UNDERSTANDING STIGMA: A COMPLEX, MULTIDIMENSIONAL SOCIAL PROCESS

Substance addiction is one of the most stigmatized conditions worldwide.

In nearly all societies, individuals are stigmatized. People have been stigmatized based on various intersecting identifiers, including but not limited to race, religion, culture, and health status. People with physical and mental health conditions, diseases, or disabilities often experience stigma. While some progress has been made to reduce stigma around some health conditions, substance use disorders remain one of the most stigmatized health conditions worldwide. Even though addiction is a complex brain disorder, societies often view it as a personal failing.

The U.S. is experiencing a crisis of drug addiction and overdoses. Increasing rates of drug addiction have contributed to recent declines in average life expectancy in the U.S. Overdose deaths in the U.S. have tripled since 1990; over 700,000 people died from an overdose between 1999 and 2017. To address this crisis, we must address stigma as a barrier to prevention, care, and treatment.

A stigma is a mark, condition, or status that is subject to prejudice by others.

Stigma was first defined in 1963 by sociologist Erving Goffman as "an attribute that is deeply discrediting from a whole and usual person to a tainted, discounted one." Goffman's early research recognized that stigma could result in "disqualification from full social acceptance" and lead to social isolation, discrimination, and health inequities.

> "*We believe the person with a stigma is not quite human. On this assumption, we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances.*"
> – Erving Goffman, 1963

Stigmatization is the social process of labeling, stereotyping, isolating, and discrimination.

Over time a robust definition of stigma has emerged that explains the social process through which stigma affects lives. **Stigmatization** is a co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context where power is exercised.

- **Labeling**: When differences are recognized, people are labeled.
- **Negative stereotype**: The dominant culture connects the labeled person to an undesirable characteristic or negative stereotype.
- **Separation of "us" from "them"**: Labeled persons experience "othering," a loss of belonging from the dominant culture; they are placed in distinct categories to separate the "us" from "them."
- **Status loss and discrimination**: Labeled persons experience discrimination and a loss of status and power, producing inequities.
- **Power and stigma:** The role of power is significant in stigma. Stigmatizing responses and experiences increase as power differences between the stigmatizer and stigmatized increase.

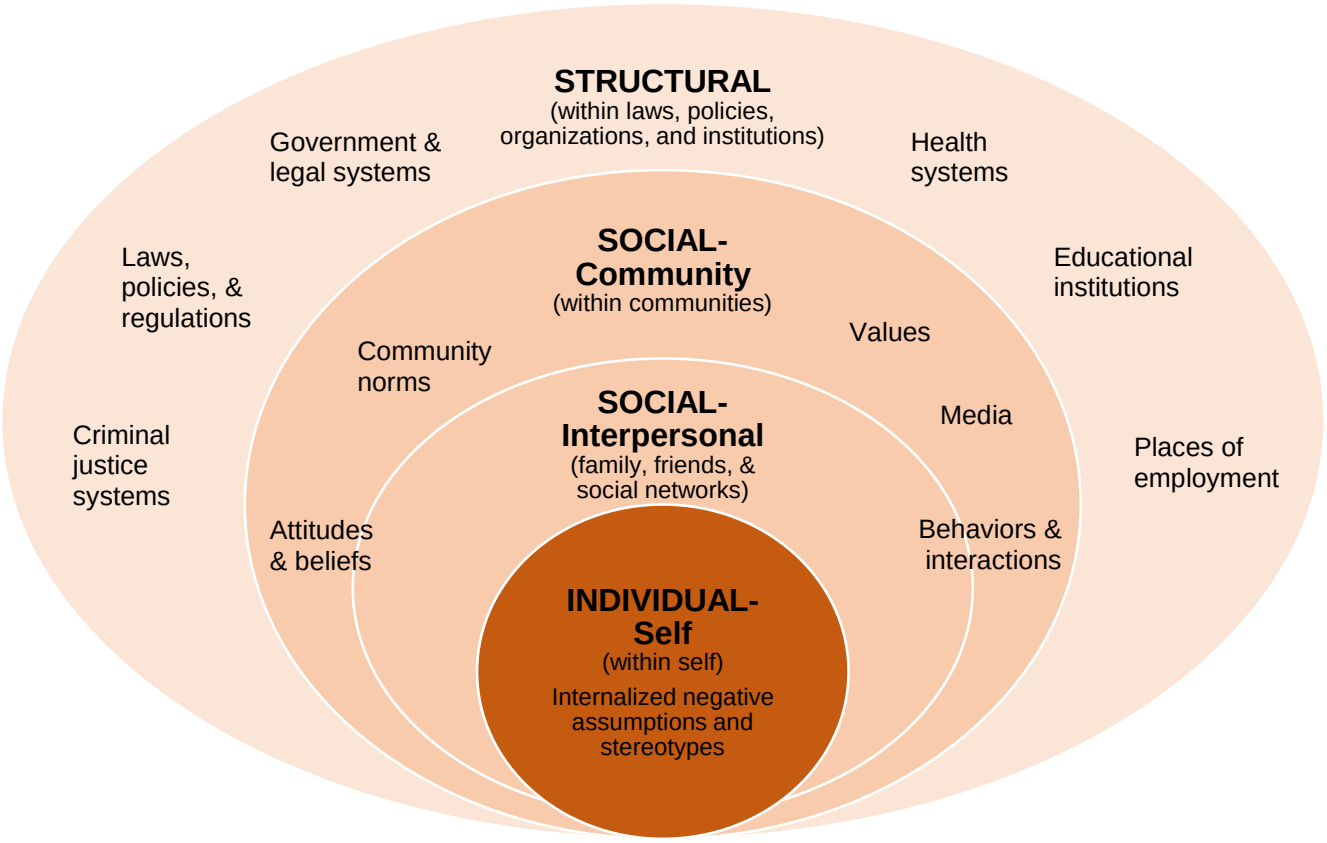
Stigma is multidimensional. It occurs—and can be addressed—at multiple interconnected societal levels: structural, social, and individual.

Structural Stigma manifests in legal and institutional systems, policies, and practices that intentionally or unintentionally limit the rights and opportunities of people with an addiction. These institutions include government and legal systems, employers, education systems, healthcare systems, social service agencies, criminal justice systems, law enforcement, and the courts.

Social (Public) Stigma manifests in our community norms, values, beliefs, and interactions between individuals. It involves harmful or discriminatory attitudes and beliefs people may hold towards addiction. Popular media (e.g., T.V., newspapers, social media) and groups with power—including educators, employers, healthcare providers, journalists, judges, landlords, legislators, police, and policymakers often intentionally or unintentionally perpetuate and reinforce social stigma.

Individual (Self) Stigma occurs when people with an addiction internalize society's negative views, beliefs, and stereotypes related to addiction and apply it to themselves. They may also fear being stigmatized or expect to be treated poorly or rejected by society.

Figure 1. Socio-ecological model of levels of stigma



While each type of stigma is distinct, they are interconnected and influence each other (Figure 1). There is a feedback loop where the various types of stigma interact and further strengthen each other for a cumulative impact on the individual. In the form of laws, regulations, and policies, structural stigma endorses social prejudice and discrimination against people with a substance addiction. This leads to social segregation and interpersonal discrimination. People with a substance addiction become aware of the stigma against them and related discriminatory practices. They internalize the perceived stigma and apply it to themselves, lowering their self-esteem and self-efficacy. The degree of social stigma in a community can determine the ultimate consequences for a person with addiction**:** the more substantial stigma is in a community, the less likely a person with an addiction will seek help.

Understanding the different levels of stigma—structural, social, and individual—and how they can help identify intervention strategies. Table 1 provides examples of how addiction stigma appears within these various levels and potential intervention targets.

Table 1. Levels of Substance Addiction Stigma

Stigma Level	How Stigma Appears	Potential Intervention Targets
Structural	• Healthcare systems and policies that reduce access to care and treatment for substance use. Limited coverage and reimbursement for addiction treatment. • Criminalization of substance use and institutional policies treat substance addiction as a criminal issue instead of a health condition. • Discrimination in housing and employment opportunities. • Limitations on civil rights including serving on a jury, holding political office, parental custody, and reduced privacy. • Disparities in funding, policy support, research, and resources for treatment. ***Examples***: • Lower insurance reimbursement rates for addiction than physical health conditions. Phibitively expensive treatment. • Restrictive insurance requirements for addiction treatment, including higher deductibles, practitioner waivers, and pre-authorizations. • Addiction is the only medical illness that is criminalized. • Individuals with substance addiction being denied a job, promotion, or housing. • Restrictions on access to government benefits- for example restricted access to federal food and cash assistance, delayed or denied federal finalnical assistance for higher education, more	• Legal strategies • Policy strategies • Advocacy strategies • Professional education • Integration of addiction treatment into mainstream healthcare • Increasing representation of people with lived experience in decision making structures

	restrited awarding of ADA federal disability beneifites.	
Social	• Negative views or stereotypes of people with addiction are portrayed in popular media (T.V., newspapers, social media). • Negative attitudes, beliefs, and behaviors of the public toward people with addiction. • Anti-drug messaging campaigns perpetuate stigma and appear to label people who use substances as unwanted by society. • Judgment, discrimination, and social snubbing of people with a substance addiction or people who care for them. • Social isolation of people with addiction. • Limited exposure between the general population and people with addiction. • Lack of public support for addiction services and funding. ***Examples:*** • Public acceptance of stigmatizing beliefs about the characteristics of people with an addiction, including seen as lacking willpower, immoral, bad, untrustworthy, or dishonest. • People with an addiction seen as their addiction and nothing else. • People with an addiction facing social rejection, isolation, judgment, bullying, or labeling at home, school, or work. • Lack of public awareness or acceptance of addiction as a chronic disease. • Less political and public support for investment and policies that improve and expand treatment.	• Media training and messaging • Integration of education on addiction and trauma-informed care into professional education for healthcare providers • Education campaigns • Community-based programming • Strategies to increase exposure and contact between the public and people with addiction • Increasing representation of people with lived experience in positions of social influence
Individual/ Self	• Internalized endorsement and acceptance of negative assumptions about one's character. Low self-esteem and decreased sense of self-efficacy • Shame related to one's addiction. • Anticipated stigma: fears of revealing addiction status due to expectations of stereotyping, prejudice, or discrimination from others. ***Examples:*** • A person with an addiction internalizing the belief that they are a devalued member of	• Education • Peer support • Empowerment strategies • Community-based programming • Increasing availability and accessibility of treatment services

	society or that someone like them is not worthy of good health. • Hesitancy to reveal addiction status to friends and family. • Expectations that providers will not take medical needs seriously.	

A MULTITUDE OF FACTORS CONTRIBUTE TO AND PERPETUATE STIGMA OF SUBSTANCE ADDICTION

There is an array of factors that contribute to and perpetuate substance addiction stigma. These factors range from lack of knowledge of addiction stigma or contact with people with an addiction to media portrayals of racism and criminalization of addiction. While some of these factors may also apply to other types of stigma and stigma of other addictions, this report focuses on the factors contributing to and perpetuating the stigmatization of substance addiction. Understanding the different factors that drive substance addiction stigma can help identify areas to intervene to reduce and address addiction stigma.

Lack of knowledge about the cause of and treatment for addiction

Even though over 20 million Americans have at least one addiction, there are many misconceptions about the cause and treatment of addictions, contributing to stigma. Most Americans do not understand that addiction is a treatable chronic disease, like asthma or diabetes. Americans are more likely to believe that people with an addiction are responsible for their condition driven by personal weakness, moral failure, poor individual choices, or a lack of discipline.

Despite the misconceptions, addiction is mainly caused by genetic and sociocultural factors, including inherited higher risk of addiction and intergenerational trauma. Genetic factors alone explain up to 60% of a person's risk for addiction. Addiction is a treatable chronic disease from which people can recover, with the most effective approach being harm reduction. A harm reduction approach is centered around "meeting people where they are" while providing compassionate, judgment-free care. It focuses on reducing the harms associated with addiction and substance use without demanding total abstinence in exchange for access to care. Harm reduction stands in contrast to the "tough love" punitive approach to addiction from previous decades.

Lack of contact or experience with people who use substances or have an addiction

People's social networks, experiences, and levels of contact with people with addiction affect their understanding of and opinions around substance use. People who do not have experience with substance use or people with an addiction are more inclined to accept the stigmatized portrayals of people who use substances and misinformation about addiction, often driven by lack of understanding, fear, and suspicion. Studies suggest that as people have more experience and contact with people with addiction, stigmatizing beliefs decrease. Some studies have found that increased contact with people with addiction can deepen stigma and negative attitudes towards addiction. Factors contributing to deepening stigma through communication include the stage of recovery of the individual with addiction and the quality of intervention if contact is done purposefully through contact-based interventions.

Negative media portrayals of people with an addiction

News, television, and movie media provide ideas and images about drug use and addiction that influence attitudes, beliefs, and behaviors towards people with an addiction. Popular media plays a crucial role in increasing the fear and perceived dangers of people with addiction and reinforces perceptions that people with addiction are beyond help. In recent years, the world of social media has provided many new avenues to deliver and spread negative portrayals and misinformation of addiction that strengthens stigma.

Prevention efforts and messaging that increase shame and stigmatization

Measures aimed at controlling and reducing substance use, such as anti-drug messaging and harsh criminal sentences for drug use, often emphasize connections between substance use and crime and appear to label people with addiction as unwanted by society. Primary prevention efforts often use stigma to discourage drug use, emphasizing a connection between crime and addiction or portraying individuals with addiction as socially undesirable. Since youth are the main target of prevention materials, these connections become instilled in young brains early on, making them harder to root out later. These measures intended to deter drug use deepen the structural, social, and self-stigma of people with addiction, contributing to the continuation of addiction through increased shame, decreased help-seeking, and criminalization (described more in the consequences section).

Separation of addiction treatment from mainstream healthcare

The U.S. health system has widespread individual and structural stigma against patients with addiction and treatment medications. This stigma is driven by addiction treatment and financing outside of “mainstream” healthcare despite its chronic condition. The separation contributes to disparities in addiction treatment access and quality relative to other health conditions. Barriers at the structural level include restrictive coverage and reimbursement requirements, lower reimbursement rates, as well as waivers and pre-authorizations that delay and prevent treatment. Additionally, clinicians’ negative attitudes towards addiction are more significant than for other medical conditions. Stigma held by providers is often caused by lack of addiction training, lack of awareness about addiction, uncertainty about treating addiction, and fear.

The separation of addiction treatment began in the early 1970s when regulations were established for addiction treatment that restricted access and isolated addiction from other health conditions. These regulations included specialized prescribing clinics, observed dosing, and close behavior monitoring. The Mental Health Parity and Addiction Equity Act of 2008 and individual payer initiatives have changed the health system to improve addiction treatment coverage and access to medications, but disparities in their implementation exist.

Treating drug use as a criminal problem rather than a public health issue

Addiction is the only medical condition that is criminalized. For decades, we have known that addiction is a treatable brain disorder, yet it continues to be penalized. Criminal punishment is not an effective approach to reducing drug use and overdose. It contributes to a higher risk of continued addiction,

relapse, and drug overdose upon release. The criminalization of drug use escalated in the United States under President Nixon with the launch of the War on Drugs in the 1970s (see Box 1 for more on the history of criminalizing drug use). Today there are a greater proportion of individuals with addiction within the criminal justice system than the healthcare system.

Institutional policies that treat drug use primarily as a criminal issue (e.g., the U.S. war on drugs) rather than a health concern contribute to creating a stigmatizing environment that marginalizes people with addiction. The illegality of drug use makes it easy to justify labeling, stereotyping, separating, and discriminating against people who use substances. Additionally, the effects of incarceration can include lost opportunity and discrimination in housing, employment, education, and access to government benefits, as well as limitations on civil rights and personal privacy.

Box 1. The U.S. War on Drugs

In 1971, President Nixon declared a "war on drugs." He significantly increased the size and authority of federal drug control agencies. He implemented harsh measures related to drug possession and use, including mandatory sentencing and no-knock warrants. The war on drugs impacted other policy areas and made addiction discrimination legal in some situations, including housing and employment. For example, the Americans with Disabilities Act (ADA) of 1990 offers only limited protections for people with substance use disorder as either tenants or employees. Additionally, drug-free workplace policies in the 1980s led some companies to implement mandated drug testing. Mandated drug testing continues in some places, although in 2010, Congress ended the 1988 requiring testing. The war on drugs rhetoric and policies have shaped generations of Americans' social understanding, interpersonal attitudes and behaviors, and individual-level self-stigma of people who use drugs. Additionally, the war on drugs disproportionately criminalizes BI&PoC communities as Black and Latinx Americans are more likely to be arrested and receive more substantial sentences for drug-related offenses.

Systemic racism and racial bias in the U.S. response to substance addiction

Addiction stigma and prejudice against certain races and socioeconomic classes are inextricably linked. Racial bias shapes the U.S. response to addiction and contributes to systemic racism. The impact of this is a response to addiction that focuses on criminalization instead of public health, disparities in access to evidence-based addiction treatment services and policy innovations for Black, Indigenous, and People of Color (BI&PoC), and ongoing racism underlying addiction stigma (Table 2).

Table 2. Racism in the U.S. response to substance addiction

Area	Examples
Over policing and criminalization of drug use	• Unequal implementation of drug testing with BI&PoC and disproportionate negative consequences for positive results.

by Black, Indigenous, and People of Color (BI&PoC)	• BI&PoC experience higher incarceration rates and harsher sentencing for drug offenses despite similar drug possession rates and use to white individuals.
Systemic racism in drug policy	• The federal and state response to crack (less expensive water-insoluble cocaine) use in the 1980s and 90s focused on funding law enforcement targeted at BI&PoC. Conversely, to address the opioid epidemic, which is closely associated with white people, funding focused on research, treatment and prevention. • The Anti-Drug Abuse Act of 1986 sanctioned a 100 times greater criminal sentencing disparity for crack associated with BI&PoC versus powder cocaine associated with middle to upper-class white people. The distribution of five grams of crack carried a minimum of a five-year sentence in federal prison, whereas 500 grams of powder cocaine had the same sentencing. More recent policies have reduced but not removed this sentencing disparity. • Historically, the primary medication-assisted treatment for opioid addiction was methadone dispensed at highly federally regulated treatment clinics. The Drug Addiction Treatment Act of 2000 (DATA 200), motivated by an association of the opioid epidemic with white people, expanded addiction treatment access to the more easily accessible medical setting, allowing physician office-based treatment with narcotic medication buprenorphine.
Inequitable expansion and access to treatment	• Opioid use disorder (OUD) treatment remains segregated. Black and Hispanic/Latinx people are more likely to receive methadone, available in highly regulated systems. White people are more likely to receive buprenorphine, available in an office-based setting. • Methadone treatment clinics are more likely to be in highly segregated Black and Hispanic/Latino counties, while buprenorphine facilities are more likely to be found in white counties. • There is a lack of research and focus on evidence-based addiction prevention research among BI&PoC. • Lack of availability of culturally appropriate addiction services and culturally competent care providers.
Racism in media portrayals of addiction	• Media often portray BI&PoC who use heroin as criminals and white people who abuse prescription opioids as sympathetic victims.

NEGATIVE CONSEQUENCES OF SUBSTANCE ADDICTION STIGMA

Addiction stigma creates barriers to effective evidence-based treatment.

Addiction stigma results in a multitude of negative consequences for both individuals and communities. Some of the most harmful effects of stigma are that it creates addiction treatment and recovery support barriers. It leads to under-diagnosis, under-treatment, and under-funding of addiction services. Before COVID-19, 90% of people who needed addiction treatment did not receive it. Only 10% of people with a substance use disorder were receiving treatment. Addiction stigma creates barriers to treatment by impacting the availability of treatment services, the accessibility of services, treatment-seeking and retention behaviors, and the quality of services provided. Table 3 highlights the pathways through which addiction stigma creates barriers to providing and accessing treatment.

Table 3. Pathways through which stigma negatively impacts treatment access

Negative Consequence	Pathway Description
Reduced availability of evidence-based services	• De-prioritization and disparities in funding for addiction research. Research on addiction receives less scientific funding than other physical conditions. • Less political and public support for investment and policies to improve and expand treatment resulting in underinvestment in high-quality addiction treatment infrastructure despite the high prevalence of substance use. • Negative perceptions of evidence-based harm reduction strategies, including needle exchange, substitution therapies, and safe drug consumption spaces or rooms, and not-in-my-backyard resistance to the provision of these community-based strategies. • Lower insurance reimbursement rates for addiction than physical health conditions disincentivize addiction treatment contributing to service gaps and provider shortages.
Restrictive requirements that limit access, provider coordination, coverage, and reimbursement to addiction treatment	• Healthcare policies and payer structures are not designed to treat addiction as a chronic disease. This carve-out perpetuates gaps in the provision of and access to affordable addiction treatment. • Insurance benefits coverage and reimbursement are more limited and prohibitive relative to physical health services. • When insurance coverage is offered, benefits often require higher deductibles, complex requirements for practitioner waivers and pre-authorizations, or only permit treatment in cases where the problem is particularly severe. • These factors limit access to treatment and result in fewer opportunities for treatment before a person is in crisis. • Substance use disorder (SUD) treatment information is subject to stringent regulations in 42 Code of Federal Regulations (CFR) Part 2. However, these federal and state privacy laws and regulations, while put in place to protect people from discrimination, are complicated, hard to understand, inconsistent with other healthcare privacy laws, and do not reflect current health technology.

	• These regulations lead to barriers in sharing health information across disciplines, prevent appropriate information from being shared, and are a barrier towards more integrated, whole-person care.
Diminished treatment-seeking and retention	• People who experience stigma related to their addiction are less likely to seek treatment and access healthcare. • Anticipated stigma, related to fears about consequences of revealing one's addiction status or expectation providers will not take their medical needs seriously, contributes to reluctance to disclose addiction or seek help. • Self-stigma leads to a lowered sense of self-esteem and self-efficacy and a "why try?" thinking that someone like me is not worthy of good health. • Hesitance to reveal addiction status and diminished help-seeking driven by stigma leads to underestimating substance use disorder burden.
Lower quality of addiction treatment and care and worse treatment outcomes.	• Stigma and negative attitudes of clinicians towards people with addiction are more significant than for other medical conditions. • Stigma held by providers who care for individuals with an addiction is often driven by negative attitudes, fear, lack of awareness about addiction, and uncertainty about treating it. • Provider stigma shows up as lower empathy, limited patient engagement, reduced willingness and competency to manage addiction as a disease, and ultimately substandard care provision. • Provider stigma can lead to the denial of care. Individuals with an addiction seeking treatment are sometimes denied care in emergency departments or other hospital settings because staff are fearful of their behavior or believe they are drug-seeking.

Addiction stigma causes and perpetuates social and health disparities.

Addiction stigma exacerbates disparities among stigmatized persons through social isolation, diminishing self-efficacy, incarceration, limiting access to opportunities, and negatively impacting health outcomes. Table 4 highlights the pathways through which addiction stigma affects inequities.

Table 4. Pathways through which stigma causes and perpetuates disparities

Negative Consequence	Pathway Description
Lowered self-esteem and self-efficacy → barriers to recovery and community integration.	• The effects of self-stigma include lowered self-esteem, decreased self-efficacy, and psychologically harmful feelings of embarrassment and shame. • Low self-esteem and low self-efficacy among people with an addiction can lead to a failure to strive to reach goals related to

	recovery or living and working independently, often referred to as the "why try" effect.
Social isolation → barriers to recovery and adverse health outcomes.	• Both experienced stigma and anticipated stigma contribute to the marginalization, exclusion, and social isolation of people with an addiction from their communities and social networks. • Social support is essential to recovery. The social isolation from addiction stigma encourages further drug-taking, exacerbates addiction, and increases vulnerability to relapse.
Increased stress and negative coping behaviors → adverse health outcomes	• Stigmatized individuals experience increased pressure due to their diminished social status. External stressors (i.e., violence, discrimination, implicit bias, microaggressions) and internal stressors (i.e., anticipating rejection, self-stigmatization) can contribute to adverse health outcomes. • Stigmatized individuals may turn to negative coping behaviors like smoking, alcohol consumption, and increased substance use, increasing the risk of poor health outcomes.
Incarceration of people with addiction → adverse health outcomes and negative impacts on livelihood	• Addiction is the only medical illness that is criminalized. • The criminalization of addiction increases isolation, risk of overdose upon release, and risk of relapse. In addition, incarceration limits future opportunities and resources related to higher education, employment, government benefits, privacy, and social integration. It also increases the risk of death from a wide variety of causes.
Decreased access to opportunities and resources → negative impacts on livelihood.	• Stigmatizing beliefs about characteristics of people with a substance addiction normalize prejudice and discrimination against them, leading to both intended and unintended loss of opportunities. • Structural and social stigma limits access to opportunities and resources related to employment, education, money, power, prestige, and social connections. For example, employers may not hire or promote individuals with an addiction, landlords may not rent. Access to government benefits and structural supports may be more restrictive for people with an addiction.

Intersecting stigmas increase the likelihood of negative consequences.

No stigma exists in a silo. Stigma experiences are shaped by intersecting social identities. Many people with a substance addiction may also be subject to other types of stigma attached to health conditions, identities, or behaviors. Intersectional stigma is when multiple stigmatized identities converge for an individual, and the interaction between stigmas increases the level of stigma experienced by an individual. This intersection can lead to compounding effects and increased negative consequences for the most marginalized populations related to treatment access, adverse health outcomes, and perpetuation of disparities. Stigmas that intersect with addiction include:

- **Stigma based on sociodemographic characteristics**: racial/ethnic minority, gender identity, sexual orientation, immigration status, religion, education level, and income.

- **Health condition-related stigma**: exclusion, rejection, blame, or devaluation based on one or more co-existing health conditions (e.g., HIV/AIDS, mental illness, chronic kidney disease).
- **Stigma related to behaviors or experiences**: incarceration, substance use, sex work, frequent healthcare use.

Box 2. Examples of the effects of intersectional stigma

- BI&PoC, youth, men, military service members, and health professionals disproportionately avoid seeking help due to anticipated stigma.
- Black, Hispanic, Latinx, Native American, and Asian Americans experience disparities in addiction treatment access and outcomes compared to white Americans. These disparities include differences in access to quality treatment, receiving an accurate diagnosis, treatment completion rates, length of stay in treatment, being diverted to addiction treatment rather than the criminal justice system, and recovery rates.
- BI&PoC individuals are more likely to experience adverse legal outcomes for drug-related offenses. Rates of drug use and selling are equivalent between racial/ethnic groups, but BI&PoC individualsare more likely to be arrested and receive harsher sentences than white individuals.

Fundamental to the concept of intersectional stigma is that the statuses connected to intersecting stigmas are socially constructed and deeply rooted within the historical, cultural, and geographic context in which they appear. Therefore, it is essential to understand the various factors contributing to addiction stigma and may intersect with addiction stigma in rural communities. Interventions to address addiction stigma should also consider the co-experience and multiplier effects of other stigmas associated with intersecting health conditions, identities, or behaviors.

ADDICTION AND ADDICTION STIGMA IN RURAL AREAS

Many factors unique to rural areas contribute to increased substance use and treatment barriers

To understand how specific elements of rural life influence addiction stigma, it is helpful to identify and understand geographic, economic, and social factors unique to rural areas that contribute to higher drug use and treatment barriers in rural communities (Table 5).

Table 5. Factors contributing to high rates of substance use and treatment barriers in rural areas

Factor	How these factors contribute to substance use
Fragmented healthcare systems	• Little connectivity between primary care and addiction treatment • Specialized addiction treatment often requires travel outside the community
Larger distances but limited public transportation	• Accessing treatment often requires traveling to a different sociocultural context, such as more urban areas • People with a substance addiction who must travel to other unfamiliar sociocultural contexts for treatment are:

	▪ more likely to return to drug use ▪ more likely to become incarcerated ▪ less likely to attend self-help groups
Limited recreational infrastructure	• Lack of entertainment options make substance use more appealing
Municipal financial stress	• Limited resources do not allow for substantial funding of social services • Substance use, being highly stigmatized, is not prioritized for public funding
Reduced employment opportunities	• High level of economic distress fuels despair, a sense of powerlessness, loss of purpose • Excess unstructured time makes high-risk individuals more likely to be driven to use or use more • Diversion and resale of prescribed opioids can provide access to economic and social capital in the absence of legal employment
A higher proportion of physically demanding jobs (e.g., agriculture, coal mining)	• Job-related chronic pain is common • More opioid prescribing leads to normalization of opioid use and greater access to opioids in general • While national prescription rates have declined in recent years, they are declining more slowly in rural areas
Public attitudes	• Normalization of drug use due to long history of work-related chronic pain or injury in the community
Social norms	• Social acceptance of drug use and lack of economic opportunities make substance use a way to gain social capital • Social norms about community strength and resilience can serve as barriers to accessing treatment
Social networks	• Family members and friends are the primary source of syringes for drug injection in rural areas • 80% of people in one rural study were initiated into injecting drugs by a friend or family member • Injecting drugs is normalized in rural areas; “everyone’s doing it.”

Addiction stigma is more pronounced in rural areas

Many factors unique to rural areas contribute to addiction stigma that is felt more acutely in rural communities. These factors include decreased anonymity, consolidated and homogeneous communities, limited access to or resistance to “neutralizing” anti-stigma information, and lack of access to addiction treatment services.

Decreased anonymity

In rural communities-smaller towns and more close-knit communities means it may be more challenging to ensure anonymity. Due to this lack of anonymity, individuals with addiction experience stigma more

acutely. It is more common that people will know if a person struggles with addiction or visits a provider for treatment. Individuals may fear or experience ostracization if substance use is made public.

More consolidated and homogenous communities

The low population density and cultural homogeneity- religious, racial, and ethnic- in rural communities reduce the exposure residents may have to "different" people and lifestyles. This lack of contact with people who are "different"—including people who use substances—contributes to addiction stigma in rural areas, driven by misunderstandings, limited interactions, and limited information. Consolidated and homogenous networks may leave stigmatized individuals and their families feeling isolated, morally, and criminally policed, and consequently less likely to share their status or seek help openly.

Limited access to or resistance to "neutralizing" anti-stigma information

Studies have found that residents in rural areas are more likely to believe, and hold on to the belief, that addiction results from character flaws, personal weakness, or moral failure than people in urban communities. These inaccurate beliefs about the causes of addiction are driven by limited interactions with or resistance to "neutralizing" information about addiction that helps develop sensitivity to or empathy for stigmatized populations.

Even when provided with scientific evidence of the causes of addiction, rural residents are more likely to deny or devalue these biomedical or sociocultural explanations for substance use. Social networks in rural areas are more disconnected from evidence-based health information networks. Negative portrayals of people with a substance addiction and misinformation about addiction are spread virally and reinforced on social media, primarily through community networks such as local news feeds on Facebook. At the same time, accurate or "neutralizing" is shared less frequently on social media.

Lack of access to addiction treatment services

Access to general healthcare and prevention and treatment services is limited in rural areas. Resistance to harm reduction and evidence-based addiction treatment is more common in rural areas. Harm reduction measures—such as clean needle exchanges and increasing availability of naloxone for opioid overdose reversal—and evidence-based treatment, such as medication-assisted treatment (MAT), are seen by rural residents as enabling substance use. Limited access to treatment in rural communities, driven by policy, funding, and public support decisions, reinforces that addiction is not a disease and not worth treating.

While addiction stigma may appear differently and more acutely in rural areas, the ultimate effects are still the same: barriers to effective treatment, decreased help-seeking, social exclusion, isolation of and reduced access to opportunities for people with a substance addiction, and increased health and livelihood disparities.

Intersectional addiction stigma increases health inequities in rural communities.

Addiction stigma causes and perpetuates health inequities in rural communities in ways that are unique to the setting. Because of limited access to treatment in rural areas—due to geographic factors of larger distances between places, limited public transportation, and fragmented healthcare services—many people struggling with addiction must travel to urban areas for care. People who must travel to other, unfamiliar sociocultural contexts for care are more likely to have adverse outcomes in several indicators, further intensifying any existing inequities. People with problematic substance use in rural communities are also

more likely to have a mental illness. Their experience of these intersectional stigmas can perpetuate and exacerbate use and make effective treatment challenging to access.

ADDICTION AND ADDICTION STIGMA IN AMERICAN INDIAN/ALASKA NATIVE POPULATIONS

Many factors contribute to disproportionately higher rates of addiction among American Indian/ Alaska Native populations

American Indian/Alaska Native populations, compared to other ethnic groups, have disproportionately high rates of addiction and mortality associated with alcohol and other drugs. Compared to other groups in the US, adolescents in these communities tend to start substance use earlier and use more heavily. Because of these disparities, it is important to understand the drivers of the high rates of substance addiction to contextualize addiction stigma within and forced upon American Indian communities.

Table 6. Factors contributing to disproportionate rates of substance use and barriers to accessing treatment

Factor	How these factors contribute to substance use
Intergenerational trauma and early exposure to adverse events	• Disparities in the rates of substance addiction in American Indian communities are associated with the effects of historic and contemporary trauma, including violent colonization, forced assimilation, discrimination, and socio-cultural inequalities. These traumas have led to greater vulnerability to substance addiction, depression, anxiety, and shame. • Many American Indians experience early exposure to adverse events which is associated with early substance use and substance addiction.
Lack of access to health care, mental health, and addiction treatment services	• The Indian Health Services is severely underfunded by the federal government. It has been estimated to cover about 55% of American Indian/Alaska Native health care needs and receive less funding per person than Medicare or Medicaid. This, compounded with other access drivers, has led to a lack of availability of all types of health services, including addiction treatment services. • Many of these communities also experience health care access challenges associated with rural areas, including being geographically remote, challenges retaining clinicians, and limited health care services.
High prevalence of mental health issues	• There is a high prevalence of mental health conditions in many American Indian communities which acts as a risk factor for substance addiction for both adults and adolescents and compounds other substance addiction risk factors.
High rates of poverty and unemployment	• Many American Indian communities experience high rates of unemployment and poverty. These communities also tend to have underfunded or poor-quality schools, housing, and social support programs. These elements can contribute to many substance addiction

	risk factors, such as needing coping mechanisms, lower self-esteem and self-efficacy, and decreased psychological health, among others.
Availability and normalization of substances	• Because of the disproportionate rates of substance addiction, many American Indians have family members who use substances which normalizes the behavior, can contribute to early initiation, and creates barriers to sustained recovery. • Substances are also easily accessible in many American Indian communities. Because of the small close-knit nature of many of these communities, there is high exposure to other members who use substances.

Lack of research driven by historic distrust leads to limited insights on addiction stigma in American Indian communities

There is a dearth of research about addiction and addiction stigma focused on American Indian populations. This trend is also present in research around mental health stigma more generally. Part of this lack of research stems from distrust due to past unethical and stigmatizing research, which has created a reluctance of American Indian communities to participate in research. These historic problems are especially salient to substance addiction related research where recruitment of American Indians has been stymied by addiction related stigma, such as stereotypes about American Indians and alcohol, and distrust of research resulting from a history of ethics violations in American Indian communities.

One example of a study that led to distrust was the Barrow Alcohol Study which examined alcohol use and addiction among the Inupiaq people in 1979. This study included minimal community involvement and overgeneralized findings resulting in a New York Times headline declaring Alaskan Natives to be a "society of alcoholics." This further stigmatized the community and created distrust of researchers.

Addiction stigma is widespread among American Indian communities and leads to treatment avoidance through a variety of pathways

Addiction and mental health stigma are prevalent among many American Indian communities. The bulk of available research on addiction stigma in American Indian communities focuses on the impacts of stigma on care seeking and treatment. In these communities', stigma is one of the most reported reasons for not seeking care or treatment. While stigma is widespread in many American Indian communities, there are 574 tribes throughout the United States who have different experiences with substance addiction and widely varying cultural practices and community norms. This heterogeneity leads to different levels and manifestations of substance addiction stigma. At the same time, there are some common trends in American Indian communities related to the sources of stigma and resulting impacts on care and treatment avoidance.

Historic mistrust of mental health providers and western medicine establishments limits care seeking

One pervasive form of stigma present in many American Indian communities stems from historic mistrust of mental health providers and western medical establishments. Some believe that seeking professional mental health care represents the "white man's" system and culture. Others are wary of care-seeking due to a long history of the government and institutions persecuting and oppressing

American Indians. The stigma associated with care-seeking also stems from more universal internalized self-stigma of perceived negative associations with substance users, such as the ideas that people who use substances are bad people, unmotivated, or “good for nothing.”

Stigmatization of traditional healing and medicine practices by western doctors hinders access to culturally competent care

Treatment plans for substance addiction that pair western medicine techniques with American Indian culture, community norms, values, and traditional healing components are generally more effective. However, there is a lack of access to these blended treatment approaches. Many American Indians receive substance addiction treatment from non-native providers who do not provide culturally competent care and do not discuss how western and traditional treatment approaches can be integrated. This lack of focus and acceptance of integrated treatments often leads to tensions that exacerbate barriers to treatment and recovery for American Indians. Additionally, many mental health providers do not understand the current and historic trauma American Indian communities face, which leads to a lack of trauma informed care and inadequately tailored treatment plans.

Misperceptions about Medication Assisted Treatment (MAT) lead to underutilization

Misunderstandings about treatments spur stigma around effective evidence-based treatment methods, including MAT among American Indian communities. For example, some American Indians believe that using MAT for opioid use disorder is simply replacing one substance for another and not a form of sobriety.

Strong community ties act as a supportive factor but also magnify barriers to care

Most American Indian populations emphasize the importance and centrality of community. For many American Indians, their community is seen as an extended family that provides support and strength that can aid in substance addiction recovery. However, the small, close-knit nature of many of these communities can also amplify the barriers to treatment that stigma causes because people are reluctant for others to learn about their addiction. American Indians living on a reservation or in rural areas tend to live in small communities where “everybody knows everybody” and this leads some to worry that if they seek treatment someone who knows their family may spread rumors about them. Part of this stigma and shame around others learning about their addiction stems from a belief by some that substance addiction is a choice.

Disproportionate impacts of the criminalization of addiction during pregnancy leads to care avoidance and additional stigmatization

Substance use during pregnancy has been criminalized through federal, state, and tribal laws. American Indians are disproportionately affected by these laws due to their race, lower socioeconomic status, and government surveillance under federal, state, and tribal law. Stigmatization and lack of access to care are compounded due to the criminalization of substance addiction in pregnant woman. This leads women who use substances to omit prenatal care, deepen distrust of healthcare providers, and avoid seeking addiction treatment because of fear of losing their children and being incarcerated.

Pregnant American Indian women are more likely to both face discrimination in health care settings and be prosecuted for substance use during pregnancy. Some states go to extreme measures to seek out these women and collect evidence for prosecution, including forced catheterization and entering

treatment facilities to take photos of patients' positive drug screenings. Because of the lack of maternal care access on reservations, pregnant American Indians are often shuttled between care settings on and off reservations resulting in exposure to rules and regulations of tribal, state, and federal jurisdictions and the potential to be prosecuted under all three.

Internalized stereotypes lead to coping based addiction and further stigmatization

Stereotypes and stigma lead to a dangerous cycle for some American Indians. Those who have a greater belief in the baseless stereotype that American Indians have a unique biological vulnerability to alcohol experience more depression, drinking to cope with negative emotions, and alcohol consequences. There is little evidence that biological or genetic differences explain the alcohol use related disparities in American Indian communities, and in contrast there is evidence that traumas contribute to these disparities. The internalization of harmful stereotypes leads to further perpetuation by contributing to depression, decreasing perceived self-control to avoid heavy drinking, and increasing coping through substances.

FROM UNDERSTANDING OF ADDICTION STIGMA TO ACTION

In summary, this report has demonstrated that stigmatization is an active process that includes labeling, negative stereotyping, separation of "us" from "them," and status loss and discrimination. Stigma occurs—and can be addressed—at multiple levels, including the structural, social, and individual. Because stigma at the structural level has the greatest influence and reach, the structural level should always be considered first to focus intervention efforts higher upstream.

Stigma has a multitude of negative effects, but the most harmful impact of stigma is that it prevents people with addiction and those who love and care for them from accessing and/or providing high-quality, evidence-based care. Stigma related to substance use is more harmful than other health-related stigmas, and healthcare workers are not immune to perpetuating it.

Factors contributing to stigma—such as lack of knowledge about the causes of addiction, negative media portrayals, lack of contact with people with a substance addiction, and punitive drug policies—can be used to identify targets for intervention strategies. When planning and designing interventions to reduce addiction stigma in the Olympic Region, it is essential to consider the characteristics of rural areas and indigenous populations that make substance-use rates higher and stigma stronger in these communities compared to other areas.

Further analysis of the conditions of substance use and substance-use-related stigma in the Olympic region and a detailed review of innovative approaches to reducing stigma will deepen this understanding of addiction stigma in the Olympic region and provide insight into how it can be reduced.

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