

Substance Use Self-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.

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Introduction

The measures presented in this toolkit assess self-stigma experienced by individuals who use or have used drugs. Self- or internalized stigma refers to an individual's endorsement of negative views and feelings associated with their stigmatized status and may include related constructs of experienced or enacted stigma (i.e., personal experiences of discrimination as a result of stigmatized status) and anticipated stigma (i.e., expectations of being the target of prejudice or discrimination). This toolkit has been divided into 3 sections of constructs that measure self-stigma experienced by individuals with opioid use disorders (OUD) specifically (Section 1), self-stigma experienced by individuals who use substances (Section 2), and measures associated with opioid use, which assess shame, and knowledge and attitudes about opioid overdose. The sections include:

1. OUD-Related Self-Stigma
2. Substance Use-Related Self-Stigma
3. Opioid Use-Related Self-Stigma

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: OUD-Related Self-Stigma

[Methadone Maintenance Treatment Stigma Mechanisms Scale \(MMT-SMS\)](#)

Smith et al., 2019

The MMT-SMS is a 25-item scale measuring experiences of anticipated, enacted, and internalized stigma of individuals in methadone maintenance treatment (MMT) for opioid use disorders, experienced from family members, employers, and health care workers. The MMT-SMS may also be adapted for individuals with other forms of medication-assisted therapy for opioid use disorders. In an initial sample of people with opioid use disorders enrolled at a methadone clinic (N = 93), the MMT-SMS demonstrated strong reliability (Cronbach's alpha= 0.81–0.95) and validity, with confirmatory factor analysis supporting the factor structure distinguishing between experiences of anticipated, enacted, and internalized stigma across family, employers, and health care workers. Responses are given on a 5-point Likert scale (1= Very Unlikely, 2= Unlikely, 3= Neither Unlikely nor Likely, 4= Likely, 5= Very Likely) with higher scores indicating greater endorsement of self-stigma.

The MMT-SMS has been used in a mixed methods study (Earnshaw et al., 2021) in Delaware of OUD disclosure as a predictor of relationship outcomes (i.e., social support; relationship closeness) among people in treatment for opioid use disorders (N = 146), where three items were used to assess whether participants had experienced enacted stigma from OUD disclosure (Cronbach's alpha= 0.92).

Anticipated Stigma:

How likely is it that people will treat you in the following ways in the future because you receive methadone?

1. Family members will think that I'm still *using drugs*.
2. Family members will not support my *MOUD* treatment.
3. Family members will think that I cannot *stop using drugs*.
4. Employers will think that I'm still *using drugs*.
5. Employers will think that I'm a bad employee.
6. Employers will think that managing my *MOUD* treatment schedule will be a problem.
7. Healthcare workers will think that I'm still *using drugs*.
8. Healthcare workers will give me poor care.
9. Healthcare workers will not prescribe me medication that I need.

Enacted Stigma:

How often have people treated you this way in the past because you receive *Medication for Opioid Use Disorder (MOUD, Ex: Methadone, Buprenorphine, Suboxone, Naltrexone)*?

1. Family members have thought that I'm still *using drugs*.
2. Family members have not supported my *MOUD* treatment.
3. Family members have thought that I cannot *stop using drugs*.
4. Employers have thought that I'm still *using drugs*.
5. Employers have thought that I'm a bad employee.
6. Employers have thought that managing my *MOUD treatment* schedule will be a problem.
7. Healthcare workers have thought that I'm still *using drugs*.
8. Healthcare workers have given me poor treatment.
9. Healthcare workers have not prescribed me medication that I needed.

Internalized Stigma:

How do you feel about your own *MOUD* treatment?

1. Receiving *MOUD* makes me feel like I'm a bad person.
2. I feel I'm not as good as others because I receive *MOUD*.
3. I feel ashamed of my *MOUD* treatment.
4. I think less of myself because I receive *MOUD*.
5. Receiving *MOUD* makes me feel unclean.
6. Being on *MOUD* treatment is disgusting to me.
7. *MOUD* treatment makes me feel like I'm still *using drugs*.

[Brief Opioid Stigma Scale](#)

Yang et al., 2019

The Brief Opioid Stigma Scale is a measure of internalized and perceived (i.e., perception of stigma in society) stigma experienced by individuals with OUD. The measure consists of subscales assessing: (1) stereotype awareness (i.e., "Most people believe... [OUD stereotype]"); (2) stereotype agreement (i.e., "I think... [OUD stereotype]"); and (3) self-esteem decrement ("I currently respect myself less because of... [OUD stereotype]"), and includes four opioid-related stereotypes: (a) "cannot be trusted"; (b) "to blame for their problems," (c) "are lazy," and (d) "are dangerous". The measure is based on the Self-Stigma of Mental Illness Scale (SSMIS;

Corrigan et al., 2006), which assesses similar constructs. Opioid-related stereotypes were derived from reviews of public stigma towards people who use drugs and a study of focus groups with people who currently and formerly used opioid, family members, and service providers. The subscales demonstrated good reliability (Cronbach's alpha= 0.68–0.72) and construct validity. A principal factor analysis supported retaining three factors with high loadings, and internal consistency (Cronbach's alpha) were 0.72, 0.68, and 0.70 for the three subscales, respectively. Responses are given on a 5-point Likert scale (1= Strongly Disagree, 2= Disagree, 3= Unsure, 4= Agree, 5= Strongly Agree), with higher scores indicating greater endorsement of stigma.

The Brief Opioid Stigma Scale was referenced in a national U.S. survey (N = 947) of the public's knowledge and attitudes towards people with and policies related to OUD (Taylor et al., 2021) where six items measuring social stigma (Cronbach's alpha= 0.78) were adapted from the scale. The scale was also adapted similarly in a U.S. survey of young adults (N = 408) on social stigma, discrimination, and policy attitudes about OUD (Adams et al., 2021).

Brief Opioid Stigma Scale:

1. Most people believe that a person who *uses drugs* cannot be trusted.
2. Most people believe that a *person who uses drugs* dangerous.
3. Most people think that a person who *uses drugs* is to blame for *their own* problems.
4. Most people believe that a person who *uses drugs* is lazy.
5. I believe that a person who *uses drugs* cannot be trusted.
6. I believe that a *person who uses drugs* is dangerous.
7. I think that a person who *uses drugs* is to blame for *their own* problems.

Stereotype Awareness Subscale:

1. Most people believe that a person who *uses drugs* cannot be trusted.
2. Most people believe that a person who *uses drugs* is to blame for *their own* problems.
3. Most people believe that a person who *uses drugs* is lazy.
4. Most people believe that a person who *uses drugs* is dangerous.

Stereotype Agreement Subscale:

1. I think a person who *uses drugs* cannot be trusted.
2. I think a person who *uses drugs* is to blame for *their own* problems.
3. I think a person who *uses drugs* is lazy.
4. I think a person who *uses drugs* is dangerous.

Self-Esteem Decrement Subscale:

1. I currently respect myself less because a person who *uses drugs* cannot be trusted.
2. I currently respect myself less because a person who *uses drugs* is to blame for *their own* problems.
3. I currently respect myself less because a person who *uses drugs* is lazy.
4. I currently respect myself less because a person who *uses drugs* is dangerous.

Section 2: Substance Use-Related Self-Stigma

[Substance Abuse Self-Stigma Scale \(SASSS\)](#)

Luoma et al., 2013

The [SASSS](#) measures self-stigma experienced by people with substance use problems. Psychometric properties were examined in a cross-sectional study of individuals in treatment for substance use (N = 352), which resulted in a 40-item measure with the following subscales: (1) self-devaluation (internalized stereotypes and judgments), (2) fear of enacted stigma (being a target of prejudice/discrimination), (3) stigma avoidance (avoiding situations where expected to experience stigma), and (4) values disengagement (not engaging in activities that align with values/goals). The measure showed a strong factor structure, internal consistency (Cronbach's alpha = 0.86), and validity. Responses are given on a 5-point Likert scale (see tables below), with higher scores indicating greater endorsement of self-stigma.

The SASSS has been utilized in a variety of research both within and outside of the U.S. The scale was used in a U.S. study examining the influence of self-stigma on substance use and depression in individuals attending intensive outpatient treatment for substance use disorders (N=17; Kulesza et al., 2014). The SASSS was also used in a study of differences in self-stigma among individuals residing in a Midwestern U.S. substance use treatment facility (N = 120; Brown et al., 2015). In addition, the scale was adapted for use in a survey of felt and enacted stigma experienced by patients in methadone maintenance treatment in Vietnam (N = 1016; Tran et al., 2016).

Self-Devaluation:

1. Most I have the thought that a major reason for my problems with substances is my own poor character.
2. I have the thought that I should be ashamed of myself.
3. I have the thought that I deserve the bad things that have happened to me.
4. I have the thought that I can't be trusted.
5. I feel inferior to people who have never had a problem with substances.
6. I feel out of place in the world because of my problems with substances.
7. I have the thought that I've permanently screwed up my life by using drugs.
8. I feel ashamed of myself.

Response Scale: 1= Never or Almost Never, 2= Rarely, 3= Sometimes, 4= Often, 5= Very Often

Fear of Enacted Stigma:

1. Most people think I'm worthless if they know about my substance use history.
2. People around me will always suspect I have returned to using substances.
3. People without a substance use history could never really understand me.
4. A job interviewer wouldn't hire me if I mentioned my substance use history in a job interview.
5. If someone were to find out about my history of substance use, they would expect me to be weak-willed.
6. People would be scared of me if they knew about my substance use history.
7. If someone were to find out about my history of substance use, they would doubt my character.
8. People will think I have little talent or skill if they know about my substance use history.
9. People think the bad things that have happened to me are my fault.

Response Scale: 1= Few People (0-20%), 2= Some People (20-40%), 3= Many People (40-60%), 4= Most People (60-80%), 5= Almost Everyone (80-100%)

Stigma Avoidance:

1. I would choose to avoid someone who seemed interested in my friendship if I knew they had never used substances.
2. When I feel incompetent at something I want to do, I stop trying.
3. I put a lot of effort into hiding my substance use history.
4. I avoid doing things where I would be blamed if it didn't work out.
5. I wouldn't try to fill roles that required a person of character.
6. Shame gets in the way of how I want to live my life.
7. I would lie to people in my life about my substance use if I were sure they would never find out.
8. I avoid situations where another person might have to depend on me.
9. I avoid situations that make me feel different.
10. I can't stand feeling like the bad things that happen to me are my fault.
11. I would willingly sacrifice important things in my life to feel like I fit in.
12. Blaming myself for my substance use history gets in the way of my success.
13. I would willingly sacrifice important life goals if that meant I could feel better about myself.

Response Scale: Never or Almost Never True, 2= Rarely True, 3= Sometimes True, 4= Often True, 5= Very Often True

Values Engagement: *

1. I do things that are good for me, even if I feel like I don't deserve it.
2. If something is important to me, I keep doing it, even if I feel incompetent.
3. I am getting on with the business of living, no matter how guilty I feel.
4. I'm willing to be in situations where I might feel different from others.
5. I am open about my substance use history with most people.
6. I pursue important goals in life, even when I fear I might not follow through.
7. I can set a direction for my life even if I feel hopeless.
8. Even if I knew the employer didn't like to hire people in recovery, I would still apply for a job if it interested me.
9. I can set a course in my life and stick to it, even when I feel like I'm a bad person.
10. If I didn't have a job, I would still look for one, even if it felt hopeless.

Response Scale: 1= Never or Almost Never True, 2= Rarely True, 3= Sometimes True, 4= Often True, 5= Very Often True

*All items in this subscale are reverse scored

Substance Use Stigma Mechanisms Scale (SU-SMS)

Smith et al., 2016

The [SU-SMS](#) is an 18-item measure of experiences of enacted, internalized, and anticipated stigma by persons with substance use disorders, with a focus on those experiences with family members and healthcare providers. The SU-SMS was developed for use in a diverse range of populations and can be adapted for individuals affected by alcohol use or specific substance use disorders. Strong psychometric properties were demonstrated in an initial study with two samples, one of patients diagnosed as “opioid dependent” and enrolled in methadone maintenance therapy (MMT; N = 93), and a second of HIV-positive, clinical care patients with active or a problematic history of substance use (N = 85). Results supported the validity of the SU-SMS, suggesting the scale was able to capture enacted, anticipated, and internalized stigma as distinct dimensions of stigma. The pooled sample (N = 175) showed high internal consistency across the three subscales (Cronbach’s alpha = 0.90–0.93) and both independent samples (Cronbach’s alpha = 0.83–0.94). Responses are given on a 5-point Likert scale (see tables below), with higher scores indicating greater endorsement of self-stigma.

The SU-SMS was used in a study exploring associations between enacted stigma in healthcare settings, health conditions, and injection risk behaviors for HIV among rural people who inject drugs in Kentucky (N = 324; Surratt et al., 2021). The scale was also used in a study in

Massachusetts on the interrelationships between internalized stigma related to HIV, sexual orientation, and substance use, as well as avoidance coping and HIV treatment noncompliance among non-heterosexual men living with HIV who use substances (N = 202; Batchelder et al., 2021). Another study used the SU-SMS to examine how help-seeking was influenced by substance use self-stigma in a national sample with a history of problematic substance use (N = 171), including individuals specifically identifying as gender/sexual minorities (GSM; N = 67; Benz et al., 2019).

Enacted Stigma:

How often have people treated you this way **in the past** because of your alcohol and/or drug use history?

1. Family members have thought that I cannot be trusted.
2. Family members have looked down on me.
3. Family members have treated me differently.
4. Healthcare workers have not listened to my concerns.
5. Healthcare workers have thought that I'm pill shopping, or trying to con them into giving me prescription medications to get high or sell.
7. Healthcare workers have given me poor care.

Response Scale: 1= Never, 2= Not Often, 3= Somewhat Often, 4= Often, 5= Very Often

Anticipated Stigma:

How likely is it that people will treat you in the following ways **in the future** because of your alcohol and/or drug use?

1. Family members will think that I cannot be trusted.
2. Family members will look down on me.
3. Family members will treat me differently.
4. Healthcare workers will not listen to my concerns.
5. Healthcare workers will think that I'm pill shopping, or trying to con them into giving me prescription medications to get high or sell.

Response Scale: 1= Very Unlikely, 2= Unlikely, 3= Neither Unlikely nor Likely, 4= Likely, 5= Very Likely

Internalized Stigma:

How do you feel about your drug use?

1. Having used drugs make me feel like I'm a bad person.
2. I feel I'm not as good as others because I used drugs.
3. I feel ashamed of having used drugs.
4. I think less of myself because I used drugs.
5. Having used drugs makes me feel unclean.
6. Having used drugs is disgusting to me.

Response Scale: 1= Strongly Disagree, 2= Disagree, 3= Neither Disagree Nor Agree, 4= Agree, 5= Strongly Agree

[Internalized Stigma of Substance Abuse Scale \(ISSA\)](#)

Ashford et al., 2019

The ISSA is an adaptation of the [Internalized Stigma of Mental Illness scale](#) (ISMI: [Ritsher et al., 2003](#)) and measures personal experiences of stigma related to substance use. The ISSA was created for use in a study assessing the usage of “addict” vs “person with a substance use disorder” labels by persons in recovery from SUD, comparing differences in SUD recovery outcomes. The ISMI has subscales measuring: (1) alienation (feeling less than a full member of society), (2) stereotype endorsement (e.g., violent, can't contribute to society), (3) perceived discrimination (negative treatment by others), (4) social withdrawal, and (5) stigma resistance (resisting or being unaffected by internalized stigma). The ISMI was developed using a validation sample of mental health outpatients (N = 127) and demonstrated high internal consistency (Cronbach's alpha= 0.90) and test-retest reliability (r = 0.92). Construct validity was supported by comparisons against scales measuring related constructs and factor analyses. Responses are given on a 4-point Likert scale (1= Strongly Disagree, 2= Disagree, 3= Agree, 4= Strongly Agree), with higher scores indicating greater endorsement of internalized stigma.

Alienation:

1. I feel out of place in the world because I have a substance *use* problem.
2. I am embarrassed or ashamed that I *use or previously used* substances.
3. I feel inferior to others who don't *use or haven't previously used* substances.
4. I am disappointed in myself *for my substance use*.
5. Having a substance *use* problem has spoiled my life.
6. People without a substance *use* problem could not possibly understand me.

Stereotype Endorsement:

1. *People who use substances* tend to be violent.
2. *People who use substances* shouldn't get married.
3. People with substance *use* problems cannot live a good, rewarding life.
4. People can tell that I have a substance *use* problem by the way I look.
5. Because I have a substance *use* problem, I need others to make most decisions for me.
6. I can't contribute anything to society because I have a substance *use* problem.
7. Stereotypes about the people with substance *use* problems apply to me.

Discrimination Experience:

1. People discriminate against me because I *use or previously used* substances.
2. People often patronize me, or treat me like a child, just because I have a substance *use* problem.
3. People ignore me or take me less seriously just because I *use or previously used* substances.
4. Nobody would be interested in getting close to me because I have a substance *use* problem.
5. Others think that I can't achieve much in life because I *use or previously used* substances.

Social Withdrawal:

1. I avoid getting close to people who don't *use* substances to avoid rejection.
2. I don't socialize as much as I used to because my substance *use* problem might make me look or behave "weird."
3. I don't talk about myself much because I don't want to burden others with my substance *use* problem.
4. Negative stereotypes about substance *use* keep me isolated from the "normal" world.
5. Being around people who don't *use* substances makes me feel out of place or inadequate.
6. I stay away from social situations in order to protect my family or friends from embarrassment.

*Stigma Resistance: **

1. *People who use* substances make important contributions to society.
2. I feel comfortable being seen in public with a person who obviously has a substance *use* problem.
3. Living with a substance *use* problem has made me a tough survivor.
4. In general, I am able to live my life the way I want to.
5. I can have a good, fulfilling life, despite my substance *use*.

*All items in Stigma Resistance scale are reverse coded

General Self-Stigma & Treatment Stigma

Kanter et al., 2008

Adapted from the Depression Self-Stigma Scale (DSSS; Kanter et al., 2008), the General Self-Stigma subscale assesses perceived and internalized stereotypes and stigmatizing attitudes of others related to a mental health condition, and the Treatment Stigma subscale assesses perceived stigmatizing attitudes about receiving treatment. Versions of these subscales were modified for use in a study of patients with opioid use disorder (OUD) in inpatient detoxification (N = 407), demonstrating acceptable levels of internal consistency (Cronbach's alpha= 0.83;.688; Bozinoff et al., 2018). The development of this measure initially for self-stigma related to depression (N = 391) involved an exploratory factor analysis which led to five factors/subscales including General Self-Stigma and Treatment Stigma, which had good internal consistency (Cronbach's alpha= 0.93; 0.79) and construct validity (Kanter et al., 2008).

Responses are given on 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= Completely Agree), with higher scores indicating greater endorsement of stigma.

General Self-Stigma Subscale:

1. Others view me as unable to care for myself because I use drugs.
2. Others view me as morally weak because I use drugs.
3. Others think that I am not worth the investment of time and resources because I use drugs.
4. People have told me that using drugs is what I deserve for how I've lived my life.
5. Since starting drugs, I worry about people discriminating against me.
6. When people learned I use drugs, they looked for flaws in my character.
7. People's attitudes about drugs make me feel worse about myself.
8. Some people who know I use drugs have grown more distant.

Treatment Stigma Subscale:

1. Receiving treatment for drug use carries social stigma (mark of shame, a black mark).
2. People will see a person in a less favorable way if they come to know *they* received treatment for drug use.
3. It is advisable for a person to hide from people that *they have been* treated for drug use.

Section 3: Opioid Use-Related Self-Stigma

[Internalized Shame Scale \(ISS\)](#)

Cook, 1987

The Internalized Shame Scale (Cook, 1987, 1996) is a 30-item measure of experiencing various shame-related thoughts and feelings. Note that the items are not directly related to substance use (i.e., they do not directly reference substance use) so we have placed it as a complementary measure. The ISS is composed of the Shame and Self-Esteem subscales, the latter of which was adapted from the Rosenberg (1965) Self-Esteem Scale. The ISS was developed based on experiential descriptions of shame from patients in treatment for alcoholism (Del Rosario & White, 2006), and has been used in multiple studies of individuals in treatment or recovering from substance use disorders (Ashford et al., 2019; Luoma et al., 2007; Luoma et al., 2008). This ISS has demonstrated strong reliability in its initial development with clinical (Cronbach's alpha= 0.95; N = 370), and non-clinical (Cronbach's alpha= 0.95; N = 645) samples, as well as high temporal stability. A principal components analysis conducted from a sample of college students (N = 184) found an underlying structure of one dominant factor ("Inferiority") and two lesser factors ("Fragility/Exposed"; "Empty/Lonely"), and significant correlations between the Shame subscale and anxiety, hostility, depression, and positive affect, supporting construct validity (Del Rosario & White, 2006). Responses are given on a 5-point Likert scale (1= Never, 2= Seldom, 3= Sometimes, 4= Often, 5= Almost Always), with higher scores indicating greater endorsement of internalized shame.

Shame Subscale:

1. I feel like I am never quite good enough.
2. I feel somehow left out.
3. I think that people look down on me.
4. I scold myself and put myself down.
5. I feel insecure about others opinions on me.
6. Compared to other people, I feel like I somehow never measure up.
7. I see myself as being very small and insignificant.
8. I feel intensely inadequate and full of self-doubt.
9. I feel as if I am somehow defective as a person like there is something wrong with me.
10. When I compare myself to others I am just not as important.
11. I have an overpowering dread that my faults will be revealed in front of others.
12. I see myself striving for perfection only to continually fall short.
13. I could beat myself over the head club when I make a mistake.
14. I would like to shrink away when I make a mistake.
15. I replay painful events over and over in my mind until I am overwhelmed.
16. At times I feel like I will break into a thousand pieces.
17. I feel as if I have lost control over my body functions and my feelings.
18. Sometimes I feel no bigger than a pie.
19. At times I feel so exposed that I wish the earth would open up and swallow me.
20. I have this painful gap within me that I have not been able to fill.
21. I feel empty and unfulfilled.
22. My loneliness is more like emptiness.
23. I feel like there is something missing.

*Self-Esteem Subscale: **

1. All in all I am inclined to feel that I am a success.
2. I feel I have much to be proud of.
3. I feel I have a number of good qualities.
4. On the whole, I am satisfied with myself.
5. I feel I am a person of worth at least on an equal plane with others.
6. I take a positive attitude towards myself.

*All items in Self-Esteem Subscale are reverse coded

Opioid Overdose Knowledge Scale (OOKS) & Opioid Overdose Attitudes Scales (OOAS)

Williams et al., 2013

The OOKS and OOAS are scales designed to measure knowledge and attitudes related to opioid overdose. These scales were initially developed to evaluate training programs for emergency naloxone use by family members and friends of people who use opioids and healthcare professionals working in addiction treatment. These measures have been widely used with healthcare providers and first responders, as well as individuals who use opioids themselves (e.g., Nielsen et al., 2018; Wilder et al., 2016). While reliability statistics are not presented when administered to people with OUD, these scales have demonstrated good reliability (Cronbach's alpha= 0.83; 0.90) and concurrent validity in other groups (Williams et al., 2013). For the OOKS, responses are given as "True or False", with higher scores indicating higher knowledge of opioid overdose. For the OOAS, responses are given on a 5-point Likert Scale (1= Completely Disagree, 2= Disagree, 3= Unsure, 4= Agree, 5= Completely Agree), with higher scores indicating higher levels of opioid overdose competency and readiness to intervene.

A. Which of the following factors increase the risk of an overdose?	Tick each correct answer
1. Taking larger than usual doses or heroin	<input type="checkbox"/> (T)
2. Switching from smoking to injecting heroin	<input type="checkbox"/> (T)
3. Using heroin with other substances, such as alcohol or sleeping pills	<input type="checkbox"/> (T)
4. Increase in heroin purity	<input type="checkbox"/> (T)
5. Using heroin again after not having used for a while	<input type="checkbox"/> (T)
6. Using heroin when no one else is present around	<input type="checkbox"/> (T)
7. A long history of heroin use	<input type="checkbox"/> (T)
8. Using heroin again soon after release from prison	<input type="checkbox"/> (T)
9. Using heroin again after a detoxification treatment	<input type="checkbox"/> (T)

B. Which of the following are indicators of an opioid overdose?	
1. Having blood-shot eyes	<input type="checkbox"/> (F)
2. Slow or shallow breathing	<input type="checkbox"/> (T)
3. Lips, hands, or feet turning blue	<input type="checkbox"/> (T)
4. Loss of consciousness	<input type="checkbox"/> (T)
5. Unresponsive	<input type="checkbox"/> (T)
6. Fitting	<input type="checkbox"/> (F)
7. Deep snoring	<input type="checkbox"/> (T)

8. Very small pupils	<input type="checkbox"/> (T)
9. Agitated behavior	<input type="checkbox"/> (F)
10. Rapid heartbeat	<input type="checkbox"/> (F)

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

D. What is naloxone used for?	
1. To reverse the effects of an opioid overdose (e.g. heroin, <i>fentanyl</i>)	<input type="checkbox"/> (T)
2. To reverse the effects of an amphetamine overdose	<input type="checkbox"/> (F)
3. To reverse the effects of a cocaine overdose	<input type="checkbox"/> (F)
4. To reverse the effects of any overdose	<input type="checkbox"/> (F)

E. How can naloxone be administered?	
1. Into a muscle (intramuscular)	<input type="checkbox"/> (T)
2. Into a vein (intravenous)	<input type="checkbox"/> (T)
3. Under the skin (subcutaneous)	<input type="checkbox"/> (T)
4. <i>Into nostrils (intranasal)</i>	<input type="checkbox"/> (T)
5. Swallowing- liquid	<input type="checkbox"/> (F)
6. Swallowing- tablet	<input type="checkbox"/> (F)
7. Don't know	<input type="checkbox"/>

F. Where is the most recommended place for non-experts to administer naloxone?	
1. Outside the thighs or upper arms	<input type="checkbox"/> (T)
2. Any vein	<input type="checkbox"/> (F)
3. Heart	<input type="checkbox"/> (F)
4. <i>Nose</i>	<input type="checkbox"/> (T)
5. Mouth	<input type="checkbox"/> (F)
6. Don't know	<input type="checkbox"/>

G. How long does naloxone take to start having an effect?	
1. 2-5 minutes	<input type="checkbox"/> (T)
2. 6-10 minutes	<input type="checkbox"/> (F)
3. 11-20 minutes	<input type="checkbox"/> (F)
4. 21-40 minutes	<input type="checkbox"/> (F)
5. Don't know	<input type="checkbox"/>

H. How long do the effects of naloxone last for?	
1. Less than 20 minutes	<input type="checkbox"/> (F)
2. About 1 hour	<input type="checkbox"/> (T)
3. 1 to 6 hours	<input type="checkbox"/> (F)
4. 6 to 12 hours	<input type="checkbox"/> (F)
5. Don't know	<input type="checkbox"/>

I. Please tick each correct statement.	
1. If the first dose of naloxone has no effect a second dose can be given.	<input type="checkbox"/> (T)
2. There is no need to call for an ambulance if I know how to manage an overdose.	<input type="checkbox"/> (F)
3. Someone can overdose again after having received naloxone.	<input type="checkbox"/> (T)
4. The effect of naloxone is shorter than the effect of heroin <i>or fentanyl</i> .	<input type="checkbox"/> (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.	<input type="checkbox"/> (F)
6. <i>Over-administration</i> of naloxone can provoke withdrawal symptoms.	<input type="checkbox"/> (T)

Competencies to manage an 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 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

[Brief Opioid Overdose Knowledge \(BOOK\) Questionnaire](#)

Dunn et al., 2016

The BOOK questionnaire is a brief measure of knowledge gaps or deficits in opioid overdose risk among people who use opioids. This scale was developed using samples of people who use opioids and patients receiving an opioid for the treatment of chronic pain (N = 848) and consists of three factors (each 4 items): Opioid Knowledge, Opioid Overdose Knowledge, and Opioid Overdose Response Knowledge. The scale demonstrated a clear factor structure and strong internal validity (Dunn et al., 2016). Response options are "True", "False", and "I Don't Know", with higher scores indicating higher levels of opioid risk knowledge. Reliability of this measure is not reported.

Opioid Knowledge Scale:

1. Long-acting opioids are used to treat chronic “round the clock” pain.	<input type="checkbox"/> True [*]	<input type="checkbox"/> False	<input type="checkbox"/> I Don’t Know
2. Methadone is a long-acting opioid.	<input type="checkbox"/> True [*]	<input type="checkbox"/> False	<input type="checkbox"/> I Don’t Know
3. Restlessness, muscle and bone pain, and insomnia are symptoms of opioid withdrawal.	<input type="checkbox"/> True [*]	<input type="checkbox"/> False	<input type="checkbox"/> I Don’t Know
4. Heroin, OxyContin, and fentanyl are all examples of opioids.	<input type="checkbox"/> True [*]	<input type="checkbox"/> False	<input type="checkbox"/> I Don’t Know

Opioid Overdose Knowledge Scale:

1. Trouble breathing is NOT related to opioid overdose.	<input type="checkbox"/> True	<input type="checkbox"/> False [*]	<input type="checkbox"/> I Don’t Know
2. Clammy and cool skin is NOT a sign of an opioid overdose.	<input type="checkbox"/> True	<input type="checkbox"/> False [*]	<input type="checkbox"/> I Don’t Know
3. All overdoses are fatal (deadly).	<input type="checkbox"/> True	<input type="checkbox"/> False [*]	<input type="checkbox"/> I Don’t Know
4. Using a short-acting opioid and a long-acting opioid at the same time does NOT increase your risk of an opioid overdose.	<input type="checkbox"/> True	<input type="checkbox"/> False [*]	<input type="checkbox"/> I Don’t Know

Opioid Overdose Response Knowledge Scale:

1. If you see a person overdosing on opioids, you can begin rescue breathing until a health worker arrives.	<input type="checkbox"/> True [*]	<input type="checkbox"/> False	<input type="checkbox"/> I Don’t Know
2. A sternal rub helps you evaluate whether someone is unconscious.	<input type="checkbox"/> True [*]	<input type="checkbox"/> False	<input type="checkbox"/> I Don’t Know
3. Once you confirm an individual is breathing, you can place <i>them</i> into the recovery position.	<input type="checkbox"/> True [*]	<input type="checkbox"/> False	<input type="checkbox"/> I Don’t Know
4. <i>Naloxone</i> will reverse the effect of an opioid overdose.	<input type="checkbox"/> True [*]	<input type="checkbox"/> False	<input type="checkbox"/> I Don’t Know

Substance Use Self-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 [Substance Use Self-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 respondents to form an opinion.

This template assessment should be used to describe the overall degree or magnitude of substance use related stigma among people who use/have previously used drugs. 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 14-16 are from a scale developed by Stone et al. to assess opioid related attitude and beliefs. The responses to questions 14-16 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.

This survey is to be completed by individuals who currently or formerly exhibit symptoms associated with a substance use, commonly referred to as substance use disorder (SUD). SUD is complicated to fully define and may or may not be formally diagnosed. For the purposes of this survey, SUD refers to a condition that may exhibit some or all of the following symptoms:

- Consuming the substance in larger amounts and for a longer amount of time than intended.
- Persistent desire to cut down or regulate use. The individual may have unsuccessfully attempted to stop in the past.
- Spending a great deal of time obtaining, using, or recovering from the effects of substance use.
- Experiencing craving, a pressing desire to use the substance.
- Substance use impairs ability to fulfill major obligations at work, school, or home.
- Continued use of the substance despite it causing significant social or interpersonal problems.
- Reduction or discontinuation of recreational, social, or occupational activities because of substance use.
- Recurrent substance use in physically unsafe environments.
- Persistent substance use despite knowledge that it may cause or exacerbate physical or psychological problems.

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

1. Have you ever been diagnosed with a substance use disorder?
 - Yes
 - No
 - Unsure

2. Are you currently using the substance(s) associated with your substance use disorder?
- Yes
 - No
3. What is your gender identity?
- Female
 - Male
 - Transgender Male
 - Transgender Female
 - Nonbinary/Genderqueer
 - Other (please specify): _____
4. 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
5. 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 (please specify): _____
6. Which race or ethnicity best describes you? (Please choose only one)
- American Indian or Alaskan Native
 - Asian/Pacific Islander
 - Black or African American
 - Hispanic
 - White
 - Multiple Ethnicity/Other (please specify): _____

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

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

Strongly Disagree Disagree Agree Strongly Agree

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

Strongly Disagree Disagree Agree Strongly Agree

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

Strongly Disagree Disagree Agree Strongly Agree

10. I would be concerned about calling emergency services if someone overdosed in case the police come around.

Strongly Disagree Disagree Agree Strongly Agree

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

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

Strongly Disagree Disagree Agree Strongly Agree

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

Strongly Disagree Disagree Agree Strongly Agree

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

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 issue.

Strongly Agree Agree Disagree Strongly Disagree

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

Strongly Agree Agree Disagree Strongly Disagree

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

Strongly Agree Agree Disagree Strongly Disagree

The next questions are about your personal experience with substance use.

17. I am embarrassed or ashamed that I use or previously used substances.

Strongly Disagree Disagree Agree Strongly Agree

18. I feel inferior to others who don't use or haven't previously used substances.

Strongly Disagree Disagree Agree Strongly Agree

19. I am disappointed in myself for my substance use.

Strongly Disagree Disagree Agree Strongly Agree

20. People discriminate against me because I use or previously used substances.

Strongly Disagree Disagree Agree Strongly Agree

21. People ignore me or take me less seriously just because I use or previously used substances.

Strongly Disagree Disagree Agree Strongly Agree

22. Others think that I can't achieve much in life because I use or previously used substances.

Strongly Disagree Disagree Agree Strongly Agree

23. I avoid getting close to people who don't use substances to avoid rejection.

Strongly Disagree Disagree Agree Strongly Agree

24. Negative stereotypes about substance use keep me isolated from the "normal" world.

Strongly Disagree Disagree Agree Strongly Agree

25. Being around people who don't use substances makes me feel out of place or inadequate.

Strongly Disagree Disagree Agree Strongly Agree

26. People who use substances make important contributions to society.

Strongly Disagree Disagree Agree Strongly Agree

27. I can have a good, fulfilling life, despite my substance use.

Strongly Disagree Disagree Agree Strongly Agree

28. In general, I am able to live my life the way I want to.

Strongly Disagree Disagree Agree Strongly Agree

The next questions are about how often people have treated you in the past because of your substance use.

29. Family members have thought that I cannot be trusted.

Never Not Often Somewhat Often Often Very Often

30. Healthcare workers have not listened to my concerns.

Never Not Often Somewhat Often Often Very Often

31. Healthcare workers have given me poor care.

Never Not Often Somewhat Often Often Very Often

The next questions are about how likely it is that people will treat you in the following ways in the future because of your substance use.

32. Family members will look down on me.

Very Unlikely Unlikely Likely Very Likely

33. Family members will treat me differently.

Very Unlikely Unlikely Likely Very Likely

34. Healthcare workers will think that I'm pill shopping, or trying to con them into giving me prescription medications to get high or sell.

Very Unlikely Unlikely Likely Very Likely

[Note: This section should be included if the survey administrator is interested in collecting further information on stigma associated with Medication for Opioid Use Disorder (MOUD). If included, a decision logic question should be included before this section: “Have you ever been prescribed Medication for Opioid Use Disorder (MOUD, Ex: Methadone, Buprenorphine, Suboxone, Naltrexone)”? NACCHO recommends the inclusion of this section to better assess stigma towards and resistance to this evidence-based intervention.]

If Yes: The next questions are about how often people have treated you in the past because you receive Medication for Opioid Use Disorder (MOUD, Ex: Methadone, Buprenorphine, Suboxone, Naltrexone).

35. Family members have thought that I’m still using drugs.

Never Not Often Somewhat Often Often Very Often

36. Employers have thought that I’m still using drugs.

Never Not Often Somewhat Often Often Very Often

37. Healthcare workers have thought that I’m still using drugs.

Never Not Often Somewhat Often Often Very Often

The next questions are about how you feel about your own MOUD treatment.

38. I feel I’m not as good as others because I receive MOUD.

Strongly Disagree Disagree Agree Strongly Agree

39. I feel ashamed of my MOUD treatment.

Strongly Disagree Disagree Agree Strongly Agree

40. MOUD treatment makes me feel like I'm still using drugs.

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 _____.

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