

Public Stigma of Substance Use 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.

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Table of Contents

Introduction.....	3
Perceived Stigma of Addiction Scale (PSAS)	4
Vignette Approach	5
Labeling.....	5
Social Distance	6
Dangerousness	6
Competence.....	6
Causal attributions.....	7
Scenario-related items	7
Social Distance Scales.....	7
Social Distance Scale for People who use Substances	8
Other Attitudes and Belief Scales that Include Social Distance	9
Treatment Seeking and Healthcare Engagement.....	11
Public Knowledge, Including Among Adolescents	11
Public Attitudes Toward Harm Reduction	12
Template Assessment.....	21
References.....	30
Appendix: I.....	34
Additional Vignettes used by Perry, Pescasolido, and Krendl (2020).....	34

Introduction

The following are proposed items from existing scales used to measure public stigma toward opioid use and people who use opioids and related constructs. The search for items was constrained to validated measures unless otherwise noted. Due to the relative dearth of scales for measuring substance use-related stigma, some scales addressing mental illness stigma are included, which could easily be adapted for substance use related stigma. The items and scales included in this toolkit will cover the following topics:

1. Perceived stigma of opioid use disorder (OUD)
2. Vignette approach to assessing labeling, social distance, perceived dangerousness, perceived competence, and attributions of blameworthiness
3. Social distance
4. Attitudes and beliefs about people who use drugs
5. Treatment seeking and healthcare engagement
6. Public knowledge about drug use
7. Public attitudes towards harm reduction

This toolkit can be used to develop 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](#).

Perceived Stigma of Addiction Scale (PSAS)

Luoma et al., 2010

The most widely used scale for public stigma toward substance use disorder is the Perceived Stigma of Addiction Scale (PSAS; Luoma, O’Hair, Kohlenberg, Hayes, & Fletcher, 2010). This scale was created via an adaptation of the “perceived devaluation/ discrimination” items of a measure of perceived stigma toward serious mental illness (Link, Struening, Rahav, Phelan, and Nuttbrock, 1997). Originally validated as a measure of perceived stigma among people living with substance use disorders (N = 252), the authors reported overall good psychometric properties: good face validity, construct validity, and adequate internal consistency (Cronbach’s alpha= 0.73). The 8-item version (PSAS-8) was also used in Ashford et al., 2019’s study of the usage of “addict” vs “person with a substance use disorder (SUD)” by persons in recovery from SUD, and differences in recovery outcomes. The PSAS-8 was validated for the general population by Tuliao & Holyoak (2020), whose psychometric analysis found good evidence of reliability (Cronbach’s alpha= 0.80) and validity among college students (N = 791; 70% female). PSAS-8 scores were negatively associated with intent to seek treatment; positively correlated with stigma associated with seeking help for mental health issues, self-concealment, and anticipated risks associated with help-seeking. They recommended removing item 7 to improve the psychometrics of the scale. Responses are given on a 4-point Likert scale (1= Strongly Disagree, 2= Disagree, 3= Agree, 4= Strongly Agree).

1. Most people would willingly accept someone who has been treated for substance use disorder as a close friend.
2. Most people believe that someone who has been treated for substance use disorder is just as trustworthy as the average citizen.
3. Most people would accept someone who has been treated for substance use disorder as a teacher of young children in a public school.
4. Most people would hire someone who has been treated for substance use disorder to take care of their children.
5. Most people think less of a person who has been in treatment for substance use disorder.
6. Most employers will hire someone who has been treated for substance use disorder if they are qualified for the job.
7. Most employers will pass over the applications of someone who has been treated for substance use disorder in favor of another applicant. * (Recommended removal of this item in Tuliao & Holyoak, 2020)
8. Most people would be willing to date someone who has been treated for substance use disorder.

Vignette Approach

Perry, Pescasolido, & Krendl, 2020

Although different than a scale alone, it is not uncommon in the mental illness stigma literature for surveys to ask items after presenting a vignette depicting someone living with the condition of interest (Yang & Link, 2016). This was also done for prescription opioid dependence as part of the General Social Survey (GSS) in 2018 (Perry, Pescasolido, and Krendl, 2020). The GSS is a cross-sectional, nationally representative survey to assess public attitudes in the United States; out of a total sample of 1169 adults, 225 adults received the version with the vignette depicting prescription opioid dependence in the box below and were asked the corresponding questions. Other adults in the survey were presented vignettes depicting subclinical distress, major depression, schizophrenia, and alcohol use disorder and asked similar items. These vignettes are included in [Appendix I](#) for reference. Perry, Pescasolido, and Krendl (2020) presented psychometrics on their social distance scale only, finding it had good internal consistency (Cronbach's alpha= 0.83).

[John/John/Juan] [Mary/Mary/Maria] is a [White/African American/Hispanic] [man/woman] who has completed [8th grade/high school/college]. About a year ago, [Name] was prescribed prescription pain medication for back pain he/she developed following a car accident. He/She took the pain medication regularly, and after a few weeks found that he/she increasingly felt the desire for more, even though his/her back pain had improved. [Name] went to several different doctors to get more prescriptions from them and then started getting them from a friend. Each time [Name] tried to cut down, he/she felt anxious and became sweaty and nauseated for hours on end and also could not sleep. These symptoms lasted until he/she resumed taking the prescription pain medication. [Name's] friends complained that he/she had become unreliable -- making plans one day, and canceling them the next. His/Her family said he/she had changed and that they could no longer count on him/her. [Name] has been living this way for six months.

The following measures accompany the vignette above:

Labeling

These items assessed how likely the respondent thought it is that the vignette character is experiencing a mental illness, physical illness, and "part of the normal ups and downs of life." Response categories are 'very likely,' 'somewhat likely,' 'not very likely,' and 'not likely at all.'

Response options ‘very likely’ and ‘somewhat likely’ are collapsed, as are ‘not very likely’ and ‘not at all likely.’

- a) Likely a mental illness
- b) Likely a physical illness
- c) Likely normal ups and downs

Social Distance

Social distance is described more in detail in the [Social Distance Scales section](#), but broadly, these items assessed: willingness to move next door, spend an evening socializing, make friends, work closely with, have a group home in the neighborhood and marry into family. Response categories are ‘definitely willing,’ ‘probably willing,’ ‘probably unwilling,’ and ‘definitely unwilling.’ The first two categories are combined and set equal to 1, else 0.

- a) Unwilling to marry into family
- b) Unwilling to move next door
- c) Unwilling to spend evening with
- d) Unwilling to have group home
- e) Unwilling to work closely
- f) Unwilling to become friends

Dangerousness

These asked how likely it is that the vignette character would do something violent toward other people or toward him or herself. Response categories are ‘very likely,’ ‘somewhat likely,’ ‘not very likely,’ and ‘not likely at all.’ Response options ‘very likely’ and ‘somewhat likely’ are collapsed, as are ‘not very likely’ and ‘not at all likely.’

- a) Likely violent toward others
- b) Likely violent toward self

Competence

These assessed perceptions of the vignette character’s competence. For the first two items, response categories are ‘very able,’ ‘somewhat able,’ ‘not very able,’ and ‘not able at all.’

- a) Can manage finances
- b) Can make treatment decisions

Also under this construct was an index of five ways the vignette character “should be forced by law to” obtain treatment, including: going to a doctor, taking medication, being admitted to a hospital for any reason, and being admitted to a hospital on condition of dangerousness to others or self.

Causal attributions

These assessed how likely it is that the vignette character's condition is caused by a series of six factors. These include bad character, a chemical imbalance in the brain, the way s/he was raised, stressful life circumstances, or a genetic or inherited problem. Response categories were 'very likely,' 'somewhat likely,' 'not very likely,' and 'not likely at all.'

- a) Likely due to bad character
- b) Likely due to way raised
- c) Likely due to stresses of life
- d) Likely due to chemical imbalance
- e) Likely due to genetic problem

Scenario-related items

In addition to these measures, another large survey to use the same vignette approach (Strata Research, Inc. for San Mateo County, 2020) asked the following items similar to the [Labeling](#) items described above. No psychometrics were provided in that report. Response categories were 'very likely,' 'somewhat likely,' 'not very likely,' and 'not likely at all.'

- a) It is likely that he/she is experiencing a substance *use* problem.
- b) It is likely that he/she is experiencing physical illness.
- c) It is likely that his/her situation is caused by bad character.
- d) It is likely that he or she is experiencing the normal ups and downs of life.
- e) It is likely that he or she will improve with treatment.
- f) It is likely that his/her situation will improve on its own.

Social Distance Scales

Bahora et al., 2008

One way to ask about public stigma is asking questions around people's willingness to be close to people with a stigmatized condition. This concept of social distance is almost exclusively measured using various adaptations of the Bogardus social distance scale (Bogardus, 1924; Link, Yang, Phelan, & Collins, 2004; Pescosolido, Medina, Martin, & Long, 2013; Yang & Link, 2016). Originally used for race/ethnicity, this scale asks the respondent how willing they would be to involve a person with the target stigmatized condition in various parts of their life, ranging from the community (e.g., if such a person should hold public office) to intimate (e.g., willingness to have a child with such a person) domains. As described above, these questions usually follow the presentation of a vignette describing a person with the stigmatized condition. Although the original scale includes more items, we recommend including the five listed below modeled after Bahora et al. (2008), who used it among police officers to assess attitudes towards individuals

with substance use disorder. This scale uses a 4-point Likert scale (1= Not Willing At All, 2= Somewhat Unwilling, 3= Somewhat Willing, 4= Very Willing).

1. How willing would you be to live next door to *someone who uses drugs*?
2. How willing would you be to spend an evening socializing with *someone who uses drugs*?
3. How willing would you be to make friends with *someone who uses drugs*?
4. How willing would you be to work with *someone who uses drugs* on the job as a colleague?
5. How willing would you be for *someone who uses drugs* to marry into your family?

In seeking to shorten the social distance scale even further, a statewide survey administered in California to assess their mental illness stigma and discrimination reduction initiative used the following three items, each of which showed a significant change (toward willingness of association) between survey time points one year apart (in 2013 and 2014, respectively; Collins, Wong, Roth, Cerully, & Marks, 2015). Responses were given on a 4-point Likert scale from “definitely willing”, “probably willing”, “probably unwilling” “definitely unwilling,” and were dichotomized into “probably/definitely willing” and “probably/definitely unwilling” for the analysis (Collins et al., 2015).

Item	Level of significance of change
How willing would you be to move next door to someone who has a mental illness?	$p < 0.0001$
How willing would you be to spend an evening socializing with someone who has a mental illness?	$p < 0.0001$
How willing would you be to start working closely on a job with someone who has a mental illness?	$p < 0.05$

Social Distance Scale for People who use Substances

This scale was adapted from Link et al. (1987)’s measure of Social Distance for people with mental illness. For this adaptation, Brown (2011) compared three established measures of

mental illness stigma, modified for substance use stigma, and found the Social Distance Scale (and the Affect Scale but not the Dangerousness scale), had good psychometric properties (Cronbach's alpha= 0.85) evaluated with a sample of 565 college students.

1. How would you feel about renting a room in your home to someone *who uses* substances?
2. How about as a worker on the same job as someone with *who uses* substances?
3. How would you feel having someone *who uses* substances as a neighbor?
4. How about as the caretaker of your children for a couple of hours?
5. How about having your children marry someone *who uses* substances?
6. How would you feel about introducing to a *person* you are friendly with?
7. How would you feel about recommending someone *who uses* substances for a job working for a friend of yours?

Other Attitudes and Belief Scales that Include Social Distance

[Stone et al., 2021](#)

[Evans-Lacko, et al., 2011](#)

Stone et al. (2021) administered the following scale to primary care physicians in the United States to assess opioid-related attitudes and beliefs. However, these items could easily be adapted to the public so they are included here. Items are responded to on a 5-point Likert scale (1= Strongly Agree, 2= Somewhat Agree, 3= Neither Agree nor Disagree, 4= Somewhat Disagree, 5= Strongly Disagree). Among a national sample of primary care physicians (N = 361), a factor analysis showed high internal reliability of the attitudes and beliefs scale (Cronbach's alpha= 0.83). Items 5 through 8 are social distance items. The remainder center on the causes and treatment of OUD.

1. Individuals with *substance* use disorder only have themselves to blame for their problem.
2. People with *substance* use disorder have poor moral character.
3. *Substance* use disorder is a chronic medical condition like diabetes mellitus.
4. People with *substance* use disorder can, with treatment, get well and return to productive lives.
5. How willing would you be to have a person with *substance* use disorder marry into your family?
6. How willing would you be to have a person with *substance* use disorder as a neighbor?
7. How willing would you be to have a person taking medication treatment for *substance* use disorder marry into your family?
8. How willing would you be to have a person taking medication treatment for *substance* use disorder as a neighbor?
9. People who need medication treatment to stop using *substances* lack willpower.

The “Reported and intended behavior scale (RIBS)” assesses intended discrimination and has shown change over the 10+ year “Time to Change” campaign in the U.K (Evans-Lacko et al., 2011). This scale has only been used for mental illness stigma and has not been used for stigma related to opioid use. However, given its responsiveness to this national level stigma campaign, it may be useful in a public stigma assessment. Items 1 - 4 are on actual social contact and have the response options of Yes, No, and Don’t Know. Items 5 - 8 are on willingness for hypothetical future contact and have 6 response options of Agree Strongly, Agree Slightly, Neither Agree nor Disagree, Disagree Slightly, Disagree Strongly, and Don’t Know.

1. Are you currently living with, or have you ever lived with, someone with opioid use disorder?
2. Are you currently working with, or have you ever worked with, someone with opioid use disorder?
3. Do you currently have, or have you ever had, a neighbor with opioid use disorder?
4. Do you currently have, or have you ever had, a close friend with opioid use disorder?
5. In the future, I would be willing to live with someone with opioid use disorder.
6. In the future, I would be willing to work with someone with opioid use disorder.
7. In the future, I would be willing to live nearby to someone with opioid use disorder.
8. In the future, I would be willing to continue a relationship with a friend who developed opioid use disorder.

Treatment Seeking and Healthcare Engagement

Kanter et al., 2008

How stigma impacts treatment seeking and healthcare engagement is assessed via negative attitudes toward treatment, as assessed by one four item measure of depression stigma (Kanter, Rusch, & Brondino, 2008). Respondents were provided a 7-point Likert scale (1= Completely Disagree, 2= Mostly Disagree, 3= Somewhat Disagree, 4= Neither Agree nor Disagree, 5= Somewhat Agree, 6= Mostly Agree, 7= Strongly Agree). These are from the mental illness stigma literature but could be adapted for opioid use disorder treatment engagement.

1. People will see a person in a less favorable way if they come to know that *they have* been treated for *substance use*.
2. Receiving treatment for *substance use* carries social stigma.
3. People tend to like less those who are receiving professional help for *substance use*.
4. It is advisable to hide from people who have been treated for *substance use*. *

* Indicates low factor (0.49) in original study

Public Knowledge, Including Among Adolescents

[Admassu et al., 2015](#)

[Abraham et al., 2022](#)

It may also be advantageous to measure public knowledge around opioid use including among certain priority populations, such as adolescents. Although not strictly a stigma scale, there has been a knowledge scale adapted and administered statewide by Maryland (Admassu et al., 2015) and Wisconsin, which was also then adapted to form the 16-item Adolescent Opioid Safety and Learning Scale administered to a sample of Midwestern adolescents (Abraham et al., 2022). These surveys cover domains such as interest in learning about opioids, access to opioids, opioid use behavior, and knowledge of opioid-related harms. The full statewide surveys are over 50 items in length and are not listed in their entirety here but are available via the reference links.

Public Attitudes Toward Harm Reduction

[Williams, et al., 2013](#)

[Agley, et al., 2022](#)

[Schlosser, et al., 2022](#)

[Tzemis, et al., 2013](#)

[McGinty, et al., 2018](#)

Several scales have been used to measure public attitudes toward various harm reduction strategies and program types. First, provision and use of naloxone is an important harm reduction strategy. Four scales and two sets of descriptive items to assess public attitudes of naloxone use are reviewed here. The first two scales reviewed, the Opioid Overdose Attitude Scales (OOAS), and the Opioid Overdose Knowledge Scale (OOKS) are the most established scales and have been used with various respondent types.

Williams, Strang, & Marsden (2013) developed the Opioid Overdose Attitude Scales (OOAS) to assess attitudes towards opioid overdose in friends and family members of people who use opioids. The measure was developed through a literature review along with prior work done by the research team. It was pilot tested among family members and friends of people who use opioids (N= 14) and healthcare professionals working in take-home naloxone training programs (N= 20). It has also been administered to the public, including community leaders, family members of people who use opioids, and other community members, in both the original and modified versions (Bascou et al., 2022; Hohmann et al., 2022; Simmons et al., 2018; Wolfson-Stofko et al., 2018). Modified OOAS measures administered to service industry employees and other community members often include a smaller number of items from the original scale, from 6 to 23 items (Bascou et al., 2022; Wolfson-Stofko et al., 2018). Williams, Strang, & Marsden (2013) tested the internal reliability and construct validity of the full measure with an independent sample of family members and friends of people who use opioids (N=42) and health care professionals (N=56). Concurrent validity and seven-day test-retest reliability were tested only among the sample of family members and friends (although for overall reliability analyses, health care professionals were also included); the scale 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).

There are three subscales related to overdose management (i.e., competence, concerns, and readiness) and 28 items in total. Responses to the OOAS are scored on a 5-point Likert-type scale (1= Completely Disagree, 2= Disagree, 3= Unsure, 4= Agree, and 5= Completely Agree).

Competencies to Manage an Opioid Overdose:

1. I already have enough information about how to manage an overdose.
2. I am 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 happen.
3. If someone overdoses, I would call an ambulance but 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

In the second scale, Williams, Strang, & Marsden (2013) also developed a measure to assess the same population (i.e. friends and family members of opioid users) in their knowledge of opioid overdose and utilization of naloxone, named the Opioid Overdose Knowledge Scale (OOKS). The full scale has also been administered to the public, along with its modified versions (Bascou et al., 2022; Hohmann et al., 2022; Simmons et al., 2018; Stover et al., 2019; Wolfson-Stofko et al., 2018). Modified OOKS measures are often shortened versions of the full scale, including 3 to 39 items (Bascou et al., 2022; Hohmann et al., 2022; Wolfson-Stofko et al., 2018).

Williams, Strang, & Marsden (2013) tested the internal reliability and construct validity of the full measure with the same sample detailed above (i.e. family members and friends of people who use opioids [N=42] and health care professionals [N=56]). Concurrent validity and seven-day test-retest reliability were tested only among the sample of family members and friends (although again, for overall reliability analyses, health care professionals were also included). The OOKS was found to be internally reliable (Cronbach's alpha= 0.83). Retest was completed by 33 family members after 14 (SD 7) days (OOKS, ICC= 0.90) with sub-scale item sets from each measure falling within the fair-to-excellent range (ICC= 0.53–0.92). The OOKS total score was positively correlated with the BORRA's Overdose Recognition ($r = 0.5$, $P < 0.01$) and Naloxone Indication sub-scales ($r = 0.44$, $P < 0.05$).

The measure contains 45 items, each divided into four subscales (i.e. risks, signs, actions and naloxone use). Responses are indicated as either true (T) or false (F).

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	☐ (T)
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, <i>fentanyl</i>)	☐ (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. <i>Into nostrils (intranasal)</i>	☐ (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. <i>Nose</i>	☐ (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 <i>or fentanyl</i> .	☐ (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. <i>Over-administration</i> of naloxone can provoke withdrawal symptoms.	☐ (T)

Several other, briefer measures are reviewed here. In the third measure, Agley et al. (2022) asked a nationally representative sample of 702 United States adults to indicate the believability (1 = Extremely Unbelievable to 7 = Extremely Believable) of six different statements about naloxone and overdose. Reliability was not calculated.

1. People who use opioids will use more opioids if they know they have access to naloxone. 2. People who use opioids will be less likely to seek out treatment if they have access to naloxone. 3. People who overdose once on opioids usually will overdose again. 4. People who experience a non-fatal opioid overdose usually die of another overdose within the next 12 months. 5. It is risky to provide take-home naloxone to people who use opioids because they can use it to get high. 6. If trained and provided with naloxone, bystanders can effectively prevent overdoses in the community.

In a fourth study, Schlosser, Habecker, & Bevins (2022) assessed knowledge and beliefs about drug use broadly (i.e., not just opioid use) and naloxone among the general public in Nebraska (N = 1712). They asked respondents to respond on a 5-point Likert scale (1= Strongly Disagree, 2= Disagree, 3= Neutral, 4= Agree, 5= Strongly Agree). Knowledge about naloxone was assessed via asking “Do you know where to get Narcan® (naloxone) if you needed it?”, with response options of Yes, No, and I don’t know what this is.

1. How much do you disagree or agree that a substance use disorder can be stopped at any time if the person truly wants to?
2. Most people believe that a person who uses *drugs* cannot be trusted.
3. Most people believe that a person who uses *drugs* is dangerous.
4. Most people believe that a person who uses *drugs* is to blame for their own problems.
5. How much do you disagree or agree that you are able to recognize a person overdosing?

The following set of detailed items assess attitudes towards various harm reduction strategies that was administered to Canadian adults in August 2011 (N= 2000; Tzemis et al., 2013). These are longer-form questions that have the advantage of providing background on the terminology used. Reliability was not calculated. The level of support was gauged on a 5-point Likert scale (1= Strongly Support, 2= Somewhat Support, 3= Neutral, 4= Somewhat Oppose, 5= Strongly Oppose).

Topic of Interest	Question Text
General harm reduction	Harm reduction strategies are public health programs that reduce the harms related to drug use. Supporters generally think these programs can significantly reduce death and the transmission of disease among people who use drugs, and that these programs can bring them into contact with public health or other services to act as a ‘bridge to recovery.’ Opponents argue that harm reduction programs encourage drug use and should not be used. I would like to know your opinion on the subject. Do you support or oppose harm reduction strategies for people who use drugs?
<i>Syringe Service Programs</i>	<i>Syringe service</i> programs provide clean needles to people who use drugs and encourage safe disposal of used needles in order to prevent needle sharing, which can spread infectious diseases. Do you support or oppose <i>syringe service</i> programs?
<i>Syringe Service Programs in one’s community</i>	Do you support or oppose the idea that there should <i>be syringe service programs</i> in your community to help people <i>who use drugs</i> ?

Safer inhalation equipment distribution	Recently there has been a change in drug use practices. An increasing number of people who are smoking or inhaling drugs and fewer may be injecting. <i>While inhaling drugs include carries health risks, it does not entail the same risk of blood-borne infections or skin and soft tissue infections compared to injection.</i> Some communities provide small glass stems and plastic tubing for mouthpieces to reduce the harms related to drug inhalation. Do you support or oppose the distribution of safer inhalation supplies such as glass stems and plastic tubing?
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Finally, similar more descriptive items were used by McGinty et al. (2018) in their nationally representative survey of 1,004 adults in the United States to assess public attitudes toward supervised consumption sites and syringe services programs. In this study, respondents read brief descriptions of the overdose epidemic and definitions of safe consumption sites and syringe services programs and then rated their support/opposition for these two strategies on a 5-point Likert scale (1= Strongly Oppose, 2= Somewhat Oppose, 3= Neither Oppose nor Support, 4= Somewhat Support, 5= Strongly Support). Reliability was not calculated.

Topic of Interest	Definition Provided
Safe [supervised] consumption sites	Opioids are a type of drug that includes heroin, synthetic opioids like fentanyl, and prescription opioids like Percocet and OxyContin. In 2015, more than 33,000 people from across the country died from an opioid overdose. Rates of opioid overdose in the United States have quadrupled since 1999 and there are currently over 90 opioid overdose deaths each day. “Safe Consumption Sites” are places where people who use drugs can bring in previously purchased opioids and other drugs and legally use them under medical supervision. These sites have been suggested in a number of different locations as a way to address the opioid epidemic.
Syringe services programs	In 2015, more than 39,000 people were newly diagnosed with HIV. Injection drug use has been a leading risk factor for HIV over the past 25 years. “Syringe services programs” are programs where <i>people who inject drugs</i> can get sterile syringes while safely disposing of used ones.

Public Stigma of Substance Use 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 [Public Stigma of Substance Use Measures Toolkit](#), [First Responder Substance Use Stigma Measures Toolkit](#), and the [Healthcare Provider Substance Use Stigma Measures Toolkit](#) which contain additional information for interpretation of assessment results. A [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 respondents to form an opinion.

This template assessment should be used to describe the overall degree or magnitude of substance use related stigma among the general public. 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 the general public. For example, questions 14-18 are from a scale developed by Stone et al. to assess opioid related attitude and beliefs. The responses to questions 14-18 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 confidential.

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

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

2. 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

3. What level of education have you completed?
 - ☐ Some high school
 - ☐ High school diploma or GED
 - ☐ Some college
 - ☐ Associate's degree
 - ☐ Bachelor's degree
 - ☐ Some graduate school
 - ☐ Master's degree or higher
 - ☐ Other (specify): _____

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

Now we will ask you some questions about what you know about overdose and overdose reponse.

5. Please indicate if you think the following symptoms are indicators of an overdose. Select each correct answer.

	True	False	I Don't Know
Having blood-shot eyes	☐	☐ [*]	☐
Slow or shallow breathing	☐ [*]	☐	☐
Lips, hands, or feet turning blue	☐ [*]	☐	☐
Loss of consciousness	☐ [*]	☐	☐
Unresponsive	☐ [*]	☐	☐
Fitting	☐	☐ [*]	☐
Deep snoring	☐ [*]	☐	☐
Very small pupils	☐ [*]	☐	☐
Agitated behavior	☐ [*]	☐	☐
Rapid heartbeat	☐	☐ [*]	☐

*[*correct response]*

6. Most opioid overdose deaths occur very quickly (within 1 hour).

☐ Not True at All
 ☐ Somewhat Untrue
 ☐ Somewhat True
 ☐ Very True

7. Most opioid overdoses occur when individuals are using alone.

☐ Not True at All
 ☐ Somewhat Untrue
 ☐ Somewhat True
 ☐ Very True

8. In order to safely administer naloxone, one needs to have advanced medical training.

☐	☐	☐	☐
Not True at All	Somewhat Untrue	Somewhat True	Very True

9. Naloxone works by blocking opioids in the brain for 24 hours.

☐	☐	☐	☐
Not True at All	Somewhat Untrue	Somewhat True	Very True

10. The 911 Good Samaritan Law provides significant legal protection against criminal charges and prosecution for possession of controlled substances in overdose prevention situations.

☐	☐	☐	☐
Not True at All	Somewhat Untrue	Somewhat True	Very True

The next questions are about your confidence in your ability to respond to an overdose.

11. I am able to administer naloxone into someone who has overdosed.

☐	☐	☐	☐
Strongly Disagree	Disagree	Agree	Strongly Agree

12. I would be able to check that someone who has overdosed was breathing properly.

☐	☐	☐	☐
Strongly Disagree	Disagree	Agree	Strongly Agree

13. I am going to need more training before I would feel confident to help someone who has overdosed.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

These questions are about what you think about people with substance use disorder.

14. Individuals with substance use disorder only have themselves to blame for their problem.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

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

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

16. 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

17. 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

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

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

There are a variety of programs that can help reduce overdose in communities. Please read the descriptions of these various programs below and indicate how much you oppose or support each type of program.

19. Harm reduction strategies are public health programs that reduce the harms related to drug use. Supporters generally think these programs can significantly reduce death and the transmission of disease among people who use drugs, and that these programs can bring them into contact with public health or other services to act as a 'bridge to recovery.' Opponents argue that harm reduction programs encourage drug use and should not be used. Do you support or oppose harm reduction strategies for people who use drugs?

☐ Strongly Oppose ☐ Oppose ☐ Support ☐ Strongly Support

20. Syringe service programs provide clean needles to people who use drugs and encourage safe disposal of used needles in order to prevent needle sharing, which can spread infectious diseases. Do you support or oppose syringe service programs?

☐ Strongly Oppose ☐ Oppose ☐ Support ☐ Strongly Support

21. Do you support or oppose the idea that there should be syringe service programs in your community to help people who use drugs?

☐ Strongly Oppose ☐ Oppose ☐ Support ☐ Strongly Support

22. Recently there has been a change in drug use practices. An increasing number of people are smoking or inhaling drugs and fewer may be injecting. While inhaling drugs include carries health risks, it does not entail the same risk of blood-borne infections or skin and soft tissue infections compared to injection. Some communities provide small glass pipes and plastic tubing for mouthpieces to reduce the harms related to drug inhalation. Do you support or oppose the distribution of safer inhalation supplies such as glass pipes and plastic tubing?

☐ Strongly Oppose ☐ Oppose ☐ Suport ☐ Strongly Support

Next are some more specific questions about your thoughts on harm reduction techniques.

23. People who use drugs who want to reduce, but not eliminate their alcohol or drug use are in denial.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

24. 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

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

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

26. Medications for Opioid Use Disorder (MOUD) such as methadone should only be prescribed for a limited period of time.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

27. Abstinence should be the only acceptable goal for people who use drugs.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

The next questions about how you believe most people feel about people who use drugs.

28. Most people believe that a person who uses drugs cannot be trusted.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

29. Most people believe that a person who uses drugs is dangerous.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

30. Most people believe that a person who uses drugs is to blame for their own problems.

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

The next questions are about what you believe most people think about people who have been treated for substance use.

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

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

32. 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

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

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

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

☐ Strongly Disagree ☐ Disagree ☐ Agree ☐ Strongly Agree

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

Abraham, O., Thakur, T., Brasel, K., Norton, D., & Rosenberger, C. A. (2022). Development of the Adolescent Opioid Safety and Learning (AOSL) scale using exploratory factor analysis. *Research in Social and Administrative Pharmacy*, 18(5), 2796–2803.

<https://doi.org/10.1016/j.sapharm.2021.06.007>

Admassu H. G., Tom S. E., Sealfon, N., Gibson M. M., & Pradel, F. G. (2015).

Maryland Public Opinion Survey on Opioids, 2015. Summary Report. Baltimore (MD): University of Maryland, Baltimore. Maryland Department of Health and Mental Hygiene, Behavioral Health Administration.

<https://archive.hshsl.umaryland.edu/bitstream/handle/10713/4875/MPOS%20Summary%20Report.pdf>

Agley, J., Xiao, Y., Eldridge, L., Meyerson, B., & Golzarri-Arroyo, L. (2022). Beliefs and misperceptions about naloxone and overdose among U.S. laypersons: a cross-sectional study.

BMC Public Health, 22(1). <https://doi.org/10.1186/s12889-022-13298-3>

Ashford, R. D., Brown, A. M., Ashford, A., & Curtis, B. (2019). Recovery dialects: A pilot study of stigmatizing and nonstigmatizing label use by individuals in recovery from substance use disorders. *Experimental and Clinical Psychopharmacology*, 27(6), 530–535.

<https://doi.org/10.1037/pha0000286>

Bahora, M., Hanafi, S., Chien, V. H., & Compton, M. T. (2007). Preliminary evidence of effects of crisis intervention team training on Self-Efficacy and social distance. *Administration and Policy in Mental Health and Mental Health Services Research*, 35(3), 159–167.

<https://doi.org/10.1007/s10488-007-0153-8>

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. (2022b). 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>

Bogardus, E. S. (1924). Measuring Social Distances. *Journal of Applied Sociology*, 9, 299.

Brown, S. A. (2011). Standardized measures for substance use stigma. *Drug and Alcohol Dependence*, 116(1–3), 137–141. <https://doi.org/10.1016/j.drugalcdep.2010.12.005>

Collins, R. L., Wong, E. C., Roth, E., Cerully, J. L., & Marks, J. (2015, November 11). *Changes in mental illness stigma in California during the Statewide Stigma and Discrimination Reduction Initiative*. PubMed Central (PMC). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5158290/>

Evans-Lacko, S., Rose, D., Little, K., Flach, C., Rhydderch, D., Henderson, C., & Thornicroft, G. (2011). Development and psychometric properties of the Reported and Intended Behaviour Scale (RIBS): a stigma-related behaviour measure. *Epidemiology and Psychiatric Sciences*, 20(3), 263–271. <https://doi.org/10.1017/s2045796011000308>

Fife, B. L., & Wright, E. R. (2000). The dimensionality of stigma: A comparison of its impact on the self of persons with HIV/AIDS and cancer. *Journal of Health and Social Behavior*, 41(1), 50–67.

Hohmann, L., Phillippe, H., Marlowe, K., Jeminiwa, R., Hohmann, N., Westrick, S., Fowler, A., & Fox, B. (2022). A state-wide education program on opioid use disorder: influential community members' knowledge, beliefs, and opportunities for coalition development. *BMC Public Health*, 22(1). <https://doi.org/10.1186/s12889-022-13248-z>

Kanter, J. W., Rusch, L. C., & Brondino, M. J. (2008). Depression Self-Stigma. *The Journal of Nervous and Mental Disease*, 196(9), 663–670. <https://doi.org/10.1097/nmd.0b013e318183f8af>

Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). The Social rejection of former Mental Patients: Understanding why labels matter. *American Journal of Sociology*, 92(6), 1461–1500. <https://doi.org/10.1086/228672>

Link, B. G., Mirotznik, J., & Cullen, F. T. (1991). The effectiveness of stigma coping orientations: Can negative consequences of mental illness labeling be avoided? *Journal of Health and Social Behavior*, 32(3), 302–320.

Link, B. G., Struening, E. L., Rahav, M., Phelan, J. C., & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behavior*, 38(2), 177–190.

Link, B. G., Yang, L. H., Phelan, J. C., & Collins, P. Y. (2004). Measuring mental Illness Stigma. *Schizophrenia Bulletin*, 30(3), 511–541. <https://doi.org/10.1093/oxfordjournals.schbul.a007098>

Luoma, J. B., O'Hair, A. K., Kohlenberg, B. S., Hayes, S. C., & Fletcher, L. (2009). The development and psychometric properties of a new measure of perceived stigma toward substance users. *Substance Use & Misuse*, 45(1–2), 47–57. <https://doi.org/10.3109/10826080902864712>

McGinty, E. E., Barry, C. L., Stone, E. M., Niederdeppe, J., Kennedy-Hendricks, A., Linden, S., & Sherman, S. G. (2018). Public support for safe consumption sites and syringe services programs to combat the opioid epidemic. *Preventive Medicine*, 111, 73–77. <https://doi.org/10.1016/j.ypmed.2018.02.026>

Perry, B. L., Pescosolido, B. A., & Krendl, A. C. (2020). The unique nature of public stigma toward non-medical prescription opioid use and dependence: a national study. *Addiction*, 115(12), 2317–2326. <https://doi.org/10.1111/add.15069>

Pescosolido, B. A., Medina, T. R., Martin, J. K., & Long, J. S. (2013). The “Backbone” of Stigma: Identifying the Global Core of Public Prejudice Associated With Mental Illness. *American Journal of Public Health*, 103(5), 853–860. <https://doi.org/10.2105/ajph.2012.301147>

Schlosser, A., Habecker, P., & Bevins, R. (2022). Harm reduction in the Heartland: public knowledge and beliefs about naloxone in Nebraska, USA. *Harm Reduction Journal*, 19(1). <https://doi.org/10.1186/s12954-022-00606-8>

Simmons, J., Rajan, S., Goldsamt, L. A., & Elliott, L. (2018). Implementation of online Opioid Prevention, Recognition and response Trainings for laypeople: Year 1 Survey results. *Substance Use & Misuse*, 53(12), 1997–2002. <https://doi.org/10.1080/10826084.2018.1451891>

Stone, E. M., Kennedy-Hendricks, A., Barry, C. L., Bachhuber, M. A., & McGinty, E. E. (2021). The role of stigma in U.S. primary care physicians' treatment of opioid use disorder. *Drug and Alcohol Dependence*, 221, 108627. <https://doi.org/10.1016/j.drugalcdep.2021.108627>

Stover, A. N., Grogg, K., Patel, J., Thornton, D., & Dwibedi, N. (2019). Opioid overdose knowledge among college students in a high overdose death state. *Journal of Human Behavior in the Social Environment*, 29(7), 887–896. <https://doi.org/10.1080/10911359.2019.1633981>

Strata Research, Inc. (2020). *Mental Health & Substance Misuse Knowledge, Beliefs & Behaviors: Community Stigma Baseline Survey*. San Mateo County Behavioral Health & Recovery Services – Office of Diversity and Equity. https://www.smchealth.org/sites/main/files/fileattachments/s19713_smc_stigma_baseline_full_report_05_rv2.pdf?1616216764

Tuliao, A. P., & Holyoak, D. (2019). Psychometric properties of the perceived stigma towards substance users scale: factor structure, internal consistency, and associations with help-seeking variables. *The American Journal of Drug and Alcohol Abuse*, 46(2), 158–166.

<https://doi.org/10.1080/00952990.2019.1658198>

Tzemis, D., Campbell, J., Kuo, M., & Buxton, J. A. (2013). A cross-sectional study of public attitudes towards safer drug use practices in British Columbia, Canada. *Substance Abuse Treatment Prevention and Policy*, 8(1). <https://doi.org/10.1186/1747-597x-8-40>

Williams, A. V., Strang, J., & Marsden, J. (2013). 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>

Wolfson-Stofko, B., Gwadz, M. V., Elliott, L., Bennett, A. S., & Curtis, R. (2018). “Feeling confident and equipped”: Evaluating the acceptability and efficacy of an overdose response and naloxone administration intervention to service industry employees in New York City. *Drug and Alcohol Dependence*, 192, 362–370. <https://doi.org/10.1016/j.drugalcdep.2018.08.001>

Yang, L., & Link, B. G. (2016). *Measurement of attitudes, beliefs, and behaviors of mental health and mental illness*. <https://nyuscholars.nyu.edu/en/publications/measurement-of-attitudes-beliefs-and-behaviors-of-mental-health-a>

Appendix: I

Additional Vignettes used by Perry, Pescasolido, and Krendl (2020)

Subclinical Distress

[John/John/Juan] [Mary/Mary/Maria] is a [White/African American/Hispanic] [man/woman] who has completed [8th grade/high school/college]. Up until a year ago, life was pretty okay for [Name]. While nothing much is going wrong in [Name's] life he/she sometimes feels worried, a little sad, or has trouble sleeping at night. [Name] feels that at times things bother him/her more than they bother other people and that when things go wrong, he/she sometimes get nervous or annoyed. Otherwise [Name] is getting along pretty well. He/She enjoys being with other people and although [Name] sometimes argues with his/her family, [Name] has been getting along pretty well with his/her family.

Alcohol Dependence

John/John/Juan] [Mary/Mary/Maria] is a [White/African American/Hispanic] [man/woman] who has completed [8th grade/high school/college]. During the last month [Name] has started to drink more than his/her usual amount of alcohol. In fact, he/she has noticed that he needs to drink twice as much as he/she used to get the same effect. Several times, he/she has tried to cut down, or stop drinking, but he/she can't. Each time he/she has tried to cut down, he/she became very agitated, sweaty and he/she couldn't sleep, so he/she took another drink. His/her family has complained that he/she is often hung-over, and has become unreliable – making plans one day, and canceling them the next.

Depression

[John/John/Juan] [Mary/Mary/Maria] is a [White/African American/Hispanic] [man/woman] who has completed [8th grade/high school/college]. For the last two weeks [Name] has been feeling really down. He/she wakes up in the morning with a flat, heavy feeling that sticks with himself/herself all day long. He/she isn't enjoying things the way he/she normally would. In fact, nothing seems to give him/her pleasure. Even when good things happen, they don't seem to make [Name] happy. He/she pushes on through his/her days, but it is really hard. The smallest tasks are difficult to accomplish. He/she finds it hard to concentrate on anything. He/she feels out of energy and out of steam. And even though [Name] feels tired, when night comes he/she can't get to sleep. [Name] feels pretty worthless, and very discouraged. [Name's] family has noticed that he/she hasn't been himself/herself for about the last month, and that he/she has pulled away from them. [Name] just doesn't feel like talking.

Schizophrenia

[John/John/Juan] [Mary/Mary/Maria] is a [White/African American/Hispanic] [man/woman] who has completed [8th grade/high school/college]. Up until a year ago, life was pretty okay

for [Name]. But then, things started to change. He/she thought that people around him/her were making disapproving comments and talking behind his/her back. [Name] was convinced that people were spying on him/her and that they could hear what he/she was thinking. [Name] lost his/her drive to participate in his/her usual work and family activities and retreated to his/her home, eventually spending most of his/her day in his room. [Name] became so preoccupied with what he/she was thinking that he/she skipped meals and stopped bathing regularly. At night, when everyone else was sleeping, he/she was walking back and forth in his/her room. [Name] was hearing voices even though no one else was around. These voices told him/her what to do and what to think. He/she has been living this way for six months.