Healthcare Provider Substance Use Stigma Measures Toolkit

The National Association of County and City Health Officials represents over 3,300 local health departments nationwide, providing leading professional resources and programs. Our mission is to improve the health of communities by strengthening and advocating for local health departments.

The Overdose, Injury, & Violence Prevention Team addresses the overdose crisis with a community- centered, equitable, and evidence-based approach. We support local health departments and their partners with funding, technical assistance, mutual learning opportunities, and resource development.

This toolkit was developed in collaboration with Dr. Lawrence Yang, Stigma Lab, LLC.

NACCHO[SM]
National Association of County & City Health Officials

Table of Contents

Introduction

The measures presented in this document assess healthcare providers' attitudes, including stigma, toward individuals with opioid and/or substance use disorders or related conditions. They have been used and validated among various healthcare provider populations including medical students, residents, physicians, nurse practitioners, and OBGYNs. This document has been divided into 4 sections of constructs reflecting negative or stigmatizing attitudes (Section 1) or sections that are closely related to stigma and may be of utility in measurement of stigma (Sections 2-4):

1. Stigma and Negative Attitudes towards OUD (+ Professional Role and Responsibility)
    a. Attitudes Towards Naloxone
2. Preparedness in treating OUD
3. Harm Reduction
4. Attitudes towards Recovery of OUD

Section 1 contains measures about providers' stigmatizing attitudes/views, as well as their professional role in interacting with individuals with OUD. Subsection 1a contains measures about provider attitudes, beliefs and knowledge towards naloxone use and prescription. Section 2 contains measures about providers' perceived preparedness and confidence in treating and interacting with patients with OUD. Section 3 contains a measure about providers' attitudes toward harm reduction principles. Finally, Section 4 contains a measure about providers' understanding of the recovery process in relation to SUD/OUD.

This toolkit can be used to develop new stigma assessments or a template stigma assessment is included at the end of this toolkit and can be used as a reference. Each scale includes a link to the original study, background information, reliability, and response scales. A complementary toolkit with information on stigma data collection and data analysis is available.

Notes on possible adjustments:

- Some original versions of these measures used stigmatizing language. NACCHO has made minor edits to ensure the language is as non-stigmatizing as possible while maintaining the integrity of the original measure. Changes are provided in italics and the original versions of the measures can be found in the referenced study.
- Most response scales utilize a 5-point Likert scale but a 4-point Likert scale that excludes the neutral option may be used instead. This requires the respondents to form an opinion and was used in the template assessment.

Section 1: Stigma and Negative Attitudes Towards OUD (+ Professional Role and Responsibility)

Medical Condition Regard Scales (MCRS)

Christison, Haviland & Riggs, 2002

The Medical Condition Regard Scale (MCRS) measures the degree to which medical students find patients with a given medical condition to be enjoyable, treatable, and worthy of medical resources. It can be seen to assess stigma and negative attitudes towards individuals with OUD. Enjoyableness and treatability resonate well with descriptions of physicians' reactions to patients they like and dislike. Medical worthiness taps the discrediting or devaluing reactions that typify responses to stigmatized individuals. It uses a 6-point Likert scale (1= Strongly Disagree, 2= Disagree, 3= Not Sure but Probably Disagree, 4= Not Sure but Probably Agree, 5= Agree, 6= Strongly Agree).

It has been used with a variety of patient conditions. In an initial sample of medical students (n=440), the MCRS demonstrated good reliability and validity (Cronbach's alpha= 0.87, test-retest reliability= 0.84).

1. I prefer to not work with patients *who use drugs*. *
2. *Patients who use drugs* irritate me. *
3. I enjoy giving extra time to patients *who use drugs*.
4. Patients *who use drugs* are particularly difficult for me to work with. *
5. Working with patients *who use drugs* is satisfying.
6. I feel especially compassionate toward patients *who use drugs*.
7. I wouldn't mind getting up on call nights to care for patients *who use drugs*.
8. I can usually find something that helps patients *who use drugs* feel better.
9. There is little I can do to help patients *who use drugs*. *
10. Insurance plans should cover patients *who use drugs* to the same degree that they cover patients with over conditions.
11. Treating patients *who use drugs* is a waste of time. *

* Reverse scored

Work Practice Questionnaire (WPQ)

Addy et al., 2004

The Work Practice Questionnaire is a purpose-built measurement tool designed to assess a wide range of factors that influence work practices in relation to alcohol and other drugs. The WPQ was developed to assess key individual, team, workplace, and organizational factors that have an impact on training transfer and work practice change, including education and training.

Sound support was obtained for the construct validity of the WPQ and most of the WPQ scales demonstrated moderate correlations with established measures of similar constructs. The Role Adequacy Scale has an internal consistency of 0.91 and a test-retest reliability of 0.86. The Role Legitimacy Scale has an internal consistency of 0.82 and a test-retest reliability of 0.81. The Individual Motivation and Reward Scale has an internal consistency of 0.89 and a test-retest reliability of 0.83. The Personal Views (i.e., stigmatizing attitudes) Scale has an internal consistency of 0.68 and a test-retest reliability of 0.75.

Items are related to the personal characteristics, beliefs, and views of individual workers. It uses a 4-point Likert scale (1 = Disagree, 2= Tend to Disagree, 3= Tend to Agree, 4= Agree).

Individual Role Adequacy:
1. I have the necessary experience to respond to drug related issues. 2. In my work I have responded to a wide range of drug related issues. 3. I am confident in my ability to respond to drug related issues. 4. I have the necessary knowledge to help people with drug related issues. 5. I do not have many of the skills necessary to respond to drug related issues. 6. I am able to respond to people who have drug related issues as competently as I respond to people with other problems.
Individual Role Legitimacy:
7. I have a legitimate role to play in responding to drug related issues. 8. I am reluctant to take responsibility for drug related issues in my work. 9. It is more appropriate for other colleagues to respond to drug related issues, than myself. 10. I am uncertain of my role in responding to drug related issues. 11. I am clear about my responsibilities in responding to drug related issues. 12. I have a responsibility to ask clients questions about drug related issues. 13. My clients believe I have a responsibility to ask them questions about drug related issues.

Individual Motivation and Reward:
14. I prefer not to respond to drug related problems as I find it too frustrating. * 15. I refer people with drug related issues onto others to prevent them from wasting my time. * 16. I believe that responding to drug related issues is important. 17. I gain a lot of satisfaction responding to people affected by drug related issues. 18. I am often bored of responding to drug related issues and wish I was involved in something else. 19. On the whole, I am satisfied with the way I work with people who have drug related issues. 20. I like to respond to drug related issues in my work.
Individual Personal Views:
21. Most people *with* drug related problems are not interested in addressing them. 22. I generally think people with drug related problems bring their difficulties on themselves. 23. I try to avoid responding to people with drug related problems as they are unreliable.
* Reverse coded

Jefferson Scale for Physician Empathy (JSPE)

Hojat 2002; Hojat et al., 2007

The Jefferson Scale for Physician Empathy (JSPE) was a 20-item measure originally developed to measure the orientation of medical students toward physician empathy in patient-care situations (Student or S Version). The scale was constructed based on an extensive review of the literature, followed by pilot studies with samples of physicians, students, and residents. In addition to the JSPE itself, the survey also comes with a pre-survey and has an innovative section that assesses the source of positive/negative attitudes. Researchers also developed a revised version of the scale for physicians and health professionals (Health Professional or HP-Version). In the HP-version, the wording of the S-Version was modified slightly to make the contents more relevant to the caregiver's empathetic behavior rather than to the student's empathetic orientation or attitudes.

The coefficient alpha reliability for the JSPE ranged from 0.80 to 0.89 for samples of medical students, residents (Hojat, Mangione, et al., 2001), physicians (Hojat, Gonnella, Nasca,

Mangione, Vergare, et al., 2002), and nurse practitioners (Hojat, Fields, et al., 2003). The test-retest reliability among physicians in approximately 3 to 4 month intervals was 0.65. The JSPE measure uses a 7-point Likert scale, with a range from 0= Strongly Disagree to 6= Strongly Agree.

Select items from pre-survey for resident physicians

1. In medical school, how many hours of required formal instruction related to substance use disorders do you estimate you had?
    a) None
    b) 1-3
    c) 4-9
    d) 10-25
    e) >25
2. In residency to date, how many hours of required formal instruction (e.g. Grand Rounds, Residents Report, M&M, other formal didactics, etc.) related to substance use disorders do you estimate that you had?
    a) None
    b) 1-3
    c) 4-9
    d) 10-25
    e) >25

Please rate your current skill level for the following:		**Not at all skilled**	**Somewhat skilled**	**Moderately skilled**	**Very skilled**
1.	Screen for substance use disorders	1	2	3	4
2.	Diagnose substance use disorders	1	2	3	4
3.	Diagnose “dual diagnosis” patients	1	2	3	4
4.	Treat substance use disorders	1	2	3	4
5.	Treat “dual diagnosis” patients	1	2	3	4
6.	Refer patients with substance use disorders to other professionals for treatment	1	2	3	4

How well do you understand:		Not at all	Somewhat	Moderately	Very well
1.	The workings of 12-step programs	1	2	3	4
2.	Pharmacotherapies for treating substance use disorders	1	2	3	4
3.	Various forms of therapeutic intervention programs used in substance use disorders	1	2	3	4
4.	Relapse prevention	1	2	3	4

The following questions address your personal views regarding patients with substance use disorders. Please select one answer that is *closest to your views.*		**Strongly disagree**	**Disagree**	**Agree**	**Strongly agree**
1.	*Patients with drug related issues* over utilize healthcare resources and provide nothing in return	1	2	3	4
2.	Physicians who diagnose drug addiction early improve the chance of treatment success.	1	2	3	4
3.	Drug addiction is a treatable illness.	1	2	3	4
4.	*Someone with drug related issues* who has relapsed several times probably cannot be successfully treated.	1	2	3	4
5.	Most *people who use drugs* are unpleasant to work with as patients.	1	2	3	4
6.	*A person who uses drugs* cannot be helped until he/she has hit "rock bottom".	1	2	3	4
7.	The care of other patients suffers because of time and resources spent on patients *with drug related issues*.	1	2	3	4
8.	Family involvement is a very important part of the treatment of drug addiction.	1	2	3	4

9.	At the core of substance *use* is a failure to exercise self-control.	1	2	3	4
10.	My feelings of disapproval *for people who use drugs* get in the way of my ability to empathize with them.	1	2	3	4
11.	I can make a great difference in the lives of my patients who *use* drugs.	1	2	3	4
12.	People *with drug related issues* have a special ability to manipulate physicians.	1	2	3	4
13.	*Medications for Opioid Use Disorder (MOUD)* is effective and worth the effort.	1	2	3	4

Some physicians have negative attitudes towards patients with substance use disorders. What do you think are the sources of those attitudes?		**Number each source below from 1-5 where "1" signifies the most important source of the negative attitude, "2" the second most important source, and so on; use each number only once.**				
1.	Negative experiences with patients with substance use disorders	1	2	3	4	5
2.	Substance use by self, family member, or close friend	1	2	3	4	5
3.	Attending physicians with negative attitudes	1	2	3	4	5
5.	Other resident physicians with negative attitudes	1	2	3	4	5
6.	Non-physician health care professionals, e.g., nurses, with negative attitudes	1	2	3	4	5

Some physicians have positive attitudes towards patients with substance use disorders. What do you think are the sources of those attitudes?		**Number each source below from 1-5 where "1" signifies the most important source of the negative attitude, "2" the second most important source, and so on; use each number only once.**				
1.	Positive experiences with patients with substance use disorders	1	2	3	4	5
2.	Substance use by self, family member, or close friend	1	2	3	4	5
3.	Attending physicians with positive attitudes	1	2	3	4	5
5.	Other resident physicians with positive attitudes	1	2	3	4	5
6.	Non-physician health care professionals, e.g., nurses, with positive attitudes	1	2	3	4	5

JSPE Measure

1. Physicians' understanding of their patients' feelings and the feelings of their patients' families does not influence medical or surgical treatment.
2. Patients feel better when their physicians understand their feelings.
3. It is difficult for a physician to view things from patients' perspectives.
4. Understanding body language is as important as verbal communication in physician-patient relationships.
5. A physician's sense of humor contributes to a better clinical outcome.
6. Because people are different, it is difficult to see things from patients' perspectives.
7. Attention to patients' emotions is not important in history taking.
8. Attentiveness to patients' personal experiences does not influence treatment outcomes.
9. Physicians should try to stand in their patients' shoes when providing care to them.
10. Patients value a physician's understanding of their feelings which is therapeutic in its own right.
11. Patients' illnesses can be cured only by medical or surgical treatment; therefore, physicians' emotional ties with their patients do not have significant influence in medical or surgical treatment.
12. Asking patients about what is happening in their personal lives is not helpful in understanding their physical complaints.
13. Physicians should try to understand what is going on in their patients' minds by paying attention to their non-verbal cues and body language.
14. I believe that emotion has no place in the treatment of medical illness.
15. Empathy is a therapeutic skill without which the physician's success is limited.
16. Physicians' understanding of the emotional status of their patients and their families is one important component of the physician-patient relationship.
17. Physicians should try to think like their patients in order to render better care.
18. Physicians should not allow themselves to be influenced by strong personal bonds between their parents and their family members.
19. I do not enjoy reading non-medical literature or the arts.
20. I believe that empathy is an important therapeutic factor in medical treatment.

American College of Obstetricians and Gynecologists Survey Questions, 2017

Ko et al., 2020

This survey was created to assess U.S. obstetrician-gynecologists' practices (management), attitudes (knowledge, preparedness, confidence, barriers, and resources needed) related to opioid use among pregnant and postpartum women specifically. While this measure focuses more on systematic barriers and professional roles and responsibility, it also has elements of stigma and negative attitudes towards OUD (e.g., thinking that "patient denial" is a barrier to treatment). No psychometrics are available. Response scales are included in the table below.

How do you manage pregnant patients who have opioid use disorders (illicit use or nonmedical use of prescription opioids)?	**Answer Options**
1. Advise opioid cessation. 2. Advise inpatient, monitored withdrawal. 3. Advise methadone maintenance. 4. Advise buprenorphine maintenance. 5. Advise buprenorphine/naloxone maintenance. 6. Conduct brief intervention/motivational interviewing/cognitive behavioral therapy. 7. Screen for alcohol or tobacco use. 8. Screen for depression. 9. Screen for anxiety or use of benzodiazepines. 10. Screen for intimate partner violence. 11. Inform about fetal effects (e.g., neonatal abstinence syndrome).	1. Never 2. Rarely 3. Sometimes 4. Usually 5. Always
How do you manage postpartum patients who have opioid use disorders (illicit use or nonmedical use of prescription opioids)?	**Answer Options**
1. Advise opioid cessation. 2. Advise inpatient, monitored withdrawal. 3. Advise methadone maintenance. 4. Advise buprenorphine maintenance. 5. Advise buprenorphine/naloxone maintenance. 6. Recommend breastfeeding if on opioid-assisted therapy. 7. Counsel on effective contraceptive methods (e.g., long-acting reversible contraceptives, oral contraceptives). 8. Refer to a treatment program or facility. 9. Refer to an addiction specialist. 10. Refer to psychiatry.	1. Not a priority 2. Moderate priority 3. High priority

To what extent is any routine screening of the following among pregnant patients in your practice a priority? 1. Prescription opioid use. 2. Nonmedical use of prescription *or other* opioids (i.e., using opioids for reasons other than prescribed).	**Answer Options** 1. Not a priority 2. Moderate priority 3. High priority
Does the Affordable Care Act include a provision that requires pregnant patients on Medicaid receive coverage for comprehensive substance use services, including both counseling and pharmacotherapy?	**Answer Options** 1. I do not know 2. No 3. Yes
To what extent are the following potential barriers to screening and treating pregnant and postpartum patients for opioid use disorder? 1. Time limitations during patient visits. 2. Concern about patient confidentiality issues. 3. Patient sensitivity to this topic (e.g., fear of offending patients). 4. Patient denial or resistance. 5. Doubt about the efficacy of brief intervention. 6. Limited training or experience in screening for opioids. 7. Limited training or experience in treating opioid use disorder. 8. Lack of facilities or resources for treatment of opioid use disorder, once identified. 9. Lack of or inadequate financial reimbursement for opioid screening, assessment, and counseling. 10. Patient inability to pay for treatment. 11. State reporting laws and repercussions. 12. Not sure what screener to use. 13. Other (please specify).	**Answer Options** 1. Not a barrier 2. Minor barrier 3. Major barrier

What resources do you need to improve treatment of opioid use disorder in your clinical practice? Check all that apply.

1. Patient information regarding adverse reproductive outcomes associated with opioids.
2. Patient information regarding infectious disease associated with use by injection.
3. Referral resources and treatment facilities for pregnant and postpartum patients with opioid use disorder.
4. Access to phone consultation line to ask questions regarding opioid use disorders in pregnant patients.
5. Information regarding relapse prevention for patients who seek treatment for addiction in pregnancy.
6. Specific standardized screening questionnaire for substance use during pregnancy.
7. Training and advice on brief interventions or motivational interviewing.
8. Reimbursement by insurance for screening and assessment.
9. Other (please specify).

Stigma of Opioid Misuse

Brown et al., 2022

This index captures a general tendency to endorse stigmatizing views of people who use opioids. Brown et al. used 10 items from the Stigma of Mental Illness Scale (Corrigan et al., 2006) to assess the stigma of opioid use. Each item was modified to reference people with OUD instead of people with mental illness. The 10-item modified scale was validated among clinicians and clinicians in training who had participated in a buprenorphine waiver training program. The scale uses a 9-point Likert type scale ranging from 1 (Strongly Disagree) to 9 (Strongly Agree) (note: no further details are provided regarding the response scale).

This measure is reliable (Spearman-Brown Prophesy estimates=.88 and Cronbach's alpha= 0.93). Brown et al. found evidence of discriminant validity and construct validity for this measure and the Stigma of Medical Treatment for Opioid Use Disorder measure below.

I think most patients who use opioids:

1. Are to blame for their problems
2. Are unpredictable
3. Will not recover or get better
4. Are unable to get or keep a regular job
5. Are dirty and unkempt
6. Are dangerous
7. Cannot be trusted
8. Are below average in intelligence
9. Are unable to take care of themselves
10. Are disgusting

Stigma of Medical Treatment for Opioid Use Disorder

Brown et al., 2022

This index evaluates stigma toward patients seeking MOUD treatment and more directly assesses a provider's reluctance to view OUD as a medical issue requiring medical treatment. The measures were developed through an extensive review of research, consultation with stigma experts, and open-ended questions to participants. This 13-item measure uses a 7-point Likert scale ranging from 1 (Not at All) to 7 (Very Much) (note: no further details are provided regarding the response scale). Higher values reflect greater stigma endorsement.

This measure is reliable (Spearman-Brown Prophesy estimates= 0.93 and Cronbach's alpha= 0.91). Brown et al. found evidence of discriminant validity and construct validity for this measure and the Stigma of Opioid Misuse measure above.

I think most MOUD patients are:

1. Dependent*
2. Manipulative
3. Desperate
4. Incompetent
5. Needs
6. Not in control of their emotions
7. Selfish
8. Untrustworthy
9. Insecure
10. Inadequate
11. Cowardly
12. Oversensitive
13. Pitiful

* Cut from index after validation stud

Modified Opioid Overdose and Attitudes Scale (OOAS): *Attitudes Towards Individuals with OUD*

Bascou et al., 2022

This subscale of the modified OOAS (11 items total; note that the OOAS is administered to other groups such as the public, people with OUD and first responders) was part of the evaluation of the Opioid Overdose Awareness and Reversal Training (OOART). The OOART and its evaluation surveys were designed by medical students with assistance from faculty advisers and members of the Philadelphia Department of Public Health. The original OOAS contains 28 questions (see the Opioid Overdose and Attitudes Scale section), which the research team reduced to 6 items concerning attitudes and knowledge regarding naloxone and overdose (see the Modified OOAS: Self Confidence Using Naloxone and Handling Overdose Situations and Modified OOAS: Attitude Towards Naloxone Usage and Overdose Reversal sections). The research team created 5 additional questions designed to evaluate stigma and attitudes toward people with OUD (shown below). All attitude questions are scored on a 5-point Likert scale (1= Completely Disagree, 2= Disagree, 3= Unsure, 4= Agree, 5= Completely Agree).

Attitudes Towards Individuals with OUD:

1. It is understandable why those who use drugs and experience withdrawal symptoms may use drugs daily.
2. We need to provide ways to keep people alive and minimize the harms associated with drug use to effectively deal with the *overdose* epidemic.
3. People often start using opioids and find it hard to quit due to lack of willpower and discipline.
4. It is understandable that many people are not ready, willing, or able to get treatment for substance use disorder.
5. My attitudes toward people who use drugs, and how I think and talk about them, has nothing to do with their ability to seek or receive help.

Section 1A: Attitudes Towards Naloxone

Providers Knowledge and Attitudes Questionnaire

Kirane et al., 2016

This provider survey examines knowledge of naloxone rescue, attitudes toward substance users, and the impact of providing naloxone on patient behavior. Study questions were developed by the research team in consultation with staff and patients who assessed the face validity of the questions, which were refined with feedback from the initial study participants. Although the majority of respondents completed the survey in a face-to-face format, a few completed the questionnaire on their own. No psychometrics are available. For the purposes of this document, open-ended questions have been removed from the questionnaire.

1. Are Substance Use Disorders: (select all that apply)
    a) Treatable
    b) Not Treatable
    c) Medical Illness
    d) Product of Moral Failings
    e) Psychiatric Illness

2. What other drugs are most often associated with fatal opioid overdose? (select all that apply)
    a) Cocaine
    b) Alcohol
    c) Xanax (Alprazolam)
    d) Klonopin (Clonazepam
    e) Catapres (Clonidine)
3. Have you completed *naloxone* training?
    a) Yes
    b) No
4. Are you a Suboxone Provider?
    a) Yes
    b) No
5. What type of drug overdose(s) does *naloxone* treat? (select all that apply)
    a) All Opiates and Opioids
    b) Only Heroin and no other opioids
    c) Cocaine
    d) Alcohol
    e) Benzodiazepines
    f) I don't know
6. What is the duration of *naloxone's* effect?
    a) Up to 15 min
    b) 30-60 min
    c) 1-2 hours
    d) 3 hours
    e) I don't know
7. Do you feel providing *naloxone* kits (increases/decreases/no impact) on the likelihood of an overdose occurring?
8. Do you feel that providing *naloxone* kits (increases/decreases/has no impact on) riskier use patterns? (i.e., due to moral hazard.)
9. Do you know where to refer patients to get a *naloxone* kit?
    a) Yes – if so, where?
    b) No
10. Does your hospital/clinic have an opioid overdose prevention program?
    a) Yes
    b) No

Naloxone-Related Experiences and Beliefs Among Rural and Small Metro Area Pharmacists Survey

Tofighi et al., 2019

This 29-item survey was designed to determine pharmacists' demographic and practice characteristics; experiences and beliefs related to naloxone dispensation; and attitudes toward expansion of pharmacy services to include on-site public health services for persons who use opioids. No psychometrics are available. These items below ascertain naloxone-related experiences and beliefs among providers. Please see the Attitudes About Pharmacist Provision of Public Health Services Among Rural and Small Metro Area Pharmacists Survey section for items relating to provision of public health services in pharmacies.

1. Support sale of naloxone in pharmacy.	☐ Y	☐ N
2. Believe pharmacist should play bigger role in overdose prevention.	☐ Y	☐ N
3. Do you think that selling naloxone to *people who use opioids:*		
a) Makes opioid use increase?	☐ Y	☐ N
b) Sends a message that opioid use is ok?	☐ Y	☐ N
c) Reduces the risk of opioid overdoses?	☐ Y	☐ N
4. Since registering for [the New York State] Opioid overdose Prevention Program, pharmacist experienced:		
a) Loss of business.	☐ Y	☐ N
b) Theft/crime potentially committed by naloxone customers.	☐ Y	☐ N
c) Increase in number of prescriptions.	☐ Y	☐ N

Overdose Education and Naloxone Distribution (OEND) Acceptance Survey

Peckham et al., 2018

This survey assesses 4 domains related to the OEND initiative including attitudes about naloxone and the OEND program; perceptions of their knowledge regarding naloxone and overdose prevention strategies; comfort with the OEND program; and fear of consequences related to prescribing naloxone. It was developed to examine prescriber attitudes, beliefs, and knowledge within the Veteran Affairs Connecticut Healthcare System. The survey uses a standard 5-point Likert scale (1= Completely Disagree to 5= Completely Agree) (note: no further details are provided regarding the response scale). No psychometrics are available.

Attitudes:

1. I believe it is good practice to discuss overdose prevention strategies with my patients who are taking opioid medication regardless if I am the clinician who is prescribing the opioids.
2. I believe it is the responsibility of the clinician prescribing opioids to discuss overdose prevention with patients.
3. I believe it is good practice to discuss overdose prevention strategies with my patients who are using illicit opioids.
4. I do not believe that discussing overdose prevention strategies with *people who use opioids* will make any difference in how they use opioids. *
5. Illicit opioid use is inherently unsafe, and it is not my responsibility to talk to patients about safer ways to engage in illegal behaviors. *
6. Abstinence is the only overdose prevention strategy that should be discussed with *patients who use drugs*. *

Comfort:

1. I am comfortable training my patients on how to administer naloxone.
2. I am comfortable talking to my patients about preventing overdose from opioids.
3. I am comfortable talking to my patients who use illicit opioids about strategies to prevent an overdose.
4. I would feel uncomfortable providing education about naloxone to my patients if I was not the opioid prescriber. *

Lack of Knowledge:

1. I am not familiar enough with naloxone administration to discuss this with my patients.
2. I am not familiar enough with overdose prevention strategies to discuss this with my patients.
3. I am not sure how to start a conversation about overdose prevention.

Fear of Consequences:
1. I am concerned that discussing overdose prevention strategies with *people who use drugs* gives the wrong message. 2. I am concerned that *people who use opioids* will use more opioids if they know they have access to naloxone. 3. I am concerned that *people who use opioids* will be less likely to seek out treatment if they have access to naloxone. 4. I am concerned about the side effects of naloxone. 5. I am concerned that training patients to respond to an opioid overdose will lead to unintended consequences. 6. I am concerned that coprescribing opioids and a naloxone kit to my patients may give the impression that I am prescribing unsafe levels of opioids. 7. I am worried that I will offend my patients if I talk to them about overdose prevention. 8. I am worried that discussing overdose prevention with my patients who are prescribed opioids will send the message that I don't trust them. 9. I am worried that discussing overdose prevention with patients in recovery will send the message that I expect them to relapse to opioid use.
* Reverse Scored

Internal Medicine Resident Knowledge, Attitudes, and Barriers to Naloxone Prescription Survey

Wilson et al., 2016

This survey was designed to evaluate internal medicine residents' knowledge, attitudes, and beliefs regarding OUD, overdose education and barriers to naloxone prescription. No psychometrics are available.

Baseline Experience with Opioid Addiction and Naloxone Amongst Respondents	**Answer Options**
1. Aware of naloxone as overdose prevention 2. Patients in clinical panel misusing prescription opioids 3. Patients at risk of overdose in clinic panel 4. Ever discussed risk of overdose and overdose prevention with patients 5. Ever prescribed naloxone to patients	1. Yes 2. No

Knowledge and Beliefs about Practical Implications of Naloxone Prescription	**Answer Options**
Knowledge regarding legality 1. My patient or bystander could get arrested for being at an overdose event. 2. My patient or bystander could be arrested for giving naloxone to someone who is *experiencing an* overdose. 3. Prescribing naloxone for individual patients is legal. 4. Prescribing naloxone to my patients to use on others who are overdosing is illegal. *Knowledge and beliefs regarding efficacy* 1. Overdose education is effective in teaching people to dial 911 when someone overdoses. 2. Overdose education is effective at getting people to give rescue breaths during an overdose. 3. Naloxone is an effective tool to reduce opioid-related overdose deaths. 4. Giving patients naloxone for overdose reversal will cause them to use more drugs. 5. Giving patients naloxone for overdose reversal will cause them to use drugs in riskier ways. 6. Giving patients naloxone for overdose reversal enables illegal drugs use.	1. Strongly Disagree 2. Somewhat Disagree 3. Somewhat Agree 4. Strongly Agree

Section 2: Preparedness in Treating OUD

Jefferson Scale for Physician Empathy (JSPE)

Hojat, 2002; Hojat et al., 2007

Please see notes on the JSPE section, the physician preparedness items regarding the treatment of OUD are taken from the JSPE pre-survey.

1. How prepared do you think you are the discuss the following with your patients?	**Very unprepared**	**Somewhat unprepared**	**Somewhat prepared**	**Very prepared**
a) Tobacco use	1	2	3	4
b) Alcohol *use*	1	2	3	4
c) Prescription drug *use*	1	2	3	4
d) Illicit drug *use*	1	2	3	4
2. How prepared do you think you are to provide counseling and initial treatment for patients about:	**Very unprepared**	**Somewhat unprepared**	**Somewhat prepared**	**Very prepared**
a) Tobacco use	1	2	3	4
b) Alcohol *use*	1	2	3	4
c) Prescription drug *use*	1	2	3	4
d) Illicit drug *use*	1	2	3	4
e) Management of chronic pain	1	2	3	4

3. How confident are you in your knowledge if substance use disorders?

Not at all confident				Somewhat confident				Extremely confident	
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10

4. How confident are you in your ability to screen patients for substance use disorders?

Not at all confident				Somewhat confident				Extremely confident	
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10

5. How confident are you in your ability to provide counseling and initial treatment to patients with substance use disorders?

Not at all confident				Somewhat confident				Extremely confident	
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10

6. How confident are you that your counseling and other treatment will make a difference for your patients with substance use disorders?

Not at all confident				Somewhat confident				Extremely confident	
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10

7. How confident are you that your counseling and other treatment will make a difference for your patients with substance use disorders involving illicit drug *use*?

Not at all confident				Somewhat confident				Extremely confident	
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10

American College of Obstetricians and Gynecologists Survey Questions, 2017

Ko et al., 2017

Please see notes on the American College of Obstetricians and Gynecologists Survey Questions, 2017 section, these physician preparedness items regarding treatment of OUD are taken from the ACOG survey.

Do you feel confident that you can appropriately treat your pregnant patients who are using opioids?	**Answer Options** 1. Not Confident 2. Somewhat Confident 3. Confident 4. Very Confident
In general, how prepared do you feel to do the following in your clinical practice: 1. Screen pregnant patients for opioid use disorder? 2. Conduct brief interventions with pregnant patients who use opioids? 3. Educate pregnant patients about the effects of opioids on their fetus or baby. 4. Use resources to refer patients who need an opioids cessation program. 5. Prescribe opioid-assisted therapy for pregnant patients. 6. Screen postpartum patients for opioid use disorder. 7. Educate breastfeeding patients about the effects of opioids on their infant. 8. Prescribe opioid-assisted therapy for nonpregnant patients.	**Answer Options** 1. Very Unprepared 2. Unprepared 3. Prepared 4. Very Prepared

Modified Opioid Overdose and Attitudes Scale (OOAS): *Self Confidence Using Naloxone and Handling Overdose Situations*

Bascou et al., 2022

Please see the Modified Opioid Overdose and Attitudes Scale: Attitudes Towards Individuals with OUD section. These questions specifically focus on the attitudes and knowledge regarding naloxone and overdose.

Self-confidence in using naloxone and handling overdose

1. I would be afraid of doing something wrong in an overdose situation.
2. If I saw an overdose, I would panic and not be able to help.
3. I would be able to deal effectively with an overdose.

Opioid Overdose Knowledge Scale (OOKS)

Williams, et al., 2013

The OOKS measures knowledge about opioid overdose in friends and family members of people who use opioids. The OOKS items used a 'yes/no or don't know'; or 'true/false or don't know' response format (each correct answer scored one and 'don't know' and incorrect responses scored zero; total score range, 0–45).

In Williams et al.'s 2013 psychometric development study, the full version of the OOKS shown below was validated in a sample of 56 healthcare professionals. It demonstrated good internal reliability (Cronbach's alpha= 0.83). The overall test–retest reliability of the OOAS was good (ICC= 0.90), with the risks, signs, actions and naloxone subsection item score totals falling in the fair-to-excellent range for test–retest reliability (ICC= 0.87, 0.69., 0.53 and 0.83 respectively).

A. Which of the following factors increase the risk of an overdose?	Tick each correct answer
1. Taking larger than usual doses or heroin	☐ (T)
2. Switching from smoking to injecting heroin	☐ (T)
3. Using heroin with other substances, such as alcohol or sleeping pills	☐ (T)
4. Increase in heroin purity	☐ (T)
5. Using heroin again after not having used for a while	☐ (T)
6. Using heroin when no one else is present around	☐ (T)

7. A long history of heroin use	☐ (T)
8. Using heroin again soon after release from prison	☐ (T)
9. Using heroin again after a detoxification treatment	☐ (T)

B. Which of the following are indicators of an opioid overdose?	
1. Having blood-shot eyes	☐ (F)
2. Slow or shallow breathing	☐ (T)
3. Lips, hands, or feet turning blue	☐ (T)
4. Loss of consciousness	☐ (T)
5. Unresponsive	☐ (T)
6. Fitting	☐ (F)
7. Deep snoring	☐ (T)
8. Very small pupils	☐ (T)
9. Agitated behavior	☐ (F)
10. Rapid heartbeat	☐ (F)

C. Which of the following should be done when managing an overdose?	
1. Call an ambulance	☐ (T)
2. Stay with the person until an ambulance arrives	☐ (T)
3. Inject the person with salt solution or milk	☐ (F)
4. Give mouth to mouth resuscitation	☐ (T)
5. Give stimulants (e.g. cocaine or black coffee)	☐ (F)
6. Place the person in the recovery position (on their side with mouth clear)	☐ (T)
7. Give naloxone (opioid overdose antidote)	☐ (T)
8. Put the person in a bath of cold water	☐ (F)
9. Check for breathing	☐ (T)
10. Check for blocked airways (nose and mouth)	☐ (T)
11. Put the person in bed to sleep it off	☐ (F)

D. What is naloxone used for?	
1. To reverse the effects of an opioid overdose (e.g. heroin, *fentanyl*)	☐ (T)
2. To reverse the effects of an amphetamine overdose	☐ (F)
3. To reverse the effects of a cocaine overdose	☐ (F)
4. To reverse the effects of any overdose	☐ (F)

E. How can naloxone be administered?	
1. Into a muscle (intramuscular)	☐ (T)
2. Into a vein (intravenous)	☐ (T)
3. Under the skin (subcutaneous)	☐ (T)
4. Into nostrils (intranasal)	☐ (T)
5. Swallowing- liquid	☐ (F)
6. Swallowing- tablet	☐ (F)
7. Don't know	☐

F. Where is the most recommended place for non-experts to administer naloxone?	
1. Outside the thighs or upper arms	☐ (T)
2. Any vein	☐ (F)
3. Heart	☐ (F)
4. *Nose*	☐ (T)
5. Mouth	☐ (F)
6. Don't know	☐

G. How long does naloxone take to start having an effect?	
1. 2-5 minutes	☐ (T)
2. 6-10 minutes	☐ (F)
3. 11-20 minutes	☐ (F)
4. 21-40 minutes	☐ (F)
5. Don't know	☐

H. How long do the effects of naloxone last for?	
1. Less than 20 minutes	☐ (F)
2. About 1 hour	☐ (T)
3. 1 to 6 hours	☐ (F)
4. 6 to 12 hours	☐ (F)
5. Don't know	☐

I. Please tick each correct statement.	
1. If the first dose of naloxone has no effect a second dose can be given.	☐ (T)
2. There is no need to call for an ambulance if I know how to manage an overdose.	☐ (F)
3. Someone can overdose again after having received naloxone.	☐ (T)
4. The effect of naloxone is shorter than the effect of heroin *or fentanyl*.	☐ (T)
5. After recovering from an opioid overdose, the person must not take any heroin, but it is okay for them to drink alcohol or take sleeping tablets.	☐ (F)
6. *Over-administration* of naloxone can provoke withdrawal symptoms.	☐ (T)

Section 3: Harm Reduction

Harm Reduction Acceptability Scale (HRAS)

Goddard, 1999

The HRAS is a 25-item measure assessing attitudes towards harm reduction interventions and can be used on drug and alcohol treatment professionals. It uses a 5-point Likert scale (1= Strongly Agree, 2= Agree, 3= Neither Agree nor Disagree, 4= Disagree, 5= Strongly Disagree). The measure shows moderately high internal consistency (Cronbach's alpha ranges 0.877 [pre-test] to 0.929 [post-test]) and moderate 3-week test-retest reliability (r= 0.825). Evidence for the validity of the HRAS includes its significant correlation with Burt et al.'s (1994) Temperance Mentality Questionnaire (r= 0.538, P<0.001) and its ability to discriminate between participants exposed to information about harm reduction vs. those exposed to information about other approaches to drug and alcohol problems (which do not necessarily endorse harm reduction principles).

1. People *who use drugs* who want to reduce, but not eliminate their drug use are in denial.
2. *People who inject drugs* should be taught how to use bleach to sterilize their injecting equipment.
3. A choice of treatment goals, including abstinence, reduced use of drugs or alcohol, and safer use of drugs or alcohol should be discussed with all people seeking help for drug or alcohol problems.
4. People who live in government-funded housing should be required to be drug free.
5. In order to reduce problems such as crime and health risks, doctors should be permitted to treat *substance use disorder* by prescribing heroin and similar drugs.
6. If their drug use does not interfere with their day-to-day functioning (for example, their ability to work, attend school, or maintain healthy relationships), women who use drugs can be good mothers to infants and young children.
7. *People who use drugs* should be given accurate information about how to use drugs more safely (for example, how to avoid overdose or related health hazards).
8. People with drug or alcohol problems who are not willing to accept abstinence as their treatment goal should be offered alternative treatments that aim to reduce the harm associated with their continued drug or alcohol use.
9. In most cases, nothing can be done to motivate clients who refuse to admit that they have drug or alcohol problems except to wait for them to "hit bottom."
10. To reduce crime and other social problems associated with drug use, substitute drugs such as methadone should be prescribed.
11. Prisons should provide sterilizing tablets or bleach in order for inmates to clean their drug injecting equipment.
12. As long as clients are making progress toward their treatment goals (for example, holding a job or reducing their involvement in crime), methadone maintenance programs should not kick clients out of treatment for using street drugs.
13. Measures designed to reduce the harm associated with drug use are acceptable only if they eventually lead to abstinence.
14. People with *issues related to drug use* may be more likely to seek professional help if they are offered treatment options that don't focus on abstinence.
15. Substitute drugs such as methadone should be an available treatment option for people addicted to drugs like heroin.
16. People whose drug use does not interfere with their day-to-day functioning should be trained to teach other *people who use drugs* how to use drugs more safely (for example, how to inject more safely).

17. Making clean injecting equipment available to *people who inject drugs* is likely to reduce the rate of HIV infection.
18. Abstinence should be the only acceptable treatment option for people who are physically dependent on alcohol.
19. It is possible to use drugs without necessarily misusing or abusing drugs.
20. Pamphlets that educate *people who use drugs* about safer drug use should be detailed and explicit, even if those pamphlets are offensive to some people.
21. *Medications for Opioid Use Disorder (MOUD)* such as methadone should only be prescribed for a limited period of time.
22. To reduce the spread of HIV and other blood-borne diseases, *people who inject drugs* should be given easy access to clean injecting equipment.
23. Women who use drugs during pregnancy should lose custody of their babies.
24. People with alcohol or drug problems should be praised for making changes such as cutting down on their alcohol/drug consumption or switching from injectable drugs to oral drugs.
25. Abstinence should be the only acceptable treatment goal for people who use drugs.

Modified Opioid Overdose and Attitudes Scale (OOAS): *Attitude Towards Naloxone Usage and Overdose Reversal*

Bascou et al., 2022

Please see the Modified Opioid Overdose and Attitudes Scale: Attitudes Towards Individuals with OUD and Opioid Overdose Attitudes Scale (OOAS) sections.

Attitudes towards naloxone usage and overdose reversal

1. If someone overdoses, I want to be able to help them.
2. Everyone should learn how to use and carry naloxone.
3. I will do whatever is necessary to save someone's life in an overdose situation.

Opioid Overdose Attitudes Scale (OOAS)

Williams et al., 2013

The OOAS measures attitudes towards opioid overdose in friends and family members of people who use opioids. All questions are scored on a 5-point Likert scale (1= Completely Disagree, 2= Disagree, 3= Unsure, 4= Agree, 5= Completely Agree). In Williams et al.'s 2013 psychometric development study, the full version of the OOAS shown below was validated in a sample of 56 healthcare professionals. It demonstrated good internal reliability (Cronbach's alpha= 0.90). The overall test–retest reliability of the OOAS was good (ICC= 0.82), with the competence, concerns and readiness item score totals falling in the fair-to-excellent range for test–retest reliability (ICC= 0.92, 0.55 and 0.65, respectively).

Competencies to Manage an Overdose:

1. I already have enough information about how to manage an overdose.
2. I am already able to *administer* naloxone into someone who has overdosed.
3. I would be able to check that someone who has overdosed was breathing properly.
4. I am going to need more training before I would feel confident to help someone who has overdosed. *
5. I would be able to perform mouth to mouth resuscitation to someone who has overdosed.
6. I would be able to perform chest compressions to someone who has overdosed.
7. If someone overdoses, I would know what to do to help them.
8. I would be able to place someone who has overdosed in the recovery position.
9. I know very little about how to help someone who has overdosed. *
10. I would be able to deal effectively with an overdose.

Concerns About Managing an Opioid Overdose:

1. I would be afraid of giving naloxone in case the person becomes aggressive afterwards. *
2. I would be afraid of doing something wrong in an overdose situation. *
3. I would be reluctant to use naloxone for fear of precipitating withdrawal symptoms. *
4. I would be concerned about calling emergency services *if someone overdosed* in case the police come around. *
5. If I tried to help someone who has overdosed, I might accidentally hurt them. *
6. I would feel safer if I knew that naloxone was around.
7. I would be afraid of suffering a needle stick injury if I had to give someone a naloxone injection. *
8. Needles frighten me and I wouldn't be able to give someone an injection of naloxone. *

Readiness to Intervene in an Opioid Overdose:

1. Everyone at risk of witnessing an overdose should be given a naloxone supply.
2. I couldn't just watch someone overdose, I would have to do something to help.
3. If someone overdoses, I would call an ambulance but I wouldn't be willing to do anything else. *
4. Family and friends of *people who use drugs* should be prepared to deal with an overdose.
5. If I saw an overdose, I would panic and not be able to help. *
6. If I witnessed an overdose, I would call an ambulance straight away.
7. I would stay with the *person who overdosed* until help arrives.
8. If I saw an overdose, I would feel nervous, but I would still take the necessary actions.
9. I will do whatever is necessary to save someone's life in an overdose situation.
10. If someone overdoses, I want to be able to help them.

*Reverse coded

Attitudes About Pharmacists Provision of Public Health Services Among Rural and Small Metro Area Pharmacists Survey

Tofighi et al., 2019

Please see the Naloxone-Related Experiences and Beliefs Among Rural and Small Metro Area Pharmacists Survey section. These items determine attitudes toward the expansion of pharmacy services to include on-site public health services for persons who use opioids.

Supportive or not supportive of:

1. Vaccinations
2. HIV testing
3. Referral to free HIV testing
4. Info on safe syringe disposal
5. Info on safe syringe use
6. Referrals to drug treatment

Section 4: Attitudes Towards Recovery of OUD

Recovery Knowledge Inventory (RKI)

Bedregal et al., 2006

The items that comprise the instrument are based on the emerging literature on recovery in psychiatric and substance use disorders, and assess four different domains of understanding of possible recovery (which can be thought of as a construct that is the polar opposite of stigma), namely: a) roles and responsibilities in recovery, b) non-linearity of the recovery process, c) the roles of self-definition and peers in recovery, and d) expectations regarding recovery. Reliability analysis estimates for the four components were 0.81, 0.70, 0.63, and 0.47, respectively. All items are scored on a 5-point Likert scale (1= Strongly Disagree, 2= Disagree, 3= Unsure, 4= Agree, 5= Strongly Agree).

Item Narrative	Theoretically Derived Domain
1. The concept of recovery is equally relevant to all phases of treatment.	Recovery-readiness
2. People receiving psychiatric/substance *use* treatment are unlikely to be able to decide their own treatment and rehabilitation goals.	Self-determination
3. All professionals should encourage clients to take risks in the pursuit of recovery.	Risk-taking
4. Symptom management is the first step towards recovery from mental illness/substance *use*.	Managing symptoms
5. Not everyone is capable of actively participating in the recovery process.	Recovery-readiness
6. People with mental illness/substance *use* should not be burdened with the responsibilities of everyday life.	Citizenship
7. Recovery in serious mental illness/substance *use* is achieved by following a prescribed set of procedures.	Individual process
8. The pursuit of hobbies and leisure activities is important for recovery.	Involvement in meaningful activities
9. It is the responsibility of professionals to protect their clients against possible failures and disappointments.	Risk-taking
10. Only people who are clinically stable should be involved in making decisions about their care.	Self-determination

11. Recovery is not as relevant for those who are actively psychotic or *using* substances.	Recovery-readiness
12. Defining who one is, apart *from their* illness/condition, is an essential component of recovery.	Redefining self
13. It is often harmful to have too high of expectations for clients.	Hope
14. There is little that professionals can do to help a person recover *if they are* not ready to *accept their* illness/condition or need for treatment.	Incorporating illness
15. Recovery is characterized by a person making gradual steps forward without major steps back.	Non-linear process
16. Symptom reduction is an essential component of recovery.	Managing symptoms
17. Expectations and hope for recovery should be adjusted according to the severity of a person's illness/condition.	Hope
18. The idea of recovery is most relevant for those people who have completed, or are close to completing, active treatment.	Recovery-readiness
19. The more a person complies with treatment, the more likely *they are* to recover.	Services aren't enough
20. Other people who have a serious mental illness or are recovering from substance *use* can be as instrumental to a person's recovery as mental health professionals.	Supportive others

Healthcare Provider Substance Use Stigma Assessment Template

*[**Note:** This survey is a template assessment that is designed for online dissemination. It could be adapted into a phone survey or pencil-and-paper survey with some changes. Information in bold is meant to provide guidance to participants. Information provided in italics and brackets is meant to provide further context to the implementor and would not be seen by the participant.]*

[The scales used in this template assessment are from the Healthcare Provider Substance Use Stigma Measures Toolkit and the Public Stigma of Substance Use Measures Toolkit which contain additional information for interpretation of assessment results. A complementary toolkit for data collection and data analysis is also available.

The measures included in this template assessment do not directly match the original measures. Minor edits were made to ensure language was as non-stigmatizing as possible while maintaining the integrity of the question. Response scales are on a 4-point Likert scale that excludes the neutral option to require respondants to form an opinion.

This template assessment should be used to describe the overall degree or magnitude of substance use related stigma among healthcare provider populations. Unless otherwise noted, participant responses to all questions in each stigma scale should be summed. The sum score can then be used to characterize the level of stigma among the sample of healthcare providers. For example, questions 29-33 are from a scale developed by Stone et al. to assess opioid related attitude and beliefs. The responses to questions 29-33 can be added together to create a summed score. In this case, a higher score would indicate that the responding individual has higher levels of stigmatizing attitudes and beliefs.

Additional notes for analysis, including reverse-coding, are included under questions in italics and square brackets.]

Thank you for your interest in completing this survey to help us better understand what people in your community think about substance use, people who use drugs, and related topics. Follow the instructions below to answer each set of questions. Please remember to answer the questions honestly, and that there is no right or wrong answer. By taking this survey, you agree that the information you provide can be used by [*Local Health Department Name*]. Your responses will remain anonymous and confiential.

This survey is to be completed by professional healthcare providers or providers in training. It is intended to be completed only by individuals who provide or will provide professional clinical or behavioral health services to patients/clients.

First, we will ask you a few questions about yourself and who you are.

1. What is your position title?
   - ☐ Doctor
   - ☐ Nurse Practitioner
   - ☐ Registered Nurse
   - ☐ Physician Assistant
   - ☐ Social Worker
   - ☐ Peer Recovery Specialist
   - ☐ Pharmacist
   - ☐ Other (please specify):_____

2. What is your gender identity?
   - ☐ Female
   - ☐ Male
   - ☐ Transgender Male
   - ☐ Transgender Female
   - ☐ Nonbinary/Genderqueer
   - ☐ Other (please specify):_____

3. Which of the following age ranges do you fall into?
   - ☐ 18-24 years old
   - ☐ 25-34 years old
   - ☐ 35-44 years old
   - ☐ 45-54 years old

☐ 55-64 years old
☐ 65 or more years old

4. Have you ever completed any specialized training or courses on addiction and/or overdose prevention?
   ☐ Yes, during school
   ☐ Yes, during training/residency
   ☐ Yes, during CEU course
   ☐ No

5. How often do you directly interact with people who use drugs (PWUD)?
   ☐ Daily
   ☐ Weekly
   ☐ Monthly
   ☐ Rarely

6. In your life, have you had friends or family members whose substance use has negatively impacted their lives?
   ☐ Yes
   ☐ No

These questions are about <u>your confidence</u> in identifying and treating substance use disorders.

7. How **confident** are you in your knowledge of substance use disorders?

Not at all confident				Somewhat confident				Extremely confident	
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10

8. How **confident** are you in your ability to screen patients for substance use disorder?

Not at all confident				Somewhat confident				Extremely confident	
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10

9. How **confident** are you in your ability to provide counseling and initial treatment to patients with substance use disorder?

Not at all confident				Somewhat confident				Extremely confident	
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10

10. How **confident** are you that your counseling and other treatment will make a difference for your patients with substance use disorder?

Not at all confident				Somewhat confident				Extremely confident	
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10

These questions are about your impression of your role, impact, and the efficacy of treating patients who use drugs.

11. I am able to respond to people who have drug related issues as competently as I respond to people with other issues.

☐	☐	☐	☐
Strongly Disagree	Disagree	Agree	Strongly Agree

12. I have a responsibility to ask clients questions about alcohol and other drug related issues.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

13. Most people with drug related issues are not interested in addressing them.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

14. Someone with drug related issues who has returned to use several times probably cannot be successfully treated.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

15. The care of other patients suffers because of time and resources spent on patients with drug related issues.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

16. My feelings of disapproval for people who use drugs get in the way of my ability to empathize with them.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

17. I can make a great difference in the lives of my patients who use drugs.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

18. Patients with drug related issues have a special ability to manipulate physicians.

☐	☐	☐	☐
Strongly Disagree	Disagree	Agree	Strongly Agree

19. Medications for Opioid Use Disorder (MOUD) is effective and worth the effort.

☐	☐	☐	☐
Strongly Disagree	Disagree	Agree	Strongly Agree

These questions are about <u>your comfort</u> in discussing overdose prevention strategies with patients.

20. Abstinence is the only overdose prevention strategy that should be discussed with patients who use drugs.

☐	☐	☐	☐
Strongly Disagree	Disagree	Agree	Strongly Agree

21. I am comfortable training my patients on how to administer naloxone.

☐	☐	☐	☐
Strongly Disagree	Disagree	Agree	Strongly Agree

22. I am not familiar enough with overdose prevention strategies to discuss this with my patients.

☐	☐	☐	☐
Strongly Disagree	Disagree	Agree	Strongly Agree

23. I am concerned that discussing overdose prevention strategies with people who use drugs gives the wrong message.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

These questions focus on <u>your thoughts</u> on harm reduction strategies and their impact on overdose prevention.

24. People with drug related issues who want to reduce, but not eliminate their use are in denial.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

25. People who use drugs should be given accurate information about how to use drugs more safely (for example, how to avoid overdose or related health hazards).

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

26. People with issues related to drug use may be more likely to seek professional help if they are offered treatment options that don't focus on abstinence.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

27. Measures designed to reduce the harm associated with drug use are acceptable only if they eventually lead clients to pursue abstinence.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

28. MOUD such as methadone should only be prescribed for a limited period of time.

☐	☐	☐	☐
Strongly Agree	Agree	Disagree	Strongly Disagree

These questions are about what <u>you</u> think about people with substance use disorder.

29. Individuals with substance use disorder only have themselves to blame for their issue.

☐	☐	☐	☐
Strongly Agree	Agree	Disagree	Strongly Disagree

30. People with substance use disorder have poor moral character.

☐	☐	☐	☐
Strongly Agree	Agree	Disagree	Strongly Disagree

31. How willing would you be to have a person with substance use disorder marry into your family?

☐	☐	☐	☐
Strongly Willing	Somewhat Willing	Somewhat Unwilling	Strongly Unwilling

32. How willing would you be to have a person taking medication treatment for substance use disorder marry into your family?

☐	☐	☐	☐
Strongly Willing	Somewhat Willing	Somewhat Unwilling	Strongly Unwilling

33. People who need medication treatment to stop using substances lack willpower.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

The next questions are about what you think <u>most people</u> think about people who have been treated for substance use.

34. Most people would willingly accept someone who has been treated for substance use disorder as a close friend.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

35. Most people believe that someone who has been treated for substance use disorder is just as trustworthy as the average citizen.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

36. Most employers will hire someone who has been treated for substance use if they are qualified for the job.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

37. Most people would be willing to date someone who has been treated for substance use disorder.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

This section will ask you to assess why other providers may have negative attitudes towards patients who use drugs.

38. Some providers have negative attitudes towards patients with substance use disorders. What do you think are the sources of those attitudes? (Number each source below from 1-5 where "1" signifies *the most important source of the negative attitude*, "2" the *2nd most important source*, and so on; **use each number only once**)

Negative experiences with patients with substance use disorders	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Substance use by self, family member, or close friend	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Attending physicians with negative attitudes	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Other resident physicians with negative attitudes	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Non-physician health care professionals, e.g., nurses, with negative attitudes	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Thank you for participating in the survey. Your responses will help your community improve its provision of overdose prevention and response services. If you have any questions about the survey, please reach out to _____.

References

Addy, Skinner, Shoobridge, Freeman, Roche, Pidd, & Watts. (2004). *Handbook for the Work Practice Questionnaire (WPQ): A Training Evaluation Measurement Tool for the Alcohol and Other Drugs Field.* https://nceta.flinders.edu.au/application/files/9416/0156/0160/EN198.pdf

Bascou, N. A., Haslund-Gourley, B., Amber-Monta, K., Samson, K., Goss, N., Meredith, D., Friedman, A., Needleman, A., Kumar, V. K., & Fischer, B. D. (2022c). Reducing the stigma surrounding opioid use disorder: evaluating an opioid overdose prevention training program applied to a diverse population. *Harm Reduction Journal*, *19*(1). https://doi.org/10.1186/s12954-022-00589-6

Bedregal, L. E., O'Connell, M., & Davidson, L. (2006). The Recovery Knowledge Inventory: Assessment of Mental Health Staff Knowledge and Attitudes about Recovery. *Psychiatric Rehabilitation Journal*, *30*(2), 96–103. https://doi.org/10.2975/30.2006.96.103

Brown, R. L., Batty, E., Lofwall, M., Kiviniemi, M., & Kizewski, A. (2022). Psychometric evaluation of two indices assessing stigma toward opioid misuse and treatment among health care providers. *The American Journal of Drug and Alcohol Abuse*, *48*(2), 158–164. https://doi.org/10.1080/00952990.2021.2007260

Christison, G. W., Haviland, M. G., & Riggs, M. L. (2002). The medical condition regard scale. *Academic Medicine*, *77*(3), 257–262. https://doi.org/10.1097/00001888-200203000-00017

Goddard, P. (2003). Changing attitudes towards harm reduction among treatment professionals: a report from the American Midwest. *International Journal of Drug Policy*, *14*(3), 257–260. https://doi.org/10.1016/s0955-3959(03)00075-6

Hojat, M., Gonnella, J. S., Nasca, T. J., Mangione, S., Veloksi, J. J., & Magee, M. (2002). The Jefferson scale of physician empathy. *Academic Medicine*, *77*(Supplement), S58–S60. https://doi.org/10.1097/00001888-200210001-00019

Kirane, H., Ketteringham, M., Bereket, S., Dima, R., Basta, A., Mendoza, S., & Hansen, H. (2016). Awareness and attitudes toward intranasal naloxone rescue for opioid overdose prevention. *Journal of Substance Abuse Treatment*, *69*, 44–49. https://doi.org/10.1016/j.jsat.2016.07.005

Ko, J. Y., Tong, V. T., Haight, S. C., Terplan, M., Snead, C., & Schulkin, J. (2019). Obstetrician–gynecologists' practice patterns related to opioid use during pregnancy and postpartum—

United States, 2017. *Journal of Perinatology*, *40*(3), 412–421. https://doi.org/10.1038/s41372-019-0535-2

Peckham, A. M., Niculete, M. E., Steinberg, H., & Boggs, D. L. (2018). A survey of prescribers' attitudes, knowledge, comfort, and fear of consequences related to an opioid overdose education and naloxone distribution program. *Journal of Public Health Management and Practice*, *24*(4), 310–317. https://doi.org/10.1097/phh.0000000000000668

Tofighi, B., Lekas, H., Williams, S. Z., Martino, D., Blau, C., & Lewis, C. F. (2021). Rural and small metro area naloxone-dispensing pharmacists' attitudes, experiences, and support for a frontline public health pharmacy role to increase naloxone uptake in New York State, 2019. *Journal of Substance Abuse Treatment*, *129*, 108372. https://doi.org/10.1016/j.jsat.2021.108372

Williams, A. V., Strang, J., & Marsden, J. (2013b). Development of Opioid Overdose Knowledge (OOKS) and Attitudes (OOAS) Scales for take-home naloxone training evaluation. *Drug and Alcohol Dependence*, *132*(1–2), 383–386. https://doi.org/10.1016/j.drugalcdep.2013.02.007

Wilson, J. D., Spicyn, N., Matson, P., Alvanzo, A., & Feldman, L. (2016). Internal Medicine Resident knowledge, attitudes, and barriers to naloxone prescription in hospital and clinic settings. *Substance Abuse*, *37*(3), 480–487. https://doi.org/10.1080/08897077.2016.1142921