WISCONSIN DEPARTMENT of HEALTH SERVICES

Wisconsin Looks at Stigma and Those Who Use Opioids

Results from a 2019 Wisconsin statewide public opinion survey on stigma toward those with opioid use disorder

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Contents

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Questions and comments are welcome to: DHSOpioids@dhs.wisconsin.gov

Executive Summary

In Wisconsin, as throughout the United States, the opioid epidemic has been with us for over twenty years. Improved practices in the prescribing of opioids for pain in the last decade brought about a reduction in overdose deaths. However, the emergence of dangerous synthetic opioids such as fentanyl in the illicit market has renewed the rise in deaths. Therefore, it is vital to better understand factors that impact harmful use of opioids that go beyond mere control of the supply. One factor that plays a part is stigma toward those with an opioid use disorder. Stigma impacts the way society responds to the problem and even how individuals who struggle with opioid use disorder see themselves.

In order to better understand stigma toward those who use opioids in Wisconsin, we conducted a public opinion survey among over 1,500 randomly selected households during the summer of 2019. The survey had a response rate of over 53% and is representative of those who live in the state.

Some important results include:*

- At the individual level, almost all respondents recognized opioid use disorder as a chronic illness (93%) as opposed to a moral failing (only 22%). Moreover, they clearly connected this with a history of trauma or abuse, or underlying mental health issues (60%), though many (55%) also felt that lack of will power plays a role.
- At the societal level (as opposed to the individual level) Wisconsin residents overwhelmingly (nearly 80%) put the blame for opioid use on drug dealers. After drug dealers, about 50% of respondents identified pharmaceutical companies, and those using opioids, as responsible.
- At the societal level, Wisconsin residents generally support greater availability of treatment for opioid use disorders. They believe it should be provided in primary care settings (82%); that insurance coverage should be expanded to pay for it (75%); and that medication to treat opioid use disorder should be provided to those who are incarcerated and have a history of substance use (70%). More than 25% are open to having a treatment center located near their home. Smaller numbers favor a more punitive approach, such as prosecution (61%); denying employment (55%); or denying housing (50%).

  **Note: More than one response was allowed for these questions.*

Recommendations

- There may be an opportunity to educate the public about substance use disorder at an earlier age, incorporating a more compassionate lens.
- Educating the public about naloxone (NARCAN®) should continue to be a priority.
- There is openness and support for widely available treatment for opioid use disorder.
- There is an opportunity to increase health care providers' knowledge about the causes and treatment of opioid use disorder. Wisconsin residents look to health care providers as the front line in dealing with opioid use disorder.

About Language

This survey deals with opioid use disorder, or what people sometimes refer to as "addiction." This term has come to be seen by many as stigmatizing because it does not take into account that use disorders of any type are diseases. The survey used language the terms "addiction" and "addicted" because most are more familiar with these terms. When we refer to specific questions or direct quotes, we leave in the reference to "addiction." However, throughout the report, we say "opioid use disorder" instead of "addiction", which is the preferred terminology.

A related issue is the use of person-centered terminology. This is important. As with the example above of the "addict" vs. the person with "a drug problem," this report, and the survey, never refers to a person with opioid use disorder as an addict. Such labeling is dehumanizing and is at the heart of stigma. A person should never be defined by a characteristic observed at a point in time. We are all so much more than that.

The survey is about people with opioid use disorder (OUD). OUD is defined in the Diagnostic Statistical Manual, 5th edition (DSM-V), as: a problematic pattern of opioid use leading to problems or distress, with at least two of 11 symptoms occurring within a 12-month period. Among these symptoms are such things as:

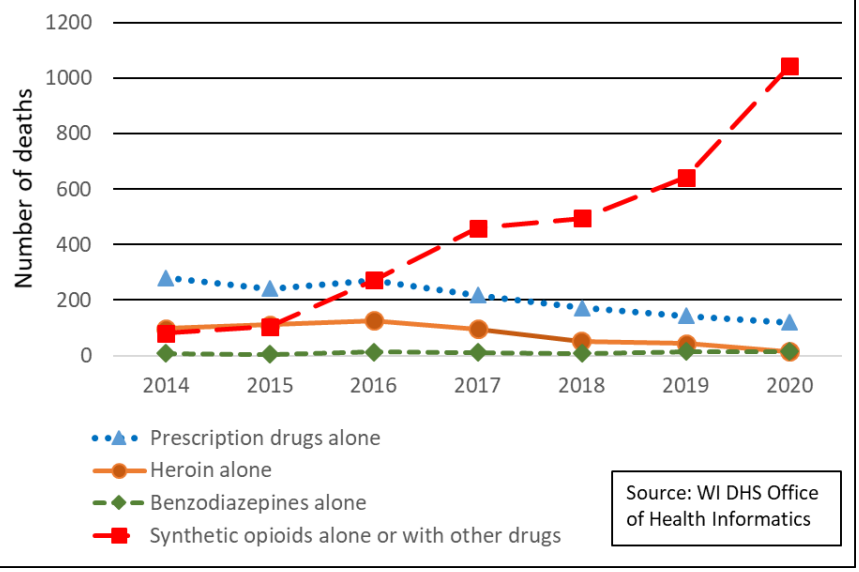
- Taking larger amounts, or taking drugs over a longer period, than intended.
- Having problems fulfilling obligations at work, school, or home.
- Experiencing withdrawal or taking opioids to relieve or avoid withdrawal symptoms.

Introduction

The tide of deaths from drug overdoses remains high, but we have made progress on many fronts. Implementation of the Wisconsin Prescription Drug Monitoring Program and prescriber education brought down deaths due to prescription opioids beginning in 2017. Treatment, including FDA approved medications such as methadone and buprenorphine, have become more widely available and accessible, including for those incarcerated. Naloxone, the overdose reversal drug, has become more widely available, often without a doctor's prescription and without cost. Prevention efforts have increased awareness of the dangers of both prescription and non-prescription opioids, and youth show a decline in experimenting.

But all of these efforts are countered by a growing challenge from the introduction of synthetic opioids such as Fentanyl (Figure 1). These are often illicitly manufactured in foreign laboratories and shipped via multiple routes into our country. They are far more powerful than natural opioids, so small amounts can yield lucrative profits for suppliers. Tiny amounts can have a powerful effect for the user, but that effect is often unpredictable, and too often, it is deadly. Over the past year, the isolation and anxiety due to the COVID-19 pandemic has exacerbated the crisis. National reports indicate a 20% or more increase in deaths due to opioids in 2020, and Wisconsin statistics point to a similar pattern.

Figure 1. Synthetic opioids, including Fentanyl, have become the primary cause of drug overdose deaths in Wisconsin



Stigma as a Barrier to Progress

While we can try to decrease the supply of opioids, we also need to help the individuals themselves. If we can reduce the demand, the supply will become less important.

Solving the problem of substance use disorder, specifically opioid use disorder in this case, has been a struggle across time. Our understanding of the solutions is always growing, but one of the biggest barriers to progress is stigma. Because opioid use disorder is a disease, it requires treatment. Yet stigma is one of the biggest barriers to this - on the part of those seeking help, because they often feel shunned, but also on the part of providers, because they lack education on how stigma can color everyone's perceptions, including their own. Furthermore, the social isolation and discrimination suffered by those with opioid use disorder due to stigma remove the support needed to progress to better health.

Our goal is to better understand the nature of stigma among Wisconsin residents. By better understanding the attitudes and experiences around stigma, we can work to reduce it. While stigma exists in those who personally experience opioid use disorder, this special group was not targeted by the current survey for reasons of logistics and cost.

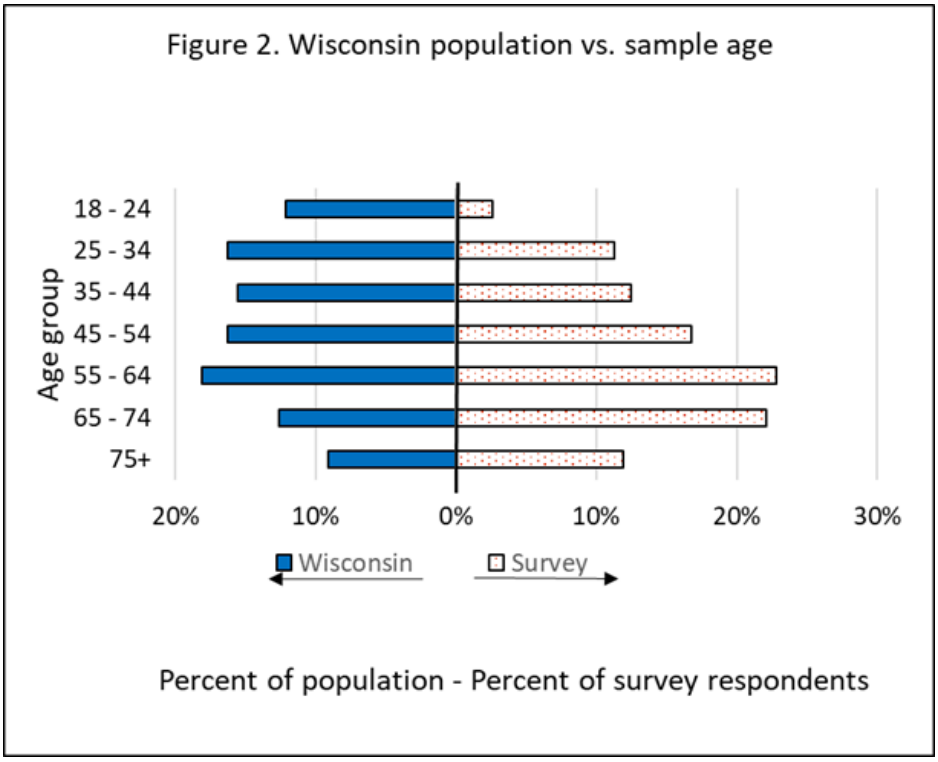
About the Survey

The survey was conducted by the UW Survey Center from June 24, 2019, through October 7, 2019, with a sample of 3,000 randomly selected residential addresses in Wisconsin. It was sent in English only. Each selected address was mailed a packet that contained a questionnaire and a first-class, postage-paid reply envelope. The initial mailing included a $1 bill as a thank you. For households that did not respond, two additional mailings were sent, though no additional dollars.

The mailings were addressed to "Wisconsin Resident." An accompanying letter indicated that "only Wisconsin residents 18 years of age or older" could participate.

Survey Sample and Demographics

A total of 1,505 completed surveys were received which yielded a final response rate of 53%. The survey included several demographic questions as well as asking for a zip code. No other identifying information was collected.



Age

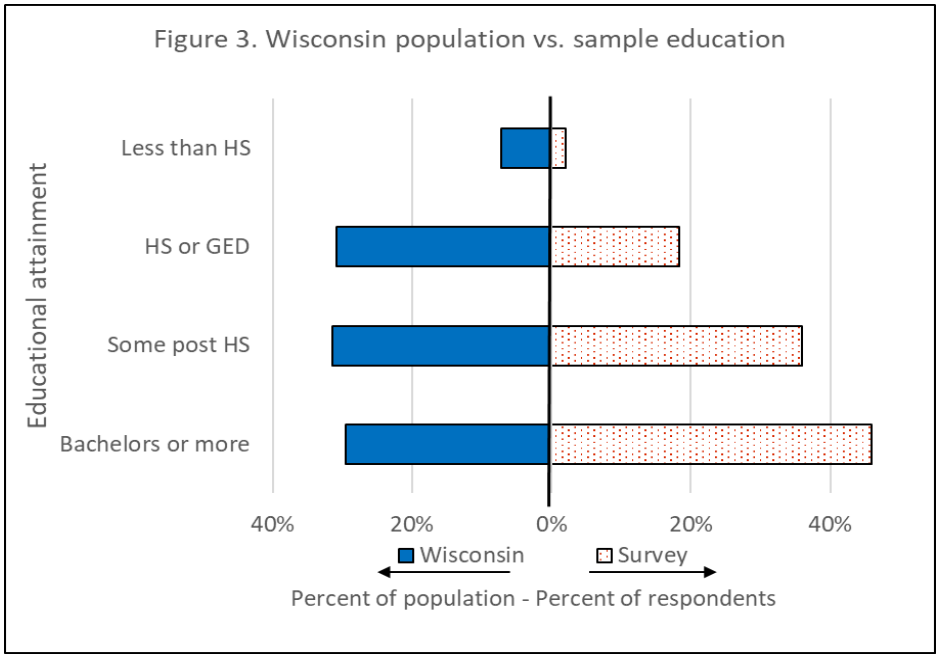
Looking at the age of those who responded, there were more older people and fewer younger people compared to the Wisconsin population (Figure 2). This is fairly common for mailed surveys. In analyzing the results, we used statistical weighting[1] of the responses to better estimate the attitudes of the population as a whole. (Notes, indicated by superscripts, can be found on the last page of the report.)

Household Income

There was a better match for household income, though the survey captured slightly fewer households in the middle-income range ($40,000 to $75,000) and those below $25,000 per year. This also was corrected via statistical weighting.

Education

For educational attainment (Figure 3), respondents in the sample reported higher levels of education than is represented for the state as a whole. In the sample, 18% reported high school or GED as their highest attainment, versus 31% according to the US Census Bureau[2]. Respondents reported 43% achieving a bachelor's degree or higher whereas the corresponding number in the Census data was 30%. Weighting corrected these differences.



Geographic Location

A final demographic was geographic location. We used zip codes to classify respondents according to rural/urban locations using a method developed by the Wisconsin Area Health Education Centers[3]. Table 1 shows that in general, the state is fairly represented geographically, except for Milwaukee, which was under-sampled. However, when weighting was applied using the age, income, and education data, this bias was largely corrected. Figure 4 gives an idea of the numbers of surveys received from zip codes around the state, with darker colors indicating more surveys.

Table 1. Comparing urban/rural setting on population and numbers of surveys.

Area	Population (2014)	Percent Population	Number of Surveys	Percent Surveys
Milwaukee County	947,830	17%	175	12%
Milw. Metro, outside Milw. County	336,467	6%	101	7%
Small rural	1,039,378	18%	281	19%
Medium-Large rural	1,177,997	21%	310	21%
Urban > 50K not Milw.	2,185,314	38%	594	41%
Sum	**5,686,986**		**1,461**	

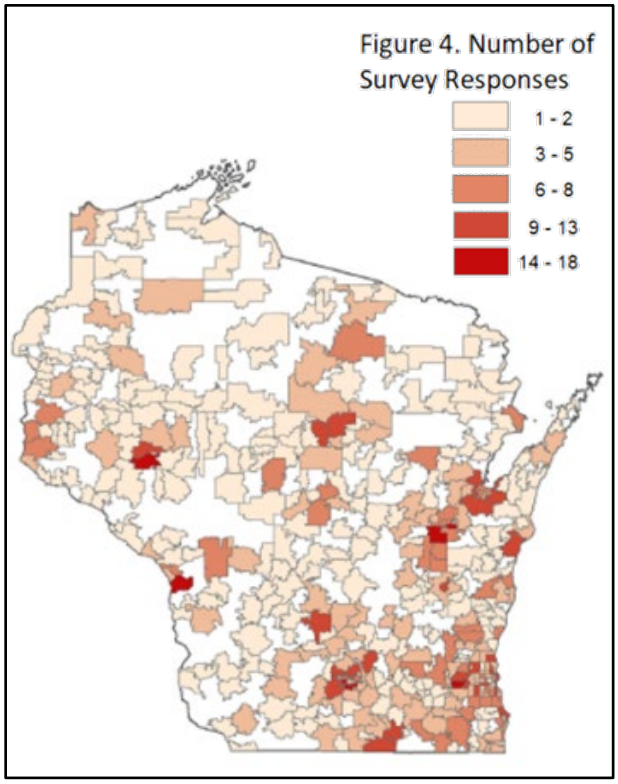
Source of population estimates: US Census Bureau. Urban/rural designations from Wisconsin Area Health Education Center System, 2014.

Personal Experience

We also asked a few questions about personal experience with prescription opioids. We limited these questions to prescription opioids because it seemed unlikely that respondents would

report using non-prescription opioids, and even if some did, the numbers would be so small that it would be hard to interpret their results separately.

A majority of respondents, 69.7%, reported that they have taken prescription opioids for pain. While it is difficult to extrapolate, the CDC reports that in 2017, 17% of Americans had at least one opioid prescription filled (CDC, 2019)[4], so it is not surprising that most people report having used prescription opioids at some time. A much smaller number, 17.3%, reported taking prescription opioids for more than 10 days continuously. The same CDC report provides 18 days as the average duration of an opioid prescription in 2017, but this is likely influenced by prescriptions for 30 and 90 days among those taking opioids for chronic conditions.



Still fewer respondents, only 3.4%, reported ever feeling they might need help in reducing their use of opioids. However, 31.2% reported that they knew a friend or family member who they thought might need help in reducing their opioid use.

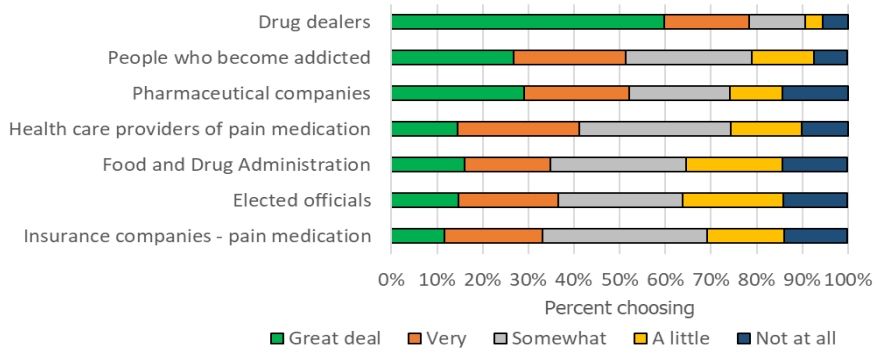
The survey consisted of 31 scaled-response questions (e.g., "agree a lot" to "agree not at all"), 5 yes/no, and 4 open-ended questions. Results are grouped according to the following general subject areas: 1) understanding causes of opioid use and dependence—both from a societal perspective and at a personal level; and 2) society's response, including treatment options.

Causes of Opioid Use Disorder—Societal

It is widely accepted that there are many things that contribute to a person becoming addicted to opioids. The first survey question asked about these. It asked: *How responsible for widespread opioid addiction are…*

As shown in Figure 5, drug dealers were seen by the most people as responsible for opioid use disorder. They are indeed easy to single out as "the bad guy" in the picture. However, separating cause and effect can be difficult. As long as there are people seeking opioids, there will probably be those selling them.

Figure 5. Societal causes of opioid addiction
"How responsible are…"



The next two highest choices for responsibility were people who become addicted and pharmaceutical companies. It makes sense to put responsibility with the person themselves. At some point, the individual makes a choice, and our culture asserts that we are in charge of our own lives. However, this becomes rather less clear when the disease of opioid use disorder is better understood.

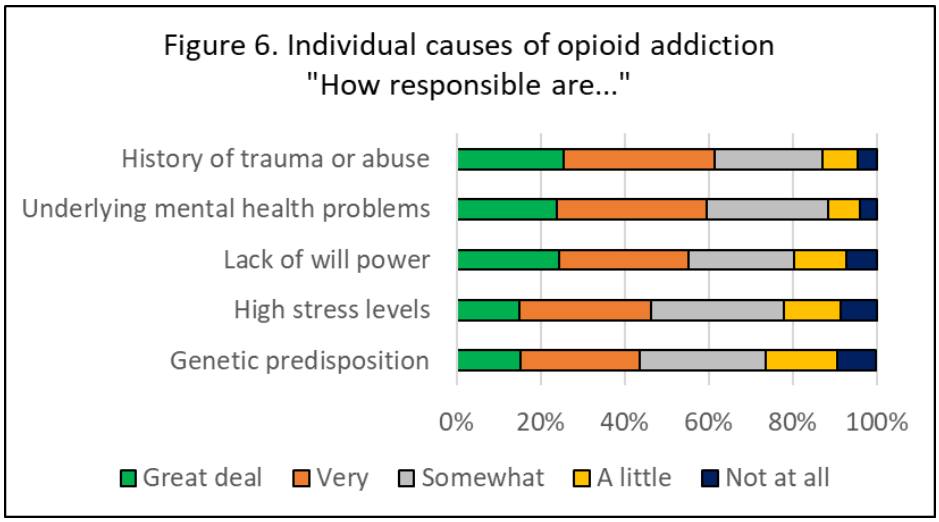
Pharmaceutical companies have been in the news quite a bit as the villains in the opioid crisis, and the evidence is strong that this is to a degree justified. Many are currently the subjects of large lawsuits for the damage caused by their actions.

The other four items - health care providers, the FDA, elected officials, and insurance companies - are all seen as somewhat to blame. It is interesting that health care providers who prescribe opioids were seen as less to blame than pharmaceutical companies, even though it is the health care providers who write the prescriptions.

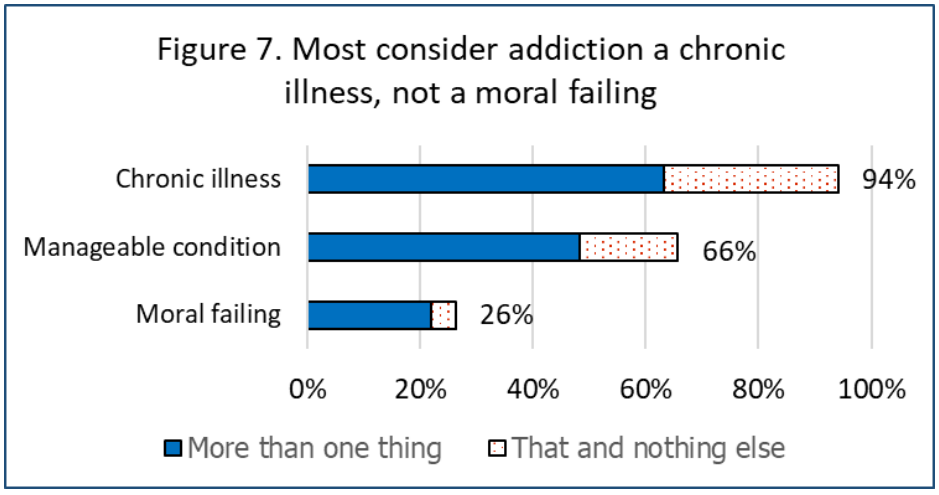
The final option for answering this question was a "fill-in." A number of responses written in focused on personal failings that led to opioid use disorder, a common theme in many narrative responses. For example, respondents singled out "spoiled teenagers experimenting with drugs," or those who "use opioids just for fun" as opposed to pain relief. Several others identified social factors that contribute to opioid use disorder. Those included poverty, restricted access to health care and mental health resources, the use of opioids to help "manage" elderly people, and the impact of military service in times of conflict. Others suggested the need for health care systems to be better organized to understand and respond to individual patient needs.

Causes of Opioid Use Disorder—Individual

On the previous question, "people who become addicted" was the number two choice, after dealers, as being responsible for opioid use disorder. The next series of questions looked at this more closely, asking how much these personal circumstances "contribute to opioid addiction."



Opinions on these were much more evenly divided (see Figure 6). Over 50% of respondents felt that a history of trauma or abuse, underlying mental health problems, and lack of will power all contribute "very much" or "a great deal" to opioid use disorder. The first two items identify factors that are largely beyond the control of the person whereas the third, lack of willpower, appears completely up to the individual. The next two items, high stress levels and genetic predisposition, were selected by fewer people. Everyone experiences stress at times. Respondents might see genetics as something that can be overcome through "will power."



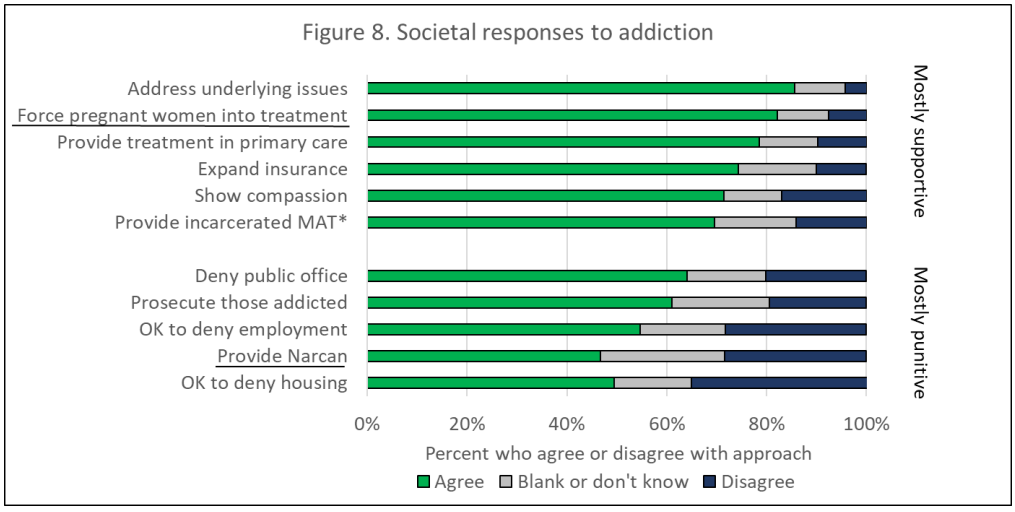
A separate question (see Figure 7) asked more directly about the nature of opioid use disorder. Respondents were asked to check one or more boxes as to whether or not "someone with addiction to opioids has…" A majority (94%) believed that opioid use disorder is a chronic illness, with somewhat fewer seeing it as a "manageable condition." Fewer than 30% saw opioid use disorder as a moral failing.

This question also invited respondents to fill in a blank. Many reiterated the three options provided or referred to the previous questions, especially those referring to childhood trauma, mental health issues, and lack of will power. Many felt that it was a combination of all of these.

Other suggestions included ideas not previously mentioned: "Inability to deal with pain"; "Lack of knowledge and other options"; "Need better coping skills"; "Lack of purpose in life"; "Bad environment"; "Bad luck"; "Complete disregard for themselves and those around them"; "I think addiction may begin from poor choices made in the middle of some stressful/traumatic situation, but as addiction progresses, the physical changes manifest much like disease. Perhaps the best analogy is diabetes." Several indicated lack of religious faith.

Responses to Opioid Use Disorder—Societal

A number of questions addressed what should be done about the problem of opioid use disorder. As is clear in the figure, the amount of support for various measures differed quite a bit, more than 85% support addressing underlying issues, while less than 50% felt it is ok to deny housing to those with opioid use disorder (see Figure 8).



Generally, the options that garnered the most support fell within a "supportive" approach toward those with opioid use disorder. These included: address underlying issues; provide treatment in primary care settings; expand insurance coverage for addiction treatment; show compassion toward those with addiction; provide medication assisted treatment for those who are incarcerated and need it.

Measures that could be considered more "punitive" in approach were: Deny public office to those with opioid use disorder; prosecute those with opioid use disorder; and deny employment or housing to those with opioid use disorder.

Pregnant Women and Treatment

However, there were two responses that appear to be "out of sync" with the grouping above. One of these is very high support for forcing women who are pregnant into treatment.

Forcing anyone into treatment rarely works, including pregnant women. However, this is compounded with stigma that providers (and others) have toward pregnant women with substance use disorder.[5] Often, women who are pregnant also have young children who must be cared for.

There needs to be a partnership between the pregnant person and their provider, offering comprehensive and compassionate support that addresses medical and psychosocial needs, linked with perinatal care and recovery support, as well as other wraparound services that address barriers to care such as transportation, childcare, financial and legal support.

Many women with substance use disorder often voluntarily seek treatment during pregnancy and are often prioritized. However, it is immediately following birth and up to 12 months postpartum that they are most vulnerable, coping with the stress of caring for a new baby, when access to treatment is often lacking.

Naloxone Availability

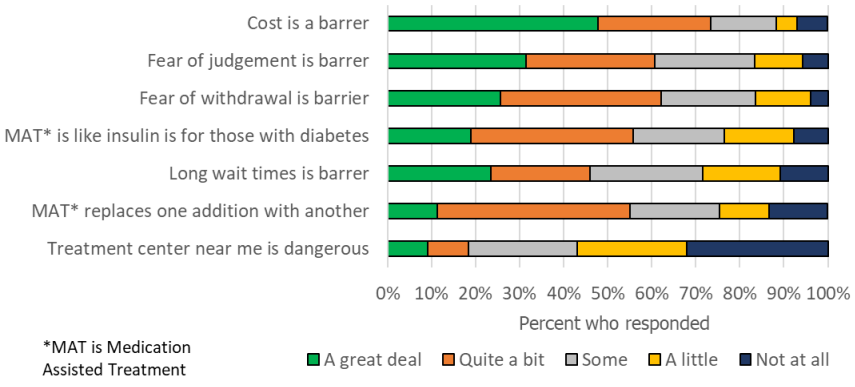
The other response that seems "out of sync" with others concerns providing "naloxone, or NARCAN®, a medication that helps save the life of a person overdosing on opioids, to friends and family of people who use opioids." It seems incongruous that the majority of respondents favor measures that are supportive of those with opioid use disorder but then are against providing a most immediate means of keeping them from dying from an overdose. This is supported by the observation that nearly 25% of respondents are neutral or not sure, the highest in this "not sure" category for the entire survey.

Since the survey was completed in 2019, there have been additional efforts to expand education around naloxone. This must be a continuing effort to reach more people in more areas.

Responses to Opioid Use Disorder Treatment

Several questions addressed issues around treatment for opioid use disorder. Respondents tended to see cost, fear of judgment (that is, stigma), and fear of withdrawal as barriers, and—a bit farther down the list—long wait times (see Figure 9). While cost and stigma can definitely be barriers to entering treatment, withdrawal, in itself, is usually eased through medication. On the other hand, long wait times can be a severe barrier. Quite often, there is a window of opportunity, sometimes in connection with an overdose event, in which a person seeks out treatment. If none is available, that window will close. Also, it is sometimes necessary to access treatment far away from home, because that is all that is available at the

Figure 9. Views about treatment



time. This cuts those in recovery off from support networks upon which they will depend on in the future.

For the question: "How much would it endanger local residents if opioid addiction treatment services, such as medication and counseling, were provided in your neighborhood?" Nearly 60% of respondents chose "not at all," or "a little," providing evidence that the public is quite open to local treatment services.

As seen in the previous section, 70% of respondents favored providing medication assisted treatment (MAT), for those who are incarcerated. Two items in this section focused on MAT, which involves drugs such as methadone or buprenorphine, "to help them avoid relapse and overdose." A majority felt that MAT serves like insulin does for diabetics (i.e., a necessary medication for a medical condition), but also that it replaces one substance with another. These seem somewhat contradictory, and analysis shows that they are indeed opposite views among people— that is, those who saw it most as being like insulin tended to be those who saw it less as replacing one substance with another.

The view from the National Institute on Drug Abuse on the question of whether MAT replaces one addiction with another is clear: "No. Buprenorphine and methadone are prescribed or administered under monitored, controlled conditions and are safe and effective for treating opioid addiction when used as directed. They are administered orally or sublingually (i.e., under the tongue) in specified doses, and their effects differ from those of heroin and other abused opioids."(NIDA, 2020)[6]

Narrative Responses

We were very interested in obtaining the broadest selection possible of thoughts and opinions from those who responded. Some of these were covered above in examining the causes of opioid use disorder. Two other questions were more open-ended.

Who Do You See?

One of these asked: "When you imagine someone addicted to opioids, what type of person do you see?" Over 1,100 of the 1,505 respondents (76%) wrote an answer. A careful analysis of the responses revealed a number of common themes. The most common theme of all (expressed in 518 responses) was that someone addicted to opioids could be "anyone." Some example responses included:

> *"I cannot [say]. The stereotype of the strung-out street junkie is far from accurate. I see housewives, mothers, fathers, children, nurses, doctors, priests, friends, family, neighbors."*
>
> *"People who are addicted to opioids could be anyone. It could be a high-end businessman making 6 figures or it could be a pregnant homeless woman on the street. It is hard to paint a picture due to so many walks of life."*
>
> *"Any person can be addicted to opioids. A person who has chronic pain and tries to work or get through each day, or a person suffering from depression and/or pain to the point*

of giving up. The person could live in a nice house or be homeless. I imagine a wide variety of people."

The next most common theme expressed was of "someone who needs help," either as a result of their opioid use disorder, or help with the underlying causes. For example:

"I see a person who is using opioids as a coping mechanism. I see this person as a victim of trauma or abuse and/or an underlying mental condition. It may also be a person living in poverty or with a chronic or manageable condition. Maybe someone dealing with overwhelming stress."

"My mom— loving, kind, giving—living in horrible chronic pain with a doctor who only feeds her more pills…"

"Someone in pain. A person who has not given other methods of pain management a fair trial because they don't know about it, can't afford it and/or cannot get to treatment."

"Someone struggling with personal demons. Be they self-inflicted or not."

"Someone without emotional support. Someone with mental health issues."

A number of responses saw those with opioid use disorder as two types:

"Generally, those who do street drugs for the high but also those who use prescriptions to deal with pain but got out of hand."

"2 types! 1) Someone who was prescribed opioids at one time and developed an addiction. They struggle daily with pain, with little to no other options to treat it. 2) Started recreationally and will do anything to feed their addiction."

Although the great majority of responses reflected a supportive view of those with opioid addiction, it was not true of all:

"…I also see strung out lazy leeches who could do better..."

"Drug Addict"

"Junkie"

"A worthless bum not willing to work."

What Else?

At the end of the survey, we asked if respondents had any additional comments. Five-hundred-sixty (37%) did. Many of these were quite thoughtful and insightful. Here is a small sampling (some have been edited to clarify or protect privacy):

"Our opioid issues must be addressed, people are dying. Addiction is a horrible curse. It affects the addict, their families and the public."

"American society is increasingly fragmented. People are lonely. We know loneliness leads to depression, which can lead to other mental health issues. Part of addressing

addiction must be a focus on the larger problem of lack of community and individual isolation. Too few of us know our neighbors or have meaningful social connections."

"For young people, peer pressure is often stronger than parental pressure. I can't give a suggestion, but if something could be done to reduce peer pressure to use drugs."

"My mother is elderly and has severe back pain. Her condition is diagnosed, and so severe that she has poor quality of life. Her physician's clinic no longer provides long-term prescriptions, so she can no longer treat her pain. Her mood and relationships have deteriorated as a result. Her pain affects not only her, but her friends and entire family! I understand the cautions doctors are exercising, but some people truly need pain meds, like my mom, and we are left helpless."

"I do not agree with people holding office make it their issue to take pain medications away from the elderly and disabled patients!!!"

"Generally speaking, the opioid problem is an underlying result of degradation of society as a whole. The U.S. no longer takes care of the sick and the mentally ill, we let them fend for themselves. If the wealthiest nation in the world provided health care for the sick and a living wage for the poverty stricken, the opioid problem would be drastically reduced. Looking at this problem pragmatically, it's simple. Nobody wants to be addicted to drugs, it boils down to the amount of stress someone can handle. If it overcomes them, people cope with drugs and alcohol. It's that simple."

"(Relative) was in nursing home to exercise for 1 month after surgery and was given 30 Vicodin tablets, only took 4 while there and was sent home with the rest. Was given pills that we disposed of. I feel it was only a money-making thing. He said he could have gotten away without any as he didn't have pain he couldn't live with. Maybe give patients 10 at a time, if they need more then fill a prescription. Handed out too easy!!!"

Recommendations

Any type of stigma results in negative impacts. Those living with opioid use disorder, however, are at greater risk of experiencing the negative impacts of stigma. Sudden death from an overdose is always a possibility. For those actively using opioids, stigma can act as a barrier to getting help of any sort, whether it is treatment or simply obtaining the necessities of daily life. That barrier exists both within the person with opioid use disorder and in those who might otherwise offer assistance. For those in recovery, the stigma of opioid use disorder remains a constant burden that often includes disruptions to other parts of life—finances, family, friends, and often, legal status.

The following recommendations are based upon the data contained in this report.

1. Education is always the primary tool for combatting stigma. We naturally fear what we do not understand, and that fear leads to defensively isolating and attacking what is feared. Education about the realities of the disease of opioid use disorder, especially its causes and treatment, is job number one. Simple, fear-based efforts ("this is your brain on drugs") and

"just say no" were tried and showed little lasting success. A separate in-depth analysis of results from the current survey showed that those with higher levels of educational attainment tended to have more compassionate views, as opposed to punitive views, compared to those with less education. Perhaps this reflects the results of exposure to more informed views about substance use disorder in higher education settings. If so, it might indicate the need for introducing more such efforts earlier in the educational process, such as in high school or earlier.

2. Also on the subject of public education, there is a need to further educate the public about naloxone (NARCAN®). Being opposed to making naloxone widely available is like being opposed to teaching CPR. Many are still uninformed and don't know what it is, so they are skeptical. Education continues to be a priority.

3. The survey revealed an openness and support for widely available treatment for opioid use disorder. The public believes it should be available in their primary care clinic (78%), in jails and prisons (70%), even in their own neighborhood (30%). And they believe insurance should be expanded to pay for it (74%). These are important findings that should be shared with decision makers within the health care and governmental sectors. The public is ready for change.

4. Wisconsin residents look to health care providers as the front line in dealing with opioid use disorder. It is therefore vital that health care providers are, themselves, educated about the causes and treatment for opioid use disorder, and the ongoing support needed by those in recovery. As trusted sources of health information, they need to share this information with their patients and the public. They also need to be aware of, and make use of, alternatives to opioids for the treatment of pain.

Appendix: Detailed Results

The margin of error for results reported below is 2.5% or smaller at 95% confidence. This means that for any given percentage quoted, we can assume that the true population figure is within plus or minus 2.5%, ninety-five times out of one hundred.

In examining responses on individual questions and knowing whether specific categories are significantly higher or lower than others, this varies question to question. But because of the relatively large size of the sample, response differences of a few percent are statistically significant.

The results reported below are based on the sample weighted to approximate the Wisconsin population 18 years and older correcting for age and education. Income was not included in the weighting because it was the least non-representative demographic category, and it also had a relatively high number of respondents declining to respond, which reduced the overall resulting sample size when included in weighting. The weighting method used is called rake weighting and adjusted weights for each respondent until the best fit to the population on education and age was produced.

Also, results are presented in their order in the survey. In the foregoing discussion the order and some labeling were changed to best reflect the context for better understanding. The tables present counts including those who left an item blank and percent after subtracting blank responses.

Question 1: In your opinion, how responsible for widespread opioid addiction are…

	Not at all		A little		Somewhat		Very		Extremely		Blank/DK*
	#	%	#	%	#	%	#	%	#	%	#
Medical providers	151	10.2	227	15.4	489	33.2	394	26.7	214	14.5	17
Health insurance	203	13.9	247	16.9	525	36	314	21.5	170	11.6	32
Pharmaceutical companies	210	14.3	168	11.5	324	22.1	337	23	426	29.1	26
Drug dealers	82	5.6	57	3.9	180	12.3	273	18.6	876	59.7	25
Those addicted	108	7.4	197	13.5	403	27.7	358	24.6	388	26.7	38
FDA	209	14.3	308	21.1	432	29.6	276	18.9	234	16	33
Elected officials	204	14.1	320	22.1	394	27.2	315	21.8	213	14.7	45

* Throughout the tables “DK” stands for “Don’t know” responses.

Question 2: In general, how much do you think each of the following contributes to opioid addiction?

	Not at all		A little		Somewhat		Quite a bit		A great deal		Blank/DK
	#	%	#	%	#	%	#	%	#	%	#
Lack of will power	108	7.3	182	12.4	371	25.1	454	30.8	360	24.4	17
History of trauma or abuse	68	4.6	121	8.2	382	25.9	528	35.7	377	25.6	16
Mental health conditions	59	4	109	7.5	422	29	519	35.7	345	23.8	38
Genetics	136	9.3	245	16.9	438	30.1	412	28.3	222	15.3	40
Stress	129	8.7	196	13.3	466	31.7	461	31.3	221	15	19

Question 3: In general, how much do you think each of the following discourages people from getting help for opioid addiction?

	Not at all		A little		Somewhat		Quite a bit		A great deal		Blank/DK
	#	%	#	%	#	%	#	%	#	%	#
Long wait for services	155	10.8	255	17.7	368	25.6	323	22.5	336	23.4	54
Fear of judgement	84	5.7	162	11	332	22.6	429	29.2	462	31.5	23
Fear of withdrawal	57	3.9	183	12.5	314	21.4	538	36.6	375	25.6	25
Cost	102	6.9	72	4.8	218	14.8	378	25.6	706	47.8	15

Question 4: In your opinion, how much would it endanger local residents if opioid addiction treatment services, such as medication and counseling, were provided in your neighborhood?

	Not at all		A little		Somewhat		Quite a bit		A great deal		Blank/DK
	#	%	#	%	#	%	#	%	#	%	#
How much danger	464	32	362	25	358	24.7	133	9.2	133	9.2	42

Question 5. How much do you agree or disagree with the following statements? If someone has an opioid addiction, then…

	Agree strongly		Agree somewhat		Agree a little		Neutral or not sure		Disagree a little		Disagree somewhat		Disagree strongly		Blank
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#
Long wait for services	360	24	292	20	157	11	253	17	111	8	135	9	171	12	14
Fear of judgment	271	18	244	17	213	15	227	15	130	9	138	9	252	17	17
Fear of withdrawal	626	43	199	14	117	8	231	16	82	6	79	5	136	9	22

Question 6. How much do you agree or disagree with the following statements?

	Agree strongly		Agree somewhat		Agree a little		Neutral or not sure		Disagree a little		Disagree somewhat		Disagree strongly		Blank
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#
Provide treatment in primary care	710	48	316	21	135	9	172	12	40	3	46	3	58	3	14
Show compassion	477	32	323	22	254	17	172	12	96	7	47	3	108	3	15
Force pregnant women into treatment	879	60	215	15	118	8	150	10	27	2	33	2	53	2	17

Question 7. In your opinion, people addicted to opioids have a… (Please check all that apply)

	Checked		Not checked	
	#	%	#	%
Chronic illness	892	59.8	600	40.2
Manageable condition	696	46.6	796	53.4
Moral failing	393	26.3	1099	73.7
Something else	292	19.6	1200	80.4

Note: Question 8 is a narrative response question, so not listed here.

Question 9. In "Medication assisted treatment," a federally approved drug, such as methadone, is prescribed to a person addicted to opioids, to help them avoid relapse and overdose. How much do you agree or disagree with the following statements? Medication assisted treatment…

	Agree strongly		Agree somewhat		Agree a little		Neutral or not sure		Disagree a little		Disagree somewhat		Disagree strongly		Blank
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#
Replaces one addiction with another	278	19	321	22	219	15	302	21	76	5	155	11	113	8	28
Helps like insulin helps people with diabetes	166	11	396	27	243	17	299	20	62	4	102	7	193	13	31

Question 10: How much do you agree or disagree with the following statements? To address the problem of widespread opioid addiction, Wisconsin should…

	Agree strongly		Agree		Neutral or not sure		Disagree		Disagree strongly		Blank
	#	%	#	%	#	%	#	%	#	%	#
Prosecute those addicted	519	35.4	377	25.7	286	19.5	202	13.8	83	5.6	25
Expand insurance	532	36.8	542	37.5	227	15.7	88	6.1	56	3.9	47
Provide NARCAN	320	22.2	355	24.5	359	24.9	265	18.3	146	10.1	47
Provide MAT for those incarcerated	466	31.9	550	37.7	238	16.3	91	6.2	116	8	31
Address underlying issues	808	55.3	443	30.3	149	10.2	38	2.6	25	1.7	30

Question 11. Names of some common prescription opioids are Vicodin®, Percocet®, Codeine, and OxyContin®, but there are others. Have you ever…

	Yes		No		
	#	%	#	%	
Been prescribed and taken opioids for pain	1041	70.4	437	29.6	14
Taken prescribed opioids for more than 10 days	259	17.3	1212	82.4	22
Felt you needed help in reducing use of opioids	50	3.4	1423	96.6	19

Question 12. Do you have a friend or family member who…

	Yes		No		
	#	%	#	%	
Has taken prescribed opioids for more than 10 days	720	48.7	757	51.3	15
You felt needed help in reducing use of opioids	466	31.9	995	68.1	31

Demographic information

Time living in Wisconsin			
		#	%
	Less than 1 year	16	1.1
	1 to 5 years	53	3.6
	More than 5 years, but not whole life	362	24.3
	My whole life	1058	71.1
	No answer	3	

Educational attainment			
		#	%
	Less than HS graduate	195	13.1
	HS grad (diploma/GED)	468	31.4
	Some college, no degree	270	18.1
	Vocational, Associate, or technical degree	192	12.8
	College undergrad degree	254	17.0
	Graduate or professional degree	113	7.6

Age			
		#	%
	18 to 24 years	181	12.1
	25 to 34 years	242	16.2
	35 to 44 years	232	15.5
	45 to 54 years	243	16.3
	55 to 64 years	270	18.1
	65 to 74 years	188	12.6
	75 or older	136	9.1

Household income			
		#	%
	Less than $25,000	230	15.4
	$25,001 - $40,000	213	14.2
	$40,001 - $55,000	149	10.0
	$55,001 - $65,000	125	8.3
	$65,001 - $75,000	121	8.1
	$65,001 - $75,000	166	11.1
	More than $100,000	219	14.7
	Blank/refused	271	18.1

Notes and References

1. *Statistical weighting.* In large population surveys such as this, samples seldom match the population exactly. A statistical technique called *rake weighting* takes each person in the survey and weights their responses either up or down, based on whether they are under or overrepresented in the sample using the demographic measures available, compared to the population whose demographics we know much better. It is an imperfect process, because there might be other characteristics that are not measured that are just as important, but it is the best approach available.

2. CPS, 2019. U.S. Census Bureau. Current Population Survey, Annual Social and Economic Supplement, 2019. Retrieved from: https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-hinc/hinc-01.html on August 18, 2021.

3. Sugden, NA, 2015. Wisconsin Urban-Rural Classification (WURC) System. AHEC System Program Office. HSLC, 750 Highland Ave., Madison, WI 53705.

4. CDC, 2019. Prescribing Practices. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Retrieved from: https://www.cdc.gov/drugoverdose/data/prescribing/prescribing-practices.html on August 18, 2021.

5. Wisconsin Association for Perinatal Care, 2018. From Just Say No to Just Say Know (and Do). Retrieved from: https://cdn.ymaws.com/perinatalweb.org/resource/resmgr/resources_by_topic/perinatal_substance_use_disorders/justsayno.pdf on August 18, 2021.

6. NIDA. 2020, June 3. Is the use of medications like methadone and buprenorphine simply replacing one addiction with another? Retrieved from: https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/use-medications-methadone-buprenorphine-simply-replacing on August 18, 2021.