering from substance use disorders. We stigmatize them, and I think that that's really hard for people that are in recovery or trying to get in recovery (coalition/task force member).

But as far as those with substance abuse disorders, I think that there's still that real negative stigma with that because of what happens, what those people do to the community, to other people, to each other, to businesses, to the parks, to the streets, and everything like that. All the negative connotation that comes with someone that is deep and heavy into their use and their addiction (criminal justice stakeholder).

When asking interviewees if they have seen shifts in attitudes around SUD in general at the community level or among colleagues, many reported that while some people were starting to understand that substance use disorders are medical issues that often stem from mental health issues and trauma, the community as a whole still has not reached that understanding.

And so, I think there are individuals who are beginning to see it more as a health issue and not just this person is a criminal (criminal justice stakeholder).

I do think that overall, I hear a lot of like, people just need to get over it.[...] And so, because I think is part of that culture in that generation that they've learned for years that mental health is not a real issue or you can get over it on your own or you don't need help (coalition/task force member).

Law enforcement emphasized that they have shifted the way they see people with substance use disorder in the past few years, and much of that has to do with the introduction of the treatment court. The process of connecting people arrested for drug possession to the medical community for treatment impresses upon law enforcement the complexity of substance use disorders and has led to a perception that SUD is a medical issue in addition to a legal issue.

I think most law enforcement would rather someone get treatment and not have to be a repeat customer. A lot of these people that we deal with are the same people over and over. They may get help and go through drug court. There's numerous people that we have cases on now that have graduated through drug court, but they've reverted back to their old ways of using and selling. Most law enforcement would rather see someone take care of their addiction problem and not be someone we have to deal with constantly, so I don't think any law

enforcement would say no to that or that they shouldn't get any help. I don't think the community actually really knows much about medicated treatment help, like a Suboxone or something like that. I have no problem with it. Anybody that can help themselves out and not have to deal with us time and time again, I'm all for it (criminal justice stakeholder).

Internalized stigma

Internalized stigma in this study was primarily investigated through the stories shared by referral sources about individuals with whom they work. In addition, a few interviewees shared their own internal stigma that was associated with family or friends who dealt with addiction and the ways in which the stigma attached to this sent the interviewee into the field as a way of associating with the actions of the friends and family members that the interviewee may have found upsetting or stigmatizing.

But I would never go to the [PROGRAM NAME] and get help. I would never go to my church and get help. I would not do that because I was too proud, too prideful, and I've learned since then, that that's a sin. I shouldn't be doing that, and I'm getting better (recovery specialist).

What got me to get into treatment. When I got my felony DUI, I was trying to own my son's bad decisions he had made that got him incarcerated, and I tried to own that. So I decided that I needed to be suicidal and tried to hurt myself (criminal justice stakeholder).

Perceived stigma

Several interviewees noted that stigma generally was a problem and made sweeping statements about how hard it is for people with SUDs to deal with the stigma they received broadly within the community. A few people were able to cite specific examples of stigma that people with SUD face, and these comments often involved the role of social media in facilitating those sentiments. When asked directly, most interviewees did not believe the community's views on SUD stigma had evolved significantly in the recent past, but many conceded that people throughout the community are beginning to accept that some causes of SUD are influenced by factors other than moral failing. The specific sectors of the community that work with people with SUD were perceived to exhibit little stigma.

If people post something on Facebook about their house was broken into or was egged or something like that, people just go off on it's about the drugs. It's about the use, drugs, alcohol, everything that people are doing or partaking in that's causing it, if that makes sense (social services provider).

I do think that there seems to be [a lot of community stigma], because I think that more individuals are affected by it [substance use], whether it's a close relative or close friend. And so, I think that they are beginning to look at it more as, "Okay, this person is not a criminal, because that's what it is." I felt like for quite a while it's just that this person who's a user is the criminal, end of story. Whereas, looking at it now, I think people are a little bit more, at least in the community, a little bit more understanding that, "Okay, this is something that needs to be treated." This is someone who's dealing with a health issue, and there are ways to treat it, and I think there are also people who probably never thought that they themselves would be in positions (criminal justice stakeholder).

Associative stigma and attitudes

Interviewees had mixed perceptions about the use of buprenorphine as a first-line treatment modality for OUD. While no one thought that buprenorphine was inappropriate or ineffective, some people believed it would be better to use an opioid antagonist, such as naloxone, instead. Though current evidence suggests that opioid-agonist treatment may be one of the most effective modalities, its association with people who abuse opioids makes buprenorphine as a treatment modality ripe for stigmatization and thus less favorable for recommended use among interviewees. Strikingly, the treatment court does not allow its use among its clients.

Interviewee: *Yep. They can only do Vivitrol or naltrexone.*

Interviewer: *Why is that?*

Interviewee: *Because Suboxone, I want to say it's looked at as the same way as an opioid, I believe. I just know that's all. Here in Hill County, they can only have the Vivitrol and the naltrexone (criminal justice stakeholder).*

People were also wary of any medication that needed to be used over the long term as a treatment modality, whether it was an opioid-agonist medication (generally recommended to be used long term for as long as the person is stable on the medication) or an opioid-antagonist medication.

And she'd been on Suboxone the whole time. She's still under the influence of the drugs, to a point. But that being said, she knows what she needs to work on. She knows what she needs to put in her life to get through it. But trying to get off of the Suboxone has been a real challenge for her. Because as they start to decrease it with her, I mean, she becomes physically ill to the point of hospitalization. And so I have a hard time with that (recovery specialist).

Some people had concerns around MAT for OUD or could cite the negative impacts of using an opioid-agonist medication for MAT. These included concerns that the medications are abused or diverted and the perception that a person on opioid-agonist medications is actually maintaining their opioid addiction.

We haven't bought Suboxone for a while. We'd buy it by the strips. There is quite a few, because we go through a lot of cell phones, messages, and Facebook where people are selling the strips. They seem like they're a little more controlled, but the people that have the prescription and selling it, we don't see it as much. I know when we're buying it, I think they had to go to Great Falls and Helena to get it through the prescribers. Now I think it's a little better regulated now that some of the people around here have been prescribing it (criminal justice stakeholder).

But if I had my way we wouldn't be selling Suboxone like it was pancakes. We'd be selling Naltrexone, that's a benign, nonaddictive substance that can help with craving and help in the early stages. Although there is room for Suboxone, I really did like Methadone, but Suboxone is not a horrible drug, but it should be second in line, not the first option. And our state is really, really, really pushing Suboxone (recovery specialist).

Others felt that buprenorphine was a helpful treatment option and were pleased to see access expanding in the Havre area.

We have had participants, though, who've been quite successful on MAT, and that's probably one of the big keys in getting them started in their treatment and helping get that chemical dependency under somewhat control. Because it's often hard to move forward in therapy when you have an individual who's just not able to stop using. And so, based on the information, I think that it should be utilized when needed (criminal justice stakeholder).

And I do know of people that have been on the Suboxone program, that was a saving grace for them. That saved their life, as you will. So I'm not talking negative about it. But my perspective of it is we need to teach them how to not be on it. Because what happens if something happens and they don't have their Suboxone? What's going to happen to them as they're coming off of that Suboxone? (recovery specialist).

Yes, there has been some shift. Absolutely. There's been some shift. There's been a lot of shift into acceptance of MAT patients to some extent. However, on the flip side of that, I will say that that doesn't mean that they understand it. Okay? They may accept that a person's on it, but they don't really understand the chemical used, buprenorphine or Methadone or Naltrexone (medical care provider).

When it comes to referring clients to an MAT program for OUD, providers with substantive knowledge about and support for MAT were more likely to make positive statements when referring to the local MAT program.

We have a federally qualified health center in town that does MAT treatment, and I'm happy to refer to them if needed. They're very receptive. We work well together (medical care provider).

The oxy or the hydrocodone, when that comes along, usually, there's a pain that happened. They got hurt somehow, and they get prescribed it, and then they're addicted. Then if that is the case, we refer them to the MAT program at Bullhook so they can get the help they need and get on whatever they need to get on so they don't have the cravings (criminal justice stakeholder).

One person shared a concern that the providers of MAT treatment are punitive, thus discouraging people and interrupting treatment.

But the problem with MAT therapy out here is the doctors are so punitive. And they want you to just stop everything. If you test positive for cannabis, you can't get your Suboxone. And it's so hard to get into (recovery specialist).

Also commonly fraught with associative stigma are harm reduction measures such as the widespread use of naloxone (Narcan) to reverse opioid overdoses and interventions such as clean needle exchanges.

I don't know, I think it's going to take the community to want it, because we're a very conservative town. I think it's still that mindset of, well if you give them syringes they're going to use more drugs. I think it's that, if you give a kid a condom they're going to have sex, you know? (medical care provider).

Reducing stigma

In all, interviewees expressed deep compassion and support toward those with SUD.

The disease of addiction will get you, it does not discriminate. It does not discriminate. You can't be anybody. It's just like any other disease, like cancer, diabetes, it doesn't discriminate (medical care provider).

Every day I'm thankful I'm doing this, and I'm thankful for every participant I see and I talk to, and I'm so happy when they graduate and then to watch their life just go where I knew it would go (criminal justice stakeholder).

Many of the interviewees described assisting clients to create opportunities for harm reduction and avoid punitive approaches because they believed that with the additional support and prevention steps, they could improve the lives of the people they were serving. One interviewee described helping a client who was using marijuana for pain to secure a medical marijuana card so that they could use it legally, thus avoiding potential legal issues. Another made sure that barriers to clean needles were removed so that access improved for those in need, thereby decreasing expensive and debilitating diseases that arise from the use of shared or unclean needles. One medical provider described changing their opioid prescribing processes to prevent inadvertent opioid addictions. Several interviewees detailed ways that they worked to decrease the barriers for certain clients so that they could receive services or access educational programs that they may not have been able to access otherwise.

But just thinking about how, just the resources that should be allocated, and if we're putting someone in a lockup who's, say they had a bad trip and they're just coming down from a high. Is putting them in a local jail, is that really helping the problem? Or should resources be utilized so that that person has a safe place to come down and to get information on substance abuse disorders. That could be the pivotal moment where reaching out to them and giving or offering the help that they would need to get clean would be something that could make a difference and could actually stop that cycle. Whereas, throwing them in detention center for a few days and they get released after they cleared out or whatever to disorderly conduct or something like that. It just doesn't seem to work. And so, my hope is that it will spark conversations about, okay, how can we treat these individuals instead of just throwing them in detention? And so, what resources are in it? (criminal justice stakeholder).

Many change efforts to improve support systems of people with SUD have already come to fruition in Havre. The treatment court and the MAT services of Bullhook are both relatively new to the community and were both held in high regard as far as their usefulness for improving services for people with SUD.

I was just going to say I haven't seen that shift yet. That's what we're working for, is to see that shift, that change, that acceptance that we can kind of stop that stigma around it and realize that these are our community members, and the more that we can support them in their journey to stay sober, the more opportunities that we have as a whole to be a healing and healthy community (coalition/task force member).

Case study 3 conclusion

Havre, like many rural communities across the state and the country, is grappling with a quickly changing landscape of substance use patterns among community members. This includes changing perceptions and understandings of people using substances, and a treatment and legal system whose evidence bases around how to support, treat, and engage people with SUDs are rapidly evolving. To improve the health of the community, novel, and sometimes controversial, interventions are being implemented. Havre continues to engage

with its situational placement as a rural border town where rurality and race-based stigmatization continue to act as barriers to care. People are still trying to understand the complexities of SUD treatment and identify new opportunities to support people with SUD. As is common for communities that are implementing new initiatives and changing long-standing programs, the residents of Havre must support the financial realities of creating new programs. With this, community members also need to realize the largely universal paradigm shift toward accepting SUDs as medical issues. This acceptance is necessary for successful growth and change. The establishment of the Bullhook MAT Program has enabled great strides toward improving access to SUD treatment as well as reducing stigma around SUD in the area.

CONCLUSION

This study attempted to distinguish between knowledge, attitudes, and stigma about SUD, SUD treatment, MAT, and OUD to clarify more precisely how stigma may be shaping treatment seeking behavior for those with an OUD in need of MAT services in Montana. To do so, the study used a comparative case study approach to try to identify differences across sites in how knowledge, attitudes, and stigma shape referral practices among potential referral sources within each community. The role of stigma as an influence in decisions about treatment-seeking behavior is difficult to distinguish and disentangle, yet it is clear that stigma does shape this behavior in a negative way and disincentivizes treatment-seeking behavior.

One unexpected finding was the broad similarities across each of the study sites. Interviewees in Hamilton, Havre, and Miles City shared high degrees of empathy toward the experience of addiction, SUD, and the challenges associated with access to treatment for SUD in Montana. Across all communities there was a view that this empathetic approach stands in contrast to the public ideals of the characteristics of a healthy adult, which include stable employment, individual toughness, and a commitment to family and family reputation. The interviewees in Hamilton believed that stigma was decreasing among members of their community more than did interviewees in Havre or Miles City.

Across all sites, interviewees had a higher degree of negativity toward opioid-agonist medications (buprenorphine) and less negativity toward opioid-antagonist medications (naltrexone). This difference was most pronounced among criminal justice interviewees in both Miles City and Havre. In Havre, interviewees reported seeing SUD stigma as intertwined with systemic discrimination toward American Indian members of the community. There was general resistance to harm reduction in the form of needle exchanges across all sites, with less resistance and negative attitudes in Hamilton than in Havre or Miles City.

This analysis was based on four separate expressions of stigma—associative, internal, received, and perceived. Associative stigma can be addressed most directly through increased education about the details and impacts of treatment modalities. One specific recommendation is provide outreach to judges in treatment courts about strategies for monitoring those who are receiving opioid-agonist medications as part of a MAT program. Internal stigma may be the most challenging type of stigma to address, as interviewees reflected on the ways in which each person's own personal history of difficulties and negative outcomes may exacerbate their negative self-conceptions. Received stigma is a concern, but on the positive side, individuals across all sites who are potential referral sources shared multiple stories about the ways education about stigma is making a difference. Interviewees who were potential referral sources tended to be well aware of the ways their expressions of stigma could deter people's pursuit of treatment for and were careful not to create these negative interactions. Perceived stigma was present in both Havre and Miles City and less so in Hamilton. This finding suggests that public media and awareness campaigns could use community members talking about their views of SUD treatment from the perspective of those who are not experiencing addiction. In doing so, such campaigns could help to shift the perception that community members view SUD and addiction negatively, potentially minimizing the internalized stigma that could limit individuals' treatment seeking out of fear of the social cost of being viewed as someone with a substance use disorder.

Most notably, interviewees demonstrated little stigma toward the majority of individuals with SUD or OUD. They had a high level of awareness about treatment within their communities, including a broad knowledge of MAT providers. The negative attitudes and stigma expressed by some interviewees specifically concerned a rather small number of individuals with whom interviewees had multiple, complicated interactions. These

interactions, with a few complex individuals with OUD or SUD, may be having an outsized impact on how stigma is shaping referral practices among frontline organizations within Montana.

Across all sites it became clear that there are challenges in balancing individuals' need to pursue treatment for a behavioral health condition and the context of a small town. The potential visibility of an SUD or OUD is a major source of fear, one that interviewees perceived as limiting the use of treatment resources. In contrast to this fear, interviewees described a slowly emerging view on behavioral health conditions as medical in origin. Across all three sites the existence of a MAT clinic appears to be having a positive impact in reducing stigma. One reason for this shift may be the shared perspective among interviewees of wanting to have the resources to support members of their communities who are struggling with an OUD.

I don't want our people in recovery to have to hide. I want them to be able to recover and stand up as role models for others that may still be struggling, to be able to say, Hey, look at that person, I had no idea (coalition/task force member).

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