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Exploring the Perspectives and Experiences of Physicians in WV who Prescribe Medication-Assisted Treatment (MAT) to Patients with Opioid use Disorder (OUD)

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**EXPLORING THE PERSPECTIVES AND EXPERIENCES OF PHYSICIANS IN WV
WHO PRESCRIBE MEDICATION-ASSISTED TREATMENT (MAT) TO PATIENTS
WITH OPIOID USE DISORDER (OUD)**

A dissertation submitted to
the Graduate College of
Marshall University
In partial fulfillment of
the requirements for the degree of
Doctor of Education

In
Curriculum and Instruction

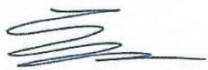

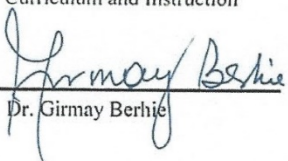
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December 2018

APPROVAL OF DISSERTATION

We, the faculty supervising the work of **Kimberly White**, affirm that the dissertation, *Exploring Perceptions and Experiences of Physicians in WV who Prescribe Medication-assisted Treatment (MAT) to Patients with Opioid Use Disorder (OUD)*, meets the high academic standards for original scholarship and creative work established by the EdD Program in **Curriculum and Instruction** and the College of Education and Professional Development. This work also conforms to the editorial standards of our discipline and the Graduate College of Marshall University. With our signatures, we approve the manuscript for publication.

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To people everywhere suffering from addiction, you deserve access to evidence-based medical, mental, and behavioral healthcare to treat addiction as others receive care for chronic illness: without stigma and without judgment. You deserve a healthy, happy life.

To Mom, Dad, my brother, Grandma Edythe, Molly, Jim, John, Patti, Amy, Leah, Delores Ward, members of the Social Work Department, my students, innumerable friends and colleagues, your memory, your example, and your constant encouragement kept me going when I wanted to make excuses and give up. Thank you for never aiding my discovery of that good enough reason to quit.

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ABSTRACT

This qualitative study explores the lived experiences of six physicians in West Virginia who treat patients with opioid use disorder using Buprenorphine, often referred to as medication-assisted treatment (MAT). MAT is an empirically-supported method of treating people who suffer from the physiological symptoms of opioid addiction and its associated psychological, social, and behavioral components to ease withdrawal. West Virginia ranks first in the nation for opioid overdose deaths, with an estimated 60,000 people needing treatment for Opioid Use Disorder (OUD) and approximately 280 physicians certified to provide MAT. Semi-structured individual interviews lasting one hour were the primary source of information for understanding the experiences of prescribing physicians in the state. Analysis of content from the interviews occurred using four conceptual frameworks i.e., phenomenology, applied research, pragmatism, and strengths perspective to identify major themes. The major themes identified in this study may be useful to medical school and social work program administrators and curriculum committee members tasked with developing content and experiential learning opportunities for students that reflect day to day realities of medical and behavioral health professionals who treat patients with OUD. Examples of specific implications for pedagogy and curriculum involve training medical students in the person-in-environment framework using a biopsychosocial assessment model to prepare physicians to inquire about and incorporate contextual factors that affect patients' recovery into treatment regimen and training social work students to function as behavioral health consultants to physicians and members of the care team, as well as social reform and cultural change leaders.

CHAPTER 1: INTRODUCTION

OPIOID USE DISORDER

Opioid use disorder (OUD) is a complex condition affecting over 2.5 million Americans (ASAM, 2016). Opioids are a class of powerful analgesic medications that include morphine, oxycodone, and fentanyl used by doctors to treat individuals suffering from chronic pain (Wesson and Smith, 2010). Methadone and buprenorphine are also classified as opioids and are prescribed by doctors as an evidence-based approach to treating addiction to pharmaceutical grade opioids and heroin (Wesson and Smith, 2010). Opioids engage brain receptors that regulate several physiological processes in the body which can lead to significant changes in the body's modulation of pain and mood (Lutz and Kieffer, 2013). The highly addictive quality of opioid medication, particularly after long-term use or misuse, makes discontinuation of the drug very difficult, producing in patients a higher risk for developing dependence and the associated mental, physical, and behavioral symptoms that accompany addiction (Lutz and Kieffer, 2013). Leung, Macdonald, Stanbrook, Dhalla, and Juurlink (2017) propose doctors' heavy reliance on opioids as an effective method of treating chronic pain increased after a paragraph appeared in *The New England Journal of Medicine* stating addiction was "rare in patients with no history of addiction" (Porter and Jick, 1980, p. 123). This frequently cited paragraph from 1980 "helped to shape a narrative that allayed prescribers' concerns" about the risk of addiction after long-term use of opioids, particularly oxycodone (Leung et al., 2017, p. 2194). Drastic increases in rates of opioid prescription and the pharmaceutical industry's intense marketing and distribution of opioid pills—over 20 million to Williamson, WV, a town of 3,000 people—have proven a fatal combination resulting in 872 statewide overdose deaths in 2017 alone (Leung, et al., 2017; Wamsley, 2018). Dr. Michael Brumage, executive director of Charleston, WV public health

department calls the upsurge of opioid addiction and overdose rates and the adverse societal consequences associated with a high rate of addiction, i.e., crime, health, and lost productivity that are straining the states' organizational and financial resources an "epidemic of epidemics" (U.S. Department of Health and Human Services, 2016; Nilsen, 2018).

OPIOID OVERDOSES AND DEATHS

For the second year in a row, the United States is experiencing a decline in life expectancy according to 2017 National Center for Health Statistics report (Kochanek, Murphy, Xu, and Arias, 2017). The decline, not seen in the U.S. since 1993 is attributed in part to "diseases of despair" such as drug overdoses, suicide, and alcoholism occurring at rates addictions expert Keith Humphrey's of Stanford University says are "deadlier than the peak of the AIDS epidemic" and unseen in other Western nations (Bernstein & Ingraham, 2017; Kochanek, Murphy, Xu, & Arias, 2017). In 2016, there were 42,249 opioid overdose deaths in the United States representing a five-fold increase in the rate of overdose deaths since 1999 (CDC, *Drug Overdose Death Data*, 2016). The Vital Signs report (2018) issued by the Center for Disease Control indicated a 30% rise in emergency department visits for opioid addiction in 45 states between July 2016 and September 2017 and though the report shows West Virginia's rates are decreasing, the state continues to suffer a significant number of deaths stemming from an opioid epidemic that has not yet plateaued.

West Virginia

West Virginia ranks number one in the nation for opioid overdose death rates registering at 52 deaths per 100,000 people — more than three times the national average of 16.3 overdose deaths per 100,000 (CDC, *Drug Overdose Death Data*, 2016). Dr. Michael Kilhenney, medical director of the Cabell County Health Department states approximately 10,000 people in Cabell

County, a county of approximately 96,000 people, are addicted to opioids (Nash, 2017).

Huntington, WV Mayor Steve Williams describes Cabell County as being “under siege” from the drug epidemic suffering a total of 1,476 reported lethal and non-lethal overdose incidents in Cabell County in 2016, a 443% increase since 2014. In 2015, Huntington’s overdose death rate was 116 per 100,000 (Mayor’s Office of Drug Control Policy, 2017, p. ii).

The *Opioid Response Plan for WV* issued in January 2018 states that in 2016, there were 880 prescribed (oxycodone) and illicit (heroin and fentanyl) opioid-related deaths in West Virginia (p. 2). The report provides statistics on the rate at which decedents interacted with various systems i.e., healthcare, law enforcement, emergency medical services, corrections and found that 81% of all decedents received some form of service from the healthcare system prior to the overdose death and 71% received emergency medical services within 12 months of their death (p. 5). Additionally, it was found that 71% of the individuals who overdosed in 2016 received Medicaid in the last 12 months, compared with only 23% of West Virginia’s adult population ages 19-64 (p. 5). The report’s authors found many missed opportunities to prevent overdose pointing toward failures to intervene on the part of emergency medical services, the system of prescription monitoring, and corrections (p. 5).

Insufficient Access to Treatment for Opioid Use Disorder

In a 2016 report on the number of substance abuse treatment facilities per state, state officials in West Virginia reported there are 106 treatment facilities across the state serving 11,572 clients in need of substance abuse treatment (Center for Behavioral Health Statistics and Quality, 2016, p. 85). Of those 106 treatment facilities in WV, only nine (8.5%) are Opioid Treatment Facilities (OTF), a required designation authorizing the prescription and dispensation of methadone (Center for Behavioral Health Statistics, 2016, p. 93). Forty facilities offered

buprenorphine with naloxone (37.7%), 32 offered buprenorphine without naloxone (30.2%), and 18 (17%) offered no pharmacotherapies (Center for Behavioral Health Statistics, 2016, p. 113-115).

The Center for Behavioral Health Statistics report offered no information pertaining to wait lists and times clients encounter when they seek MAT services; however, the waitlist for MAT through West Virginia University's Comprehensive Opioid-Addiction Treatment (COAT) program is 200 patients long, down from 600 when the clinic first opened in 2005 (McMurtie, 2017). In October 2015, the state Department of Health and Human Resources reported nearly 60,000 (approximately 3%) West Virginians were identified as in need of substance abuse treatment (Nuzum, 2015). The West Virginia Behavioral Health Providers Association states that in 2015, 15,000 people received some form of drug abuse or addiction services leaving 45,000 individuals without services (Nuzum, 2015).

Emergency departments are often the place those struggling with addiction go when they are ready for change and accept treatment. Sometimes patients turn to emergency departments based on referrals from physicians as a first step in the recovery process or as is often the case, after an overdose. Emergency department visits present a potential turning point in the life of a person struggling with opioid addiction; however, a retroactive review of visits to the WVU School of Medicine academic emergency room between 2013-2014 reveals missed opportunities due in part to insufficient numbers of inpatient and outpatient treatment facilities. Tadros, Tillotson, Hoffman, Sharon, and Burrell (2018) found that of the 843 patients who visited the emergency room for substance abuse related conditions, fewer than 25% were placed into treatment following the visit (p. 36). Researchers attribute these low placement rates to the absence of inpatient treatment beds and long waitlists for outpatient treatment (p. 37).

A public health investigation conducted by the West Virginia Bureau for Public Health following a rash of 20 overdoses between the hours of 3pm and 8pm in Cabell County on August 15, 2016 found that 90% of the patients arrived by EMS, all 20 patients survived, but none received referral to treatment or support services of any kind from emergency department physicians or staff (Massey, et al., 2017, p. 975). A study performed by the Department of Emergency at Yale's School of Medicine states the neurobiological and behavioral changes that occur in the brain of an opioid dependent individual warrants initiation of treatment upon presentation in the emergency department as is true with other chronic medical conditions such as asthma, hypertension, and diabetes; however, as indicated by the Massey et al., investigation, medication-assisted treatment initiated upon admission into the emergency department is not standard practice (D'Onofrio et al., 2015).

Jones, Campopiano, Baldwin, and McCance-Katz (2015) looked at nationwide and state-level gaps between medication-assisted treatment need and capacity to deliver treatment and found in 2012 nationwide, approximately 2,319,213 people experienced opioid-dependence (p. e57). That same year, there were 16,095 DATA-waived physicians authorized to provide office-based MAT using buprenorphine with a 30-patient limit; additionally, there were 6,103 DATA-waived providers with 100-patient limit (p. e57). Assuming those providers were treating at maximum capacity, a scenario not supported by the evidence, a gap of nearly one million people in need of medication-assisted treatment exists nationally (p. e57). According to the Substance Abuse and Mental Health Services Administration website, West Virginia currently has 280 DATA-waived physicians; however, it is unknown the number of those physicians opting to provide medication assisted treatment services.

Evidence Supporting Medication Assisted Treatment

Designated as a “partial opiate agonist” because it attaches to the mu opiate receptor with “less than full effect” buprenorphine, also known by trade names Suboxone, Subutex, and Zubsolv is a prescribed pharmacotherapy used by doctors to alleviate opioid withdraw symptoms (Wesson and Smith, 2010, p. 162). In the 1960s, doctors prescribed buprenorphine as pain treatment, but later studies supported its use as an effective measure for treating alcohol addiction (Wesson and Smith, 2010). Eventually research into buprenorphine’s utility as an intervention for use with opioid dependent individuals revealed a rate of efficacy similar to methadone, without the higher risk of overdose associated with methadone.

Buprenorphine’s lower-level “ceiling effect” renders the drug ineffective beyond a certain dose, which lowers the risk of unintentional overdose (Wesson and Smith, 2010, p. 166). Buprenorphine’s partial rather than full engagement of opioid receptors limits the feeling of euphoria often produced by methadone and the once/daily sublingual tablet or film can be prescribed by a DEA waived physician in accordance with the Controlled Substances Act and self-administered by the patient at home, making it a far more convenient choice for patients (U.S. Department of Health and Human Services, *The Surgeon General’s Report*, 2016).

In controlled, randomized studies buprenorphine has shown to be as effective as methadone in mitigating withdrawal symptoms and retaining patients in treatment; however, a patient is less likely to overdose on buprenorphine if taken alone and the medication can be administered in primary care (Wesson and Smith, 2010). A large-scale, randomized controlled trial study of prescription opioid addiction treatment (POATS) evaluating buprenorphine-naloxone’s effectiveness after 18 months of treatment found 62.2% of opioid treatment recipients were opioid abstinent during the past year and past month compared with 38.8% among those

not receiving the treatment, (Potter et al., 2015). Participants who received opioid agonist treatment reported improvements in general health and significantly less multiple drug use (Potter et al., 2015).

PROBLEM STATEMENT

This study explores the experiences, perspectives, behaviors, and attitudes of physicians in West Virginia who overcome stigma and other pronounced barriers to provide medication-assisted treatment, an evidence-based intervention, to people struggling with opioid addiction and withdrawal. The research on medication assisted treatments points to numerous barriers doctors must overcome to provide pharmacotherapy, barriers including but not limited to state and federal policies such as limitations on Medicaid reimbursement; geographical factors; and inadequate exposure in medical school to addiction studies. Doctors also cite insufficient time to devote to each patient, fears of being overrun with patients seeking pharmacotherapy, and they reveal attitudes, concerns, and perceptions about managing a caseload of people with complex medical and psychosocial needs. Despite the challenges associated with pharmacotherapy and the stigma surrounding opioid dependent patients, many physicians have opted to provide this service and through exploration of their experiences, this study will contribute to the literature on what works in pharmacotherapy in West Virginia.

PURPOSE OF STUDY

The purpose of this study is to explore the factors, perspectives, and attitudes influencing physicians' decisions to engage in the practice of medication assisted treatment (MAT) for people with opioid use disorder. MAT is an empirically-supported method of treating people who suffer from the physiological symptoms of opioid addiction and its associated psychological, social, and behavioral components with opioid agonist (full or partial) to ease

withdrawal symptoms. Research has identified numerous operational and attitudinal barriers that prevent physicians from implementing MAT as a healthcare intervention. This dissertation uses the qualitative method of applied research as a framework for conducting semi-structured interviews with MAT prescribing physicians in West Virginia.

RESEARCH QUESTIONS

The following research questions were investigated:

1. What are the most significant influences on prescribing doctors' decisions to provide MAT?
2. What barriers, if any, must doctors overcome to become MAT prescribing physicians?
3. How do physicians overcome those barriers?
4. How might doctors' perspectives inform teaching and learning in medical school and continuing education curriculum?

CONCEPTUAL FRAMEWORK

Phenomenology

Accessing the lived experiences of doctors who provide care to a highly stigmatized patient group such as people struggling with addiction presents an enormous challenge. Aside from time constraints that limit their availability to participate in phenomenological studies, sharing personal and professional experiences related to providing medical care may be perceived by physicians as a risky venture. Physicians may be of the opinion that sharing information will expose their vulnerabilities or, if they are not careful, they may reveal too much information potentially jeopardizing their standing in organizations and communities or the confidentiality of their patients. Despite these obstacles, exploration of doctors' experiences and the meaning they attach to them is valuable if we, speaking from a societal point of view, are to

understand, through their own descriptions, doctors' motivations for treating people dismissed by society as making a conscious choice to ruin their lives through drug addiction.

In a qualitative study of doctors' perspectives, the presumption may be that the conversation hinges on the science of rendering diagnoses and curing disease; however, the phenomenological framework offers structure and guidance for explaining "the primacy of the life world in relation to the world of science" (Kvale, 1996, p. 54). My intent is to capture doctors' descriptions of mental, emotional, and physiological reactions and events that occur as they work with people who are addicted and use them to point out the filter through which doctors view their patients, helping them span the chasm between the science of medicine and the art of providing medical care. Kvale (1996) describes the phenomenological approach as culminating in more than a set of explanations but as a method to elucidate experiences that may precede or perhaps "counteract a technological colonization of the life world that reduces qualitative diversity to isolated facts and variables that transforms intentional human interaction to a means-ends rationality" (p. 54).

Applied Research

Applied research is a common "solution-focused" research method in social science fields (Applied Research, 2001). In the social work profession, researchers and practitioners identify problems in the social environment and apply theoretical frameworks (i.e. feminist theory, critical theory, person-in-environment, systems theory, or social constructivist theory) and empirical evidence to inform the development of strategies designed for the goal of effecting change. In social work, neither research nor practice have life independent of one another and this assertion supports the social work mantra and ethical standard that practice informs research and research informs practice (Tierney, 1993; NASW, 2008).

Collecting data and interviewing key players and populations directly affected by social problems are core functions of social work and are necessary activities for stimulating targeted change in systems, policies, and interventions that distinguishes social work practice from other disciplines. Social work is an integrated profession, meaning we take a multidisciplinary approach to the evaluation of problems, accessing findings from across disciplines to inform decision-making and best practices, but unlike other disciplines, where basic research to generate new knowledge is the expectation, social work research is about solving problems, creating change, and demonstrating real-world impact (Applied Research, 2001; Simpson & Lord, 2015). Bogdan and Biklen (1992) note that “basic research carries more prestige and holds higher status than applied research because it is seen as more ‘pure’ and less contaminated by the complications of everyday life,” but everyday life is the inescapable domain of the helping professional (p. 199).

Pragmatism

William James’ (1907) famously noted that pragmatism as a frame of reference “unstiffens all our theories.” The “unstiffening” quality of pragmatism, an orientation deriving from the works of American philosophers Charles Peirce, William James, John Dewey, and Jane Addams is a complementary component to the solution driven essence of applied research. Borden (2013) posits that theories should serve “the human good” and the benefit of knowledge gained through research should be tangible, in the form of “concrete outcomes” that inform coping and adaptation to conditions in the environment (p. 261). Much like solutions to complex problems, pragmatism does not adhere to any one philosophy, theory, or truth, and pragmatically-oriented research “occurs in a social, historical, and political context,” toward the goal of finding answers to the question: what works? (Creswell, 2014, p. 11).

The treatment of opioid use disorder is a fundamentally pragmatist venture because it calls not for the application of an absolute truth or “grand theory,” but instead for interventions that work for the people experiencing the problem (Creswell 2014; Schneiderhan, 2011; Borden, 2013). The answer to the question “what works?” in the lives of people suffering from opioid use disorder is highly individualized and depends on the biological, psychological, social, and environmental circumstances of the patient. Borden (2013) asserts the unique situation of each patient calls for collaboration between the provider and the person accessing treatment services instead of generalized applications of common treatment protocol (i.e., 12 step models, intensive short-term treatment). The act of collaboration between the physician expert who is willing to consult with the patient to achieve a solution that fits the individual’s circumstances defies empiricist and absolutist orientations and involves an element of uncertainty and vulnerability for both the provider and the patient to adapt to need (Berlin, 2005; Borden, 2013).

Strengths Perspective

Among social work’s most prominent theories, the strengths perspective offers a guideline for practitioners to see beyond the problems individuals or communities present and find the attributes and strengths that propel them forward, adapting to circumstance and overcoming barriers (Birkenmaier, Berg-Weger, & Dewees, 2014). A strengths-based approach assumes people possess assets and draw upon them when they encounter problems or barriers. The sustained use of personal or environmental resources as they confront problems augments resilience and advances them toward a desired outcome or aspect of change (Birkenmaier, et al., 2014). Saleebey (2001) posits that in our culture, the tendency is to focus on problems rather than strengths, and consequently pathologize “almost every trait, pattern, bent of behavior or

habit typical of the human condition” which in his view creates “a frothy concoction of diagnoses, labels, and besmirched identities” (Saleebey, 2001, p. 11).

Patients seeking treatment for opioid use disorder are often viewed from a pathology orientation so severe that doctors may decline to treat them. Even though medication assisted treatment is a strongly supported, evidenced-based intervention, doctors who decide to offer treatment risk suffering a besmirched identity as having been “duped” into prescribing by “wily, drug-seeking” clients or they risk legal entanglement and malpractice lawsuits if incorrect dosages are administered or if patients abuse or misuse the medication (Dineen and DuBois, 2016, p. 5). In the complicated world of substance abuse treatment, the strengths perspective provides a method for viewing physicians’ abilities to overcome barriers posing risks to their practice and reputations in ways that help to lessen the stigma of addiction and treatment.

RESEARCH METHODS

This dissertation is a qualitative study using an exploratory descriptive design to gather data from primary sources i.e., physicians who use medication assisted therapies to treat patients with opioid use disorder. Rog and Bickman (2009) assert exploratory designs require flexibility in administration to ensure data collection is complete and derived from a variety of individuals; therefore, a series of semi-structured interviews with physicians identified through purposive, snowball sampling is the desired methodological approach. Snowball sampling, characterized by Noy (2008) as a practical approach to sampling is a widely used tactic in the social sciences, often selected for use with vulnerable, stigmatized, or “hidden populations” (p. 330).

Noy (2008) argues the “dynamic and “accumulative” traits of snowball sampling make it an appropriate choice in the quest for social knowledge, which is a constantly changing, emergent, and inherently constructivist phenomenon (p. 330). The reticence among physicians

to treat patients using medication assisted treatment portrays a static perspective that appears immune to the extensive body of literature showing MAT's efficacy and hints at the need for creating momentum toward the adoption of proven interventions. Accessing the professional network of prescribing doctors in West Virginia is a practical method for building on the knowledge of evidence-based practice to move addiction treatment forward in the state.

Considered experts in their area of specialty, doctors in West Virginia hold positions of respect and authority. Because physicians hold status in the community as highly regarded experts in their field, gaining access for the purpose of conducting interviews to explore their attitudes and perceptions on a well-publicized issue can be challenging, particularly for a researcher outside the profession. The "respondent-driven" characteristic of snowball sampling enables access to the population of doctors who, for an outsider, may be difficult to locate and approach (Noy, 2008, p. 330). Moreover, physicians in West Virginia who perform medication-assisted treatment are somewhat stigmatized in a community where the abstinence-only philosophy of the 12-Step treatment model seemingly dominates recovery culture and practice. Atkinson and Flint (2001) note that snowball sampling "lies somewhat at the margins of research practice," making it a suitable method by which to access sample of physicians who practice somewhat at the margin of medicine.

LIMITS OF STUDY

While this study seeks to understand the experiences of doctors, it is not a truly ethnographic study. Doctors' viewpoints and personal accounts were obtained primarily through interviews. Due to the complexity of federal laws that protect patient privacy and sensitivity to patients' right to confidentiality, direct observation of doctors within the cultural context of their practice is unattainable. Snowball sampling is limited as a method of data collection as it is

respondent-driven and reliant upon the connections people have with one another. The implication of relying on people's networks, personal and professional, introduces selection bias and a lack of diverse experiences among people who work with similar populations and whose work is limited regionally.

SIGNIFICANCE OF STUDY

A common barrier to medication assisted treatment found in the literature is the lack of consultation or mentorship with a more seasoned prescriber. Given that many doctors revealed a greater willingness to prescribe if there were opportunities for consultation with other physicians, the strength of this study is that it provides a collection of insights from doctors who overcame barriers to offer the treatment. Exposure to the positive experiences of prescribing physicians could sway those whose skepticism and apprehension overrides their willingness to provide care to this underserved patient population.

Another strength of the study is that it aims to present Geertz's (2000) "experience-near" perspective of doctors practicing with a stigmatized population located in rural West Virginia, where resources i.e., money, transportation, staff, healthcare infrastructure, and professional support are scarce (note: Huntington and Cabell County are not considered rural, but outlying Boone, Mason, and Logan counties are characterized rural; however patients in these counties travel to more populated regions of WV such as Huntington and Charleston to acquire medication assisted treatment). Soliciting the attitudes and behaviors of physicians who voluntarily treat highly stigmatized patients addicted to opioids from rural locations will reveal the larger meaning doctors attribute to working with this population.

Bogdan and Biklen (1992) write that action research as a qualitative method relies on people's words to understand a problem and promote social change. Through the personal

accounts of doctors who choose to serve a commonly described difficult population of patients, the work of helping people may become less fraught with assumptions about doctors' motivations and less reliant on stereotypes about those who struggle to recover from opioid addiction. Perhaps contributing doctors' perspectives and the meaning they attribute to medication assisted treatment will add to the conversations physicians have amongst themselves and with their patients and may eventually be incorporated into medical school curriculum to improve young doctors' understanding and willingness to practice pharmacotherapy.

CHAPTER TWO: LITERATURE REVIEW

Deciding upon an approach to the treatment of substance use disorders occurs within a cultural and sociological context that Murphy (2015) describes as ambiguous and complicated by Americans' conflicted perceptions of drug addiction as both a disease that deserves medical treatment and a criminal act, borne of a conscious choice with known consequences, deserving of punishment. Murphy (2015) chose to observe operations and interview staff and participants in an outpatient treatment facility and in a metropolitan-based drug court to help her better understand how the institutions designated by society to address drug addiction contend with our culture's nuanced and sometimes juxtaposed view of drug addiction as a criminal act, a medical illness, or a moral issue. Labeling theory and the medicalization of addiction are the broader sociological frameworks Murphy uses to examine addiction treatment that she found in both drug courts and treatment facilities where the disease model of addiction is accepted but treatment interventions and management of the disease are punitive. Murphy calls the overlap between therapeutic and punitive interventions "therapeutic punishment" (p.4).

Organizations such as Alcoholics Anonymous, founded in 1935, characterized addiction to alcohol as a disease well before the medical community accepted addiction as a medical problem (Murphy, 2015). Now many medical professionals along with the substance abuse treatment community promote addiction as a disease, but some physicians continue to prefer the 12-step recovery model developed by Alcoholics Anonymous for treating addiction rather than using medical interventions such as medication assisted treatment options (Rychtarik, Connors, Dermen and Stasiewicz, 2000).

Murphy (2015) credits the medical community's reliance upon abstinence-only 12 step models in favor of medication assisted treatments to the stigma attached to drug use and

addiction as a moral issue rather than a medical problem and the widely-held perception that people who use drugs are morally weak and that it is considered cheating and they cannot be considered “clean” if they are provided medication assistance to alleviate craving and withdrawal (p. 13). In the 2013 ASAM report Executive Summary authors state that opioid addiction and heroin use are now viewed by medical professionals “as a chronic disease rather than a character defect;” yet Steven Bentsen, M.D. reveals biases do in fact persist when he advocates for the use of Naltrexone, an opioid antagonist that blocks the intoxicating effect of opioids, in primary care among providers who prefer an abstinence-based philosophy (“Beacon calls for primary care,” 2015).

Doctors’ perceptions of people with addiction issues are important to understand because the biases against this population of patients affects not only the attitude toward the patient, but also the level of competence physicians exhibit when diagnosing and treating people with substance use disorders (SUD). In 2000 near the beginning of the national opioid crisis that has yet to plateau, the National Center on Addiction and Substance Abuse (CASA) conducted a study of 648 primary care physicians and 510 patients receiving substance abuse treatment and found that when presented with early symptoms of alcohol abuse 94% of the physicians failed to diagnose the condition and 41% of pediatricians failed to diagnose drug abuse in adolescents presenting with classic symptoms (p. 5). The study describes primary care providers as “gatekeepers” of the American healthcare system and places responsibility directly upon them for assessing substance abuse disorders and intervening early to prevent the costly and devastating public health effects of drug and alcohol addiction; and yet, the study found a lack of training and continuing education available to doctors that would improve assessment and diagnosis of SUD.

MEDICATION-ASSISTED TREATMENT

The term medication-assisted treatment (MAT) refers to the prescription of medication as part of a harm-reduction treatment regimen for people addicted to opioids to ease withdrawal symptoms, prevent relapse, and sustain recovery. Medication-assisted treatment is an evidence-based practice that is accepted and promoted by the World Health Organization (WHO), the U.S. Department of Veterans Affairs (VA), and the Substance Abuse and Mental Health Services Administration (SAMSHA). Empirical support for MAT is extensive and the administration of MAT to opioid dependent patients is a global practice reaching patients in the United States, Russia, China, Australia, France and the United Kingdom (Pecoraro, Ma, & Woody, 2012). However, despite the evidence supporting MAT and its use worldwide, stigma, misconceptions, and restrictive legislation have led to an imbalanced disposition of opioid treatment programs here in the US as seen in states like Wyoming, Montana, and the Dakotas that prohibit the establishment of methadone clinics (Salsitz and Wiegand, 2016).

MAT prescribers have at their disposal several pharmacotherapy options, with methadone, buprenorphine, and naltrexone the most prevalent among them. Methadone falls into the class of opioid agonist analgesic (meaning it fully occupies opioid receptors in the brain) and is used as a method of tempering withdrawal symptoms and reducing cravings to support immediate and long-term recovery (Volkow, Frieden, Hyde, & Cha, 2014; Pecoraro et al., 2012).

One study found that methadone is most effective over a longer period of time in contrast to treatment models that use methadone as a weaning off transition to abstinence. In this particular study treatment retention among patients in the transition to abstinence group was much lower and illicit drug use was higher in the group of patients who received only four

months of methadone treatment versus the higher treatment retention rates found among those receiving methadone treatment over a 14-month period (Salsitz and Wiegand, 2016).

Another study examining the presence of chemicals in the brain that are activated through addiction found the brain biochemistry of patients using methadone over a 137-week period closely resembled brain chemistry of non-users, whereas the results for patients using methadone for a 39-week registered abnormal. The findings of this study suggest the prolonged use of methadone in a once addicted person may return brain chemistry to resemble that of a non-addicted person (Salsitz and Wiegand, 2016).

Over 50 years of research on methadone's effectiveness repeatedly show the medication significantly reduces risk factors of death, poor health, illegal activity, and rates of HIV infection that typically accompany opiate and opioid addiction (Pecoraro et al., 2012). However, the use of methadone as an alternative to heroin or opioids is often perceived as merely replacing one addictive substance for another (Salsitz and Wiegand, 2016).

Buprenorphine was made available in the US in 2002 after passage of the Drug Addiction Treatment Act of 2000 (Olivia, Maisel, Gordon, & Harris, 2011). Unlike methadone, which is obtained through highly-regulated specialized clinics, patients can access buprenorphine, a partial opioid agonist, via a doctor's prescription making it available through general practice (Sigmon, 2015). The less restrictive pathway to accessing buprenorphine is attributed, in part, to its status as a partial agonist meaning it does not fully engage opioid receptors in ways that mimic the intoxicating effect of the abused substance as is true for methadone (ASAM, 2013). Moreover, buprenorphine can be combined with naloxone, an opioid antagonist that completely blocks opioid receptors to fully block the opioid effect. Buprenorphine, as a mono-therapy, eases withdrawal symptoms during the detoxification process, and over the long-term when

combined with naloxone supports recovery by automatically inducing withdrawal should a person choose to ingest illicit opioids (ASAM, 2013).

Naltrexone is an opioid antagonist meaning it blocks the effects of opioids thus prohibiting engagement of opioid receptors (Sullivan et al., 2015). Naltrexone has been available in 50 mg tablet form for the treatment of opioid dependence since the FDA approved it in 1984; however, the FDA no longer labels Naltrexone in tablet form as a recommended treatment for opioid addiction due to patients' non-compliance with the required daily dosage leading subsequently to low rates of recovery retention (ASAM, 2013; Pecoraro et al., 2012). In a randomized, placebo-controlled clinical trial Comer et al., (2006) found that injectable time-released naltrexone was well-tolerated among the study's sixty heroin-dependent participants and led to greater retention in treatment programs when compared with the placebo-control group.

BARRIERS TO PHARMACOTHERAPY

Despite its proven effectiveness as a treatment for opioid dependence, medication-assisted treatment is underutilized as a means of helping people suffering from addiction. Olivia et al., (2011) report the existence of systematic barriers that may explain insufficient use of medication-assisted therapies in light of the high rates of opioid addiction and overdose death. Barriers to MAT manifest through government and insurance policies that limit access to and payment for MAT services, for example, private insurers may require prior authorization for the treatment causing significant delays in prescribing or place caps on the number of visits and prescriptions made available under the policy (Olivia et al., 2011). A large portion of the people in need of treatment often have no medical insurance and require assistance through non-profits whose reliance on federal and state funds further restricts a program's ability to offer MAT to clients (Olivia et al., 2011).

Vashishtha, Mittal, and Werb (2017) assert that a lack of nationalized health care in America presents significant hurdles for people with opioid use disorder to access treatment. In Vancouver, Canada, a country with a nationalized system of health care, pharmacies dispense methadone and people access mental health and support services like counseling through an integrated healthcare system designed not only to treat the cravings but also to treat underlying causes of addiction, for example, mental health disorders or a history of trauma. In the U.S., pilot projects in San Francisco and Massachusetts modeled after out-patient integrated care approaches have proven successful, but because of health care policy restrictions and social bias in favor of abstinence-only programs, MAT programs are rare (Vashishtha et al., 2017).

Attempts by federal agencies such as SAMHSA to reduce barriers to MAT access include widening the pool of eligible prescribers to nurse practitioners and physicians' assistants but even among physicians, only 2.2% nation-wide have taken the 8-hour training that is required to prescribe buprenorphine (Vashishtha et al., 2017, p. 2). The Drug Addiction Treatment Act of 2000 allowed for office-based treatment in-lieu of previous restrictions on location that required MAT to occur only in specialized clinics; however, office-based care requires significant logistical resources including staffing and electronic medical record keeping capability that ensures patients' confidentiality (Olivia et al., 2011).

Medication assisted treatment is recognized globally as the "gold standard" in opioid addiction treatment, so understanding how other countries deliver the treatment to patient and barriers to treatment are important (Olivia et al., 2011, p. 375). Stöver's (2011) quantitative study of 100 treating (those who currently treat patients using opioid substitute) and 51 non-treating (those who are certified to prescribe but opt not to) physicians and 200 patients and active opioid users in Germany explored the target populations' perceptions of barriers to opioid

substitution treatment. The study found patients and physicians living in more populated regions reported less difficulty accessing the treatment versus those living in the Southern regions (54%), and that access to treatment was difficult or very difficult indicating geographical barriers to access (p.48).

Geographic Barriers

Rosenblatt, Andrilla, Catlin, and Larson (2015) used the DEA Drug Addiction Treatment Act (DATA) Waived Physician List, the list of physicians nationwide who received a waiver to treat patients with office-based buprenorphine and the American Medical Association Physician Masterfile to retrieve physicians' demographic information (p. 23). Researchers used the demographic information (i.e. age, location, specialty, and urban-rural status) to map providers' location nationwide thus identifying the concentration of providers and existing access disparities between urban and rural locations (Rosenblatt et al., 2015). After excluding physicians with inactive practice status, those who were older than 80 years, and those with addresses outside the US or medical students not yet in their final year of training, the final tally of physicians showed only 2.2% of the of 829,044 physicians listed on the AMA Masterfile had obtained the DEA waiver permitting them to prescribe office-based buprenorphine (Rosenblatt et al., 2015, p. 24).

By mapping the locations of physicians authorized to prescribe buprenorphine, researchers exposed the inequitable access to treatment people in rural counties suffer. Of 3,143 counties in the nation, only 1,465 or 46.6% of them reported physicians who could prescribe buprenorphine, which is an especially startling figure when noted that 90.3% of the U.S. population lives in these counties (Rosenblatt et al., 2015, p. 24).

Furthermore, over 20 million people live in a rural county where there are no physicians who can prescribe buprenorphine (Rosenblatt et al., 2015, p. 24). Researchers were careful to add that having a waiver did not necessarily mean physicians were apt to prescribe buprenorphine to their patients and cited “the only national study of the issue” which found that the average waived physician saw a mean of 26 patients, while 25% of waived physicians had not treated patients since obtaining the waiver (Arfken, Johanson, diMenza, and Schuster, (2010) as cited in Rosenblatt et al., 2015, p. 25).

In their investigation of whether the supply of waived physicians grew with implementation of the Affordable Care Act (ACA), Knudsen, Lofwall, Havens, and Walsh (2015) discovered significant increases in the numbers of buprenorphine doctors in ACA supportive states, which are those that created a state-based exchange and expanded Medicaid coverage to reach citizens at 138% of the poverty line (p. 36). ACA-hybrid states, those that expanded Medicaid or created a state-based exchange, but not both, and ACA-resistant states that rejected Medicaid expansion and the state-based exchange experienced little, if any growth in the number of buprenorphine doctors (Knudsen et al., 2015, p. 38).

ACA-supportive states included mostly Western and Northeastern states, whereas southern states were more apt to decline Medicaid expansion and the state-exchange framework altogether, while midwestern states moved toward ACA-hybrid models (Knudsen et al. 2015, p. 38). West Virginia was one of three southern states that opted to expand Medicaid coverage and insurance through a state-based exchange (p. 39). It is worth noting that ACA-supportive states had the least number of uninsured residents and the highest number of opioid treatment programs per 100,000 residents, but surprisingly ACA-supportive states experienced higher rates of opioid-related overdose deaths per 100,000 residents (Knudsen et al., 2015, p. 39).

Healthcare policy and insurance coverage are critical factors in determining patients' access to buprenorphine prescribing physicians. Knudsen (2015) revealed that "macro-environmental" resources prove as important to increasing rates of buprenorphine-waivered physicians as the expansion of Medicaid, and notes that states' economic development, political control, and geographic characteristics are linked to states' supply of physicians, opioid treatment programs, and behavioral health services.

In her study, Knudsen (2015) evaluated the impact of the independent variables she labeled "macro-environmental" factors on the supply of buprenorphine doctors and found that a state's per capita income, Democratic control of state government, and states with a higher percentage of the population covered by Medicaid were all associated with higher numbers of buprenorphine prescribing physicians (p. 648). Moreover, the number of opioid treatment programs, the overall population of physicians in a state, and state spending on mental health services were all positively correlated with the supply of waived physicians (p. 648). States with greater numbers of uninsured residents claimed fewer buprenorphine physicians (p. 648). Given these indicators, Knudsen (2015) proposes that "treatment-rich" states are in a better position to attract buprenorphine waived physicians (p. 651).

Physicians' Barriers

According to the U.S. Drug Enforcement Administration's Controlled Substances Act (CSA) Registrants database, in 2013 there were 23,629 physicians in the United States who were authorized to prescribe buprenorphine, with the lowest number of prescribing physicians in Iowa and the highest number of physicians registered to prescribe found to be in Vermont (Knudsen, 2015, p. 647). In 2013, West Virginia reported 10.8 buprenorphine-waivered physicians per 100,000 residents (p. 648). Hugh and Dunn (2017) conducted a nationwide survey of 588

waivered and non-waivered physicians to determine reasons why non-waivered physicians do not prescribe buprenorphine and why waivered physicians do not prescribe to capacity (p. 2). Of those who responded, 41.5% practiced in an urban setting, 40% in a suburban location, and 18.3% in a rural region; 484 of the respondents indicated they had received the waiver to prescribe; however, only 43.8% reported prescribing to capacity (Hugh and Dunn, 2017, p.3).

Seventy-four (13.3%) of the survey's respondents fell into the non-waivered category and cited not wanting to be over-run with requests for buprenorphine from patients and apprehension over misuse of the prescription as primary barriers to obtaining the waiver (Hugh and Dunn, 2017, p. 3). Moreover, these respondents reported their reluctance to request a waiver could be assuaged if paired with a more experienced prescriber, continuing education opportunities, and information about counseling services (Hugh and Dunn, 2017, p. 3). Interestingly, over one-third of the non-waivered respondents indicated nothing would improve their willingness to apply for a waiver to treat opioid use disorder (Hugh and Dunn, 2017, p. 3).

Thirty-six percent of waivered physicians cited no time for more patients as the top reason for not prescribing to capacity and more than half reported no interest in prescribing buprenorphine at capacity (Hugh and Dunn, 2017, p. 3). Aside from insufficient time, physicians who received the waiver to prescribe indicated a lack of confidence in efficacy of opioid-agonist treatment and low reimbursement rates as reasons why they do not prescribe buprenorphine at capacity (Hugh and Dunn, 2017, p. 3).

The physicians Stöver surveyed cited a number of “organizational and policy-related” impediments to providing MAT that fuel the disparate rates of supply and demand for the treatment. Twenty-four percent of physicians surveyed identified limited capacity or resource availability as reasons why they do not administer office-based treatment (2011, p. 49).

Bureaucratic red-tape aside, more than two-thirds of the physicians in this study expressed concern over the responsibility for managing heavy caseloads of opioid dependent patients who are perceived as prone to misusing or diverting their medication without the assistance or cooperation of other physicians, pharmacists, nurses, and mental health providers who could offer consultation, function as “stand-in” should a physician wish to go on vacation, and offer the critical psychosocial services and linkages to community resources (Stöver, 2011, p. 50).

These concerns expressed by physicians in the Stöver study provide a general overview of physicians’ reluctance to prescribe buprenorphine from primary care practices but a study by Netherland et al. (2009) applies Everett Rogers’ theory about the diffusion of innovation as a framework to better understand conditions that support the incorporation of new technology into practice, in this case, the incorporation of buprenorphine into primary care settings. Netherland et al. (2009) surveyed 172 physicians ranging from inexperienced to experienced in treating opioid addiction using a 5-point Likert scale to determine the extent to which a factor prevented the use of buprenorphine as an evidence-based technology (2009, p. 246).

Results of the survey indicated that regardless of experience, physicians across the board felt strongly that the absence of clinical staff training, poor access to behavioral health services, and an inadequate system of referral for services were influential in their unwillingness to prescribe (Netherland et al., 2009, p. 247). However, other findings from the study indicate that physicians with more experience prescribing buprenorphine were less concerned with logistical issues and patients’ access to support services than inexperienced physicians, who unlike their more experienced colleagues, were less concerned with reimbursement for services (Netherland et al., 2009, p. 248). The survey found that “adequate reimbursement for drug-abuse-related office visits” was the most significant factor for experienced physicians (Netherland et al., 2009,

p. 249). In sum, the study found that experience reduces physicians' concerns about prescribing buprenorphine; however, findings suggest the experience must be significant before unease diminishes and according to Netherland et al. this finding is consistent with Rogers' innovation theory (2009, p. 249).

Prior to prescribing medications, doctors must first screen patients to determine whether substance use disorder factors into a patient's presenting issue. Research supports the health benefits associated with tobacco and alcohol screening and intervention but screening and intervention for illicit substance use disorder is an inconsistent and irregular occurrence in primary care due in part because of the "low prevalence of drug abuse in primary care settings and insufficient direct evidence of the benefits of screening" (Friedmann, McCullough, and Saitz, 2001, p. 248).

A 2001 national study with a sample size of 1,082 general practitioners, family physicians, obstetricians and gynecologists, and psychiatrists found that 32% of primary care physicians and psychiatrists reported they do not regularly screen patients for illicit substance use; however, 68% of the physicians reported they usually or always ask new outpatients about illicit drug abuse (Friedmann et al., 2001, p. 248). Fifty-five percent of the physicians surveyed responded that when patients are affirmed to have symptoms of substance use disorder, they "usually" or "always" refer to a formal addiction treatment program while 61% indicate their preference for referral to 12-step programs (Friedmann et al., 2001, p. 249).

Fifteen percent of physicians reported they do not intervene at all even after patients screen positive for substance use disorder (Friedmann et al., 2001, p. 249). Psychiatrists were most likely to intervene and shared with the majority of primary care physicians a preference for 12-step programs as a referral source compared with formal, long-term addiction treatment like

medication assisted therapies, a practice the study's authors find curious especially given the strong evidence supporting efficacy of medication maintenance programs compared with 12-step programs (Friedmann et al., 2001, p. 250).

Friedmann et al. (2001) found stigmatizing attitudes influenced physicians' willingness to screen and intervene accompanied by insufficient confidence in the efficacy of treatment interventions. Physicians indicated a lack of confidence in their ability to obtain an adequate patient history for reasons such as not enough time during a visit to devote to the screening process and the assumption that patients do not want to be asked personal questions about their drug use; however, authors make the point that evidence supports the opposite is true and that when asked, patients will provide answers indicating the history and pattern of use. Younger doctors with positive attitudes about the effectiveness of treatment and those who had fewer patients with history of drug abuse were most likely among those surveyed to intervene (Friedmann et al., 2001). Recent medical school graduates and specialists like psychiatrists and obstetricians and gynecologists were most likely to screen; yet, surprisingly, obstetricians and gynecologists were the least likely to intervene with a substance dependent patient (p. 249).

Opioid use disorder often co-occurs with other conditions such as mood or anxiety disorders placing psychiatrists in a key position to treat opiate addiction in an office-based setting, and in 2009 approximately 28% of physicians who obtained a Drug Enforcement Administration (DEA) waiver to prescribe office-based buprenorphine were psychiatrists (Suzuki, Ellison, Connery, Surber, and Renner, 2016). Using a seven-point Likert scale to determine attitudes toward OBOT and how programs prepare residents to prescribe buprenorphine, the researchers surveyed 41 psychiatry residency programs nationwide that reported favorable attitudes toward office-based opioid treatment (OBOT) but in their responses,

identified numerous barriers to training psychiatrists in the practice of OBOT. The survey found that the majority of programs that responded offer training on the DEA waiver process and provide opportunities to treat patients with opioid use disorder under the supervision of an attending physician (Suzuki et al., 2016, p. 500). The survey revealed residents who participated in a buprenorphine training during residency were more inclined to continue OBOT in their practice (Suzuki et al., 2016, p. 501).

The study's authors divided respondent programs into two categories "HP" for those who reported half or more of their residents completed buprenorphine training and "LP" for programs with fewer than half their students completing some form of training (Suzuki et al., 2016). Findings from the survey point to factors present in lower levels of training completion. Twenty-four percent of the LP programs reported buprenorphine training is not a priority of their program, while 14.6% reported there were no addiction faculty to run the buprenorphine training and 12.2% disclosed a lack of addiction faculty available to supervise residents as they learn prescription practices, detoxification protocol, and management of patients with opioid use disorder (Suzuki et al., 2016, 501). A lack of organizational support for the training was cited by 24.4% of the LP respondents; important to note is that HP designated programs cited no barriers to offering the treatment (Suzuki et al., 2016, p. 501). Regardless of whether a program offered the training or not, 85.4% reported strong agreement with the statement that buprenorphine is an effective treatment for opioid dependence (Suzuki et al., 2016, p. 500).

LITERATURE SUMMARY

Exposure to the literature on MAT helps to better understand the evidence supporting the practice as part of the solution toward mitigating the toll opioid addiction is taking on individuals, families, communities, and the systems designed to support people when the need

arises. In West Virginia, there is a shortage of physicians providing care to people with substance use disorders. The literature exposes some of the barriers physicians encounter that prevent them from offering MAT as part of a recovery option; some of those barriers include government and insurance policy restrictions that limit patient access to medication and low reimbursement for services provided by physicians. Significant logistical demands like staffing and use of electronic medical records are costly, especially for physicians practicing in rural areas most hit by the opioid epidemic and poor economic conditions. Finally, studies in the literature review show physicians' reluctance to provide MAT, citing preconceived notions about the complex and time-consuming needs of people who seek treatment for opioid addiction and feeling underprepared to manage their needs with medication many believe does not work.

Numerous studies have demonstrated MAT's efficacy in retaining people in treatment and demonstrating significant reductions in the biopsychosocial symptoms of addiction that include risk for overdose, death, HIV and Hepatitis C due to intravenous drug use, cravings and withdrawal symptoms, incarceration, unemployment, family dissolution, exposure to trauma, and child protective service's involvement in the family. A review of the literature reveals many physicians do not screen patients for substance use disorder, but upon disclosure of an addiction issue, some physicians demonstrate a preference for referring patients to 12-step abstinence-based programs or no referral at all.

CHAPTER THREE: METHODS

QUALITATIVE RESEARCH DESIGN

Qualitative research as a method of understanding people and their experiences is an old method finding its roots in Western colonialism and early ethnographic-like descriptions by missionaries, colonial authorities, and ethnologists whose work sought to capture the culture and civilization of “primitive” peoples “thought to be less civilized...living replicas of ‘the great chain of being’” (Hogden, 1964, p. 386-432). But since the emergence of more scientifically situated ethnographic study by anthropologists such as Mead, Boas, and Malinowski, disciplines outside anthropology have made use of qualitative methods to explore experience and its socially constructed meaning (Denzin and Lincoln, 2000, p. 8).

Spanning historical periods and disciplines, qualitative research has morphed from a method of understanding “others” and their ways of seeing the world to a method of understanding the complexity of human experience within context. In the modern era, education, sociology, social work and other social sciences use qualitative methods as a means of giving voice to direct experience (often to “the powerless and the excluded”) in ways that challenge what Becker (1970) refers to as the “hierarchy of credibility” (Becker, 1970, as cited in Bogdan & Biklen, 1992, p. 21).

Unlike other forms of research that may call for the researcher to separate herself from the study to maintain objectivity in the search for a testable reality or truth, the qualitative researcher is ethically bound to recognize “all research is interpretive; it is guided by a set of beliefs and feelings about the world and how it should be understood and studied” (Denzin and Lincoln, 2000, p. 19). This ethical mandate requires awareness of the researcher’s unconscious biases and how her upbringing, personal experiences, culture, and values permeate the choices

she makes pertaining to the population to be studied, the questions asked, methods of data collection, and analysis of the data (Creswell, 2014; Denzin and Lincoln, 2000). To counter the influence of bias and personal influence over research tasks, qualitative researchers must be explicit in describing how personal experience may affect choice of themes or may prompt the researcher to search for evidence in support of a preferred conclusion (Creswell, 2014, p. 188).

Explicitly stated, my interest in researching the perspectives of doctors originates from a desire to understand the motivation of doctors to treat a stigmatized population using a stigmatized method. The World Health Organization (WHO) in 2009 issued a report stating that medication-assisted treatments such as methadone and buprenorphine “reduce the cycle of intoxication and withdraw” and decrease risk of criminal activity, transmission of HIV and Hep C through contaminated needles, and overdose death when compared to detoxification and abstinence programs (p. xi). In spite of empirical evidence supporting the practice and the widespread use of medication assisted therapies in other parts of the country, medication assisted treatment is difficult to access in West Virginia, dubbed the opioid overdose capital of the nation, where the overdose death rate of 52 per 100,000 is 3x the national average at 16.3 deaths per 100,000 and in Cabell County, the overdose death rate is 7x the national average with 116 per every 100,000 (Mayor’s Office of Drug Control Policy, 2017, p. ii).

A study by Knudsen (2015) suggests regional disparities make the availability of medication-assisted treatment scarce for people living in West Virginia where there are only 10.8 SAMHSA waived physicians per 100,000 residents (p. 648). Compared to states in the northeastern region of the country i.e., Vermont 27.9%, Maine 21.2%, and Massachusetts 18%, West Virginia lags in offering medication assisted treatment as a recovery option. Knudsen (2015) says more research is needed to explain regional differences but suggests “professional

norms that are rooted in differences in medical school curricula about SUDs may also explain additional variation in physician supply” (p.651). Given the critical need for alternative therapies to treat opioid use disorder in West Virginia and upon suggestion from Dr. Beth Campbell, I decided rather than investigate why doctors are not prescribing, a strengths-based, pragmatic, solution-focused inquiry into the attitudes and perspectives of those who do prescribe may prove informative and transformative.

The opioid crisis in West Virginia is taking an ever-mounting toll on the state’s systems of care. Family systems are under pressure with a generation of parents either deceased or incarcerated necessitating elderly grandparents care for their grandchildren. If next of kin are unavailable, the Department of Health and Human Resources’ Child Protective Services intervene to locate families to care for children. As of October 2017, over 6,100 children are in state’s custody, and according to Linda Watts, acting commissioner for the Bureau for Children and Families (BCF), approximately 82% of cases are due to prescription drug abuse (Kersey, 2017). Since 2000, inpatient and emergency room admissions resulting from opioid overdose have increased 200% placing a significant strain on rural hospitals and providers of medical and mental healthcare and adding to the \$8.8 billion economic burden incurred by the state and its citizens (Ostling et al., 2018; Eyre, 2018). The West Virginia Pharmacists Association states the \$8.8 billion burden amounts to 12% of the WV GDP, which is more than double that of any other state (Stevens, 2018).

CONCEPTUAL FRAMEWORKS

Phenomenology

To capture the experience of physicians in West Virginia who administer pharmacotherapy to their patients, I will rely on a phenomenological research design that involves a series of interviews with physicians across West Virginia. Finlay (2012) says “phenomenologists seek down-to-earth, richly detailed descriptions of the lived experience...” to move the investigation beyond impressions and perceptions toward “concrete” experience that represents a “dynamic process” that is unique to the individual and to the context of the experience but may also be shared by others in a similar context (p. 181).

Phenomenological researchers are attuned to experience and in interviews with participants ask questions that go beyond brief descriptions of a feeling or an interaction to re-enact participants’ lived experience, from a sensory perspective. The sensory aspect of medical practice with a stigmatized population must be understood if it is to be normalized. In an opinion article written for the *New England Journal of Medicine*, Dr. Audrey Provenzano (2018) describes the fear she had to overcome to treat patients with opioid use disorder. Dr. Provenzano admits to a feeling of discomfort that arose from “navigating the gray shades of harm reduction...” and the complex medical, mental health, and social needs of patients who “test [my] clinical judgement” (p. 601). Normalizing physicians’ experiences in relation to treating individuals with opioid use disorder is a necessary step in reducing stigma associated with addiction as so many avoid the discomfort by refusing to treat this group of patients or by foregoing the addiction screening process.

Creswell (2014) states that qualitative research is an emergent design, meaning the exact plan for the process is subject to change depending upon the information gleaned from

participants. Interview questions and methods of data collection may be altered in response to emerging information and as the understanding of the issue or phenomenon under investigation grows more nuanced. The research methods must be flexible and able to be adapted to follow the participant's lead or risk the researcher's unconscious bias taking the lead toward a predetermined idea, outcome, or point of view (Bogdan and Biklen, 1992).

Applied Research

Social work and education share change as a common objective of professional interventions; the same could be said for physicians who seek to change health outcomes for patients through education and the application of clinical knowledge and skill. For educators, social workers, and physicians the concept of change bears special significance because without observable and measurable change in the lives of students, clients, and patients, members of these professions cannot claim to be effective in their professional roles. Bogdan and Biklen (1992) propose that the goal of change is to "improve life for people" and achieving change can be challenging because asking people to change may call into question their identities, their habits, and their beliefs (p. 200). Calls for change without a context to understand why it is needed and how it occurs can be threatening to those being asked to modify their practices or routines, especially if the status quo appears adequate; this feeling of vulnerability is one shared by the professional and the recipient of the service whenever the determination is made that current practice is insufficient toward resolving a persistent problem.

To help budding qualitative researchers think through the "so what?" question that befalls us all in the beginning stages of planning the research design Maxwell (2009) alludes to Thoreau who once asked what is the benefit of traveling around the world to count the cats in Zanzibar (p. 219). Thoreau's question implies there is little purpose in traversing the globe to count cats in a

distant locale. Some might argue the question gets to the heart of the difference between basic and applied research: basic research conducted for the sake of generating new knowledge to be applied arbitrarily, as needed, and applied research undertaken for practical application toward change or problem resolution. The ability to answer, “so what?” signifies the research has relevance and applicability within a larger context, potentially leading to the change, an inherent goal of applied research, that may “improve life for people” (Bogdan and Biklen, 1992, p.200).

In preparation for conducting my research, I ask myself, given West Virginia’s opioid overdose death rate and resultant social cost and deterioration of family, community, and systems of care, why it is important to understand the attitudes, perspectives, and experiences of the minority population of physicians in the state who administer medication-assisted treatment. The relevance of the research is that the information gathered from these physicians may be of use in shaping the attitudes and practices of other physicians, opening them up to overcoming assumptions and bureaucratic barriers and learning more about their patients through a screening process to determine risk of opioid use disorder and associated co-morbidities and developing a plan for treating the disorder that may involve pharmacotherapy.

Demystifying the process and experience of treating people struggling with addiction may alleviate stigma associated with the population that characterizes these patients as drug-seeking, manipulative, and immoral. Highlighting practices of reputable doctors who attend to patients with care and concern, whose actions are directed through adherence to policy and consideration of empirical evidence and result in improved health outcomes for patients may inform medical school curriculum throughout the region. The answer to the “so what?” question pertinent to my research is consistent with social work values of doing what works and focusing

on strengths rather than deficits to give people options, make change possible, and improve their lives.

Pragmatism

Cherryholmes (1992) distinguishes the usefulness of pragmatism as a conceptual framework for research from the positivist notion that scientific study can produce a definable reality or truth. Unlike positivists who assert the conviction that scientific inquiry produces truth independent of connections to people, situations, time and place, pragmatists adhere to the belief that research methods and outcomes evolve from a historical, social, and political context that shape “reality” and so reality and truth are relative to those contextual factors, and without them lose their explanatory value (Cherryholmes, 1992). Pragmatists are driven in their research by problems and consequences rather than a focus on methods, as truth for the pragmatist is established based on what works discovered through the researcher’s freedom “to choose the methods, techniques, and procedures of research that best meet their needs” (Creswell, 2014, p. 11).

When it comes to determining what works in treating drug addiction in America, pragmatist approaches are often challenged by a moralistic view of the problem and the people who experience it. Nadelmann (1998) compares the effectiveness of harm reduction approaches in curtailing drug addiction like needle exchange programs, methadone maintenance and decriminalization of drugs taken up in European countries against moralistic zero-tolerance policies and mandatory minimum sentencing adopted in the United States. Citing numerous examples of Americans’ preference for strong rhetoric and criminal justice solutions to combat drug addiction, Nadelmann demonstrates that while those tactics win votes, they do not work to reduce drug addiction or its associated risks. A poignant example of moralism cited by

Nadelmann was the federal government's ban on funding the supply of needle exchange programs serving intravenous drug users diagnosed with HIV. The ban was overturned in 2016 after an outbreak of HIV in Indiana imposed upon politicians and the public a critical need for effective programming to reduce the risk of HIV transmission (Gorman, 2016). Nadelmann (1998) makes the point that politicians and the public opposed needle exchange programs despite countless studies that demonstrated the intervention reduced needle sharing, connected intravenous drug users to healthcare and treatment opportunities, and did not increase illegal drug use (p. 116). Opting for bans on funding and tough penalties for drug use are methods that evolve from a belief that harm reduction strategies encourage illicit behaviors rather than protect against them.

In American culture, pragmatism and moralism are perpetually at odds. Americans oppose interventions they perceive to be permissive, especially if the intervention involves behaviors that are construed as criminal or immoral. In the case of drug addiction, Americans prefer criminal-justice solutions to addiction treatment that "are ideologically wedded to abstinence-only treatment and insulated from cost-benefit analysis" (Nadelmann, 1998, p. 111). Nadelmann continues his argument by pointing out that American politicians and public officials rarely ask the question "what works?" in treatment but instead tend to focus on the question "is it tough enough?" (p. 126).

Dr. Carl Sullivan, one of the earliest proponents of medication-assisted treatment for drug addiction in West Virginia reveals this attitude of moralism exists among doctors and the public who often respond negatively to the idea of pharmacotherapy as an option for treating drug dependence. In 2010 he writes "a common question posed by care providers, patients and their families is 'aren't you just trading one thing out for another?'" (Marshalek and Sullivan, 2010, p.

61). Sullivan reports that he responds in the affirmative to the question and recommends other interventions such as therapy and social support through affiliation with 12-step programs (though the philosophy of 12-step programs tends to oppose members' use of medication to maintain sobriety) to support recovery.

Strengths Perspective

It is important to consider the sway philosophical attitudes like pragmatism and moralism have over a doctor's prescribing practices as they relate to a population of people society views as morally bankrupt. Dr. Steven Bentsen (2015) of Beacon Health Services acknowledges social bias and that the "pervasive view of addiction as a moral failing" has hindered access to medication assisted treatment. Presumably, the social bias against people who are addicted extends to medication assisted therapies and the doctors who offer them, which may explain Nadelmann's suggestion that harm reduction takes courage. Even with the backing of case studies, statistical data, and evidence of improved outcomes from policy changes, deviating from the status quo to suggest a less aggressive, more pragmatic approach to drug treatment accompanies risk for public officials and doctors.

A suitable accompaniment to pragmatism, the strengths perspective represents another orienting framework through which to examine real life. Saleebey (1996) writes, "Child sexual abuse is real. Pancreatic cancer is real. Violence is real. But in the lexicon of strengths it is as wrong to deny the possible as it is to deny the problem" (p. 297). This statement articulates the essential tenet at the heart of strengths-based practice: as much attention should be given to potential as to pathology, even when circumstances are grim. Resilience, characterized by growth and development that occurs over time, endowing those who survive adversity and overcome challenges with a reservoir of "energy and skill" comprises another component of

strengths theory and applies as much to care providers as to those seeking care for addiction. Through interviews with physicians, I will explore strengths-based approaches doctors use to provide care to people with opioid use disorder.

RESEARCH QUESTIONS

Creswell (2014) says that the nature of emergent design precludes “tightly prescribed” plans for research (p. 186). The central aim of the research questions I ask will explore the how and why of physicians’ direct experiences working with people with opioid use disorder and the attitudes, behaviors, and perspectives physicians bring to and gain from the experience thus enabling them to overcome significant barriers to providing the services that are described in the literature. The following research questions comprise the core of the inquiry; however, questions pertaining to direct experience will arise and be contingent upon individual physician’s insights and involvement. Mantzoukas (2008) states that variables in qualitative studies cannot be pre-determined and “take shape during the process of data collection” (p. 374).

1. What are the most significant experiences influencing prescribing doctors’ decisions to provide MAT?
2. What barriers, if any, must doctors overcome to become a MAT prescribing physician?
3. How do physicians overcome those barriers?
4. How might doctors’ perspectives inform teaching and learning in medical school and continuing education curriculum?

Data Collection

Creswell (2014) advises anywhere from 3-10 interviews are necessary for a phenomenological study. Between the months of June and July 2018, I will conduct face-to-face interviews with physicians who administer medication assisted treatment in West Virginia. I

have identified two physicians Dr. Rolly Sullivan, professor and former Vice-Chair and Director of Residency Training, Department of Behavioral Medicine and Psychiatry, WVU Medical School and Dr. Richard Knapp, Boone County Memorial Hospital who have agreed to recorded interviews. Consistent with the process of snowball sampling, I will identify other physicians through referrals from Dr. Sullivan and Dr. Knapp. The setting where the interviews will take place is yet to be determined. Presently, I am uncertain whether observation of physicians during sessions with patients is possible, but I will make the request in the IRB application. My preference is to interview 3-4 doctors from the northeastern part of WV and 3-4 doctors from southern WV to capture regional differences. Interviews will be semi-structured, audio-recorded, and transcribed. In anticipation of the interviews, I will develop interview and observation protocol in accordance with Creswell's (2014) recommendations, and I will document my impressions, reactions, personal reflections. After completing face-to-face interviews and analyzing the data gleaned from that process, I will convene a focus group composed of 4-6 members as a form of member checking (Creswell, 2014) for validity of interpretation and themes and to gather final thoughts and recommendations from participants.

As I approach this study using qualitative methods, I am mindful of the subjective nature of interviews as a means of understanding individuals' lived experiences. I recognize the inherent subjectivity of my choice to study physicians' responses to the opioid epidemic with the goal of informing medical practice and/or education based on insights gleaned from the interviews. My inclination is to compare qualitative interviewing to the style of therapeutic interviewing I am familiar with through my practice as a clinical social worker. Marlowe, Appleton, Chinnery, and Stratum (2015) describe the development of social workers' "use of self" as a clinical tool formed through practitioners' critical attention to intra-and interpersonal

dynamics that arise during an interaction (p. 62). Reflection and awareness of self are critical skills in social work that must be developed to protect against harm that comes to clients when clinicians are inattentive to the relationship's power differential or when they are unable to recognize the infusion of assumptions, value judgments, and emotional reactions into their work with clients. Risk to the client arises when the clinician's interpretation of the client's experiences influences or displaces the client's and replaces client self-determination with the clinician's agenda.

The relationship between the social worker and the client in a clinical setting is the most critical element of clinical work. For the relationship to be effective and produce the desired change, the client assumes equal status in the relationship meaning the clinician recognizes his or her limited knowledge of the client's life and experiences, even as the client provides important history, background and context and defers to the client's interpretations of the problem and contributing factors. Kvale (1996) makes the philosophical connection between the therapeutic interview and the qualitative interview and writes that the interdependence that occurs between the therapist and the client creates knowledge he describes as "inter-relational" (p. 45). And, much like the clinician's use of self as an instrument in the therapeutic interview, Brinkmann and Kvale (2015) explore the qualitative researcher's use of self as a "research instrument" in social research.

As a therapist, I have years of experience interviewing individuals using my "self" as a resource, following a method that closely resembles, at least philosophically, the components of ethnographic research. As is true for ethnographers, in my role as therapist, I fully embrace the notion that "...there are many different ways for human beings to be themselves" (Nicole Beaudry, as quoted in Campbell and Lassiter, 2015, p. 2) and as anthropologist Douglas Foley

explains in Campbell and Lassiter (2015), I have spent “endless hours” listening to people, observing their mannerisms, gestures, and expressions, and reflecting on the cognitive, emotional, and physiological reactions I have in response to what I hear and observe (p. 3). I apply ethnographer H.L. “Bud” Goodall’s quote about “being an ethnographer” to clinical social work: “The choice...is a profound philosophical commitment...” to life in the gray area where people live within a context they often cannot articulate as words are generally insufficient (Campbell and Lassiter, 2015, p. 3). Campbell and Lassiter (2015) offer that ethnography “... is about engaging in, wrestling with, and being committed to [the] human relationships” and the same can be said for clinical social work.

Campbell and Lassiter (2015) share insight on the importance and limitations of the ethnographic interview as a method of data collection. Lassiter’s time with Kiowa singers in Oklahoma led him to realize the expectations people have when engaging in interviews often shape their behaviors in ways that restrict communication to a “careful, rational, measured” exchange (p. 86). This point identifies a concern I have about interviewing physicians. Henry and Henry (2002) note that often physicians are reluctant to express emotion or offer reflection on the personal and professional ramifications of their medical practice partly because the status physicians hold in communities and organizations is accompanied by expectations that they should speak with authority, as experts, and never risk exposing doubts or insecurities. In their interviews with doctors, Henry and Henry (2002) discovered connections were more easily developed through storytelling rather than mechanically posed questions about a particular phenomenon. Dr. David Hilfiker explains that doctors are “privy to the deepest of humanity’s experiences” and are more inclined to share those moments in the form of stories (Henry and Henry, 2002, p. xiv).

Thinking about the mechanics of the interview process, I will follow Campbell and Lassiter's (2015) advice and create approximately 10 interview questions to start, keeping in mind it is not required that I ask every participant every question, nor is it a requirement that I ask everyone the same questions. I may find the need to revise questions based on information from previous interviews and as new information is revealed I may wish to explore themes further in subsequent interviews. Kvale (1996) suggests too many questions can become burdensome, leading to too many pages of transcription running the risk of yielding little more than small talk while short interviews can produce rich material if the right questions are asked in the right way, generally beginning with "why" and "what" with a progression toward "how" (p. 130). I plan to provide participants with some of the questions before the scheduled interviews for opportunity to recall distant memories of people, situations, and lessons learned (Campbell and Lassiter, 2015).

After the one-one interviews, I plan to convene a focus group composed of six physicians who were not originally included in the interviews to further explore the themes that arose during previous interviews. The purpose of this phase of data collection is to see if new themes arise and to check accuracy of the themes against the views of other members in the field. Brinkmann and Kvale (2015) explain that focus groups are becoming more widely used in academic research as a way of engaging participants in spontaneous, expressive conversation in a forum that is less confining compared to the interview process. Reaction to others' views in a focus group often produces impromptu responses that are also unfiltered and reveal thoughts and opinions less likely to be expressed in one to one interviews (Brinkmann and Kvale, 2015). Moreover, research on focus groups as a qualitative method speaks to the "ethnographic potential" of this method as a more natural process resembling a conversation, increasing the likelihood

participants will reveal to the researcher the “jokes, insults, innuendos, sensitivities and dynamics of the group...” leading to thicker description and contextual understanding of the themes (Hyde, Howlett, Brady, & Drennan, 2005, 2589).

Data Analysis

Brinkmann and Kvale (2015) state quite emphatically that a plan for analysis should precede the interviews and actual analysis of data can occur simultaneously with the interview. As a novice researcher, I will approach data analysis in this manner returning again and again to Brinkmann and Kvale’s (2015) advice posed as questions: “How can the interviews assist me in extending my knowledge of the phenomena I am investigating?” and “How do I analyze what my interviewees told me in order to enrich and deepen the meaning of what they said?” to help me develop questions that position the interview toward meaningful analysis (p. 218).

Data analysis will begin after the first interview and may affect the line of questioning delivered during the next interview to further investigate themes that arise from the initial set of questions. I will transcribe raw data from the interviews and the focus group, keeping in mind important points about the philosophical approach to data analysis suggested by Brinkmann and Kvale (2015) which is that the words and stories obtained through interviews are not merely objects to be collected, they are part of a living conversation and the analysis of those words and stories cannot and should not be dissected or separated from the context in which they occurred or from the original interview. The authors suggest “a narrative alternative to analysis” (p. 219). I suspect preserving the narrative tone of the conversation with interviewees will be one of the greatest challenges of this project.

After transcribing and reading through all the material “to get a sense of the whole” I will begin the coding process, dividing segments of text into categories that are labeled thematically,

using “in-vivo” or “the language of the participant” whenever applicable (Creswell, 2014, p. 198). I will perform the coding by hand rather than use a computer software program like MaxQDA and give myself the opportunity to become familiar with the details of the data and the coding process. Harding (2013) discusses the advantages of coding data and breaks the process down into a series of steps starting with identifying categories; writing codes in the margins of transcripts and field notes; reviewing codes and revising categories and looking for emerging themes (as cited in Brinkmann and Kvale, 2015, p. 228). Having completed a similar process in Dr. Linda Spatig’s course, I am comfortable with these steps, and I think following this process will afford me the greatest level of familiarity with the data and will enable me to maintain the narrative connection.

Bogdan and Biklen (1992) suggest a process for establishing coding categories that involves reading through materials looking for repetition of words, ideas, or phrases that begin to form patterns or themes. Overarching representations of the repeated patterns and themes are identified and labeled as categories or “coding families” and are applied to chunks of material that may fall into overlapping categories. Examples of such coding families are setting/context codes, perspectives held by subjects, process codes, activity codes, and relationship/social structural codes (p. 167-171).

Following the coding process, I will identify 5-7 emergent themes and produce a qualitative report, giving form to the themes through interpretation that draws from participants’ experience and perceptions; connects to the literature; underscores the implications for practice; and makes a call for action. I will present findings from my research using description and narrative forms relying upon lessons learned from physicians’ experiences prescribing medication assisted treatment that may form the basis for changes in attitudes toward MAT as an

intervention and changes in how medical school curriculum addresses the treatment of opioid use disorder (Creswell, 2014).

ETHICAL CONSIDERATIONS

Collaborative Ethnography

Prior to embarking on an ethnographic study of Muncie, Indiana's African-American community, Lassiter (2005), fellow collaborators, colleagues, and students worked on compiling a set of ethical standards that shaped the context within which the research would occur. The ethical code composed of seven tenets Lassiter and others formulated codifying a "morally-negotiated co-commitment" to contributors by recognizing their expertise and representing them accurately through a review process that enabled contributors to provide feedback on researchers' descriptions of findings derived from interviews and participant observation (p. 83). The first of the seven tenets developed by Lassiter (2005) and collaborators states, "Our primary responsibility is to the community of consultants with whom we work." This statement is very similar to the *National Association of Social Workers Code of Ethics*, the document that guides social work practice at all levels with all constituencies. The first of six ethical social work practice standards enshrining the primary responsibility of the social worker is to the interest and well-being of the client.

Acting on referrals received from colleagues and professionals in the field of addiction at Marshall University, I used email to reach out to prospective collaborators. In the email, I introduced myself briefly explaining my credentials and interest in MAT as a treatment intervention. Bearing in mind doctors' very busy schedules and the likelihood they receive numerous emails soliciting their participation in studies, I took special care to write a detailed but succinct description of my intentions and what would be expected from their participation. I

explained Marshall University's IRB approved the study and that the semi-structured interview would last about 60 minutes. I included the option to keep their identity confidential or they could choose to be cited as a professional source. I advised that prior to the interview I would review all consent forms to ensure consultants are clear on how I will honor their contributions and accurately portray their experiences and perceptions. I also offered to provide a copy of the interview questions prior to the interview.

In some cases, I relied on my colleagues in addiction and social work to introduce me via email to prospective consultants. My colleagues sent an email essentially verifying my credentials and credibility copying me on the email, and then I followed up with a subsequent email to introduce myself and explain the study. All the consultants responded to my emails quickly, offering date and time when they were available to be interviewed. When I met with consultants, my first question sought permission to record the interview, and I explained that the recordings would be downloaded to my computer under password protection and kept confidential. I advised that after completion of the degree, recordings would be deleted. With each consultant, I reviewed the Informed Consent to Participate in a Research Study (see Appendix B), taking extra time to explore options to either remain confidential or be cited as a source in the final report. At this time, I also explained and sought their commitment to the review specific sections containing information they provided to affirm the writing accurately reflects the spirit and intention of their contributions. I advised the report will not be finalized until this criterion is met.

Not until after the first interview did I fully appreciate my ethical and moral responsibility to my consultants, all of whom consented to be named in the final report. After that first interview, I realized the physicians participating in my study were knowingly putting

themselves in a vulnerable position by agreeing to be named when sharing their honest, professional perspectives on the healthcare system they are immersed in. Their personal stories and examples expand the narrative about addiction treatment in ways that highlight the healthcare system's shortcomings while acknowledging the positive aspects of patient care that currently exist and the potential to improve services here in West Virginia, where they are so desperately needed. The realization that these physicians were lending their time and reputations not for my benefit or theirs but for their patients impelled me to capture their professional integrity and write not just for a general audience of concerned citizens or healthcare professionals, but for them—for their work, their time, and their commitment to helping a stigmatized patient population whose lives have been dismantled by addiction.

Social Work, Ethics, and Ethnography

Many connections are made in the literature between qualitative interviews and therapeutic interviews. In social work, therapeutic interviewing is a primary skill buttressed by skillful reflexivity that undergirds micro-level social work practice. Marlowe et al., (2015) suggest the development of reflexivity in social work students is essential to their identity formation as members of a profession bound to uphold the ethical commitment to client self-determination. In their work with clients and as a matter of ethical practice, social workers must be able to identify where they begin and end in relationship to their client; such awareness prevents encroachment of the social workers' values and preferences onto the client. The literature on qualitative interviewing asserts the expectations that exist for therapeutic interviewing to defend the client against the will of the clinician exist in qualitative interviewing for similar reasons, to provide space for the interviewee's perspectives without interference from the interviewer.

To continue with the theme of owning one's perspective, it helps to look at how earlier proponents of phenomenological research differed in their methods for dealing with the baggage or what Finley (2008) calls the "pre-understanding" of the topic researchers bring to the interview with them (p. 2). Phenomenology's founding father, Edward Husserl argued that to deal with pre-understandings, researchers must identify them and undergo a process he called "bracketing" which involves an abstract cognitive process of separating identified one's own pre-understandings from the interpretation of another's experience (Finlay, 2008, as cited in Hopkins, Regehr, and Pratt, 2017). In contrast, Heidegger made the case that humans interpret events and make meaning of them in a naturally occurring process that cannot be extracted for the sake of objectivity, but instead suggests pre-understandings are assets that enrich comprehension of the phenomenon under examination (Hopkins et al., 2017). Reflexivity becomes a process that amplifies the strength of researcher's inevitable subjectivity in lieu of excluding or separating it from interpretation of experience.

My concern with reflexivity as a novice researcher is the focus of my reflections in this early stage of writing is on me, how I am in the interviews and how I respond in the role of interviewer to the interviewees. Perhaps this is a good place for me to discuss my pre-understandings and my biases as they relate to MAT, to healthcare, and to the role of physicians in providing substance abuse treatment so I can deal with them and move them aside to put focus where it belongs—on the interview process, the physicians and their experiences.

Being Honest about Bias

Bearing in mind the scholarly criticism leveled against "confessional reporting," which is characterized as the inclusion of one's personal stories in ethnographic study, I decided that sharing my personal story would serve a three-part purpose beyond mere anecdote (Williams,

1988, as cited in Lassiter, 2005, p. 107). Sharing personal experience in this study enables me to shed the objectivity “pretense” expected of researchers (Rabinow, 1977, as cited in Lassiter, 2005, p. 109). In all pursuits, I strive to be authentic, and it would be disingenuous of me to pretend prior experience with addiction in my family and abstinence-based treatment programs have not influenced my interest in addiction treatment and my desire for more options to be made available to people in West Virginia.

I choose to include personal experience in this study after reading Behar’s (1996) position on the personal narrative where she states personal stories “can lead the reader not into miniature bubbles of navel-gazing, but into the enormous sea of social issues” (as cited in Lassiter, 2005, p. 110). From the perspective of a loved one and a member of the mental and behavioral health workforce with over a decade of practice in West Virginia, I estimate access to empirically-supported addiction interventions that respect individuals’ dignity and self-determination is lacking due in part to the dominance of 12 Step programming over the recovery landscape. A dearth of viable treatment options that align with individuals’ goals, beliefs, and worldview is a social justice issue in West Virginia.

Lastly, my experiences with addiction recovery, both personal and professional, have led me to certain opinions that are unpopular in recovery circles among adherents to 12 Step philosophy and among people charged with developing programs and making policies in a high-stakes environment where resources are desperately needed. In the past when I have shared my perceptions of abstinence-only addiction recovery—even prefaced with a statement that 12 Step programming should always be an option—people’s responses have varied from indignant hostility that I would question an intervention that gave them their lives back, to confusion because alternatives are virtually unknown so why criticize a method that at least helps some, to

being stonewalled and cut out of the conversation altogether. Sharing my perspectives has led me to feel vulnerable for fear of being misunderstood, an actualized fear in some instances. As a result of sharing their experiences in this study, the physician collaborators might also be misunderstood or misjudged or have their reputations and intentions scrutinized. Lassiter (2005) acknowledges sharing experiences and “embracing our vulnerabilities” comes with the risk of “attracting criticism” (p. 115). Ultimately, my choice to include the following personal story rests on sharing risk. How can I ask others to assume risk if I am unwilling?

Underlying my interest in MAT is the stigma associated with its use in treating opioid use disorder. Nine years ago, my younger brother was hospitalized during withdraw from OxyContin. Nine years prior to his hospitalization, while in college, he became addicted to opioids and his life took a quick and unexpected departure from his original plan. For nearly a decade, he struggled to maintain the appearance of normality even though his addiction led him to behaviors that induced shame, guilt, and rendered him virtually unrecognizable to us, his loving family. Eventually, he was forced to abandon appearances on a day he was unable to obtain enough of the drug to keep withdrawal at bay; the illness overtook him, leaving him in such a desperate state, he was prepared to take his life. My family intervened, and he was admitted to the hospital for a 3-day detoxification and upon release was referred to a methadone clinic. In the program, he complied with the treatment regimen of daily visits to the clinic and attended individual and group therapy. The treatment was not easy. In fact, it was very costly and inconvenient, and even though he was doing the treatment, he was surrounded by many of the same people he bought from and used with.

He attended NA groups but expressed frustration over poor management of the group discussions typically dominated by one or two participants he described as competing, and

almost bragging about who had it worse, who made the worst decisions, and who did the most damage during their years in active addiction. He understood every group has its own culture and that he could not judge an entire program based on negative experiences in one group. Even so, he decided NA was not helpful to him, so he abandoned group meetings and the NA recovery program, opting instead to continue with his regimen of individual counseling and medication.

As an observer in his life, I witnessed changes in his routine, for instance, for the first time in a long time, the family knew where he was and what he was doing, signaling a dramatic shift from previous years when the question was always “Where’s Buddy?” and no one ever had the answer. His behavior was changing. No longer stealing from my parents, the family experimented with trusting him. We had taken trust for granted until missing items piled up and their disappearance could no longer be attributed to poor memory or misplacement. But now, we observed with renewed hope as he followed through on his commitments and respected the boundaries of ownership. After a couple years of stabilization on methadone, he switched to Suboxone and his life continued to improve. He found employment, he was coping with stress and frustration, and he was tending to his relationships. He proved his dependability by being present in our lives, attending family gatherings, being a wonderful uncle to my sons, and helping our parents with work around the house. His life shifted toward the positive in meaningful and measurable ways. He remained on Suboxone, weaning down, for another year or two, continuing with counseling until reaching the point where he was able to manage his cravings and stress levels without the help of a substance, instead relying on the new routines, relationships, and behaviors he established while on MAT.

This process took years, and during that time, I can recall the obstacles he encountered sometimes in the form of people’s uninformed opinions about his use of Suboxone. Those

uninformed opinions have a shaming effect that is not only counterproductive but potentially destructive to a person trying so hard to reconstruct his or her life after addiction. I recall a conversation I had with a man in a wheelchair sitting at the NA table. He was in recovery from an opioid addiction, and when I mentioned my brother's struggle, the man at the table prompted me for information about his addiction and recovery. Expecting this man to listen and offer some encouraging advice and hopeful words in support of another's recovery effort, I shared some details from my brother's story, naively mentioning his use of Suboxone to manage withdrawal symptoms. As if triggered by the word Suboxone, the man from NA interrupted me and without hesitation stated that my brother's recovery was a farce, abruptly advising me "if he's using Suboxone, he's not clean."

Physically, I felt an immediate sting, but my brain took a while to process the implication of his statement. Without knowing my brother, without seeing his transformation, and without validating his successful struggle to change habits and find new relationships, this man dismissed my family's reality. To avoid making comments I might regret, I walked away. I did not respond to this man from NA, but I've heard his statement repeated time and again by others in the program about their own recovery and the recovery of the anonymous others who got better using MAT. I share the story with permission from my brother, permission I obtained via text message. I asked if I could include his recovery story as I saw it unfold from my vantage point, assuring him I would not submit anything without his review and approval.

People in 12 step programs draw strength from spiritual connections to a higher power they self-identify to achieve abstinence from all substances and assume accountability for past behaviors. Support in the form of a sponsor and group meetings further enhance rehabilitation building on the principle that recovery requires new relationships with people who also abstain

from addictive, mind and mood-altering substances. More than a decade of exposure to the 12-step philosophy by way of my clientele and employment in organizations offering addiction recovery services led me to conclude that while his comment was hurtful and presumptuous, the man at the NA table did not intend to be harsh or judgmental in his assessment of my brother's recovery. He was simply assessing the situation per the Narcotics Anonymous program literature that describes the reasoning and behaviors outlined in the 12 Steps. The NA guidelines decree that addiction is a disease people in recovery are not responsible for acquiring but cautions participants that they are responsible for their recovery. According to the guidelines, working the program involves taking moral inventory of their lives and asking God (or designated higher power) to rid them of "character defects" manifesting as the bad choices that led to the disease of addiction (*An Introductory Guide to Narcotics Anonymous*, 1992). The guidelines also state "the ultimate weapon of recovery is the recovering addict." The man at the NA table meant no harm as he was dutifully upholding the 12 Step philosophy.

I share this story not to cast aspersions on the 12 Step program model. Social work ethics bind me to the belief that every individual has the right to self-determination, meaning people deserve to have their voices heard and their wishes honored. Within the context of recovery, self-determination manifests through treatment options that accord with one's unique cultural, spiritual, social identity and improve the likelihood of a successful recovery by giving people choices that complement their values, traditions, and unique life circumstances. Programs like NA and AA have helped millions of people overcome addiction through honest self-assessment, strength drawn from connections to a higher power, and on-going support and encouragement from others in the struggle. For people recovering from opioid addiction, NA should always be an available option.

In West Virginia, referral to abstinence-based treatment programs has been the default addiction treatment intervention to help people with opioid use disorder as access to medication-assisted treatment has been slow to evolve. Reflecting on my professional experience as a social worker, educator, advocate, and now qualitative researcher, I must admit I have been frustrated by the lack of referral options and the appearance of institutional endorsement and preference for NA on the part of government, medical, and social service agencies that in essence force people into a treatment modality that, for a variety of reasons, may not work for them and if unsuccessful in the program, participants face potentially devastating consequences like incarceration, overdose, or losing custody of their children.

Author Gary Enos (2016) discusses the research of Dr. John Kelly who asserts an underutilization of NA as a treatment option for people with opioid use disorder due to misconceptions about abstinence-only programs. Dr. Kelly describes the misconceptions he has encountered explaining that anecdotal reports of people who are reluctant to try NA due to its position on medication-assisted treatment, to which he replies that NA invites and welcomes everyone but hopes, with time, people learn to sustain their recovery without medical intervention. The numbers of people who avoid NA because of this misconception are unknown but the authors agree the nonprofit's stance presents a significant philosophical barrier for people using MAT. I share this information to demonstrate the NA philosophy may present a barrier for people who use MAT, keeping in mind that NA is not underutilized in West Virginia.

In a study by Majer et al. (2018) examining the philosophical conflict between abstinence-only programs and treatment using MAT, researchers surveyed participants of Oxford House. Oxford House is a community-based residential treatment program with over 2000 homes that promote an abstinence-only approach to treatment and is listed on the SAMHSA

national registry of evidence-based programs since 2011 (p. 572). The program strongly encourages an abstinence-only approach to recovery but accepts participants who are medically treated with the hope that eventually, after exposure to NA programming, medically treated participants will abandon prescription-based interventions in favor of clean living (Majer et al., 2018; Narcotics Anonymous, 2016).

Researchers gave brief surveys to 90 participants from 21 of the 53 Oxford Homes located in Maryland to gauge participants' attitudes regarding peers' use of medication-assisted treatment. The findings indicated Oxford House residents possessed negative attitudes toward the use of MAT and concluded people using MAT would not likely be "voted into" most Oxford House programs (Majer et al., 2018, p. 575). Consequently, the report suggests people who are prescribed Suboxone and Methadone, also an evidence-based practice, should consider alternatives to Oxford House for residential, community-based care. To my knowledge, there are no residential treatment programs in West Virginia that serve MAT patients.

Though only one study, the Majer (2018) report substantiates my lived personal and professional experience as it pertains to abstinence-only substance abuse treatment. These lived experiences left me with the presumption that stigma surrounding the use of MAT derives, in part, from NA doctrine, especially in communities where NA programs dominate recovery landscape and services as is true in West Virginia.

CHAPTER FOUR: THE PHYSICIANS

DR. MATT CHRISTIANSEN

I conducted the first interview with Dr. Matt Christiansen whose name I acquired by referral from two people well-known for their work in the addiction treatment community at Marshall University. In mid-June, I sent Dr. Christiansen an email requesting an interview, and in the email, I explained the purpose of the study and my desire to interview him as a provider of MAT services. Despite being on vacation, Dr. Christiansen responded the next day affirming his interest in participating in the study, and through email we arranged to meet days later in my office over coffee and pastries from Huntington's River and Rail bakery.

When Dr. Christiansen arrived at my office, I greeted him with coffee and a cinnamon roll. I was impressed by and grateful for his willingness to meet with me while he was on vacation. He stopped by my office on his way home from Utah, and after the interview, planned to get back on the road to go camping. His status as a physician made me acutely aware of his time and knowing he only had a week of vacation reinforced the need to hurry up with the questions and move through the interview so as not to waste a second of his vacation. But, the casual attire, polite grin, and slow reach for his coffee assured me he meant it when he said, "I could talk about MAT all day." Before starting the interview, I explained the informed consent to participate, and he gave consent for participation and to be named in the final report.

Dr. Christiansen, the son of a primary care physician in Spencer, WV, fills several roles as a family care physician in the Huntington community. He recalls there was a period in his youth when people in small-town Spencer would ask if he planned to take over his dad's medical practice someday; he chuckles, remembering that as a "rebellious teen" his response to the question was "no way I'm doing that." After a few years working in the Pacific Northwest, the

example of his dad as a respected physician whose role in the community as a trusted, appreciated “healer” resonated with Dr. Christiansen and prompted him to apply to medical school. He graduated from Marshall University’s School of Medicine (MUSOM) in 2013, completed his residency in 2016, and today, Dr. Christiansen holds an appointment as an assistant professor in the department of family medicine at Marshall University’s School of Medicine.

Teaching future medical students represents only a portion of his responsibilities. He works part-time at River Park hospital where he assists with medication management for psychiatric in-patients; along with teaching residents at Cabell Huntington Hospital and performing addiction medicine consultations with OUD patients admitted to the hospital, he provides MAT services at the Valley Health office in Highlawn. Some of his time is spent on the neonatal therapeutic unit (NTU) at Hoops Family Children’s Hospital where babies born dependent on substances are weaned down and at Lily’s Place, which is a step-down care facility that continues to treat babies with Neonatal Abstinence Syndrome (NAS) and support families through the transition from the hospital and off substances. Aside from a medical degree and a strong background in biological sciences, Dr. Christiansen holds a master’s degree in public health (MPH), also from Marshall University, and uses his education to engage in healthcare policy analysis and advocacy explaining, “If physicians and healthcare providers are interested in and care about how healthcare is practiced, we need to be at the table. Like they say, if you don’t have a seat at the table, then you’re for lunch.”

His interest in MAT began during residency with a patient who received a total of three aortic valve transplants due to infective endocarditis, a condition seen in patients with a history of intravenous drug use. Dr. Christiansen explains that the risk of a new aortic valve is poor

blood supply to the valve, cutting off access to immune-fighting cells, making it susceptible to repeated infections with continued use of intravenous drugs. After the second aortic valve transplant “I told this guy, if you use again you’re probably going to die because I don’t know anyone who’s going to replace your aortic valve three times,” he recalls. The man continued to use heroin, a habit he had maintained for over 20 years, and soon enough returned to Dr. Christiansen with fever and chills, the telltale signs of another infection. Surprisingly, this patient was transferred out of state back to the transplant center where he received a third transplant.

The patient intrigued Dr. Christiansen because the man was not suicidal. He recalls thinking “he [the patient] doesn’t want to kill himself; he’s not doing this out of a desire to harm himself.” Most interesting to Dr. Christiansen was his inability to answer the patient’s question “what is it about this drug that makes me unable to stop?” He recalls a shift in his own thinking, pausing to reflect on the implications, for himself and his patient, of having no satisfactory answer. For Dr. Christiansen, this patient’s question prompted him to read and learn about better options for patients who struggle with the life or death dilemma of continuing to use a substance despite knowing the likelihood continued use will kill them. The question Dr. Christiansen posed “is he just destined to be in this situation where he is imprisoned by this substance that he can’t get away from?” stimulated personal and professional growth as he searched for better options for his patients with substance use disorder.

When physicians don the white coat, they are immediately endowed with authority and expertise; patients expect them to know; the physicians expect themselves to know. I asked Dr. Christiansen if the curiosity and self-awareness that led him to recognize the importance of the patient’s question and his inability to answer it are inherent personality traits he happened to be

born with or are they skills that can be taught to medical students and other health professionals. Dr. Christiansen responds, “There is risk in saying to a patient or to a colleague ‘I don’t know.’ For some, it might feel better to pretend like you do know or dismiss the patient’s complaint altogether.” Dr. Christiansen shares his belief that “curious humility” enables a physician to admit uncertainty and ask questions and value the patient’s experience; it can be taught through example—and experience.

Although addiction medicine is situated within medical practice as a sub-specialty, Dr. Christiansen holds the view that the treatment of addiction is similar to treating other chronic conditions like diabetes because there is a situational context, perhaps involving co-morbidity with other conditions, within which patients’ behaviors and choices work for or against wellness. Dr. Christiansen explains that addressing patient behaviors whether in addiction medicine or family medicine requires physicians to develop awareness of the unique quality of patients’ circumstances because, given the highly individualized behavioral component to chronic disease, there are no easy, one-size-fits-all medical solutions. “We want there to be one answer...but where does one go with all these different comorbid health problems, social stressors, and history of trauma?” These are powerful questions that get at underlying issues, but to ask them, Dr. Christiansen suggests physicians embrace the subjectivity inherent in behavioral medicine. People self-medicate with drugs, alcohol, food, smoking for reasons that make sense to them. Dr. Christiansen’s approach, in collaboration with his patients, has evolved to explore the question “What are you making yourself feel better from?”

Such a simple and powerful question represents a paradigm shift for most physicians who Dr. Christiansen suggests are “underprepared to have conversations with patients about mental health and non-medication conversations to address underlying issues rather than suppress

symptoms.” Doctors do not typically counsel patients; instead, they inform, educate, interpret, and advise which is not to imply these activities are unimportant. In fact, these activities are critical, and they are time consuming leaving little space available for lengthy conversations about underlying issues. But, an empathetic approach and the right questions validate the connections between mental health and self-medicating behaviors and reinforce the importance of behavior change as part of a strategy for treating the whole person, not just symptoms. The empathetic questioning approach acknowledges patients’ experiences and enhances the doctor-patient relationship. Doctors who ask “what are you making yourself feel better from” demonstrate they are not afraid of the answers, which translates to patients as the doctor acknowledging their pain and seeking to understand them.

Dr. Christiansen asserts that most of the patients he sees in his practice for OUD meet diagnostic criteria for Post-traumatic Stress Disorder (PTSD) stemming from the experience of using heroin, not even including the adverse experiences or trauma preceding drug use. Many persist in their use because they feel guilt and shame over choices that led to serious consequences they are unable to cope with, stating, “It’s not like people are out there living it up and getting high at our [taxpayer] expense.” Instead, Dr. Christiansen encourages empathy and the realization that, “People who have addiction disorders stigmatize themselves. They feel incredibly guilty because they see it as a choice.” He adds addicted patients deal with stigma directed at them by almost everyone in society, but “they see how their lives have gone completely down the drain; they know those choices better than anyone; and they feel bad about every single one of them.”

Taking an empathetic approach to stigmatized patients and engaging them in conversation about their addiction takes skill, compassion, and a willingness to learn from the

patient. When other physicians or health professionals make assumptions about drug addicted patients, doctors who have experience with the population may find themselves in the awkward position of educating their fellow medical providers. I asked Dr. Christiansen if he experiences or hears stigma coming from other providers, and he states, “I’m confident that I’m doing the right thing, so I don’t feel stigmatized for providing MAT.” Amongst physicians, the attitude appears to be “Better you than me.” Dr. Christiansen smiles tentatively almost as if to apologize on their behalf. I asked him why he thinks some physicians feel that way, and he answered because “No one wants to deal with the ‘addicted’ patient. They don’t want them in their waiting room, and they don’t want to deal with their problems.”

Dr. Christiansen sees stigma as a historical phenomenon dating back to prohibition with the framing of drug addiction as a moral failure that persists today, even among educated professionals in society’s helping professions. He explains that society’s dichotomous framing of addiction as either a moral failure or a disease has the potential to narrow one’s treatment options, legal options, and healthcare options to the opinions and preferences of intervening therapists, judges, or physicians. If their doctor happens to believe addiction is a choice, then that doctor can withhold treatment based on that judgment. Dr. Christiansen clarifies where he stands, “None of my patients chose ever to be addicted. They chose to use, yes, but they never chose to be addicted. All of them, especially women have undergone trauma—domestic violence or sexual violence—and they are self-treating, trying to feel normal.”

A strong advocate for education, Dr. Christiansen expresses optimism that viewpoints do change or at least soften with exposure to fact-based information. Recently he has been asked to provide training on the difference between disease and addiction to local police with the hope

that education will ease law enforcement's frustration with people who are addicted and draw support for harm reduction initiatives that some officers have yet to buy into.

DR. RICHARD KNAPP

I met Dr. Richard Knapp through my husband who invited him to speak to his Drug War class about MAT. My husband came home raving that the material Dr. Knapp presented opened students' eyes to another method of managing the opioid epidemic, a harm reduction strategy that was slowly catching on in parts of the state but encountering some barriers, most notably in the form of stigma. The Knapps invited my husband and I to their annual Thanksgiving celebration, and because my husband continued to speak so highly of Dr. Knapp, I agreed to attend the event and take the opportunity to meet the doctor and hear his perspective on treating people with medication to ease withdrawal from opioids. That evening's conversation with Dr. Knapp left me feeling adamant that someone should capture and share what I dubbed his "social work approach" to treating people who suffer from addiction.

Dr. Knapp and I decided on a date, time, and location for the interview. We convened at his home amid his family's evening routine. His children were slurping spaghetti when I arrived, and after chit-chatting in the kitchen with his wife Meghan, he and I moved to the deck facing the wooded area behind his home. He closed the sliding glass door, silencing the familiar sounds of dinner and amplifying the clicking of the invisible cicadas in the surrounding trees. To kick off the interview, I reviewed the consent forms and he initialed, signaling his consent to participate and be identified in the final report.

Coming from southern West Virginia, Dr. Knapp recalls having few career options available to him, either work in the mines or become a dentist, doctor, or lawyer. He opted for

college, starting out as a biology major and was later accepted to medical school, stating the “humanity” and the “science” of medicine appealed to him. He graduated in 2011 and needed a job quick, so he took a position in family medicine at Boone Memorial Hospital in Madison, WV. The major factor in his decision to pursue MAT in 2014 was that none of the other physicians were willing to take it on; a program was being developed but the lead doctor on the initiative transferred to another hospital. Dr. Knapp explains, “Nobody else wanted to do it...it had been offered to everybody and everybody else refused. So, it kind of just fell to me. Just right place, right time.” Because he was new, curious, and needed to provide stability for his family, he saw the hospital-based MAT clinic as an opportunity to establish his niche.

He admits to having virtually no medical training on medication-assisted treatment when he assumed responsibilities in the Suboxone clinic. Medical school exposed him to methadone treatment, but prior to his involvement in the MAT clinic, he had never even heard of Suboxone. He recalls, “I was like, all right, let me go look it up because I don’t know what it is,” and he proceeded to consult Google. But, before he could start prescribing Suboxone, he had to obtain the DATA waiver through SAMHSA, a process made known to him by a therapist who instructed him on the steps to log in and begin the required 8- hour training. In addition to training on medication-assisted treatment, Dr. Knapp, like all physicians who prescribe controlled substances, had to fill out an online form to obtain a DEA X number as part of the Drug Enforcement Administration’s system of monitoring controlled substances. Dr. Knapp explains that any physician who plans to prescribe narcotics must file for a DEA X number. The literature on physician barriers to treatment names the required training and DEA paperwork as obstacles to prescribing MAT, but Dr. Knapp characterizes the process as “just another form to fill out,” adding “it wasn’t hard.”

Significant barriers arose in the start-up phase of developing the clinic. Dr. Knapp describes feeling “clueless” on the process of checking patients in and evaluating them for substance use disorder, performing drug screens, and blood work. Even more complicated was figuring out the steps involved in billing insurance and cash-based service delivery. Without a set of guidelines to follow or seasoned mentors to advise Dr. Knapp and his partner, the program therapist, through the process Dr. Knapp admits he and his partner were “making it all up as we went.” SAMHSA provided confidentiality waivers, but nothing in the form of an information packet explaining rules or regulations or offering guidance on how to handle situations with patients who repeatedly fail drug screens, for example. He also received no information from the DEA or from the state. He and his partner again relied on Google to develop templates for forms and accessed university websites for appropriate language and criteria to include in their policy statements with the entire process left to their own discretion.

To clarify Dr. Knapp’s perception of the assistance he received during the start-up, I asked how the doctors working with him and around him responded to his predicament, and he responded, “Nobody had a clue. Yeah, I was new down there, so I didn’t know a lot of them very well. But even the ones you talked to, they had maybe heard of Suboxone, but nobody knew how the drug worked, it’s half-life, none of that. None of them had any idea.” When Dr. Knapp started working in the MAT clinic nobody knew who he was, but his anonymity was short-lived. He explains, through exaggerated whisper, that soon he became known to his colleagues as “the guy that does Suboxone.” I sensed that Dr. Knapp finds the double-meaning of “does Suboxone” both humorous and perplexing. Dr. Knapp points out “I’m writing the script just like they’re writing their Hydros and their Oxys and Percocets. I don’t know if mine is any different, but to them it is.”

The literature on physician barriers to MAT describes the role addiction stigma plays in deterring doctors from administering MAT to patients stereotyped as manipulative and non-compliant who also possess a multitude of health and mental health problems that complicate their treatment. While completing the literature review, I began to wonder if doctors experience stigma for offering medication-assisted treatment. With the rise in opioid addiction, doctors have been implicated by the public for allegedly overprescribing opiates to patients who later become addicted; along with that, it is not uncommon to hear doctors derided by the public as drug dealers and drug pushers.

Dr. Knapp's stories support my suspicion. He tells of doctors who otherwise show no interest in MAT coming to his office, furtively closing the door behind them before delivering the familiar narrative of a family friend, from the proverbial good family, who mistakenly got caught up in drugs and now needs medication assistance. Asked to elaborate on the meaning he makes of those meetings with his colleagues, Knapp says "...it just cracks me up. One guy has been practicing for like 30 years and that's how he did it, whispering down the hall, coming in and closing the door, making sure I didn't have a student in there to talk about this guy who I'd never met needing Suboxone treatment."

Dr. Knapp smiles when discussing fellow doctors' discomfort with Suboxone and their inability to see the irony of that discomfort, especially because many physicians prescribe highly addictive medications. In the interview I mentioned that I was surprised these physicians did not possess a medical perspective about MAT to which Knapp replies "You would think." I liken his descriptions of the conversations to a drug deal, almost as if they're trying to score weed or something. Dr. Knapp chuckles and kicks his head back, "Yeah, it's like, I'll meet you at the Quicky Mart." His easy-going disposition and ability to find humor in the awkward situations he

encounters as a provider of MAT are strengths that make him well-suited for the practice of MAT.

Never does he speak unfavorably of his colleagues, nor does he indicate he takes their discomfort with MAT personally; in fact, his amicable personality and relaxed expression suggest he is both approachable and open. He verbalizes bewilderment at their reluctance to broach the subject of MAT when he says, “In monthly meetings at the hospital, all the providers come together to discuss any changes to policy or any current things on the agenda like medical licensing. MAT stuff has come up before, and it’s like they’re trying not to make eye contact with me. I’ve been there long enough. They all know I do it, and I don’t want to keep it a secret, but they just cannot discuss it.”

Dr. Knapp’s encounters with colleagues and the stigmatizing attitudes he has witnessed highlight a critical need for addiction and mental health education to enhance physicians’ competence in these areas and challenge physicians’ value judgments about people in need of medication assisted treatment. Knapp asserts,

They [physicians] need education. They need to remove the stigma themselves. It depends on how you define addiction as to whether it’s a choice or a mental illness. In our clinic, we classify addiction as a mental illness. People do make choices to take it, don’t get me wrong, but a lot of times it will trigger something within them that they didn’t know they had. Or it will treat something that they didn’t know needed to be treated. All of a sudden, they find this thing that silences that voice or that demon or that thought and represses it, and it’s just that powerful and they just keep chasing it because it’s just that alluring.

Lack of education about addiction and medication assisted treatment may create barriers to care even for health issues that are not directly related to the addiction. Knapp gives examples of physicians in primary care passing on treating patients currently taking Suboxone or with a history of addiction. Admittedly, he concedes that treating a caseload of patients on a multitude of medications e.g., pain pills, Benzodiazepines, Adipex, Neurontin can be overwhelming for doctors. Further complicating the provision of care, when others withhold service to patients on powerful narcotics, complex cases get assigned to one physician in a clinic. Surprisingly, Knapp explains that Suboxone patients are some of the easiest to treat in primary care because doctors cannot prescribe opioids to them, so if patients ask for opioids, doctors can easily deny the request because the patient takes Suboxone—and the Suboxone is managed in another setting, as in Dr. Knapp’s case his DEA X address is through the Suboxone clinic, not his primary care practice, so in his capacity as primary care physician, he is not authorized to prescribe it out of the primary care clinic. Physicians are responsible for knowing what medications are contraindicated with Suboxone.

I asked Dr. Knapp why he thinks some physicians are so averse to treating this population and he replied, “I think they’re afraid they’re going to get manipulated or the patient is going to be a headache.” But, he counters the assumption that this patient population, specifically, is deceitful by sharing an axiom commonly used in medical school, which is “patients never lie,” delivered in a slightly sardonic tone because as Knapp points out “patients do lie; they’ll tell you they feel fine and you come back to their scan and they’re...they’ve got cancer and are really hurting.” Knapp speculates that people lie to their doctors for a variety of reasons, but he has found that “they hate disappointing the physician; they want to please.” Interestingly, Knapp states that in his experience, “Drug addicts are so used to dealing with police, the courts that you

can just be honest with them. If you just ask them, they'll answer. Don't get me wrong, they'll lie to you too, but you can be more honest with them.”

From Dr. Knapp I gleaned the importance of trust, collaboration, and the casual conversation as critical components of the doctor-patient relationship. He acknowledges that when he began MAT practice, he lacked experience and education on the subject. His desire to learn led him to ask his patients questions about their experiences in other programs, with other medications. His willingness to ask the questions rather than feign having the answers not only informed his practice, but also engaged the patients as expert collaborators similar to the social work approach to relationships with clients. Through a wide smile, he admits “In the beginning, I was milking them for info, but at the same time, they loved it because they were telling me about themselves, where they've been. People want to be understood, and they want to be remembered.”

DR. ZACH HANSEN

My referral to Dr. Zach Hansen came from his father, Bob Hansen, director of addiction services for Marshall Health, but I did not immediately make the father-son connection. I contacted Dr. Hansen through email, and we volleyed several responses back and forth trying to negotiate summer schedules before we finally settled on a day, time, and location for our meeting. I arrived at the Valley Health location on 3rd Avenue in Huntington and was greeted by a member of the office staff. She invited me to take a seat. In the lobby, a bored security guard played with his watch, and a toddler sipped from a super-sized McDonald's cup while waiting with women I assumed were her mother and grandmother. They sat quietly until a heavily tattooed man with a tired expression appeared hastily through the door leading to exam rooms. He had a piece of paper in hand and with a stiff nod motioned to the women it was time to leave.

Swiftly, they gathered their belongings, grabbed the toddler, and shuffled out the door, their voices and footsteps at a distance behind him. I made a mental note “he’s in a hurry to fill that script.”

Within a minute or two Dr. Hansen opened the same door leading to the exam rooms. He welcomed me to the clinic and on our way to the conference room I encountered a good friend of mine, former co-worker and excellent mental health therapist. I was conscious of Dr. Hansen’s time and tight schedule, so she and I took only a moment to catch up. In the conference room, I pulled out my voice recorder, the consent forms, my notepad, and pens. Hits from the 80s came through overhead speakers and put me at ease, giving the sense I was among friendly, relaxed people. I reviewed the consent forms and Dr. Hansen initialed the pages. Citing his role as a leader and mentor in the community, he reasoned that if anyone has questions about his statements or wants to know more, he wants them to be able to contact him, so he consented to being named in the report.

When he entered medical school in 2000, Dr. Hansen planned on a career in pediatrics, but after a rotation in pediatrics, he realized family practice was a better fit because he could see children and adults. He participated in an accelerated residency program and graduated from medical school in 2004, completed his residency and began working at Valley Health in 2006. Valley Health is a federally-qualified health center (FQHC) that serves people on Medicaid and treats patients regardless of their ability to pay. Dr. Hansen explains he felt called to work with a population whose access to quality healthcare is limited due to their lower socio-economic status. He worked for a while at Cabell Huntington Hospital admitting Valley Health patients before deciding to dedicate his practice to outpatient primary care. At that time, he reports “feeling as if there were a void in my practice.” He recalls needing something more, “a more immediate sense

of gratification” similar to the feeling he experienced at the hospital working with patients who were sick, and after good care would go home because “they’re better and you get a pat on the back and a feeling that you’ve accomplished something today.”

His dad, then CEO of Presteria Center, a community-mental health agency, encouraged him to become certified as a Suboxone provider, so he did, and soon started groups with patients suffering from addiction. “These patients came to group and were in such a bad way, desperate, despondent, afraid of their own future. Seeing them respond to the medication, turn their lives around, and achieve some sense of normalcy gave me the gratification I was seeking.” He reports that over time, he built a caseload of over 100 people and the MAT program has continued to expand. His daily schedule consists of family practice and addiction medicine with a designated schedule for each service, with family practice from 8am-11am. MAT group therapy begins at 10am, after which he sees patients individually. At 1pm, he sees more MAT patients who then attend group therapy from 2-3pm. Dr. Hansen states “Our philosophy is to tie group therapy and medical management together to increase compliance with group therapy.” Patients must also undergo individual therapy, so the goal is to schedule all appointments on the same day because patients struggle to find transportation.

I wanted to know more about the separation of MAT services from primary care practice. Dr. Hansen explained the difficulty of trying to tie the group therapy component of the program to his primary care practice, so grouping patients together according to services makes it easier to see as many patients as possible while meeting all requirements. I assumed primary care and MAT could occur at the same time, with the same physician, but the reality is that patients typically see a physician for MAT services and a different physician for primary care services. With candor and humility, Dr. Hansen describes the difficulty of attending to both primary care

services and addiction medicine at the same time, “I’ve realized I can’t effectively fulfil my role as a primary care physician when I’m primarily concentrating on the addiction behavior. I don’t often remember to ask about pap smears with female patients, or colonoscopies for patients over 50, or when the last A1C was if they happen to be diabetic.”

Dr. Hansen adds “I want to do it all, but I have to accept my limitations.” I’m typically seeing 10 patients in a span of an hour, so to add in multiple health problems in a particular visit is not very efficient leaving patients waiting for prolonged periods.” This candid statement speaks to the challenge of providing quality care to people with health issues compounded by addiction. Without hesitation Dr. Hansen acknowledges the difficulty in finding referrals to primary care for these patients. But, an even greater challenge from his perspective is making referrals to psychiatry for two reasons: this patient population with co-occurring mental health and substance abuse issues are perceived as unreliable and access to psychiatric services is so sparse, “psychiatrists can have a very successful and busy practice limiting their referral sources and pre-screening patients.” Referrals to primary care through Valley Health are easier because some primary care physicians also do addiction medicine, so doctors refer to each other depending on the needed service.

Regarding the training necessary to prescribe Suboxone, Dr. Hansen states he thinks the process of registering for and obtaining the DATA waiver is “super-easy, too easy probably,” speculating the ease of the process “has created an environment in which individuals with less than stellar motives can open practices and charge patients large sums of money.” To get the DATA waiver, one must sit through an 8-hour training and then complete DEA paperwork. The DEA paperwork requirement applies to physicians who prescribe controlled prescriptions—essentially all physicians. Dr. Hansen asserts that there are an increasing number of providers

doing MAT who accept cash and are not adhering to standards of care. Per Dr. Hansen, the stigma surrounding MAT comes from the public's perception that Suboxone clinics operate like pill mills, a view often perpetuated by negative media coverage of clinics that have been shut down.

Stigma around medication-assisted treatment does not prevent patients from seeking the service. Dr. Hansen's experiences suggest that "people who are addicted and desperate will seek this service because they know it's going to help, and in many cases, it's the difference between life or death, between divorce or marriage, between keeping the kids or losing custody. The social stigma does not matter." Patients are not the only people stigmatized by MAT, sometimes the providers are stigmatized as well. Dr. Hansen denies ever being challenged, criticized, or called a name for providing the services, but he recalls times when people have not understood why he offers Suboxone because they do not understand addiction or recovery. Optimistically, he sees these situations as teachable moments, "opportunities to discuss philosophies and discuss why doctors provide MAT." One of the arguments people make is that patients should be discharged from the program if drug screens reveal patients have been smoking marijuana, "three strikes and you're out" or that programs should be graduating people quickly, "get them on, get them off." But, with addiction Dr. Hansen says, "it's not that easy because these are debated topics in the addiction and medical communities, and there are no clear answers."

The public struggles to accept addiction as a chronic disease, even when the medical and addiction communities endorse the notion. Many hold the belief that people who are addicted made the choice to use drugs and to get off drugs, they must fix a moral failure. To illustrate similarities between addiction and chronic disease, doctors who prescribe MAT often compare the behavioral component of addiction to that of diabetes. Dr. Hansen expressed frustration with

non-compliant diabetic patients stating that “diabetes is often related to lifestyle choices, and I might be inclined to consider discharging diabetic patients who don’t take their medicine, don’t change their diet and don’t exercise, but everyone would judge me harshly for that and say, ‘That’s not fair. Diabetes is a disease.’” He continues the point by noting that very rarely in his practice do people who are diabetic shift to non-diabetic because they have made major lifestyle changes.

I asked Dr. Hansen to share what he believes to be his greatest strengths. He answered, “compassion and empathy,” characteristics which are supported by his statements throughout the interview. He also stated, “I have a willingness to be wrong. I’ve made mistakes over the years and have had to modify things that weren’t working, and we’re still not perfect, but we do pretty well for our patients. I’ve learned a lot through trial and error because the body of knowledge was sparse when I started to run my MAT program.” When I asked if compassion, empathy, and willingness to be wrong are traits that can be taught in medical school, Dr. Hansen quickly responded that they cannot; they are aspects of one’s personality, but he backtracks a little and makes clear that when he worked with students, he made sure to emphasize that patients do not expect them to have all the answers, and that “the ability to connect with a patient will get you a lot further than book knowledge that may make you a great diagnostician, but not a great physician.”

The art of rapport-building with patients can be taught only through exposure to patients, especially if patients are heavily stigmatized by society as is true for people who are addicted or mentally ill. Dr. Hansen gives an example of his first Suboxone patient; he recalls being nervous and unsure what to expect. Having no real context within which to place her other than the criminal context so often associated with people who use drugs, he feared she might be violent or

try to steal his wallet. He admits his preconceived notions interfered with his ability to see her as a patient, but “forty minutes into the conversation, I began to see her as a mother, as somebody’s daughter, as a person.” He likens the reframing of his preconceived notions about this client to his multiple trips to Haiti, “people want to know what is that like, but I can’t tell you. You can’t understand what it’s like to be in Haiti until you feel the heat, smell the smells, and see the sites.” Only through exposure to patients can oversimplifications and stereotypes be debunked.

DR. PATRICK MARSHALEK

The introduction to Dr. Patrick Marshalek came through my colleague and fellow social work friend Dolly Ford-Sullivan. Dolly and I met as members of the National Association of Social Worker’s board of directors. Dolly is married to Dr. Carl (Rolly) Sullivan, former director and vice chair of West Virginia University’s addictions programs in the Department of Behavioral Medicine and Psychiatry in the WVU School of Medicine. I made Dolly aware of my interest in MAT prescribing physicians, and she introduced me via email to Dr. Patrick Marshalek, assistant professor in the clinical track of WVU’s Department of Behavioral Medicine and Psychiatry. Dr. Marshalek agreed to meet with me, so I took a trip to WVU’s Chestnut Ridge Center in Morgantown, WV.

I arrived at Chestnut Ridge a little early on Friday, June 22. I was familiar with Chestnut Ridge after working for three years in an in-patient psychiatric hospital that received patients from and transferred patients of all ages to Chestnut Ridge for in-patient psychiatric services. After passing through the security, I walked to a reception area and asked for Dr. Marshalek. The receptionist informed me he was in group, so I would have to wait. She invited me to take a seat in the small waiting area where I found a spot and decided to take another look at the interview questions. For some unidentifiable reason, I felt nervous. The nerves caught me off

guard because I have worked in mental health for over a decade but the physical sensations I was experiencing prompted me to check into the moment and consider the patient experience. How might patients feel as they sit and wait for the MAT doctor? Another 30 minutes passed and during that time, I observed the coming and going of people I identified as patients or staff, depending on their attire, whether they wore a name tag. Eventually, several people came out from behind the door indicating group was over, so I scanned each individual relying on stereotypes about psychiatrists to identify Dr. Marshalek. Even though he did not fit any of the stereotypes, no white coat, I was able to identify him just a second before the receptionist got his attention and pointed in my direction. We shook hands, made the formal introductions, and walked to his office to begin the interview.

After going over the consent forms, I asked Dr. Marshalek for his educational background and interest in addiction psychiatry. Originally from Morgantown, WV, Dr. Marshalek attended medical school at WVU and graduated in 2006. During medical school he had the chance to work with Dr. Rolly Sullivan, which he states, “solidified” his decision to pursue a residency training program in psychiatry. He explains the two-week clerkships he experienced during medical school exposed him to patients who are dually diagnosed, meaning they have both a mental health disorder and a substance use disorder. After finishing residency in 2010, he decided to remain in the WVU School of Medicine where he treats patients using Buprenorphine.

Dr. Marshalek credits Dr. Sullivan with being an early pioneer of MAT and “knocking down” many of the policy barriers physicians encounter when they start prescribing. The ability to conceptualize and structure the treatment process, convincing insurers why they should pay for the treatment and how much they should pay, and establishing dosages for medicine, “how

much is too much?” are all considerations that must be addressed but doctors who do not have the answers can be deterred from the practice, undermining access to treatment options. WV’s placement at the center of the opioid epidemic became “the mother of invention” because the problem “forced programming” and forced physicians to figure out how to implement recovery alternatives to address the growing need.

In the beginning of his practice, Dr. Marshalek learned a lot about MAT by listening to his patients who were coming to the Suboxone clinic after being treated with Methadone. There is a substantial body of research supporting the efficacy of Methadone as a pharmacotherapy option for people recovering from opioid addiction, but patients expressed dissatisfaction with having to present to the clinic every day for their dose, and some patients said they felt “stuck on it and didn’t have a way to get off.” Other patients did not see a reduction in their dosage to wean down while others felt their medication had been unnecessarily increased. Dr. Marshalek takes a diplomatic stance on his patients’ perceptions, recognizing there is a bias because they left one clinic for another, and he recognizes the debate about Suboxone versus Methadone is ongoing in the recovery community, but clarifies that “people should not feel stuck on medication and they should not feel forced off.”

Dr. Marshalek describes MAT as an evidence-based practice but adds “like any intervention ranging from Tylenol to Suboxone prescribing is a risk/benefit calculation, not a one-size fits all.” He explains that “a direct advantage” of working with this population is seeing them recover. “They get their families back; they get back to work, back to school, find stable housing, and remain sober. They get some wins.” He cautions that MAT is a life-saving intervention for many people, but it is not “a silver bullet.” Comparing addiction to cancer he states that “despite almost heroic efforts sometimes we’ve been unable to retain people in

treatment. Like a nasty, wide-spread form of cancer you can throw chemo, radiation, and surgery at it, but it can still take people down.” What appears to be a heroic effort in one person’s opinion looks to others like enabling and cheating by replacing one drug for another. Dr. Marshalek attests to experiencing stigma associated with MAT service—even among doctors. He states that the physician community, if not trained or educated, “could easily dismiss what we’re doing as a cash grab, pat on the back, here’s a pill and not really see the true, good things that can come from it.” To counteract the stigma, he believes in the power of education, often through comparisons to other remitting, chronic, treatable conditions.

He affirms that prescribing MAT saves lives but saving lives with MAT is not as “glamorous” as putting a stent in to prevent cardiac disease. He supposes the mental health component of addiction may further add to the stigma of treating addiction as does the generational gap occurring in medicine with “the biggest pool or most active generation” of physicians having completed medical school at a time when education about substance use disorders, mental health, and managing chronic pain were not well integrated into the curriculum. But, Dr. Marshalek sees changes taking place. Just today a first-year medical student sat in on the MAT groups and a pediatric resident on rotation in adolescent medicine recently requested time in the MAT clinic. He concludes that requests to visit the clinic and observe the practice of addiction psychiatry through month-long rotations in addiction demonstrate a growing interest among the next generation of practitioners to treat addiction and co-occurring disorders.

Staying current on curriculum is one of the strengths of WVU’s School of Medicine, according to Dr. Marshalek. He explains the school’s use of “thread directors” which are faculty members appointed to explore designated topics ranging from diversity to pain and addiction.

These topics are taken up by the curriculum committee who decides how to integrate them into the course of study via lectures and clinical opportunities. Dr. Marshalek explains “this is a shared problem, so it is critical that trainees from other disciplines get an opportunity to rotate through the behavioral clinic to achieve the first-hand experience of acute inpatient care with patients who are dually diagnosed.” A key component of the first-hand experience is seeing the practice of “meeting the patient where they are,” meaning there is an individualized component of the care because rigid structure may do more harm than good for clients. From the psychiatry perspective, students see physicians at ease with “varying shades of gray,” because through their training, psychiatrists, learn to accept “certain degrees of uncertainty.”

From Dr. Marshalek’s perspective, establishing an alliance with the patient is a skill in psychiatry generally achieved through genuine interactions with patients. He quotes Dr. Sullivan, “Patients are quick to smell BS. They’ll know who they can BS.” Dr. Marshalek took that to mean sometimes you must speak the patient’s language and avoid “the stuffy white coat thing where you’re looking down your nose at them.” Patients complain that doctors do not care about them, a complaint leveled against physicians for “maybe not keeping a family member long enough or maybe the doctor didn’t run enough tests.” In addition psychiatry, program rules, structure, and policies can “feel like punishment to patients,” especially when a patient’s circumstance are not taken into consideration. In patient-centered programs, bending the rules for the sake of fairness can be challenging but operating on extremes where rules are ignored, or rules are never evaluated or revised in response to patients’ circumstances conveys a lack of concern. Dr. Marshalek says, “Sometimes you have to tweak a policy a little bit in an ongoing attempt to maximize benefits and minimize risk, just make decisions in the best interest of the patient.”

Dr. Marshalek summarizes his work with high need populations realistically stating, “I talk about successes a lot, but you have to be willing to accept a lot of failures.” For this population, relapse is part of the recovery process and with relapse patients risk overdose and death; they risk losing their children and their jobs. Getting better, for this population, is a process of small successes and sometimes big failures that set the treatment back and create high stakes for everyone involved: patients, their families, and providers. But, Dr. Marshalek shares that he “feels blessed” to be able to help people, despite the barriers and failures because “people get better.” He provides a poignant example of the ways in which people get better that are difficult to measure from a medical standpoint but demonstrate treatment is working. He describes a patient who returns to group after a week of family vacation and the patient tells the group, “This is the first vacation I remember where I wasn’t preoccupied with getting high.” Outcomes like these cannot be measured like an A1C, or high blood pressure, but these outcomes are exciting “because they’re proof the patient is recovering.”

DR. JAMES BERRY

Hailing from Michigan, Dr. James Berry attended Michigan State University both as an undergraduate and a medical student. His original plan was to practice family medicine, and he was accepted into a family medicine residency program but a “powerful rotation” in addiction psychiatry offered him the chance to observe the treatment of addiction and witness patients getting better. His interest in addiction treatment grew, but he realized there would be little time in family practice to devote to treating addiction. His fascination with psychiatry and addiction persisted until he eventually decided to shift course from residency training in family practice to a psychiatric residency program that was “strong in addiction.” The pursuit of a strong psychiatric residency program led him to West Virginia where he completed his residency

training under the mentorship of Dr. Sullivan. After residency at WVU, Dr. Berry went to the University of Hawaii for one year of additional training as an addiction psychiatry fellow. In 2006, upon completion of the fellowship, he returned to WVU and joined the WVU Behavioral Medicine Department where he runs the inpatient dual-diagnosis unit and the Comprehensive Opioid Addiction Treatment (COAT) clinic at Chestnut Ridge.

In his many roles, Dr. Berry spends time teaching medical students, training other physicians and members of the community, including legislators, on the disease of addiction, to “help them wrap their heads around what medication assisted treatment is.” He explains that his position as a professor in the department, versus a private medical practice, affords him latitude to engage the community through education and advocacy to improve understanding of addiction as a chronic disease. Dr. Berry sees the role of the physician as “not only a clinician, but also an educator and a translator, helping the common person understand medical science regarding a particular disease or treatment.” He emphasizes the importance of translation as a fundamental skill doctors should possess to be able to “break information down into understandable bits for people,” adding “medical students need to understand effective communication is their job.”

West Virginia’s designation as the center of the opioid epidemic pushed Dr. Berry into an advocacy role he was unable to foresee early in his career. He says, “people are hungry to learn about the opioid crisis and MAT; it has captured a national audience,” so Dr. Berry has participated in interviews and has spoken at conferences to help spotlight the opioid problem and MAT as a part of the solution. I wondered, given the need for the translation of science-based information and advocacy if medical students have the option to take a course in communication or community advocacy. According to Dr. Berry, Dr. Sullivan instituted a program where fourth year psychiatric residents in collaboration with public relations staff at the university learn how

to give interviews and appear on camera in ways that objectively inform audiences and do not perpetuate stigma.

Dr. Berry's handlebar moustache is a rather distinguishing feature that suggests an air of nonchalance, but his keen enunciation of the incorrect beliefs and assumptions repeated by the public, medical students, and practicing physicians connotes a very serious commitment to the work of challenging the persistent, uninformed addiction and treatment narrative. He explains that medical students enter the clinic for observation of MAT with one set of assumptions and leave with a new attitude about MAT and addiction; a common response from medical students sounds like, "I thought these people were making the choice to be addicted. They are doing it to themselves. They needed to live with the consequences," and "MAT is basically just trading one drug for another." After a little bit of time in the clinic, students leave with the understanding that "people really do get better and MAT is a powerful treatment option if done the right way."

Dr. Berry speaks frankly about the pitfalls of treating addiction in a medical culture where medically trained professionals fail to grasp the concept of addiction as a chronic disease. He offers a general scenario to capture the influence of an "attending physician or nurse with a strong personality" who happens to have an uninformed view of addiction medicine. Even after students spend time in the clinic and undergo a shift in their thinking about substance use disorders, "they enter into a medical system where some doctors and nurses are very unenlightened, very judgmental, and without proper mentorship, that understanding dissipates."

Fortunately, Dr. Berry says he has never felt stigmatized for prescribing Suboxone through the clinic, at least not from his colleagues within the medical profession, but he has experienced stigma from people in the community at public events. He reports people have called him names, and he has been harshly criticized by some who remark that his method of

using MAT to treat addiction is “crazy” and “ridiculous.” Dr. Berry admits he used to get angry and sometimes still does, but the anger is a result of frustration. To cope with frustration, he reminds himself of “all the patients I treat on a daily basis who are doing well.”

Bringing people into the clinic to see for themselves the type of change patients undergo has proven a powerful tool used to ameliorate stigma and improve the public’s image of MAT. Dr. Berry asserts that when family members and people from the community “very, very anti-addiction-as-a-disease folks or very anti-MAT” see the treatment take place and take the opportunity to be educated on the facts, “it restores my faith in people’s ability to change their minds.” People walk up to him afterward and admit to experiencing “a total 180” that has them seriously reconsidering their previous position. He admits to presenting invitations to the clinic as almost a challenge to “come spend some time, so at least you know what you’re talking about.” This tactic works especially well on legislators.

Persuading others to think or act differently can be exhausting work and as Dr. Berry notes, it is also very frustrating when people cling to their views despite evidence. Dr. Berry’s efforts to change public perception about MAT require a strategy that enables skeptics to witness a process and interpret the meaning of that process on their own, without interference or inducement. By welcoming naysayers into the clinic, Dr. Berry eliminates the push and pull that naturally occur when people argue for and firmly defend their positions. Instead of convincing and coaxing, inviting people to come to the clinic allows them to talk to patients, hear their anecdotes, and do the work of refuting presuppositions themselves rather than be dragged along by a fact-wielding expert. A similar push-pull dynamic can exist between doctors and patients when patients are reluctant to commit to behavioral change, like that required in addiction treatment. With ambivalent patients, doctors exhaust an inordinate amount of mental and

physical energy wooing them to make changes that will improve their health. Without a process that enables patients to identify internal motivation the doctor-patient relationship can become yet another obstacle to change. So, when I asked Dr. Berry to share his philosophy on providing care, I was not surprised by his response, “I’m a huge proponent of motivational interviewing because it creates a partnership between patient and provider.”

Motivational interviewing as a technique “frees the patient to be open to really consider all aspects of their life without the doctor taking a paternalistic stance.” The doctor’s role in motivational interviewing is to ask questions that help the patient delve into the benefits and pitfalls of current behaviors without judgment or pressure to see addiction as totally problematic and serving no purpose. The conversation about change is “couched within the healthy,” and encourages patients to define healthy living for themselves, rather than have it imposed upon them. Dr. Berry describes it as a partnership where the physician contributes expertise and training, “without any sort of moralistic-laden terminology” and patients honestly explore the pros and cons of behavior change and then make decisions that best reflect their values, goals, and preferences.

Questions that arise during the conversation investigate periods of patients’ lives when they were sober and ask patients to compare life when they were sober to life now. In response to those questions, Dr. Berry says patients begin to identify areas of their life that are the most important to them. They say things like, “When I was sober, I had my kids,” or “I didn’t wake up hurting every day. I remembered what happened the night before. I got to work on time with a clear head. I maintained my relationships.” According to Dr. Berry, “Patients identify not only their mental and physical health preferences, but also the relational and social components of health that are so important to everybody. The patients identify those things and want them back

in their lives.” Dr. Berry asserts that increasingly medical students understand the importance of relational and social health “that we doctors aren’t just treating biology, we’re treating the whole person.” And, treating the whole person requires listening to patients, not telling patients, which is why Dr. Berry says motivational interviewing should be taught in the first two years of medical school to all students, not just those entering addiction medicine.

In healthcare culture, listening is viewed as a peripheral skill that certainly adds value to doctor-patient relationship and enhances likelihood for improved outcomes but listening as a soft skill appears less important compared to the science of diagnosing and treating illness. The same is true for empathy, a quality like being a good listener is advantageous to medical practice but not a core component of good practice. In social work, empathy is viewed as a professional competency that can be learned and improved upon with practice; without it, one cannot practice ethical social work. I asked Dr. Berry about empathy as medical skill, can it be taught to students? He responds that it is difficult to teach empathy, “Some students who rotate with me, they just have it. I can tell right away, but others do not appear as empathetic. The only way to really judge a student’s empathy is through real, live interaction with a patient.” He agrees empathy should be attended to. Students’ attention should be drawn to their responses and evaluated for effectiveness to determine whether another approach, be it a gesture or verbalization, could have more impact on the patient.

Dr. Berry runs through activities of an average day at the medical school beginning with a morning huddle where students discuss the day’s patient caseload “with a team composed of a nurse, a clinical therapist lead, one or two therapists, a case manager, and one or two residents.” The team gathers and shares information about patients, and then medical students interview patients, return to the group and share information gleaned from the interview. The resident

makes treatment decisions and a team visit with the patient. After the early morning huddle, the team “rounds” with the patients and “huddles up again” to discuss impressions and give feedback after which more treatment decisions are made. In the afternoon, he visits the COAT clinic that houses the MAT program, and then attends to teaching and administrative responsibilities.

I concluded the interview by asking Dr. Berry to describe the most fulfilling aspect of his work, to which he replied, “advocating for people who are suffering due to stigma is highly motivating for me, and it is something I’m passionate about.” He then told the story of Dr. Ignaz Semmelweis, an obstetrician from Hungary who in 1846 solved the mystery of why the rate of mothers dying in childbirth was so much higher in the doctors’ clinic versus the midwives’ clinic. Through an evaluation of practices in the two clinics, Semmelweis found that the midwives regularly washed their hands using a chlorine solution (Davis, 2015). As it were, Dr. Semmelweis traveled the European continent to spread the word of handwashing as a method for reducing infection, but doctors rejected his findings because “they didn’t want to change what they had already perceived to be their medicine,” and the doctors interpreted Semmelweis’ theory as blaming doctors for spreading infection.

Dr. Berry draws a parallel between the story of Dr. Semmelweis and the story of MAT noting that

We’ve got this tool, without a doubt, all the evidence demonstrates increased rates of survival and quality of life. I see it on a daily basis. It affects me because I feel called to make this message part of my professional mission, and so when I get discouraged or feel like giving up, I realize it’s not an option; otherwise people are just going to suffer and suffer more.

DR. KELLY CUMMINGS

I met with Dr. Cummings in her office at Marshall Health's Obstetrics & Gynecology Specialty Care Unit where she specializes in maternal-fetal medicine and high-risk pregnancy. Dr. Cummings' patient population comprises pregnant women, many of whom receive medication-assisted treatment to treat opioid addiction and reduce the risk of harm to mother and baby. My assumption going into the interview was that treating mothers with substance use disorders must be a complicated affair fraught with stress and anxiety but during our meeting, Dr. Cummings showed no signs of tension or worry. Instead she appeared energetic and youthful, with her hair pinned back in a loose pony tail. She took a sip from her bottle of water before plunking into her chair and inviting me to have a seat. Her casual demeanor put me at ease and certainly countered my presuppositions about what to expect from physicians who treat pregnant women with substance use disorders.

Dr. Cummings says she always wanted to be a doctor, but it was not until her third year of medical school, after she gave birth to her first child, that she decided to become an OB/GYN. Her interest in maternal-fetal medicine (MFM) developed during residency while doing a fellowship in MFM in Arkansas and through exposure to the obstetric population while in residency at Marshall University's School of Medicine. Curious about the barriers to providing MAT to the obstetric population, I asked Dr. Cummings if she experienced obstacles to MAT certification. She responded that residents in OB/GYN at Marshall University all take the training required to get certified but following through on the paperwork is optional. She and her colleague Dr. Chaffin are the only two certified MAT providers at Marshall Obstetrics.

Dr. Cummings credits her partner Dr. Chaffin for mentoring her into the practice of MAT at a time during her residency when the opioid epidemic in West Virginia catalyzed the

development of Cabell Huntington Hospital's MAT clinic where methadone was the primary medication administered to pregnant women. The drug epidemic was the jumpstart for the MAT obstetrics program at Cabell Huntington Hospital, where Dr. Cummings' initiation to MAT began, but during her fellowship experience in Arkansas working with a psychiatry team that had a special interest in maternal addiction and pregnancy Dr. Cummings developed a distinctive level of comfort with the practice of prescribing MAT. She states it is rare to find residents who have a fellowship experience prescribing buprenorphine, but her exposure prepared her to meet the immediate needs of pregnant women in Cabell and surrounding counties and distinguishes her as the only female in the state who specializes in high-risk pregnancies.

When asked about the strengths she brings to her specialty care practice, Dr. Cummings says, "being a female because I couldn't imagine being an obstetric doctor and trying to relate to, trying to discuss issues you've never felt before." I was curious as to whether being a female and a mother had ever created a barrier to rapport with clients given that most of her patients, prior to accepting MAT services, continued drug use despite being pregnant. I wondered if she ever struggled to connect with a patient based on her own motherhood experience and societal expectations for mothers' behaviors and the mother-child connection. Dr. Cummings responded, "I've been blessed with some great bedside manner, so I think that's helped. I always sit down with all my patients and just talk to them. I'm nice to them. I treat people how I want to be treated." She emphasizes the importance of developing the relationship with her patients because "they're not going to tell you everything at the first visit." In her experience working with women with substance use disorders, she has learned "A lot of these women don't trust other people. They've been hurt by a lot of people."

Apart from her empathetic, non-judgmental approach Dr. Cummings explains she is unencumbered by the moralism often associated with treating addiction where care providers experience conflict over the question of whether addiction is a choice. The question of choice creates a dilemma for providers because if providers act on the presumption that addiction is a choice they may be less inclined to believe patients with substance use disorders deserve medical treatment for conditions arising from poor choices. For Dr. Cummings, the question of choice appears irrelevant because she views addiction as a disease and states, “As doctor you help patients overcome disease. That’s what you’re taught, diagnose and treat the problem.” I asked her if doctors are ethically bound to treat disease, and she responded, “Yeah. That’s how I look at it. I have no problem prescribing women medication to treat disease.” She adds, “No one wakes up in the morning and says, ‘I’m going to use for the hell of it.’ These women use because they are fighting withdrawal.”

Patient education is an important component of treating patients with prescription interventions. Dr. Cummings says she educates her patients on the pros and cons of medication-assisted therapy and admits that she cannot guarantee specific outcomes for mothers or babies. She advises mothers that their babies may go through withdrawal from the substance and may be subject to long-term risks, many not well-known that could potentially involve neural developmental disorders such as Attention Deficit Hyperactivity Disorder (ADHD). According to Dr. Cummings, what is known is that stability and treatment involving one drug administered with medical oversight is preferable over the use of varying illicit drugs during pregnancy for the growth and development of the baby. Dr. Cummings’ experience as a physician, seeing the harm patients endure from prolonged use of illicit street drugs clarifies for her the question of whether and how to treat pregnant women with substance use disorders. She asks, “Do we want them to

continue to use off the street or be in a program?” because women who do not receive pre-natal care and addiction treatment “have unknown infective endocarditis and vegetative lesions on their hearts. They are more likely to deliver early and have growth-restricted babies.”

Women in the maternal addiction services program receive the medical treatment they need along with ancillary services that support their mental and behavioral health. Dr. Cummings notes, “These women don’t have a good support system. Usually they don’t have parents. They have no parental skills and don’t know how to be parents.” Child Protective Services (CPS) opens a case on all the mothers coming through Dr. Cummings’ program and while the outcomes of CPS are never certain, Dr. Cummings has observed that for her patients, “Their goal is always to get better for their baby, to keep their baby and not have it taken away.”

After giving birth, the moms continue to receive addiction services for 6 weeks under Dr. Cummings’ supervision. During this time, the babies go to the Neonatal Therapy Unit where they are observed for 5-7 days for withdrawal symptoms and prescribed medication, most often buprenorphine. For the moms, Dr. Cummings states their challenge is to stay committed to recovery during a very stressful time, so they continue to attend individual and group counseling and sometimes wean down from their dose, “but we don’t really push it because it’s not the ideal time. They need to get their mental disorders and social lives straightened out.”

After 6 weeks in the program, the mothers are referred to outpatient treatment services. Some of the moms are referred to a treatment program through Cabell Huntington Hospital, but the availability of services depends upon location. For women returning to rural counties, access to MAT, counseling, and psychiatry services is likely to be scarce so mental and behavioral health needs go untreated. And sadly, Dr. Cummings points out when they leave her program, “Many of these women have no place to go because they’ve burned all their bridges.” Their

babies may have to remain in the NTU and these post-partum women now face an onslaught of acute stressors that will challenge their recovery, and some will relapse under the pressure. Dr. Cummings affirms that relapse is part of recovery but finding another stable program after relapse is a big challenge. Once the women are discharged from maternal addiction services Dr. Cummings reports “I feel like we lose them,” meaning currently there is no mechanism in place to stay connected to patients and continue offering support.

Dr. Cummings employs an approach to her pregnant and post-partum patients with substance use disorder that is both empathetic and pragmatic. Because she is a woman and a mother, Dr. Cummings understands the physical and emotional changes that occur during pregnancy, making it such a special and unique period in a woman’s life-span. Even under the best conditions, a normal pregnancy without risk--where the woman enjoys family support, financial stability, and access to social safety nets--pregnancy and post-delivery are often stressful periods of adjustment to the new role of parent and care-giver to another person.

Most of the women on Dr. Cummings’ caseload do not have the benefit of best-case-scenarios and instead contend with a history of untreated trauma and a co-occurring mental health and substance use disorder. They may have health problems and experience severe dependence from prolonged drug use that has continued through pregnancy, placing the baby at risk for physical dependence and unknown developmental complications. A lack of internal resources in the form of healthy coping mechanisms to manage stress and external resources such as family and social support means these women are in the difficult position of having to change deeply habituated responses to stress during one of life’s most trying periods, and they often do so without much support.

Given all the realities her patients must negotiate, Dr. Cummings does not have the luxury of poring over the moralistic arguments against or in favor of medication-assisted treatment for pregnant women. Instead, she takes a pragmatic stance stating, “Because addiction is so prevalent here, and has been for a while, we have to take action. Our pregnancy population, it’s here and we have to deal with it. We have babies being born addicted. We have to respond.” I asked if her views on administering medication-assisted treatment have changed over the years, and she responded saying, “I was raised on prescribing MAT.” She contextualizes the statement by explaining the drug epidemic in West Virginia surged during her residency placing demand on physicians to respond medically to the addiction crisis, so early on in her medical career she was introduced to the practice of MAT and sees the intervention as a practical response. Unlike other physicians interviewed in the study, Dr. Cummings denies that she has experienced stigma associated with prescribing stating, “I haven’t received any negative feedback. In fact, most people want me to see their patients,” indicating physicians are referring their patients to Dr. Cummings for MAT.

Dr. Cummings may not experience stigma but her work with pregnant women exposes her to the unfortunate circumstances her patients and their babies endure, particularly those women who are pregnant, using multiple drugs, and not ready for help. She states, “With training and experience you get used to handling bad situations and outcomes. You just hope that the next one you see gets a good outcome. Just take it on a case-by-case basis.” Luckily, her training in residency made her aware of the need for self-care, so she has developed a strong support system of people to talk to when she feels affected by situations she encounters at work. As difficult as it may be to see her patients struggle, Dr. Cummings is confident that she is part

of the solution to the drug-epidemic and smiles assuredly when she states, “It’s rewarding to see women get help and have a healthy relationship and good outcome with their child.”

CHAPTER FIVE: ANALYSIS AND INTERPRETATION OF EMERGENT THEMES

From the interviews with physicians emerged a series of patterns representing similar experiences and interpretation of those experiences shared by doctors who treat patients with addiction and co-occurring mental health and physical health problems. The experiences of doctors interviewed for this study are supported by the literature on barriers to prescribing MAT and the need for and ways to improve medical school and continuing education curriculum for physicians and other health professionals. In this chapter, themes are organized around answering the research questions, using “in-vivo” language when applicable to interpret the larger meaning physicians link to the practice of prescribing MAT and treating people with substance use disorders.

What are the most significant experiences influencing prescribing doctors’ decisions to provide MAT

EARLY EXPOSURE TO ADDICTION MEDICINE

Though circumstances were different in each example, physicians’ choices to practice addiction medicine in its respective forms and venues arose in response to an identified need either within themselves or within their patient population, agencies, and communities. Dr. Hansen explains that he chose Valley Health because

I felt called to work with a patient population that probably doesn’t get healthcare otherwise because not many private physicians want to see patients with Medicaid or patients without insurance and Valley is uniquely set up to be able to handle that population.

Here Dr. Hansen explains that his intentional choice to enter medical practice geared toward the treatment and care of an underserved population grew from his desire to provide care to people whose healthcare access is limited by their inability to pay for it. Dr. Knapp expresses

similar motivations citing the Hippocratic Oath “if you go back to the Hippocratic Oath ... that's who you're supposed to target. That's who you're supposed to help, the needy who have nobody to fight for them,” and references “the plastic surgeons of the world” who are making money providing an in-demand service but are not necessarily upholding the oath to care for “people that legitimately need medical help who are not getting it.”

After entering practice at Valley Health, Dr. Hansen noticed within himself a need for “immediate gratification” in his practice. He explains he wanted to see conditions improve, so he took his dad’s suggestion and decided to get certified to administer Suboxone.

I was seeing these patients come in in a bad way, desperate, despondent, afraid of what their future was going to bring them and to see them respond to the medication and be able to turn their lives around, achieve some sense of normalcy gave me the gratification I was missing.

For Dr. Marshalek, the opportunity in medical school to witness first-hand the drastic improvements patients underwent after receiving MAT “opened my eyes to addiction treatment.” In Dr. Carl “Rolly” Sullivan, Dr. Marshalek had an experienced mentor, a factor the literature identifies as highly influential in medical students’ choice to enter addiction medicine. Working with Dr. Sullivan “solidified my decision to pursue a residency training program in psychiatry,” says Dr. Marshalek adding, “We’re ahead of things; we’re progressive in terms of the amount of exposure to substance use disorders, addiction, psychiatry, and addiction medicine.” Dr. Berry echoes a similar awakening in his last medical school rotation.

Dr. Christiansen’s interest in addiction medicine developed while he was treating a patient with infected endocarditis. The patient, an IV drug user, had been addicted to heroin for over two decades and despite warnings that he could die from the infection and could potentially

be denied future valve replacements if he continued to use, this patient could not stop using. Dr. Christiansen recalls, “I thought, there’s got to be something different with this guy. He’s not suicidal. He doesn’t want to harm himself. He just can’t stop.” When the patient asked Dr. Christiansen for answers as to why he continued to use heroin knowing it would kill him, Dr. Christiansen admits he could not produce an answer for the patient. But, not having the answer compelled Dr. Christiansen “to do a lot of reading and learning about better options for this patient. Is he just destined to be in this situation, imprisoned by this substance he can’t get away from?”

The upsurge in pregnant women with substance use disorder presents a variation on the theme of an inability to quit substance even while knowing continued use will endanger patients’ health or the health and well-being of their children. With the highest rate of babies born with Neonatal Abstinence Syndrome (NAS) in the nation, physicians and residents at Cabell Huntington Hospital had no choice but to respond to the need within the community by providing medical intervention for substance use disorder to pregnant women and their babies and training in the practice of prescribing MAT to their residents. Dr. Cummings states that she was “raised on prescribing” because the demand for medical interventions to reduce the risk of harm to pregnant women and their babies was so great during her residency, learning MAT was a natural and logical component of her training.

What barriers, if any, must doctors overcome to become a MAT prescribing physician?

The logistics of setting up an office-based MAT practice and becoming certified to prescribe buprenorphine requires physicians to undergo training through SAMHSA to comply with the DATA 2000 and obtain the DEAX number to prescribe controlled substances. The research indicates these processes are significantly more cumbersome for physicians who

received no exposure to the patient population and no opportunity for education, mentorship, and practice prescribing MAT in medical school or residency training (Olivia et al., 2011; Stöver, 2011). Physicians' attitudes toward the practice of prescribing, addiction, and the patients who suffer addiction may present as barriers to prescribing if medical residents are not trained to understand the biological, psychological, social, economic, and spiritual contexts in which addiction manifests (Friedmann et al., 2001).

DATA WAIVER/DEAX NUMBER/REGULATIONS

Because obtaining the DATA waiver and DEAX number was identified in the literature as a significant barrier to MAT, I asked the physicians in this study if they encountered difficulty with the process of becoming certified to administer office-based MAT. All the physicians, except Dr. Knapp, entered the practice of MAT through a pre-existing infrastructure that familiarized them with addiction medicine and MAT in residency and none reported the process of obtaining waiver and certification as daunting or as an obstacle to providing care for those who are already familiar with the process. Without exposure to requirements early in one's residency, a physician may be less inclined to administer MAT due to the extra time, paperwork, and money involved in becoming certified. Dr. Cummings states that she took the DATA waiver training in residency after becoming familiar with the concept of addiction medicine through her residency and fellowship experiences. She reports that by the time she took the training, "I already knew prescribing," thus minimizing impediments to becoming certified.

Even with exposure to addiction in residency, the process of achieving certification may be viewed as inconvenient or not worth the time. Dr Christiansen states,

The DATA waiver is a small barrier. It takes maybe 10 hours to complete the training.

They tell you it's 8, but it's 10. That's a barrier. It costs money, and it requires you to sit down and take a Saturday to do it, but it's relatively simple information."

Once a physician has received the training, Dr. Christiansen points out the regulatory guidelines establishing office-based MAT mount other challenges to greater access to MAT for example,

You have to have an office manager with experience in behavioral health disorders and treatment; you've got to have staff training; you get audited; it's this whole burdensome thing. When I started out, I wanted to treat the few patients with OUD with buprenorphine because it is one of the more effective treatments, and I couldn't because of those rules.

Hugh and Dunn (2017) found low reimbursement rates from Medicaid and private insurance for MAT and counseling services may deter physicians' interest in becoming certified to offer MAT services. Dr. Marshalek explains payor sources i.e., private insurance companies and Medicaid providers often do not understand "what the treatment [for substance use disorder] looks like and what they should pay for." To circumvent the burden of regulation and low reimbursement rates, some physicians have opted to open cash-only clinics as a way of meeting the high demand for MAT services in WV. Without government oversight to set and enforce policies, patients may become vulnerable to exploitative practices such as overpricing for office visits and medication without access to supportive counseling and group therapy—and without accountability measures for patients like frequent drug screenings. The presence of these clinics leads Dr. Hansen to observe "There are no barriers to prescribing. It's super easy. Too easy probably." He adds,

Because it is so easy to get certified and start a practice, it has created an environment where individuals with less than stellar motives started opening up practices and are taking advantage of the patient population to make large sums of money.

Dr. Christiansen proposes, “Demand is high for the service, so you can see a lot of patients. Medicaid reimbursement is adequate.”

STIGMATIZED PATIENTS

Substance use disorder is a condition associated with moral weakness. The connection between addiction and moral weakness is made clear in Narcotics Anonymous program literature urging people who are addicted to ask God to fix the “character defects” manifesting in their lives through bad choices (Narcotics Anonymous, 1992). Research shows that healthcare providers tacitly comply with social and cultural stereotypes that categorize people with addiction disorders as criminal, needy, difficult, and complicated by declining to see patients with SUD or offer addiction services (ASAM, 2013; Friedman et al., 2001; Provenzano, 2018).

The physicians interviewed for this study are aware of the social implications of their patients’ addiction; often patients have committed crimes or hurt others in pursuit of drugs. Some patients have lost custody of their children and go years without contacting their families. Many have burned bridges with parents, employers, and members of their community. Awareness of and a willingness to admit and confront biases about this population are important duties to be undertaken as a basic function of treating someone with SUD. Dr. Christiansen describes the biases he has encountered,

The concept among physicians is that this is a population that is very hard to treat and would just ruin your day on top of all the other stressors you’re dealing with. Patients are

stigmatized. No one wants to deal with the addicted patient or the person they don't want in their waiting room. They don't want to deal with the patient's problems."

To be effective, physicians who treat patients with SUDS not only have to recognize and confront their personal biases, but they also must admit to experiencing fear and uncertainty about their patients, not a simple undertaking for members of a profession who are expected to care for all their patients and have answers to their patients' problems.

Dr. Hansen describes the fear he experienced before meeting with his first MAT patient stating,

Before seeing that first patient after getting my waiver I'm thinking 'is she going to pull a gun on me? Is she going to pull a knife? Is she going to pickpocket me and steal my wallet?' I had this preconceived idea that this person is practically a murderer, but 40 minutes into the conversation, I began to see her as a mother, as somebody's daughter, as a person.

In this example, Dr. Hansen reveals his own vulnerability and demonstrates he was able to overcome it by spending time with this patient and hearing her story. Dr. Christiansen makes the point that patients often stigmatize themselves. He states, "They feel incredibly guilty about their drug use. They tell themselves stories just like we all do." Given the prevalence of stigma about addiction, patients experience vulnerability about accessing treatment which may prevent them attempting recovery through the healthcare system. Dr. Berry suggests that patients endure stigma throughout their recovery, after they have worked up the courage to seek help and endure the struggle of changing habits and confronting past behaviors. He states, "Even when patients get better, people will sometimes have the attitude 'wait, you're cheating by using this medication.' They would never say that to a person with diabetes."

STIGMATIZED DOCTORS

Nowhere in the literature on treating patients with SUD did I encounter information about the stigma doctors face for offering medication-assisted treatment to their patients. The interviews with these physician collaborators revealed that all the doctors were secure in their decisions to provide MAT, citing the studies that demonstrate the method's efficacy, but some physicians note a lack of education among the public and other physicians and healthcare providers that perpetuate stigma toward patients receiving the treatment and prescribing physicians.

Dr. Hansen denies he has ever directly experienced stigma for prescribing and asserts much of the stigma doctors encounter originates from the "pill mill" pain clinic schematic associated with the onset of the opioid epidemic where treatment for pain and discomfort was reduced to paying for a prescription opioid, which turned out to be highly profitable for many physicians and drug companies. Dr. Christiansen also denies that he has ever directly experienced stigma but states, "People who are against MAT think I'm the addict's drug dealer. I'm just giving them something that they're addicted to now. People say, 'you're just giving them another drug. You're just another pill mill.'"

Other physicians I interviewed provided concrete examples of stigma they have experienced from the public and their colleagues. Dr. Knapp recalls the refrain he has become accustomed to hearing when people learn he prescribes MAT, "Oh my gosh, I can't believe you do that. You're just giving a pill, a drug for a drug." He responds to these statements by pointing out the lack of education on the part of the individuals, "I say to that, 'you're telling me heroin is the same as Suboxone?' If they say it is, they do not know how Suboxone works." When Dr. Knapp first started prescribing MAT, he did so for a year through a Suboxone clinic at

Boone Memorial Hospital until one evening “At a hospital board meeting, a Madison City Council member, state trooper, and the prosecuting attorney showed up and said ‘If you don’t shut down that Suboxone clinic, we’re going to sue the hospital for housing a clinic inside city limits.’” He reports the hospital chose to shut down the clinic, but soon after Dr. Knapp partnered with a licensed professional counselor experienced with MAT and together they opened their own clinic because the need in Boone County was so great.

Much of the stigma doctors encounter could be alleviated by public education about addiction and MAT. All the physicians interviewed acknowledge the need to raise public awareness and several engage the community through educational forums like panels, workshops, and other platforms. Dr. Berry has a solid reputation for his work educating community members and members of the legislature on addiction and MAT. Regarding stigma, he describes his experiences,

In the community, I have experienced stigma, especially at community, public events where I’m standing up telling people this is a treatment of choice for folks struggling with addiction. I’ve been called names and asked [in an accusatory tone] ‘how can you use Suboxone to treat someone who already has an opioid addiction?’

In response to the comments he hears Dr. Berry admits, “I used to get angry, and still do, but it’s mostly frustration now.”

Dr. Christiansen states he has not felt stigmatized and explains, “I’m confident that what I’m doing is the right thing. Amongst physicians, I think most people are of the ‘better you than me’ philosophy because no one wants to deal with the addicted patient.” Dr. Marshalek shares that he has also felt stigma, but he takes the view that “If you’re poised to look for people to insult you or look down on you, then you’re missing opportunities to educate and correct,” and

adds that he understands how people, even physicians, can get the wrong idea about MAT. He states,

If physicians haven't been educated or trained about these abuse disorders, I can see how they could perceive what we're doing as a cash grab, pat on the back, here's a pill, and not really see the good things that stem from MAT.

How do physicians overcome those barriers?

MENTORSHIP AND ORGANIZATIONAL SUPPORT

Most physicians in this study report having received guidance from an experienced mentor during medical school or in residency. Experienced mentors in the fields of addiction medicine, addiction psychiatry, or behavioral health facilitated their familiarity with addiction through curriculum and access to patients struggling with addiction. Both Dr. Berry and Dr. Marshalek state the mentorship they received from Dr. Sullivan at WVU's Department of Behavioral Medicine and Psychiatry came with opportunities to practice screening, assessing, building rapport with patients and prescribing MAT under the supervision. The two physicians credit Dr. Sullivan with being an early proponent of MAT and breaking down the logistical and organizational barriers that the literature suggests preclude participation in MAT.

Dr. Hansen and Dr. Christiansen offer office-based MAT services in an integrated care setting designed to service people on Medicaid, so the practice is staffed with administrative and support personnel whose role is to ensure organizational compliance with Medicaid allowing the physicians to see an underserved population and maintain compliance with state regulations. Although Dr. Knapp did not receive exposure to addiction medicine as a resident or support for prescribing Suboxone from his employer and the community, he was able to partner with a behavioral health professional who shared his knowledge of addiction from a behavioral health

perspective and together they were able to build a practice that treats addiction in a very high need area. Dr. Cummings cites Dr. Chaffin's influence and expertise and her exposure to addiction medicine throughout residency as primary factors in becoming the only female high-risk pregnancy specialist in WV treating pregnant women with MAT.

DOCTORS' STRENGTHS

Using the strengths perspective as a theoretical framework for contextualizing the experiences physicians shared in the interviews enabled me to identify the attitudes, behaviors, and approaches that help physicians overcome obstacles like stigma and build therapeutic relationships with their patients. Dr. Dennis Saleebey (2001) promoted the strengths perspective as a lens through which to view potential, not just pathology, though it is important not to ignore pathology or gloss over it with superficial positivity. The idea behind the strengths perspective is to see problems as they are rather than avoid them and then recognize each individuals' potential to use available resources to prevail over pathology. Consistently, I heard from these physicians a willingness to *see* their patients, not just look at them, not just interact with them or treat them but to be witness to the patient's struggle with addiction by asking questions, taking time to listen, and accepting their patients' complexities and failures all while affirming patients' potential to get better and improve their lives.

Okay with Not Knowing

Physicians are trained experts, and as trained experts, their patients expect them to have the answers to all their questions and to know for certain the approach to remedy ailments. Physicians feel the weight of these expectations, especially when they do not know the answers. The physicians in this study gave numerous examples of situations where they did not know the answer and provided insight on how they handled not knowing. Working with patients who are

addicted, physicians should expect to encounter questions they do not know how to answer, as was the case for Dr. Christiansen when his patient asked “why can’t I stop using?” Dr. Christiansen says, “In medicine, it’s hard when you don’t have answers for people, but it stimulates personal growth.” Admitting mistakes and being comfortable with uncertainty are characteristics common to the physicians in the study. Dr. Zach Hansen states, “I have a willingness to be wrong. I’ve made mistakes as the program has grown, but we modified and changed and found better ways,” and Dr. Marshalek affirms, “I’m comfortable with uncertainty. Psychiatry is not a black and white world. It’s a lot of grey, very subjective.”

Unfortunately, under the pressure of having to know, physicians may be tempted to dismiss patients’ concerns outright rather than admit uncertainty as Dr. Christiansen points out, keeping in mind the context here is with patients who have substance use disorder, “Physicians in particular, if they don’t have an answer they put up a wall and say ‘Well, you’re just lying.’” But he also notes that “the concept of humility, being curious and able to say ‘I’m not 100% sure. Can you tell me more about what that’s like for you? How does this diagnosis affect your life? What does it mean for you?’” Critical to piecing together a workable recovery, Dr. Berry suggests, “Physicians have to ask patients to describe their version of what it means to be healthy. Ask them: Have you ever had periods of sobriety? What did you like about that life? What was going well for you?” The information gleaned from asking questions like these cannot be known by the physician through his or her training because the answers are unique to each patient.

Dr. Knapp readily admits that when he began prescribing he was “learning on the fly” and when patients who had been through other programs came in to his office, “I’d pepper them with questions: ‘Hey, what did they do over there? How did they test you? How often would

you come back? How much did they write for?’” and like that, his patients became almost equal partners in the practice. The patients possessed information Dr. Knapp needed so rather than pretend he had all the answers, he asked them about their experiences and found “They love telling about themselves and where they’ve been. They’re getting something out of it. We’re engaging from both sides.”

Meet Patients Where They Are

Engagement with patients amounts to more than friendly interaction during an office visit. Dr. Marshalek sums up the basic skill of patient engagement with the phrase, “meet patients where they are,” and doing so requires that “Doctors show patients that you really care because the stigma. Patients often have yet to encounter someone who actually cares and is willing to help them.” Doctors show they care through a willingness to individualize care, meaning “when patients break program rules or present with a positive drug screen the automatic response to those infractions should not be to kick them out of the program.” Dr. Marshalek continues, “Sometimes you have to tweak the rules to individualize the treatment for patients.” Dr. Christiansen agrees that rather than “firing” patients for breaking rules, the doctor is responsible for discussing the problem with the patient and working toward supportive intervention rather than undermining recovery with punitive measures.

Dr. Hansen explains that “kicking patients out of a program that’s keeping them from using heroin, injecting, exposing themselves to HIV or Hepatitis because they’ve smoked marijuana goes against the way my brain works, my logic, and my training.” Individualizing the treatment means doctors take time to understand that “each patient has unique issues to work through: custody issues, pain issues, pregnancy, comorbidity/psychiatry, and relationship issues. It’s never clear cut.” Further demonstrating the importance of meeting patients where they are

and complementing the notion that patients' circumstances vary is Dr. Berry's observation that patients also possess unique motivations, internal and external. Identifying motivational factors requires "learning how to be with people in a way that elicits and invokes their inner motivation," adding, "this is true not only for addiction treatment, but any treatment."

For Dr. Knapp engagement means "being able to read people." Knowing who your patients are, their personalities, and their preferences comes through astute observation and a desire to learn about the patient. Dr. Knapp provides an example, "There are some patients you can joke with and some you can't. Notice the way they walk, the way they sit and talk. Do they have tats? You learn quickly to pick up on little cues." Taking time to notice small but significant details and engaging patients with open-ended questions may seem like a luxury to busy doctors with stacked waiting rooms. Dr. Knapp can relate to the pressure of a full waiting room but implies that pressure pales in comparison to the high stakes for patients with substance use disorder cautioning, "You may have 20 patients to see, but for that one person in your office, this might be their life and death visit," a powerfully stated reality that begs doctors' attention and connection to patients. Over the span of his practice Dr. Knapp says he has learned to

honor patients' honesty and their story. Keep the conversation casual. What brought you here? What did you do in the past? What led you to addiction? We're not trying to grill you or bust you. I want to hear your story. Give them a chance to tell it.

Dr. Christiansen also advocates for observing clients and "reading between the lines" because sometimes patients do not volunteer information, or they are vague about their reasons for the visit; for example, patients may say things like "Hey this doctor told me to come and talk to you." Dr. Christiansen responds by asking, "What do you want to talk about?" while showing interest, easing the patient into the conversation and making sure he or she understands that "If

you're asking for help, it's really my privilege to be able to help you. It's not a burden on me.”

As Dr. Knapp says, “there's an art to patient interaction, and some people are better at it than others. You learn as you go and you get better at it.”

But, Dr. Marshalek points out sometimes physicians' approach to patients can be off-putting and undermine trust so he advises

Patients are quick to smell BS. They'll know if somebody is BSing them. They'll know who they can BS. I think it's part of meeting some of those folks where they are and speaking a language they can speak as well and not trying to come at folks from a high and mighty standpoint. That stuffy white coat thing, looking down your nose. That might be part of it.

Get Some Wins

Despite research demonstrating MAT's effectiveness, studies examining barriers to physicians' acceptance of MAT indicate a lack of confidence in the efficacy of MAT among physicians (Hugh and Dunn, 2017; Friedmann et al., 2001). Dr. Marshalek concedes that “MAT is not a silver bullet. Like a really nasty widespread form of cancer, you can throw chemo, radiation, and surgery at it, but it can still take people down. That's what abuse disorders can do.” Treating substance use disorders is a highly individualized practice with no guarantee of success, but the physician collaborators in this study expressed feeling fulfilment through seeing their patients' lives improve in measurable and profound ways. Bearing witness to the dramatic changes patients experience in recovery occurs consistently, validating the treatment method and the hope that people get better. Knowing patients get better keeps doctors focused on the strengths paradigm, which builds resilience and the ability to rebound after inevitable disappointments, frustrations, and patient relapses.

What changes do doctors observe to help them measure patients' outcomes and build their own professional resilience? As Dr. Marshalek puts it "The direct advantage that I enjoy so much is watching folks who have been so negatively affected get their life together, get some wins associated with remaining sober." The "wins" come in many forms and for patients and doctors alike the small wins eventually become big wins. Dr. Berry points out the most obvious win is patients' survival. Patient survival is a primary measure of an intervention's efficacy and a boost for doctors who see patients in poor health, at risk of premature death from years of struggling with addiction. Dr. Hansen finds gratification from seeing patients discover a sense of normalcy in their lives. He states

These patients come in a bad way, desperate, despondent, afraid of their own futures.

They come in and their memory isn't good, and they can't express themselves, but if we do it right, you can see a definite difference in patients between Week 1 and Week 4.

You start to see the lights come back on. It's really neat when kids come in with their parents and say, 'Mommy's so much better.' Kids notice the difference. That's a great reward.

Working with pregnant women, the stakes may seem higher for Dr. Cummings in terms of patient relapses and missteps in the program, but she keeps her attention on helping patients achieve small goals like stability and passing drug screens. She says those are her "number one priority" because once a patient is consistently stable and not failing drug screens, "you begin to see them rekindle their relationship after all that's been broken in the process of using." Mended relationships lead to greater levels of stability and "you see them get back into stable housing away from people who are using, and then they find jobs, and become active members of society again." Dr. Berry explains that changes in the patient translate to changes among family and

community members in terms of how they perceive MAT. Dr. Berry has observed that “Once they see good treatment, community and family members come around; this restores my faith in people’s ability to change.” Dr. Marshalek measures success in terms of patients’ behaviors, for example,

They get their driver’s license back. They get jobs. They’re working and going on vacation. People return from vacation and say ‘I went on vacation and actually remember what happened!’ People start to enjoy things other than using. It’s exciting because they are recovering.

Dr. Cumming articulates the difference in measuring successes with this population versus other patients with chronic disease. The difference with substance use disorder is “success is not defined by the numbers as with hypertension, kidney function, diabetes, hemoglobin. In these situations, you measure improvements by looking at numbers.” To further exemplify how powerful and affirming patients’ transformations can be for patients and doctors, Dr. Cummings offers a case example involving a woman who was homeless, pregnant, and addicted to opioids.

Dr. Cummings recalls

This patient was homeless, on the streets, and diverting her drugs. She was very ill at the beginning of her pregnancy. She was intubated in the ICU. At the end of treatment, she was stable on her dose, found a place to live and was trying to improve herself for her baby. You see that, and it makes you want to keep going, to help other women.

At Dr. Knapp’s clinic patients’ successes are shared and celebrated on the “Success Wall” where patients display the artifacts from their daily lives as evidence of their recovery and achievement of goals they once believed to be unattainable. As an example, Dr. Knapp says one

of his patients recently displayed notification that she made the Dean's List. Dr. Knapp shares the meaning he makes of his patients' recovery

You're not just treating disease; You're treating their whole life. You're treating them medically, but you also get to watch their social development. They were physically, mentally, financially incapable of doing it, but by giving access to MAT and ancillary services, life opened up for them. It's awesome to watch.

Understanding Disease: The Diabetes Metaphor

Nadelmann (1998) and Murphy (2015) argue that Americans prefer criminal justice responses to illegal drug use and addiction and the assertion is well-supported by persistent increases in numbers of people incarcerated for drug use, possession, and illegal, non-violent activity associated with drug use. For over 100 years, since drugs became illegal in the United States, lawmakers and citizens alike have wrestled with the moral, legal, and medical implications of prohibition, opting repeatedly to contextualize addiction as a moral failing requiring abstinence and punishment rather than choosing evidence-based, harm-reduction strategies. The pragmatist framework with its orientation toward what works guides thinking and action toward answering the very question what works?

The body of literature supporting MAT as a medical intervention to mitigate addiction withdrawal and related behavioral symptoms is extensive and physicians in this study have demonstrated their commitment to intervene from a medical perspective using strategies backed by empirical evidence, even if the strategy diverts from traditional, moralistic approaches involving the criminal justice system and abstinence-only programs. Rather than look at addiction as a moral failing and a choice one makes because of a character defect, these physicians apply their medical training to addiction, treating it as a chronic illness rather than a

bad choice. As Dr. Berry put it “understanding the disease component of addiction helps to approach patients in a non-judgmental, clinical manner.” The physicians acknowledge choices and behaviors factor into disease and compare the behaviors of people living with other chronic diseases, like diabetes, to highlight the ways behavior undermines or enhances health outcomes. Dr. Christiansen sees “the behavioral component as a symptom of the disease, which is true for diabetics, too.”

Dr. Christiansen explains what he describes as a “familiar equation” that shapes people’s view of addiction and asserts

Since the history of prohibition and drug treatment we have framed it as an idea of a moral failure. You’re not a strong person. You brought this on yourself. I don’t use heroin, so I don’t know why you do. You decided to go out and have fun one day, and now you’re addicted.

This line of thinking is important to identify and evaluate because from Dr. Christiansen’s perspective “everything depends on it.” He elaborates by explaining that when a society decides to approach addiction from a moralistic perspective treatment options and legal options are modeled to reward or punish good and bad behaviors. He adds

If we decide these are just bad people, then we lock them up. If we say maybe we need to determine their underlying stressors and figure out how to stabilize them so that they’re not existing in chaos, we start to look at elements that are outside of their control.

To dispel the conception of addiction as a moral failure doctors compare addiction to diabetes as both conditions improve or are worsened by choices and behaviors. Dr. Marshalek posits that with Type II diabetes “Patients started on a path with some decisions, right?” He

further elaborates on the role of behavior in chronic disease and the double-standards that exist in healthcare when a moralistic view is applied to certain conditions.

Behavior can be part of addiction, and a large part of other ones. How many times do we do stents on people that smoke two packs a day, eat a horrible diet, haven't managed their hypertension? No one says, 'don't put another stint in that person.' We continue to lop people's limbs off after diabetes runs rampant.

From a pragmatic perspective, treating addiction as a disease with medical intervention answers the question what works in drug treatment, particularly because addiction is often accompanied by co-morbidities like mental health diagnoses, environmental factors, and histories of trauma. Dr. Hansen states "We have a lot of patients with underlying co-morbidities that make it unlikely they're going to be able to maintain long-term sobriety without some form of medication-assistance" because the addiction behaviors are used as a method of coping to deal with symptoms from other conditions, like mental health and traumatic experiences. But, Dr. Hansen adds, "If I discharged diabetic patients for not taking their medicine or changing their diet, or not exercising, people would be very judgmental of me. Their attitude would be 'That's not fair. It's a disease.'"

Dr. Cummings takes a similar stance with her pregnant patients. She explains that she was trained to view addiction as a disease comparable to diabetes. "My boss always says, 'Diabetes is a disease. They're addicted to sugar.' The same is true for drug addiction. My patients have a disease, and my job is to treat the disease and help them get better."

These physicians understand and accept patients' behaviors are part of their condition and should be treated medically rather than punitively. The acceptance frees physicians from the burden of making moral judgements about who does and does not deserve medical intervention

and under what conditions. This is not to imply physicians are not at times frustrated with persistently maladaptive behaviors as Dr. Berry notes, “Doctors get frustrated when people don’t take their recommendations, but usually, those are the sickest of the sick.” And Dr. Knapp wants to know, “Are we supposed to punish the diabetic patient because their disease is affecting them, and they ate that Twinkie?”

How might doctors’ perspectives inform teaching and learning in medical school and continuing education curriculum?

The benefit of applied research on physicians’ experiences treating patients with substance use disorder is that information gleaned from the qualitative method of interviewing can be organized thematically and used to inform stakeholders about what works for a segment of prescribing physicians in West Virginia. As Bogden and Biklen (1992) propose, the importance of applied research is most visible when findings from the research are used to inform change that improves people’s lives. The information obtained through this qualitative study could be useful to physicians to help challenge stigma and moralistic attitudes that prevent some physicians from working with patients with substance use disorders. Findings could also shape medical school curriculum by infusing information on addiction medicine and patient care, that is, building rapport and treating the patient from a biological, psychological, and social perspective rather than sole focus on biology. Presentations and continuing education opportunities for physicians and healthcare providers are other potential uses of the information.

SHADOW PHYSICIANS

Along with the broad suggestions mentioned above, the physicians offered specific insight that presumably would enhance medical education and medical practice. The first and most common suggestion from doctors is to expose students and residents to patients with mental

and behavioral health disorders like substance use disorder throughout their education. Dr. Christiansen suggests medical students and residents should shadow a prescribing physician to better understand the complexity of addiction and how to assess and screen patients, which involves asking difficult questions and being asked difficult questions. He states, “All our residents spend a day in drug court, Recovery Point, an abstinence-based treatment. They spend the day with me at the Neonatal Therapy Unit or Lily’s Place, and they go to Harmony House,” so not only are residents exposed to patients, students become familiar with community resources that address life domains other than biological, but also the psychological, social, environmental, and spiritual.

Challenge Presuppositions and Bias.

Dr. Knapp states, “Visiting and spending time at a Suboxone clinic exposes students to a different side, they see a different demeanor and they get to hear success stories.” Seeing a different side of medicine and hearing success stories help dissolve stigmatizing attitudes about patients. Dr. Berry would agree stating there is a need to “challenge presuppositions and biases” and in his experience, “a two-week rotation on the addiction unit” would be helpful for students. Moreover, supervised exposure to patients assists physicians in their assessment and feedback of students’ performance in this area. Take empathy for example. Dr. Berry states

It’s hard to teach empathy. Some students just have it; some not so much. You need to be able to watch students in real live interaction with patients to be able to assess that and ask students, ‘How do you think patients experienced that comment?’

Dr. Cummings states that students learn experientially by “getting in there and doing it.” Dr. Knapp expressed a similar sentiment, “students need hands on work with patients. We need to encourage them to get in there and do it.” And Dr. Marshalek states, “students who rotate with

us see what acute inpatient psychiatric care, the dual-diagnosis level looks like. They see office-based MAT. It's a first-hand experience.”

Many of the suggestions involve building interpersonal skills, the foundation of the therapeutic relationship with patients. Dr. Knapp recalls a lesson from medical school on developing relationships with patients. He says at the time he thought the information was rudimentary, common sense, but in retrospect, he realizes the difficulty is in applying that information with patients in real time when problems are complex and intractable. Dr. Berry and Dr. Christiansen both advocate for teaching motivational interviewing to students. Motivational interviewing is an evidence-based clinical method to assist people with resolving ambivalence around change and discovering internal motivations (Miller and Moyers, 2006). Dr. Berry says motivational interviewing is used

to be with people in a way that invokes their inner motivations. This is true not only for addiction treatment, but any treatment. I practice motivational interviewing every day as a critical set of techniques for establishing a collaborative approach to treatment.

Motivational Interviewing

Dr. Christiansen sees motivational interviewing as a “way of talking to patients and getting them into treatment.” Getting patients into treatment also involves “educating patients about MAT, making known the services available to them, which may improve patient honesty on screenings if they know they can get help.” On the theme of patient education, Dr. Berry has observed

medical students need to learn not just what medicines do, the physiology and biology, but also how to communicate effectively with people and be able to translate information you've spent years learning in medical school and residency.

The literature on physician barriers to prescribing MAT indicates doctors lack confidence screening patients for addiction issues partly from fear they will not have the answers patients expect. To remedy that issue, Dr. Hansen proposes more opportunities are needed to talk to patients and learn “they don’t expect you to have all the answers.” Dr. Christiansen suggests physicians provide a model for how to handle uncertainty. Motivational Interviewing (MI) is an evidence-based clinical skill often used by mental and behavioral health professions in addiction recovery to assist clients with resolving ambivalence about change (Miller and Moyers, 2006). Rather than dictate behavioral change to patients, MI provides a structure for communicating with patients that is patient-centered, meaning patients’ input, experiences, and perceptions are valued and incorporated into the treatment regimen, which has shown over time to reduce patients’ resistance to change and highlight the internal motivation. Engaging patients in a process of behavior change without power differentials and power struggles is a primary benefit of MI.

Understanding Addiction

Medical school and residency programs provide up and coming physicians with opportunities for understanding patients with substance use disorders, but what opportunities are available for physicians who have been in practice for years? Dr. Marshalek explains “the biggest, most active generation of physicians today may not have received much education about substance use disorder or how to manage pain or the risk of opioids.” Dr. Cummings suggests all physicians need to understand addiction, not just those in addiction medicine, addiction psychiatry, and specialty care and not just opioid addiction, but methamphetamines, alcohol and others.

CONCLUSION

Not all collaborations for this study were with physicians. Before deciding to include information about my family's ordeal with addiction, I asked my brother for consent to incorporate his story as part of my own and asked that he review content for accuracy from his vantage point before I submitted the final document. Even though I was directly affected by his addiction and have my own version of events that unfolded over almost a decade, my brother co-owns the experiences I have written about and interpreted from my perspective. My brother reviewed the section Being Honest about Bias to affirm my version of events meshed with his recollections and were not manipulated or enhanced to serve my academic purpose. Unlike the physicians in the study who consented to be named, he requested I not use his name.

The review process with the physicians unfolded in similar fashion. After completing each section in Ch. 4, I sent them to the respective physicians in an email inviting comments and suggestions. Consultation on Chapters 4 and 5 revisions occurred over the phone or via email. I was unable to coordinate focus groups before the deadline for submission of this manuscript; however, physicians agreed to participate in a focus group to discuss implications of this study and relevance to education and training on addiction medicine for health professionals.

The information gleaned from the interviews with physicians filtered through the conceptual frameworks yields a hopeful prospect that the opioid crisis is catalyzing a shift in patient care that centralizes the doctor-patient relationship, one built on trust and interdependence, as a primary component of improving patient outcomes that is generalizable to practice with every patient regardless of the presenting issue or complaint. The doctors interviewed in this study share the philosophy that addiction is a disease with physical, mental, and behavioral symptoms exacerbated by conditions in people's lives. Conditions like

comorbidity, a history of trauma, a lack of social support, unstable employment, inadequate housing, involvement in the criminal justice or child protective system, a lack of transportation, and a dearth of wellness resources in isolated regions of the state that interlace to form an entanglement of obstacles that patients must surmount seemingly all at once if they are to achieve wellness and recovery.

The prevalence of stigma often delays patients' access to evidence-based medical interventions for years, during which time people lose jobs, commit crimes to support their habit and avoid becoming "dope sick," lose their children to the state, or acquire illness; consequently, they may become deeply enmeshed in social systems intended to alleviate problems but place restrictions upon patients, demand compliance with policies, and deliver consequences that often complicate patients' lives, exacerbate their problems, and undermine recovery efforts. Even the most determined patients risk a lapse in their recovery if, due to unreliable transportation, they miss a job interview or an appointment with a physician or probation officer and the resulting consequence is removal of their children from their custody, incarceration, or expulsion from a recovery program.

Stakes are high for all patients with chronic illness as a worsening of their condition has potential to seriously limit their day to day functioning and may result in death. Unlike people with substance use disorder, sufferers of other chronic illness like diabetes, heart disease, and cancer typically are not subject to discrimination and delayed access to care due to stigma and behaviors associated with their condition—even though doctors acknowledge behaviors exacerbate many common health problems. Dr. Marshalek highlights this bias in medical care citing patients who receive numerous stents though they continue to smoke cigarettes compared to patients with substance use disorder who are kicked out of MAT programs for missing

appointments or for failure to adhere to program rules. The physician collaborators offer their numerous anecdotes demonstrating the obstacles to evidence-based medical intervention people with substance use disorder encounter in their pursuit of recovery and wellness.

There are a number of pedagogical and curricular implications deriving from this study. All of the physicians in the study from primary care to specialty care understand addiction as a complicated amalgam of factors that are different for every patient requiring physicians to spend time learning about the patient. To elicit this information from patients, these physicians apply a biopsychosocial approach to understanding patients' needs within a context. Biopsychosocial knowledge about patients is obtained through on-going assessment of biological, psychological, and social needs and strengths to gather insight about conditions and stressors in patients' environment that affect behavior. The biopsychosocial approach factors patients' behavioral adaptation to the environment into the diagnosis and treatment of chronic disease and recognizes the role of behavior in the improvement or worsening of illness. Recognizing the environment's influence on behavior and the influence of behavior on wellness, particularly as it relates to addiction treatment, enriches physicians' view of the patient as a whole person rather than as a medical condition that either responds or does not respond to treatment.

For physicians trained in the medical model of treating disease without considering environmental factors, building rapport with patients may seem awkward and unnecessary if the goal is simply to cure disease or reduce symptoms by administering medication or performing surgery. But, the physician collaborators in this study demonstrate the relationship with patients is a critical piece of addiction recovery and building the relationship requires physicians to view their patients with unconditional positive regard, a Rogerian concept fundamental to building trusting relationships upon which change is predicated. Revealed throughout the interviews is

the notion that stigma surrounding addiction serves as a barrier to the patient-physician relationship whereas genuine interaction with patients elicits trust and patients share experiences giving physicians the opportunity to see their clients with empathy and as a whole person.

It is recommended early in students' medical training there should be an opportunity for interaction with patients who have substance use disorders to challenge preconceived stereotypes and moralistic attitudes directed toward people who experience addiction. Going one-step further, students early in their medical training should receive content on medication assisted treatments and opportunities to shadow physicians who use MAT in the care of their patients. Continuing education on addiction and biopsychosocial approaches should be offered on a regular basis to practicing physicians in primary and specialty care to present still more opportunity for understanding addiction not as a moral failing but as a chronic condition and to promote evidence-based practice within the medical profession.

The responsibility for the advancement of medical treatment does not fall solely onto the shoulders of physicians and the medical profession. Social workers, as members of a profession with a history of social reform, also bear responsibility. Jane Addams, often referred to as the mother of social work, sought to understand root causes of social problems, often researching and working with professionals across disciplines to improve conditions for immigrants, workers, women, and children in early 19th century Chicago. Addams modeled action-oriented research at all levels of social work practice by investigating multiple causes of social problems and advocating for system-level changes to laws, ordinances, and policies while tending to the needs of individuals entangled in systems, trying to overcome illness, poverty, and oppression (Elshtain, 2002).

Pedagogical and curricular implications of the study for social work involve preparing

social work students to assume the role of behavioral health consultant in primary care settings and addiction recovery, a role not limited to individual patient care, but dedicated to a generalist practice framework that draws upon Jane Addams' model of social reform with the social worker at the center of change efforts (Mann et al., 2016). Social work programs should prepare students to know and assert the social work perspective, serving as a model for building relationships across disciplines, providing people-centered addiction care that honors patients' experiences, strengths, and treats patients with dignity and worth. Furthermore, social workers functioning in the role of behavioral health consultant should possess not only clinical skills but also the ability to advocate for evidence-based practice and improve communication across disciplines. Social work programs must prepare graduates to take leadership roles among other professionals versus a passive stance as members of care teams, deferring to others on matters involving patient care and policy change. Finally, social workers should be aware of the larger issue of system culture and the effect of culture on access to services, the treatment of patients, and patient outcomes; and be prepared with knowledge and skill—should the culture prove harmful or counterproductive to the health and wellness of patients—to lead in the development of a new and improved culture of care.

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APPENDIX A: MARSHALL UNIVERSITY IRB APPROVAL LETTER



Office of Research Integrity
Institutional Review Board
One John Marshall Drive
Huntington, WV 25755

FWA 00002704

IRB1 #00002205
IRB2 #00003206

June 7, 2018

Eric Lassiter, PhD
Graduate Humanities Program, MUGC

RE: IRBNet ID# 1249395-1

At: Marshall University Institutional Review Board #2 (Social/Behavioral)

Dear Dr. Lassiter:

Protocol Title: [1249395-1] Exploring the experiences and perspectives of physicians in WV who prescribe medication-assisted therapy (MAT) to patients with Opioid Use Disorder (OUD)

Expiration Date: June 7, 2019

Site Location: MUGC

Submission Type: New Project APPROVED

Review Type: Expedited Review

In accordance with 45CFR46.110(a)(7), the above study and informed consent were granted Expedited approval today by the Marshall University Institutional Review Board #2 (Social/Behavioral) Chair for the period of 12 months. The approval will expire June 7, 2019. A continuing review request for this study must be submitted no later than 30 days prior to the expiration date.

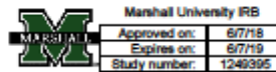
This study is for student Kim White.

If you have any questions, please contact the Marshall University Institutional Review Board #2 (Social/Behavioral) Coordinator Bruce Day, ThD, CIP at 304-696-4303 or day50@marshall.edu. Please include your study title and reference number in all correspondence with this office.

Informed Consent to Participate in a Research Study

Exploring experiences and perspectives of physicians who prescribe medication-assisted treatment (MAT) to patients with Opioid Use Disorder (OUD)

Kimberly White (Ed.D. candidate & Co-Investigator)
Eric Lassiter (Dissertation Chair & Principal Investigator)



Introduction

You are invited to be in a research study. Research studies are designed to gain scientific knowledge that may help other people in the future. You may or may not receive any benefit from being part of the study. Your participation is voluntary. Please take your time to make your decision and ask your research investigator or research staff to explain any words or information that you do not understand.

Why Is This Study Being Done?

The purpose of this study is to understand the experiences and perspectives of physicians who use medication-assisted treatment as an intervention to treat opioid use disorder. The insights gained from this study may be of use in the development of medical school and continuing education curriculum for health professions.

How Many People Will Take Part In The Study?

About six people will take part in this study. A total of 10 subjects are the most that would be able to enter the study.

What Is Involved In This Research Study?

In this study, participants engage in a 60-minute recorded interview to answer questions about the practice of medicine with people who suffer from opioid use disorder. Participants will be asked to share their experiences working with a stigmatized patient population and describe how they overcome barriers to treating these patients using medication-assisted therapies such as Suboxone. Some interview questions will be provided prior to the interview, but other questions will be asked within the context of the interview. By agreeing to be interviewed, you are agreeing to take part in this study.

How Long Will You Be In The Study?

You will be in the study for about 60 minutes.

You can decide to stop participating at any time. If you decide to stop participating in the study we encourage you to talk to the study investigator or study staff as soon as possible.

Subject's Initials _____

The study investigator may stop you from taking part in this study at any time if he/she believes it is in your best interest; if you do not follow the study rules; or if the study is stopped.

What Are The Risks Of The Study?

The only risk may be a breach of confidentiality but we will do our best to protect your identity.

Are There Benefits To Taking Part In The Study?

If you agree to take part in this study, there may or may not be direct benefit to you. We hope the information learned from this study will benefit other people in the future. The benefits of participating in this study may include changes to medical school and health professions curriculum that improve health professionals' understanding of medication-assisted therapy as a treatment option and reduce stigma associated with use of medication-assisted treatment.

What About Confidentiality?

We will do our best to make sure that your personal information is kept confidential. However, we cannot guarantee absolute confidentiality. Federal law says we must keep your study records private. Nevertheless, under unforeseen and rare circumstances, we may be required by law to allow certain agencies to view your records. Those agencies would include the Marshall University IRB, Office of Research Integrity (ORI) and the federal Office of Human Research Protection (OHRP). This is to make sure that we are protecting your rights and your safety. If we publish the information we learn from this study, you will not be identified by name or in any other way.

For this study, you will have the choice to keep your identity confidential, meaning your name will not be included anywhere in the study. This is to protect you from the unforeseen harm or consequences of providing information of a personal and professional nature. Conversely, you are being asked to provide information that could potentially influence changes to the practice of addiction treatment; therefore, you may wish to be acknowledged for those contributions.

The recruitment strategy for this study is through a process known as "snowball sampling" meaning participants in the study provide names and contact information for other potential participants. To protect your confidentiality, I must prepare for a scenario where a physician may want to know who referred me to them. I cannot provide that information without your consent. You do not have to give consent to participate in the study. *(Please initial one of the four choices below)*

I give consent to share my name as a referring physician for the purpose of this study, but I wish not to be identified in the final report.

Subject's initials

I give consent to share my name as a referring physician for the purpose of this study, and I wish to be identified in the final report.

Subject's initials

Subject's Initials _____

I do not give consent to share my name as a referring physician for the purpose of this study, and I wish not to be identified in the final report.

Subject's initials _____

I do not give consent to share my name as a referring physician for the purpose of this study, but I wish to be identified in the final report.

Subject's initials _____

What Are The Costs Of Taking Part In This Study?

There are no costs to you for taking part in this study. All the study costs, including any study tests, supplies and procedures related directly to the study, will be paid for by the study.

Will You Be Paid For Participating?

You will receive no payment or other compensation for taking part in this study.

What Are Your Rights As A Research Study Participant?

Taking part in this study is voluntary. You may choose not to take part or you may leave the study at any time. Refusing to participate or leaving the study will not result in any penalty or loss of benefits to which you are entitled. If you decide to stop participating in the study we encourage you to talk to the investigators or study staff first.

To ensure you are accurately represented in the final report, you will have opportunity to review every section of the document containing information you provided. The report will not be finalized until you verify that the writing reflects the spirit and intention of the answers you provided in the interview.

Whom Do You Call If You Have Questions Or Problems?

For questions about the study or in the event of a research-related injury, contact the study investigator, Dr. Eric Lassiter at (304) 746-1923 or Kimberly White at (304) 696-3743. You should also call the investigator if you have a concern or complaint about the research.

For questions about your rights as a research participant, contact the Marshall University IRB#2 Chairman Dr. Christopher LeGrow or ORI at (304) 696-4303. You may also call this number if:

- o You have concerns or complaints about the research.
- o The research staff cannot be reached.
- o You want to talk to someone other than the research staff.

You will be given a signed and dated copy of this consent form.

Subject's Initials _____

SIGNATURES

You agree to take part in this study and confirm that you are 18 years of age or older. You have had a chance to ask questions about being in this study and have had those questions answered. By signing this consent form you are not giving up any legal rights to which you are entitled.

Subject Name (Printed)

Subject Signature

Date

Person Obtaining Consent (Printed)

Person Obtaining Consent Signature

Date

Subject's Initials _____

APPENDIX C: INTERVIEW QUESTIONS

Interview Questions

1. Let's begin with you sharing a bit about your professional background.
How long have you been practicing medicine?
What led you into this field?
2. What factors influenced your decision to prescribe medication-assisted treatment?
3. What barriers did you have to overcome to begin prescribing MAT?
4. Is there anything unique about conditions in WV that create barriers for you as a provider?
5. What strengths do you bring to the practice of medication-assisted treatment?
How were those strengths developed?
How have they helped you overcome barriers?
6. Before you began prescribing MAT, what were your opinions or assumptions about the practice?
7. Once you began prescribing, how did your views on the practice change?
8. Can you provide an example of an MAT success story?
9. What have you learned from inevitable mistakes?
10. How might these lessons inform pedagogical approaches to addiction?
In other words, what kind of teaching & learning is needed?
What do students need to know?
11. What are the continuing educational needs of doctors and health professionals related to MAT?
12. How do you respond to people's negative opinions about MAT?
13. Have you experienced stigma for offering the service?
14. How does prescribing MAT conform with medical ethics?

APPENDIX D: CURRICULUM VITAE

Kimberly A. White, MSW, LCSW
Assistant Professor
Department of Social Work
Marshall University

EDUCATION

Doctor of Education, Marshall University, South Charleston, WV Dec 2018

Research Interests: Medication-Assisted Treatment, School Social Work, Social Justice, Behavioral Health, Professional Socialization, & Self-Care

Master of Social Work, University of Kansas, Lawrence, KS May 2005

Secondary Education Credential Program, Humboldt State University, Arcata, CA May 2001

Bachelor of Arts, English, Humboldt State University, Arcata, CA May 2000

ACADEMIC APPOINTMENTS

Marshall University Huntington, WV
Assistant Professor August 2016-Present

- Graduate Teaching Assignments: Human Behavior in the Social Environment; Social Work Practice I & II; Social Work Policy, Military Mental Health & Trauma, Military Culture, Integrated Behavioral Health Care Models.
- Academic advisor to MSW students
- Faculty field liaison
- Regional trainer delivering West Virginia Social Work Education Consortium (SWEC) ethics curriculum to provisionally licensed social workers with the Department of Health & Human Resources
- Co-coordinated development of College of Health Professions Behavioral Health Center as practicum site and community wellness center to treat veterans, families, and individual and groups with substance abuse, mental, and behavioral health disorders

PROFESSIONAL EXPERIENCE

Marshall University Huntington, WV
Director of Military & Veterans Affairs July 2015-August 2016

- Central point of contact for all active duty military and veteran students
- Respond to veterans' questions and concerns in a respectful and timely manner
- Advocate for veterans' services and resources on campus

- Collaborate with campus departments and university administration to meet goals set forth in the Higher Education Policy Commission's 5 Star Challenge and to reduce barriers to degree attainment
- Refer active military and veteran students to campus and community services (i.e. VAMC, Vets Center, Community Action, Workforce West Virginia)
- Coordinate with faculty and staff to create supportive campus and classroom environment
- Plan and implement meaningful programs that engage veterans on campus (Development of new veterans' lounge and work space with \$22,500 grant from Enterprise Car Rental, veteran-only First Year Seminar, priority registration for veterans, veteran-specific new student orientation, veteran scholarships through Marshall Foundation)
- Perform outreach activities (tabling in the Memorial Student Center, Rec Fest, Goodwill Industries, tailgates, VA homeless veteran stand down) to spread awareness of veterans' services on campus and in the community
- Supervise four veteran work-study students
- Apply knowledge and skill to individualize support for each veteran

Marshall University

Huntington, WV

Mental Health Specialist

Oct 09-Oct 15

- Provide individual and couple's counseling to Marshall University students
- Assess students for suicide risk, substance abuse, and mental health disorders
- Deliver educational programs to university staff and students (Connections Training, UNI 101, RA training)
- Engage in planning and implementation of Counseling Center goals, objectives, and evaluation
- Crisis intervention

River Park Hospital

Huntington, WV

Treatment Team Coordinator

Mar 07-Oct 09

- Acted as liaison between residents and the courts, the Department of Health and Human Resources, family members, attorneys, juvenile probation, and clinical/direct care hospital staff
- Conducted psychosocial assessments; wrote daily progress notes
- Developed treatment plans with client centered, measurable goals and objectives
- Led weekly Cognitive Behavioral Therapy groups
- Met individually with residents to provide feedback on progress, address questions and concerns, and offer support and direction
- Educated families on risk factors, trigger events, and other vital aspects of recovery to prevent relapse
- Coordinated transition from in-patient care back to home environment

Kansas Department of Corrections (KDOC)

Kansas Social and Rehabilitative Services (KSRS)

Topeka, KS

Grant Writer

June 05-Apr 06

- Liaison between the Kansas Department of Corrections (KDOC) and KSRS for the development of resources and offender programs

- Coordinated with Senior Administrators within KDOC and KSRS to implement strategic plan
- Performed needs assessments and developed rehabilitative programs for incarcerated population
- Performed research to identify and access grant-based funding opportunities
- Established program goals, measurable objectives, and evaluation of program effectiveness
- Supervised planning and work teams to prepare grant applications
- Compiled, organized, wrote, edited, and revised grant applications
- Successfully developed outcome-based programs that were awarded \$1.5 million in federal and private funding

Kansas Department of Corrections

Topeka, KS

Advanced Practicum Social Work Intern

Aug 04-May 05

- Monitored inmate use of rehabilitative programs
- Member of Veterans Re-entry Committee which established protocols to ensure that incarcerated veterans were evaluated by VA personnel for benefits eligibility prior to release from prison
- Performed needs assessment to identify areas where correctional counselors could improve case management practices
- Co-authored statewide reference and resource guide for correctional case managers based on findings from needs assessment

Veterans Affairs Medical Center—Domiciliary

Leavenworth, KS

Advanced Practicum Social Work Intern

Aug 03-May 04

- Co-managed (with supervisor) 100-person case load
- Conducted psychosocial assessments and screening interviews to determine needs and interventions
- Facilitated weekly veteran re-integration groups
- Member of a multidisciplinary treatment team
- Wrote detailed progress notes
- Served as press liaison for the veterans' chapter of the National Alliance for those with Mental Illnesses
- Assisted veterans with transition from in-patient hospitalization to independent living
- Participated in the Topeka Veterans Stand-Down homeless veterans outreach program

PROFESSIONAL, ACADEMIC, COMMUNITY MEMBERSHIPS & SERVICE

- National Association of Social Workers Political Action Committee, Chair Jan 2018-Present
- Mental Health Matters WV Statewide Advocacy Coalition Feb 2014-Present
- President, National Association of Social Workers WV Chapter June 2014-June 2016
- Phi Alpha Honorary Society, Honorary Member Apr 2015
- Marshall University Social Work Department Advisory Committee 2012-Present
- Marshall University Women's Studies Advisory Committee 2011-2014
- National Association of Social Workers President Elect June 2013-2014
- National Association of Social Workers Vice President June 2012-2013
- National Association of Social Workers Board Member June 2010-June 2016

SELECTED GRANTS AND AWARDS

- Received Women of Marshall Award, May 2016
- West Virginia Social Worker of the Year by the National Association of Social Workers West Virginia Chapter, April 2016
- Awarded \$22,500 grant from Enterprise Foundation for student veteran lounge Feb 2016
- Awarded \$1,000 grant from WV Elks Association Jan 2016
- Awarded (as member of interdisciplinary grant writing team) \$945,000 SAMHSA grant for SBIRT at Marshall University Sept 2015

PRESENTATIONS

- *Pragmatic Ways of Being: Social Work Pedagogy and Community-Built Solutions*, Appalachian Studies Conference, Cincinnati, OH, April 2018
- *Cultural Considerations: Women Veterans in Appalachia*, Marshall University continuing education workshop, September 2017
- *Military Families Grief & Bereavement*, NASW Huntington Branch continuing education workshop, May 2017
- *Ethical Dilemmas Involving Colleagues*, NASW Spring Conference, April 2017
- *Women in the Military*, Invited speaker at Sidwell Friends School, Washington D.C., Jan 2017
- *Classroom and Campus Contributions of Veteran Students*, Keynote speech at Marshall University's Veterans' Day Ceremony, Nov 2016
- Moderator, *Mental Health Matters* statewide panel, Sep 2016
- *Being a Veteran Ally in the Classroom*, Marshall University English Department, Jan 2016
- *Women in the Military: Veterans Day Tribute to Female Service Members*, Invited speaker at Cabell County Democratic Women's Club, Nov 2015
- *Expanded School-Based Mental Health*, NASW Spring Conference, April 2015
- *Mindfulness-Based Stress Reduction and Communication*, River Valley Day Care Center Staff Retreat, March 2015
- *Expanded School-based Mental Health*, NASW Fall Management Conference, Oct 2014
- *Mindfulness Based Stress Reduction and Communication Practice*, West Virginia State Council for the Society of Human Resource Management, Nov 2013
- *Mindfulness-Based Stress Reduction and Communication*, Becker Inc., Aug 2013
- *Veteran-Friendly Campus* panelist, Higher Education Policy Commission 2012 Veterans Symposium

PUBLICATIONS

White, K. (2016). [Review of the book *Working with in/out the System: Educational leadership, micropolitics, and social justice*. Ryan, J. and Armstrong, D. Eds.]. *Critical Questions in Education*, 7(2). Charlotte, NC: Information Age Publishing

OTHER PROFESSIONAL HIGHLIGHTS

- Awarded \$433,300 Bureau of Justice Affairs *Comprehensive Approaches to Sex Offender Management* (CASOM) grant Kansas Department of Corrections FY 2006
- Awarded \$60,000 U.S. Department of Education *Life Skills for State and Local Prisoners* grant Kansas Department of Corrections FY 2006
- Awarded \$999,905 Bureau of Justice Affairs Prison Rape Elimination (PREA) grant Kansas Department of Corrections FY 2006
- Awarded \$3,000 Kansas Humanities Council *Children of Incarcerated Parents* Kansas Department of Corrections FY 2006
- Awarded *Goodwin Garfield Practical Theorist Scholarship* \$500 University of Kansas 2005
- Awarded U.S. Navy Achievement Medal 1997