Received: 1 August 2022 | Revised: 19 September 2022 | Accepted: 11 October 2022

DOI: 10.1111/jnu.12837

JOURNAL OF NURSING SCHOLARSHIP

Perceived stigma, barriers, and facilitators experienced by members of the opioid use disorder community when seeking healthcare

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Funding information
Foundation for Opioid Response Efforts

Abstract

Introduction: Healthcare professionals, particularly nurses, have negative attitudes towards individuals with opioid use disorder (OUD) and these attitudes can contribute to suboptimal care.

The aim of this study was to identify stigma, barriers and facilitators experienced by members of the OUD community when interacting with the healthcare system.

Design: A qualitative exploratory design used semi-structured focus group interviews to address the study aim.

Methods: Following IRB approval, purposive sampling was used to recruit participants with a history of OUD, family caregivers of individuals with OUD, and support group leaders from regional recovery groups to provide a broad perspective of stigmatizing issues and barriers to care. Focus group discussions were conducted, and video recorded using web-based conferencing software. Transcripts from the focus groups and field notes were analyzed and coded into themes.

Results: Both structural and social determinants of health were identified by participants as stigmatizing and/or barriers to care. Thematic content analysis resulted in eight themes: stigmatizing language, being labeled, inequitable care, OUD as a chronic illness, insurance barriers, stigma associated with medications for OUD (MOUD), community resources, and nursing knowledge and care.

Conclusion: Members of the OUD community are challenged by both internal and external stigma when seeking healthcare. Stigma negatively affects public support for allocation of resources to treat OUD. Interventions aimed at reducing stigma are critical to support effective OUD treatment and prevent barriers to OUD care.

Clinical Relevance: Understanding the complex relationships between stigma and structural determinants of health will allow nursing science to develop educational interventions that provide the next generation of nurses with the knowledge, skills, and attitudes needed to advance health equity for individuals with OUD.

Sigma Theta Tau International Chapter: Theta Kappa.

KEYWORDS
substance use/substance abuse/alcohol use/tobacco use/drug abuse, social support/support networks/social environment, education/curriculum/learning, nursing practice, health disparities, nurse-patient relations/nurse patient relationship

INTRODUCTION

Opioid use disorder (OUD) remains a public health crisis in the United States (CDC, 2021). Over 10 million Americans misused an opioid in the past year (SAMHSA, 2020). In 2019, 70.2% of overdose deaths involved opioids (CDC, 2021). However, only 10.3% of Americans with OUD received treatment in the past year (SAMHSA, 2020). Reasons cited for not receiving treatment included fears of being labeled (SAMHSA, 2020) or stigmatized by health care providers (Corrigan et al., 2017; Madras et al., 2020). Additional barriers to care were inadequate insurance coverage and a lack of providers trained to treat OUD (Madras et al., 2020). Medication for opioid use disorder (MOUD) is not well utilized even as it has been validated as evidence-based and effective, in part because both providers and patients have misperceptions about its efficacy (Cioe et al., 2020).

Stigma is a complex phenomenon shown to be a major barrier to care for patients with OUD (Brener et al., 2007; Corrigan et al., 2017; Harling, 2017; Madras et al., 2020; Morgan, 2014; Van Boekel et al., 2013; Van Boekel et al., 2014). According to Goffman (1963), stigma is an attribute that discredits and devalues an individual within the construct of societal norms. Stigma can emanate from both within and outside the stigmatized individual. Internal stigma can occur when the individual expects discrimination or when negative societal attitudes become ingrained in the individual's sense of self (Meyer, 2003). For example, patients may delay care because they fear discrimination in the healthcare setting. External stigma originates from outside the individual and can include episodes of discrimination experienced on an individual level (Meyer, 2003), such as decreased quality of nursing care provided to patients with OUD. Hatzenbuehler (2016) describes a form of external stigma as structural stigma in which “societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and well-being of the stigmatized (p. 2).”

Embedded in structural stigma are social determinants of health (SDOH) which are barriers to treatment and have been associated with poor patient outcomes in OUD (Hansen et al., 2022). Stress related to a history of trauma, including adverse childhood events, can intersect with discrimination based upon race, ethnicity, sexuality, or gender identity leading to higher rates of OUD and overdose in these populations (Hansen et al., 2022). Persons of color are disproportionately incarcerated (Kaye, 2019) and this places them at risk for a future overdose and an increased OUD mortality rate (Binswanger et al., 2007; Gan et al., 2021). Low-income and unstable housing can impede access to insurance and social supports which facilitate MOUD treatment (Zoorob & Salemi, 2017). To improve outcomes for patients with OUD, the effects of stigma, including stigma resulting from SDOH, must be better understood.

Nurses often care for patients with OUD and are in a unique position to help patients overcome barriers to treatment. However, nurses do not feel prepared to care for patients with OUD (Ross et al., 2015). Nurses also harbor negative attitudes towards patients with OUD (Brener et al., 2007; Morgan, 2014; Van Boekel et al., 2013, 2014), sometimes regarding them as dangerous (Neville & Roan, 2014). These attitudes and perceptions can lead to substandard patient care and poor patient outcomes (Brener et al., 2007; McKenna et al., 2012; Morgan, 2014; Van Boekel et al., 2013, 2014). While much is known about the attitudes of nurses towards patients with OUD, little is known about patients' perceptions of the barriers they face related to interactions in healthcare and nursing in particular. If nurses are to provide care that optimizes patient outcomes, it is essential that the role nurses play in perpetuating OUD stigma, and barriers and facilitators to OUD treatment is understood.

The aim of this study was to explore perceived stigma, barriers and facilitators experienced by individuals in the OUD community when seeking healthcare. Data were collected from members of the OUD community and included individuals with OUD, family members of individuals with OUD, health educators in the field, and organization and support group leaders addressing the opioid crisis. Specifically, issues or experiences related to stigma, barriers and facilitators by nurses associated with OUD care were explored.

RESEARCH DESIGN

A qualitative exploratory design using focus group interviews was used to address the study aim. Focus group interviewing made it possible for the moderator to facilitate the participants' various opinions without the purpose of attaining agreement. Semi-structured interviews empowered the participants to express their experiences in their own words (Polit & Beck, 2021).

METHODS

Recruitment

Purposive snowball sampling was used to recruit focus group participants with collaboration from two community partners who supported entry into the community of interest. An email invitation was provided to the community partners for distribution. Additionally, a flyer to recruit potential participants was circulated via clinical bulletin boards. The inclusion criteria for participants included: (1) 18 years of age or older, (2) the ability to communicate in English, and (3) one or more of the following: (a) person with OUD, (b) person with a history of OUD, (c) affected family member for an individual with OUD, or (d) support group leader for persons with OUD.

Participants

A total of 10 participants were recruited. The majority were female (55%) and ranged in age from 34–64 years. None of the participants identified as a minority member by race or ethnicity. One participant identified as bisexual, a historically excluded demographic in sexual orientation. The participants reported their experience with OUD via a 'select all that apply' question in three categories: (1) coping with OUD, (2) caregiver for someone with OUD, (3) group leader for individuals with OUD. Eight participants reported coping with OUD, four participants were caregivers for someone with OUD and five identified as group leaders. Most participants identified with more than one group. Those who identified themselves as caregivers of persons with OUD had 13–29 years of experience caregiving. Individuals with a history of OUD reported coping with OUD for 7–21 years, and additionally reported being in recovery for 2–3 years. Participants who identified themselves as group leaders for individuals with OUD reported 3–24 years of experience in areas of recovery coaching (and supervision), certified peer support, social work, and licensed alcohol and drug counseling.

Data collection

Semi-structured focus group interviews were conducted between March 2022 and May 2022 via a web-based conferencing software (Zoom) at a mutually agreed upon time for the participants and researchers. Semi-structured interviews followed a prepared interview guide designed by nurse researchers with expertise in OUD, family caregiving, and stigma related work. A series of 10 questions prompted participants to share their experiences and perceptions of OUD-related stigma and other barriers to receiving healthcare. The questions prompted participants to consider barriers and facilitators in healthcare in relation to their past encounters with healthcare providers and their experiences in various healthcare settings (i.e., emergency rooms, physician's offices, rehabilitation facilities, waiting rooms, telehealth meetings). The questions also prompted participants to think about other resources and interventions they felt were necessary to help persons with OUD and their families, in addition to training they would recommend for healthcare professionals treating individuals with OUD. The interviews lasted between 45 and 120 min. To acknowledge the value of participants time and experience, a $50.00 Amazon gift card was provided to each participant. Field notes were written after each interview to document first impressions and any biases (Rubin & Rubin, 2012). Data collection continued until data saturation was reached.

Data verification

The strength of qualitative research is the rich data provided by participants. However, the emergence of highly subjective data must not compromise the rigor of the research design. Strategies by Rubin and Rubin (2012) were used to safeguard accuracy, believability, credibility, and thoroughness. Accuracy was addressed by informal member checks performed during the interviews using various probing and clarifying statements (Mann & Stewart, 2006). These types of statements allowed immediate comment by the participants on the initial interpretation of the researcher. Believability was supported by the inclusion criteria in identifying individuals with firsthand experience and diverse perspectives. To ensure credibility and prevent introduction of investigator bias into the research, the researchers employed post-interview reflection and peer debriefing to uncover biases, perceptions and assumptions.

Ethical considerations

Institutional Review Board approval was obtained. Participation was voluntary and participants could withdraw from the study at any time. Participants who responded to the recruitment email or flyer were sent a secure survey link in response. The survey provided information regarding the study, informed consent, inclusion criteria, and demographic questions. Once the consent and demographic information was submitted a member of the research team contacted qualified participants to address any questions and schedule an available focus group time.

Data analysis

Interviews were transcribed verbatim and compared to the audio recordings for accuracy. Field notes collected by the researchers were analyzed and coded. The investigators read through focus group data for understanding and a sense of wholeness and compiled a preliminary summary of each transcript (Sandelowski, 1995). An iterative process was used assigning descriptive codes to organize and simplify large data segments into retrievable terms (Coffey & Atkinson, 1996). Data was then grouped into themes. Data transformation continued until categorical themes were identified within and across data groups by the investigators (Sandelowski & Barroso, 2003). All decisions regarding the choice of codes and themes were made by reaching consensus among the research team and were documented in the codebook. Final themes were determined and analyzed against the study aim.

RESULTS

Participants provided in-depth narratives of their experiences with stigma in healthcare, and other barriers and facilitators experienced when interacting with the healthcare system. Both structural and social determinants of health were identified by participants as stigmatizing and/or barriers to care. Thematic content analysis resulted in eight themes: *stigmatizing language*, *being labeled*, *inequitable care*, *OUD as a chronic illness*, *insurance barriers*, *stigma associated with medications to treat OUD (MOUD)*, *resources/community and nursing knowledge and care*.

Stigmatizing language

The first theme was *stigmatizing language*. All participants recounted instances when stigmatizing language was used by nurses and other healthcare personnel in various settings, often without awareness of the negative connotations. Participants identified language they felt was especially offensive including, “dirty urine”, “drug addict”, “clean date”, “junkie” “crackhead”, “frequent flyer”, and “drug seeking”.

> One participant summarized the impact of stigmatizing language when seeking care, “…any type of language that is disempowering, debilitating, dehumanizing, we can put it all under the “D” list. Instead, we should use the “A” list, which leaves a person feeling awesome… makes a person feel “appreciated.” That stuff is where the healing happens. It's where people become empowered. We want to be seen, we want to be validated, we want people to believe in us when we do not believe in ourselves.”

Being labeled

The second theme, *being labeled*, was described by many participants as one of the greatest barriers to care. This theme could be separated into two subthemes, *fear of being labeled* and *being treated as a diagnosis*. Participants described experiences where they refused or declined MOUD for fear of being labeled “an addict” based on their medication list. Some described refusing care that would identify them as having OUD in their permanent medical record.

> “Once you go down that path, and you know say it, and it's out there…. it's never gonna go away….it's a title and it'll follow you…you can't go back from that.”

Another participant shared her experiences with how the fear of being labeled became a barrier to care when she talked about her son who died from an overdose:

> “My son would not reach out for treatment…(he) just didn't want to be thought of that way…. I tried to get him to consider treatment and he would not because of the stigma.”

Additionally, participants described their experiences in the healthcare setting when seeking care for other ailments and feeling as if they were being seen as “drug seeking.” One participant shared the story of his experience related to falling off a ladder:

> “I had fallen off a ladder and I split my head open, … I just wanted them to look at it, and they were kind of coming off like…. they knew I was…, I was there for something, but I just walked out.”

The second subtheme, *being treated as a diagnosis*, was described by participants as occurring across the continuum of healthcare settings. The stigma of being seen as a diagnosis instead of as a person with OUD often created barriers to establishing rapport and providing compassionate care. *“When we see people as their diagnosis, we treat them like their diagnosis. Nobody wants to be a “case.” Nobody wants to be “managed.”*

Inequitable care

Participants described numerous instances where they experienced inequitable care secondary to OUD stigma. One participant stated they overheard a nurse while they were waiting to be seen say to a colleague, *“Well, we're not going to waste a real bed on this person.”* When seeking emergency care, they often encountered delays in care, what they perceived as inadequate treatment, and stigma/bias from healthcare workers.

> “So many negative messages. Some are verbal. Some are nonverbal. I saw the nurse running around making sure everyone was warm, …you're giving other people blankets…. because I'm there… having a crisis…you're not going to treat someone kind, with humanity?”

One participant described a situation where her daughter experienced a significant delay in care related to her diagnosis of OUD:

> “I walked in and they (the nurses) were talking about her….she's in this room and she's covered in vomit and it's been a couple of hours and nobody thought to wash her.”

These experiences affected their willingness to seek treatment going forward. *“How I was treated in the ER….it left me so that I did not want to seek care under any circumstances.”*

OUD as a chronic illness

Defining OUD as a chronic illness was identified as a facilitator to comprehensive care by participants.

> “Seeing it (OUD) as a disease process, I think that changes it too. It changed the picture for me. When you look at it as a disease process... it's a diagnosis. There's a treatment plan for it!”

By defining OUD as a disease process, participants felt it would also decrease stigma and guilt for family caregivers and encourage sharing.

> “Because of the stigma people do not get out there and share their success stories....bringing it out as a disease process and getting people to share their struggles and stories of success...There is a way out of this thing!”

Several participants described experiences with other chronic diseases and felt if healthcare personnel consistently treated OUD as a chronic illness, then more resources would be available and accessible. One participant described their experiences with cancer as a chronic illness compared to OUD and the role stigma played:

> I had the unfortunate experience of having a son deal with cancer and my daughter deal with opioid addiction and let me tell you the support for him was enormous... You cannot help if you get cancer.... (with OUD) there's this kind of “You get yourself out of it, you got yourself into it” kind of attitude.”

Another participant noted when describing her sisters experience with being a kidney donor for her mom who was coping with chronic kidney disease:

> “They supported us, there was counseling. They got funding to pay her rent...and when I envision healthcare for OUD, why is it not looking like that?”

Insurance barriers

Insurance barriers and leaving against medical advice (AMA) were identified as the fifth theme. Participants described experiences of being denied care either due to lack of insurance, or because their insurance only covered certain services or selective facilities. Long waits for inpatient placements often resulted in days spent in the emergency department, often on uncomfortable stretchers placed in the hall to free up patient care areas. This frequently resulted in the individual seeking care for OUD to leave AMA before a placement was available.

Family caregivers described situations where they believed their loved ones received inadequate care because insurance would not cover the care they felt was needed. They reported struggling with copious amounts of paperwork and ultimately paying out-of-pocket for private facilities or medications that their insurance would not cover.

> “Navigating the insurance...you need to take classes practically! All of the paperwork, not to mention the language barrier...it took a lot of phone calls and a lot of time.” “Vivitrol....insurance doesn't cover it. And it was $1200 a shot (per month). And we did that for a year!”

Stigma associated with medications for OUD (MOUD)

Participants described stigma associated with MOUD from both within and outside the OUD community. This was frequently seen as a barrier to seeking care. Medications most frequently discussed were suboxone (buprenorphine/naloxone), vivitrol (naltrexone), and methadone. Participants discussed the stigma associated with methadone treatment, noting the need to “*report to the clinic every day*” resulted in fear of who would see them at the clinic, or how it was thought to “*replace one drug for another.*” Participants noted it was difficult to hold certain jobs when taking the medication because of the daily dosing at a clinic. Furthermore, for many participants, they perceived stigma *within* the recovery communities that did not accept individuals on MOUD as “sober” or “clean”.

> “I've heard people refer to it as a “crutch,” even some of the members in the recovery community are very against it. Most of the older school recovery people who believe that abstinence is the only answer... It's (also) still a barrier in some professions. Some professions will not accept people on MAT (medication assisted treatment) to return back to their work.”

Other participants discussed their experiences with suboxone (buprenorphine/naloxone) and vivitrol (naltrexone), noting similar stigma within and outside the OUD community. Many felt vivitrol was less stigmatizing since the treatment only requires once-a-month dosing. Misinformation was a factor in the decision-making process when starting and continuing MOUD and was often received from a peer. Most felt MOUD had a place but only as an adjunct treatment. *“I think that (MOUD) is wonderful but I do believe it's an adjunct. There needs to be other stuff with it, be that continuous therapy, community resource groups.”*

Community resources

Resources were identified as both a barrier and a facilitator when seeking healthcare. Participants discussed lack of beds/placements as a major barrier to care. Though this varied by state, with some states providing more services and easier access to Medicaid than others.

Other facilitators described by participants included ready access to insurance, decriminalization programs, drug assistance resource teams (DART), peer support with recovery coaches, recovery centers, Anti-Opioid Task Forces, drug diversion courts, and family support services. One participant noted:

> "They taught me about the disease process, and they assured me this was a diagnosis and there was treatment for it and I dedicated myself to the treatment. And I continue to get that feedback now. That's very much alive in the opioid use disorder treatment facilities which I have been associated with."

> "... thing that made the difference this time is the peer support. What is more powerful to you than someone else saying, "Me too." You know what I mean? "I've been there. Me too." But the other part in that and why this works is that, I'm saying "me too" ..., not let me show you what I did to get out of it."

Nursing knowledge and care

When asked to discuss the role of the nurse in their care, participants generally thought nurses lacked training in OUD and often failed to act on teachable moments and opportunities to connect individuals to recovery resources/support. *"I think we have a long way to go in training people in mental health." "They want to help, they try to help. They are usually overworked and understaffed."* Another participant described ongoing support as a necessary component of training,

> "To have initial training as part of their professional preparation is great. But then to have ongoing support I think would be important....people who reach out and work with them and can ask questions or be a sympathetic ear because recovery means work. The community working together. And nurses are a key part of that."

Several participants felt nurses, in particular emergency department nurses, were often unaware of the available community resources in recovery and/or failed to make a warm handoff.

> "We had three nurses. They were really wonderful people, however they weren't trained in recovery.... It's just sad that somebody working for years as an ER nurse....didn't know about recovery (resources)."

> "It would be really wonderful if nurses, doctors, hospitals in general, can work towards some sort of warm handoff.... (rather than) "Okay here, call them when you get out. To put all the onus on the person who's suffering...you have to hope they have the support.... So to have a next step that is something they don't have to necessarily struggle to get to would be just so helpful."

However, nurses were also described as facilitators to care. When asked to describe their experiences with nurses when seeking healthcare, many participants provided positive experiences with nurses even as they discussed other negative experiences in healthcare. They felt most nurses were caring and *"Really tried to help and support me and my family."*

DISCUSSION

This paper explored stigma, barriers, and facilitators within the healthcare system as experienced by members of the OUD community. Eight themes emerged from the data: stigmatizing language, being labeled, inequitable care, OUD as a chronic illness, insurance barriers, stigma associated with medications for OUD (MOUD), community resources, and nursing knowledge and care. Findings were consistent with previous research showing individuals with OUD experience stigma about their medical condition, treatment options, and resource allocation from healthcare providers and members of the community (Garrett & Young, 2022; Kennedy-Hendricks et al., 2017; Winstanley, 2020).

There are different types of stigmas that contribute to negative sequela and can be barriers to quality healthcare. This study identified examples of external (structural, public) and internal stigma experienced by the OUD community. Structural stigma is imbedded in rules, policies, and procedures that arbitrarily restrict the rights and opportunities of individuals (Hatzenbuehler, 2016). Structural stigma was evidenced by such things as MOUD prescribing barriers, the need to go to specialized prescribing clinics, limited access to treatment, and insurance barriers (Atkins et al., 2020; Garrett & Young, 2022). Participants in this study reported additional structural stigma in the form of treatment delays, inequitable care, and inadequate treatment when seeking care because of their OUD or history of OUD.

Public stigma is defined as a general negative perception of people with OUD, and it is exacerbated by constant negative media coverage (Harling & Turner, 2012; Kennedy-Hendricks et al., 2017; Perry et al., 2020) and OUD-related misinformation on social media (Garrett & Young, 2022). The use of stigmatizing language, including the use of labels when referring to a person with OUD, reinforces public stigma. Participants in this study spoke directly about the stigmatizing language used to describe and interact with people with OUD. Participants noted the need for healthcare providers to use more person-first and professional language. For example, instead of referring to a client as *clean* or *sober*, participants expressed preference for "*a person in recovery*."

Healthcare providers should also be cognizant of terminology used in a person's medical record. Participants explained what it was like to live with an OUD label in their medical record and the continued stigma experienced because of this type of documentation many years into recovery. Participants in this study felt using person-first language helped to frame OUD as a chronic illness where periods of exacerbations and remissions are expected and managed with a treatment plan. Previous research supports using an approach of person-first language as an evidence-based stigma reduction intervention (Hawk et al., 2021; Stone et al., 2021).

MOUD-related stigma is well documented in the literature (Amura et al., 2022; Cioe et al., 2020; Garrett & Young, 2022; Kennedy-Hendricks et al., 2017). Findings from this study revealed participants continue to experience stigmatizing behaviors from healthcare professionals, family, and community members about MOUD. Our findings were consistent with Cioe et al. (2020); participants expressed concern with the need to take MOUD because of the perception that it was replacing one drug with another, fear of being seen at a MOUD clinic, and being judged from others in the recovery community. MOUD is considered the most effective treatment for OUD, but stigmatizing attitudes negatively affect retention and adherence to the treatment regimen (Amura et al., 2022; Cioe et al., 2020; Hawk et al., 2021). Amura et al. (2022) found withdrawal and detox treatment modalities were favored by some people over MOUD regardless of the known detrimental effects of these inferior treatment approaches. In contrast, implementing MOUD has been associated with a reduction in opioid use and other drug use, as well as improvements in healthcare utilization (Amura et al., 2022; Hawk et al., 2021). Researchers also found better access to MOUD in communities helped to reduce stigma associated with MOUD (Lin et al., 2022). According to Lin et al. (2022), offering MOUD services in a community increases exposure and improves awareness of the treatment option, which ultimately helps to normalize MOUD.

Similar knowledge gaps exist in nursing education (Kaiser, 2020). The literature supported negative attitudes of nurses towards individuals with OUD led to feelings of marginalization and contributed to decisions to delay healthcare and specifically, treatment for OUD (Dion, 2019). In contrast, when nurses were knowledgeable and empathetic about challenges associated with OUD, quality of care and patient outcomes improved (Clinton & Pollini, 2021; Corrigan et al., 2017; Sinclair et al., 2017). Findings from this study revealed members of the OUD community believed nurses require more OUD education and interdisciplinary experience. The Association for Multidisciplinary Education and Research in Substance Use and Addiction (AMERSA) (2018) discipline specific competencies for nursing can be used to effectively guide the development of OUD-specific nursing education and nursing care of the individual with OUD. Adding OUD-specific education, including care and treatment of patients with OUD, management of overdose, and screening for opioid-related risks to nursing curriculum, could also help combat stigma (Atkins et al., 2020; Lanzillotta-Rangeley et al., 2020; Lewis & Jarvis, 2019). Smothers et al. (2018) reported education on substance use disorders produced a positive impact on nursing student knowledge, attitudes, and skills; however, the authors did not discuss types of education provided. Recent work by Bell and McCurry (2020) noted while any type of OUD education increased nursing competency, simulation and debriefing produced the greatest retention over time. Thus, there is an opportunity for nurse educators to develop simulation-based educational activities that facilitate undergraduate and graduate nursing student understanding of the multifaceted needs of individuals with OUD.

Caring for a person with OUD is complex and requires an interdisciplinary approach to treatment engagement. These collaborative approaches include working with addiction specialists, office based opioid treatment programs (Donroe et al., 2020), or, in an inpatient setting, the implementation of programs such as a substance use intervention team (SUIT) (Tran et al., 2021) to facilitate the transition of care from an inpatient to outpatient setting. A SUIT was described by Tran et al. (2021) as an innovative program that involved physicians, nurse practitioners, pharmacists, social workers, and nurses with the goal of providing inpatient consultation services to facilitate the transition of care for patients with OUD. Collectively an integrated, interdisciplinary care system reduces anxiety, depression, feelings of hopelessness, and increases self-esteem and hope in individuals with this disorder (Bador & Kerekes, 2020).

Previous research suggests persons with OUD experience more structural determinants of health inequities because of poverty, social inequities, and stigma (Radic et al., 2022). For example, higher rates of emergency department (ED) utilization were noted in participants treated for OUD that were Black, with low social support, with multiple co-morbidities, and with more frequent addiction provider visits (Radic et al., 2022). People in crisis often need additional resources to assist with transportation, housing, employment, and navigating insurance. Participants in this study spoke about the need to make healthcare providers, including staff nurses working in acute care, more aware of community resources for OUD to facilitate better community connections for patients in crisis.

Social support interventions, such as recovery coaches and peer navigators, reduce ED utilization in patients with OUD by connecting patients with community resources (Radic et al., 2022). Recovery coaches are often a volunteer-based service or a covered benefit with some state insurance plans (RIZE, 2022). Recovery coaches are required to have a high school diploma or equivalent, lived experience in SUD, and Recovery Coach Academy certification. They provide assistance with navigating healthcare systems, connecting individuals with support services, and providing education to help remove barriers to recovery.

Peer navigators may be either peer recovery specialists or peer support workers. Peer recovery specialists are certified in motivational interviewing and address social, environmental, and personal factors that promote optimal health outcomes for OUD (Goedel et al., 2019). Peer support workers are persons who have successfully navigated the recovery process and help others by sharing their personal experience. Peer support workers engage in advocacy, education, sharing of resources, and mentoring for recovery (SAMHSA, 2022). These services are accessed as part of a comprehensive treatment approach through primary care, insurance referrals, or the Department of Public Health. Funding is available for services through state insurance, grants, and private insurance (DPH/BSAS, 2019).

Other social support resources include recovery support navigators and licensed clinical social workers. Recovery support navigators are paraprofessionals with a bachelor's degree in social work, psychology or a related field. These specialists have professional training specific to SUD but are not required to have lived experience with SUD (DPH/BSAS, 2019). Licensed clinical social workers also work collaboratively to deliver a variety of interventions to help patients in crisis, such as treatment referrals and cognitive behavior therapy (Goedel et al., 2019).

In the Supporting Harm Reduction through Peer Support (SHARPS) study, a peer navigator-based intervention was effective in reducing drug use, risky behaviors, and increased prescriptions for MOUD (Parkes et al., 2022). SHARPS study participants were also able to reestablish trust in the healthcare system through building supportive relationships with their peer navigators (Parkes et al., 2022). Participants in this study suggested healthcare providers working in acute care, i.e. emergency departments, physician offices, and urgent care clinics, should have a list of recovery centers and harm reduction resources for patients upon discharge.

Results of this study reaffirm the need for interprofessional collaborative practice among healthcare workers. Participants reported it was helpful when healthcare providers initiated a warm handoff referral, providing a pre-arranged transfer of care, so the patient did not have the added burden of calling multiple facilities to find a treatment bed. There is an opportunity for nurses and other healthcare providers to collaborate with social workers, recovery coaches, behavioral health specialists, licensed counselors, and community support specialists to facilitate addressing the complex needs of individuals with OUD.

Limitations

This study is not without limitations. Most participants were white, middle-aged females who self-selected and may not adequately represent the experience of all people with OUD. Additionally, participants were asked to describe their experiences in healthcare both good and bad – with a reliance on memory. This may have presented some degree of bias. Lastly, findings reflect a limited geographic and cultural context.

CONCLUSION

The findings of this study reaffirm stigma as a barrier to healthcare for members of the OUD community. Individuals and their families are challenged with both internal and external stigma when seeking care. More research is needed to understand the potential barriers and facilitators to healthcare for minorities and those more severely affected by social determinants of health. Stigma negatively affects public support for allocation of resources to treat OUD; thus, interventions aimed at reducing stigma are critical to support effective OUD treatment and prevent barriers to OUD care. Understanding the complex relationships between social and structural determinants of health will allow nursing science to develop interventions that provide the next generation of nurses with the knowledge, skills and attitudes needed to advance health equity for individuals with OUD.

CLINICAL RESOURCES

1. Shatterproof Addiction Stigma Index - https://www.aha.org/system/files/media/file/2021/11/Shatterproof-Addiction-Stigma-Index-2021-repo.pdf
2. Words Matter- https://nida.nih.gov/sites/default/files/words_matter_handout.pdf
3. Social Determinants of Health- https://health.gov/healthypeople/priority-areas/social-determinants-health
4. Communicating with patients-https://www.cdc.gov/drugoverdose/training/communicating/accessible/training.html
5. Suboxone Treatment Guidelines- https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf

ACKNOWLEDGMENTS

This study was supported by funding from the Foundation for Opioid Response Efforts. The authors would like to acknowledge and thank the Massachusetts Organization for Addiction Recovery (MOAR) Executive Director Maryanne Frangules and the MOAR community members for their support.

CONFLICT OF INTEREST

The authors have no conflicts of interest to declare.

ETHICAL CONSIDERATIONS

Institutional Review Board approval was obtained from the University of Massachusetts Dartmouth.

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How to cite this article: McCurry, M. K., Avery-Desmarais, S., Schuler, M., Tyo, M., Viveiros, J. & Kauranen, B. (2022). Perceived stigma, barriers, and facilitators experienced by members of the opioid use disorder community when seeking healthcare. *Journal of Nursing Scholarship*, *00*, 1–10. https://doi.org/10.1111/jnu.12837