Stigma of Addiction Summit

Innovation Abstracts

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Stigma of Addiction Summit Innovation Abstract Compendium

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1. A Collaborative Model for Assessing Trauma-Informed Practice in Agencies and Systems: A Promising Practice for Reducing Stigma

Authors
Laurie Drabble; Vivian Brown

What is your project or initiative?
This project was designed to explore the benefits of a trauma-informed systems assessment and improvement initiative conducted in the context of a family drug treatment court (FDTC).

Why did you develop this?
A growing body of literature documents the importance of trauma-informed and trauma-specific services and systems change in both addiction treatment and child welfare fields.

Who is the target audience?
Dependency courts, child welfare, and addiction treatment fields.

Is this based on established work, or does it draw from other existing work?
See the following references:

- Brown, V. B., M. Harris, R. Fallot. 2013. Moving toward trauma-informed practice in addiction treatment: a collaborative model of agency assessment. *Journal of Psychoactive Drugs* 45(5): 386-393. https://doi.org/10.1080/02791072.2013.844381.
- Drabble, L., S. Jones, and V. Brown. 2013. Advancing Trauma-Informed Systems Change in a Family Drug Treatment Court Context. *Journal of Social Work Practice in the Addictions* 13(1): 91-113. https://doi.org/10.1080/1533256X.2012.756341
- Fallot, R. D., and M. Harris. 2006. T*rauma-Informed Services: A Self-Assessment and Planning Protocol.* Washington, DC: Community Connections. Available at: theannainstitute.org/TISA+PPROTOCOL.pdf (accessed May 27, 2021).

How does your project or initiative work?
The trauma-informed systems assessment involved a collaborative trauma-informed "walk-through" of several key partner organizations involved in a FDTC. The systems included the family dependency treatment court, child welfare agencies, and substance use disorder treatment agencies working with the parents who were referred to the FDTC (see references below for details about the intervention and study). The assessment is a tool for helping agencies and systems recognize potential trauma triggers within their agency and develop mitigation strategies for addressing change. The assessment includes questions such as whether the facility/system offers a safe place for clients/families; whether screening includes substance use, mental health, and trauma questions; the degree to which clients receive clear explanations and information about program procedures; types of choices clients are given about services; and sensitivity of staff to the potential of re-traumatization during certain procedures. The assessment is designed to reveal actionable opportunities for improvement in systems and practices.

What are the results? If results are not yet available, what results do you hope to achieve?
The assessment process, trauma-informed training, and practice adaptations helped to reduce stigma experienced by parents with substance use problems in two ways (see Drabble et al., 2013, included above).

1. **Benefits for clients.** A common response regarding the benefits of implementing trauma-informed systems change is that service providers "have a higher level of sensitivity and respect for parents…in part, because of the trauma-informed trainings." The process challenged

providers to “really try to put ourselves in their shoes and treat each other the way we want to be treated” and makes providers “think about what we do and when we do it and why we do it the way... and it just makes us more aware of how we interact with our parents or how we talk to them or how we ask them to do things.” The strengths-based and trauma-informed approach in made parents feel “heard” and “not judged.” The parents were more likely to engage in the process and to open up in the court setting.

2. **Support and advocacy through peer mentors.** Research about the intervention underscored the value of a peer support program (a key program component of the FDTC), which matches clients with mentor parents who are in recovery and have been through the child welfare system. Mentor parents were critical in helping to normalize the process of both trauma recovery and recovery from addiction. They also helped to mitigate the potential stigma of involvement in the child welfare system by sharing their own experience and helping parent navigate successfully through the court and child welfare process. In addition to providing reducing stigma and providing support and hope for clients, peer mentors also provided important, needed insights to lawyers, social workers, other officials, and the judge in understanding what the parent goes through as they navigate the system. Peer mentors were frequently mentioned as key in prompting systems change because they are the window for the court into the lived experience of parents and children in family drug treatment courts.

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Keywords
criminal justice, lived experience, simulation, training, trauma-informed, young adults

2. A Team around You: Continuous Connected Care Supported by Technology, Supporting the Person Dealing with Addiction and Their Loved Ones

Authors
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What is your project or initiative?
Our project creates a bundle of curated services around a core care planning and coordination technology platform, enabling collaboration and continuity of care and support while addressing the individual, social, structural, and environmental contexts needed to treat addiction and to prevent recurrence of use.

Why did you develop this?
Lack of continuity of care and 24/7 support, as well as numerous distinct gaps and barriers to accessing services leads to frequent recurrence of use, in spite of the success of a given effort to obtain and retain treatment. The current annual rates of recurrence of use are 40% to 60%. The “yo-yo” or “snakes and ladders” nature of the experience is profoundly demoralizing for the impacted person, as well as loved ones, and leads to a societal perception of stigma or “mark of disgrace” associated with the idea of “why couldn’t the person stay well after the initial success of the treatment they were given?” Yet continuous care is not readily available and even when in place, tends to not be coordinated or technologically-augmented, preventing the support teams from collaborating well, identifying early signs of recurrence of use, and also from gathering data on what works in order to create continuous quality improvement (CQI) of the offered program. In addition, addiction often leads to isolation, and the lack of knowledge about addiction amongst the family and friends on the patient side means they don’t have a support network to lean on and too often are the victims of stigmatization, which reduces the changes of successful treatment and prevention of a relapse.

Who is the target audience?
Clinical service and care delivery, payers, and health system stakeholders.

Is this based on established work, or does it draw from other existing work?
Evidence-informed from established work, including research like:

- Journey Mapping Substance Use Treatment: An Exploration of Health Care Provider and Peer Experiences in Delivering and Receiving Primary Care. Available at: https://bcpsqc.ca/wp- content/uploads/2018/03/Journey-Mapping-Substance-Use-Treatment-Report-1.pdf (accessed May 27, 2021.)

How does your project or initiative work?
In our proposed solution, people with addiction can access, through one platform, a suite of services that, in combination, are appropriate to their needs throughout the journey of dealing with addiction. Whether it’s treatment, outpatient, or follow-up, the services act as a guided pathway on their journey of dealing with addiction. The platform uses a combination of human-delivered services with advances in technology and devices to better diagnose, treat, and support people with addiction. The platform also enables the person to rally family and friends, and through the technology platform, educate them on addiction and how to support their loved one. Family and friends, through the technology platform, can also offer them the support that they may need. Monitoring of patterns using data analytics will help alert the team supporting the patient to assist with early intervention to prevent a recurrence of use. In addition, using the Institute for Healthcare Improvement Plan-Do-Study-Act methodology,

augmented with the data gathered, will help with CQI in identifying patterns, gathering feedback on what works and what doesn't, and rapidly test new approaches.

What are the results? If results are not yet available, what results do you hope to achieve?
As current rates of recurrence of use are 40% to 60%, we intend to reduce this to at least 20 to 30%. The use of a technology-enabled approach will enable us to:

1. provide continuous support for people with addiction and eliminate the barriers to ask for help when they need it;
2. identify early signs of potential relapse and intervene, thus decreasing the stigma people with addiction experience living with the seemingly inevitable ever-present threat of a relapse; and
3. enable family and friends to learn more about addiction, destigmatizing the disease for the immediate support network of the person, who then, can more effectively support their loved one being treated for addiction.

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Keywords
care coordination, technology

3. Abolish Stigma: Examine Our Own Biases as Health Care Workers

Authors

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What is your project or initiative?

The initiative is an innovative partnership between Rush University Medical Center addiction education experts and Live4Lali. Live4Lali is a local not-for-profit organization that provides essential harm reduction services, peer recovery coaching, and is a leader in education and advocacy locally and nationally. Together, the partners implemented a novel, interdisciplinary training for medical students with the goal of identifying bias in future healthcare providers and to orient them towards actively reducing substance use disorder (SUD) stigmas present in modern health systems.

Why did you develop this?

It is well established that healthcare providers may harbor negative perceptions of patients with SUD that both deter patients from engaging with treatment and negatively impact recovery. The high prevalence of SUD indicates that students will likely encounter patients affected by SUD irrespective of what medical specialty they choose to pursue. Accordingly, to provide the best care for patients affected by SUD, it is essential for all medical students to be provided training on the stigmatization of SUD along with standard therapeutics. This initiative is designed to impact students early in the medical school years, and may be duplicated in other health professional schools.

Who is the target audience?

The initiative is designed for all health professional students, recognizing that stigma is a far reaching issue and patient care is executed in interprofessional settings. Faculty are also encouraged to attend the training.

Is this based on established work, or does it draw from other existing work?

The initiative drew upon the experience of its community partner, Live4Lali, resting on the value of inclusion of the voices of persons with lived experience with SUD to lead a project on stigma training for future health care providers. Upon review of other medical school curricula, few other medical colleges include curriculum dedicated to examining stigma surrounding SUD in the health care setting.

How does your project or initiative work?

Content is provided to medical students in a 2 hour, synchronous virtual meeting. The session was driven by group dialogue and stigma didactics facilitated by trained health educators with lived SUD experiences. The educators first provide background on harm reduction and Live4Lali's services before sharing their own experiences with stigma in healthcare settings. These educators then lead a didactic presentation focusing on the effects of stigma and discrimination on individuals and communities, common misconceptions and misrepresentations of SUD, the power of using de-stigmatizing language, and provide actionable steps for healthcare providers to actively work towards reducing the harm stigma will inflict on their future patients. This session is to be held annually for medical students and can be used for other health professional colleges. Within the session, breakout rooms are offered for students to meet with the educators to examine their own biases about SUD, recognizing that without such dialogue, overcoming stigma about SUD is not feasible.

What are the results? If results are not yet available, what results do you hope to achieve?

At the conclusion of the session students completed a post-session evaluation to assess attitudes towards SUDs and provide feedback on the session. Evaluation results are compiled by the faculty in order to positively shape future sessions. A pilot session was performed in March 2021. Faculty reviewed evaluations and the dialogue during the session; reinforcing the essential need for the session earlier in the medical school curriculum.

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Keywords

education, lived experience, training, workforce

4. Addressing and Redirecting Stigmatizing Behaviors in the Healthcare System through Job-Specific Trainings

Authors
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What is your project or initiative?
This project involves a combination of targeted digital advertising, an electronic learning (e-learn) curriculum, and the engagement of "champions" among various hospital departments, from hospital security to billing personnel, nurses, physicians, and more. The e-learn curriculum is a newly developed, interactive training session created and tested by a combination of physicians and nurses who have extensive experience with substance use disorders (SUD) and non-clinical individuals. The curriculum has two tracks, for clinical and non-clinical staff, to reach, educate, and impact individuals with the most effective stigma reduction training for their work environment.

Why did you develop this?
Despite available education and the recognition of SUD as a legitimate medical diagnosis, employees of healthcare systems like hospitals are often among the most stigmatizing groups regarding SUD. After assessing stigma in Huntington, West Virginia and finding that healthcare professionals were not performing better than the average person regarding stigmatizing beliefs, a plan was developed to address stigma among various community groups, starting with employees of two local hospitals.

Who is the target audience?
Decision makers and employees of healthcare systems, as well as community advocates for SUD stigma reduction.

Is this based on established work, or does it draw from other existing work?
This is based on a 2019 campaign does by Marshall Family Medicine and Quality Insights to assess SUD stigma at the local level and determine methods for future stigma reduction that may be effective. Healthcare workers scored among the highest in stigmatizing beliefs and attitudes in that assessment.

How does your project or initiative work?
Individuals from each department and area of the two local hospitals will be approached to participate in the e-learn system trainings. It is also being worked on as a potential inclusion in mandatory on-boarding trainings for new hires.

What are the results? If results are not yet available, what results do you hope to achieve?
We hope to assess improved scores from pre-test to post-test knowledge checks once the system is utilized, and to then gather qualitative research long-term regarding the interactions of individuals with SUD and employees in our two local hospitals.

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Keywords
education, technology, training

5. Addressing Stigma as Part of a Massive Open Online Foundational Addiction Course for Professional Healthcare Training Programs

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What is your project or initiative?

A massive open online course (MOOC) foundational course on addiction. The course is fully online, interactive, and freely available. The course consists of 6 modules, each with 3-5 short lessons per module, in-video quiz questions, a clinical case vignette, interprofessional panel discussions, an interactive map activity allowing students to identify treatment settings in their geographic region, and a module quiz.

Why did you develop this?

Despite improvements over the past 20 years, healthcare for persons who use alcohol and other drugs largely remains siloed in a specialty-care substance use treatment system that is inaccessible or not desired by many who may benefit from it. To move to a more integrated care model that addresses a range of substance use-related health problems, educational efforts are needed to prepare the current and future interprofessional healthcare workforce. Central to expanding to an integrated care model is addressing stigma of substance use-related conditions among healthcare providers and trainees. To increase substance use education among healthcare trainees, interprofessional faculty from Yale University with substance-use related expertise designed a foundational, easily accessible, flexible, and transportable curriculum appropriate for interprofessional healthcare profession students using a MOOC format.

Who is the target audience?

Healthcare profession students and trainees and interprofessional faculty needing curriculum content.

Is this based on established work, or does it draw from other existing work?

The online design was based upon known trends for adult learning theory and for online learning including clear objectives; brief, targeted segments rather than extended lectures; interactivity (e.g., discussion forums to post learner questions or comments, reflection prompts, an activity to locate local substance use treatment resources); demonstration of clinical application of knowledge (e.g. case vignettes and video demonstration of skills, interprofessional roundtable discussions); and information recall (e.g., through quizzes).

How does your project or initiative work?

2 of the 6 modules focused on stigma. The first module focused on learning objectives of avoiding stigmatizing language and using patient-centered language and communication. The last module focused on structural determinants of health and social disparities, including historical factors in substance use disorder (SUD) treatment that exacerbated stigma. The other 4 modules focused on screening and diagnosis, treatment options, medications for SUD, and psychological and behavioral therapies for SUD. Although not directly, many components of these modules (e.g., neurobiology of addiction) indirectly addressed stigma.

What are the results? If results are not yet available, what results do you hope to achieve?
A 10-item assessment evaluated self-efficacy in screening, diagnosing, discussing treatment options, and providing supportive care for individuals with SUD (e.g., "I am confident screening patients for at-risk substance use"), with a possible range of 0-50. 485 healthcare students and trainees from programs in nursing, medicine, social work, physician assistance, and psychology completed the assessment prior to course initiation. 310 (64%) completed the course and 174 completed the post-course assessment (56% of completers). A Linear Mixed-effects Model found that self-efficacy scores increased dramatically (26.5 to 39.2, $p < .001$). Despite limitations in the study design and lower than expected response rate, findings suggest that an interactive, online, and foundational substance use course including substantial stigma-focused content can substantially improve substance use treatment self-efficacy among a healthcare students and trainees.

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Keywords

education, interprofessional, training

6. ASAP: Access to Syringes at Pharmacies. Reducing Pharmacy-Based Stigma to Increase the Sale and Purchase of Over-the- Counter Syringes in Arizona

Authors
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What is your project or initiative?
Access to Syringes at Pharmacies (ASAP), is a pharmacy-level intervention to reduce pharmacist and pharmacy technician ambivalence (stigma) about selling syringes without a prescription to customers who inject drugs. This two-year NIDA-funded project (R03DA053252) will iteratively develop and beta-test the ASAP intervention with pharmacies in three Arizona counties (Pima, Maricopa and Mohave).

The intervention involves:

- Accredited online/on-demand development training for pharmacy staff about the importance of reducing blood-borne illness through access to sterile syringes; the role of pharmacies in an underfunded public health system in a state without syringe access legislation; and specific practices which can be engaged when customers request to purchase syringes. The intervention content is an adaptation of Fuller et al's training with motivational interview components, online accredited delivery, and intentional focus on ambivalence reduction.
- Pharmacies will work with our team to iteratively develop ASAP in the formative (PY01) year; followed by a 3-county beta-test of ASAP in different pharmacies. Test pharmacies track syringe sales using a QR code method which transmits sales data to the research team at the time of purchase.
- 'Secret shopper' attempts to purchase syringes at pharmacies ("Buy Studies"), will measure baseline and post-intervention pharmacy syringe sales and the degree to which stigma was expressed and/or experienced by community 'buyers.'
- We are raising funds for this evaluation of syringe sales. Results will not be available until 2022, though we hope to observe a significant reduction in pharmacy staff ambivalence about selling non-prescription syringes for likely injection drug use, and increases syringe sales. The plan is to submit an R01 application for a Hybrid Type II study (implementation/impact) in three states.

Why did you develop this?
Arizona (AZ) is among 21 states without state law permitting syringe service programming (SSP). SSPs are locally permitted in a few locations, and underground programs also exist. The lack of access to sterile syringes throughout AZ has resulted in high rates of hepatitis C and HIV. Two of AZ's 15 counties were identified by CDC as being at risk for an HIV or HCV outbreak (Mohave) or as being among counties contributing to over 50% of new HIV infections in the U.S. (Maricopa). Community pharmacies have long been seen as an opportunity to expand health access to populations who are underserved. Our 2019 study found that less than half (42.3%) of AZ community pharmacists have personally dispensed syringes for likely injection drug use in the past 2 years. This lack of experience selling syringes and developing comfort doing so likely predicts future pharmacy syringe sales to people who inject drugs. That same year, Arizonans who sought to purchase syringes at pharmacies without a prescription reported experiencing stigma and judgement by pharmacy staff when requesting to buy syringes, having internalized feelings of stigma, and observing inconsistent policies and practices by pharmacies regarding syringe sales. The reported outcomes included decisions that pharmacies were "syringe access points of last resort," and that participants would have to share or reuse their syringes without access to sterile syringes.

Who is the target audience?
Our target audience is community pharmacy staff (pharmacists and technicians) working in three Arizona counties. The project is also advised by a Community Advisory Board comprised of pharmacy staff and harm reduction community partners.

Is this based on established work, or does it draw from other existing work?
Yes on both counts.

How does your project or initiative work?
See project/initiative above.

What are the results? If results are not yet available, what results do you hope to achieve?
Reduction in reported pharmacy staff enacted stigma during syringe purchase and increase in syringe sales at pharmacies.

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Keywords
education, harm reduction, pharmacy

7. Begin the Turn: A Mobile, Multidisciplinary Recovery Unit Meeting People Experiencing Substance Use Disorder Where They Are At

Authors

David T. O'Gurek, MD; Jonetta Gibbs, MS; Sam Stern, MD; Joseph D'Orazio, MD; Kathleen Reeves, MD

What is your project or initiative?

Begin the Turn, part of the Center for Urban Bioethics within the Lewis Katz School of Medicine at Temple University, is an integrative, trauma-informed, community-based outreach and mobile care recovery program, serving persons experiencing opioid use disorder through buprenorphine services, counseling, case management, and rehabilitative services and opportunities.

Why did you develop this?

With its location in and near the Kensington and North Philadelphia neighborhoods, The Temple University Health System is situated in the heart of the neighborhoods of Philadelphia deeply affected by the overdose crisis and was poised to serve as a leader in addressing this public health crisis in North Philadelphia and beyond.

Who is the target audience?

Begin the Turn initiated treatment services at two locations in Kensington – one at the corner of F & Allegheny and another at the corner of Ruth & Somerset. These sites were identified as locations with high rates of overdose and overdose death. The populations served at these sites including individuals experiencing homelessness in the immediate and surrounding areas who are able to access street-side services.

Is this based on established work, or does it draw from other existing work?

Based on the CeaseFire model, an initiative launched in Chicago in 1999 that uses prevention, intervention, and community-mobilization strategies to reduce gun violence, the program was developed to serve as a model around community engagement to address addiction, particularly among individuals experiencing homelessness. This model was selected based on its public health strategies and community-based approaches; however, modifications included centralizing the community mobilization, education, and services around delivering buprenorphine treatment.

How does your project or initiative work?

All new patients to the program complete a self-administered adverse childhood experience (ACE) assessment and a social needs questionnaire after engagement with an outreach worker. After completion, the patient completes an intake assessment and biopsychosocial assessment by our behavioral health director and a comprehensive medical evaluation with a waivered physician. Patients are initially seen weekly for buprenorphine treatment for 4 weeks. After 4 weekly visits, visits are spread out to biweekly for 2 visits and then monthly based on progress and absence of opioids in the urine drug screen. No medication is stored on the mobile unit; rather, patients receive prescriptions to be filled at local pharmacies. Established patients are provided ongoing behavioral health counseling, case management, connections with social services, acute care needs with a bridge to primary care, and buprenorphine treatment with a low-barrier harm reduction approach. When the COVID-19 pandemic hit and affected North Philadelphia, Begin the Turn has maintained its presence in Kensington. Although the unit was re-purposed to assist the Temple Health System perform COVID-19 testing, the team adapted taking to the street to deliver care, maintaining behavioral health treatment and case management virtually with in-person contact for buprenorphine care. Begin the Turn's commitment to the community seeks to continue to reduce the stigma of addiction and deliver evidence-based care to ensure for our community there is hope beyond addiction.

What are the results? If results are not yet available, what results do you hope to achieve?
Since July of 2019, Begin the Turn has engaged with over 400 individuals. While our model is innovative in creation and design without another model like it nationally, early data suggests that our retention rates in care are similar to that of other programs caring for a similar population. This data shows that our population have high rates of prior overdose (49.7%) as well as use intravenously (67.3%). Additionally, our population has significant rates of trauma with average adverse childhood experience scores of 4.6 and 63% having a score of 4 or greater.

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Keywords

lived experience, medications for opioid use disorder, trauma-informed

8. Changing the Narrative: De-stigmatizing Substance Use, Addiction, and Pain in the Media

Authors
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What is your project or initiative?
Our project is called Changing the Narrative. We're a network of reporters, researchers, academics, and advocates concerned about the way that media represents drug use, addiction, and chronic pain. Our mission is to help journalists and opinion leaders provide accurate, humane, and scientifically grounded information in this contested terrain. We offer expert sources—including people with lived experience of the issues—and up-to-date, fact-checked, and evidence-based information on news and controversies.

Why did you develop this?
Most people today seek information about addiction from the media. Through analyzing news articles we found that critical sources of information were often filled with stigma, inaccurate stereotypes, and outdated perspectives on treatment and policy. We developed Changing the Narrative because stigma cannot be effectively addressed so long as so many communicators continue to traffic in these harmful tropes. These stigmatizing narratives are also a barrier to more humane treatment and effective policy. Ultimately, Changing the Narrative presents what the research actually shows to help journalists and others with large platforms do better.

Who is the target audience?
We focus much of our efforts on journalists who are covering the overdose crisis and issues related to chronic pain, opioid treatment, and harm reduction. However, our reach goes well beyond the news media. Our toolkit and style guide is open access and made freely available to anyone who communicates to the public about addiction, drug use, and chronic pain. Nonprofits, organizers, activists, professors, researchers, and health care providers have all used our toolkit and style guide in a professional capacity.

Is this based on established work, or does it draw from other existing work?
While Changing the Narrative is an original project, it is modeled on best practices in health communication and media style guides for other delicate topics, such as climate change, suicide, and criminal justice. Since our inception in 2018, we have made updates as the research literature and discourse evolves. We closely follow research related to media/content analysis, such as from the Johns Hopkins Stigma Lab. The Stigma Lab concluded: "establishing journalistic standards to de-stigmatize the language of addiction is a public health priority," which is precisely what Changing the Narrative was created to do.

How does your project or initiative work?
We maintain a glossary of flawed narratives, tropes, and often misunderstood topics that is fact checked and easy to navigate. This is constantly updated with new entries and examples as flawed stories develop and get traction. We also intervene in instances where a media publication or prominent communicator perpetuates stigma or inaccurate information. Multiple prominent journalists on the addiction beat collaborate with Changing the Narrative. They are constantly plugged into the latest news and research and when they see stigmatizing, misleading, or inaccurate articles, they take

it to a group and discuss how to intervene. We email the reporter/ editor to request corrections and direct them to our style guide and expert directory to help prevent further errors. If after sending corrections behind the scenes results in no engagement, we publicly advocate for corrections on social media channels.

What are the results? If results are not yet available, what results do you hope to achieve?
Our objectives are difficult to measure but we have documented progress and change over time, especially in the realm of person-first language. Years ago, terms like “addict,” “alcoholic,” or worse, “drug abuser,” were constantly used in media articles and by policymakers and health care providers. Since founding members of Changing the Narrative consulted with the Associated Press for their style guide entry on addiction, use of such stigmatizing nouns is less common. We’ve also been instrumental in excising phrases like “addicted baby” and debunking myths like first-responders “overdosing” on fentanyl from passive exposure. Still, there is much to do; many writers, communicators, and professionals still use terms like “substance abuse” without recognizing that labeling people who use drugs as “abusers” is stigmatizing. In the future, we aim to collaborate with media researchers to analyze quantitative change over time.

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Keywords

awareness, lived experience, person-centered language, policy and guidelines

9. Collaborating with Community Partners in Educating Emergency Department Health Care Providers on Caring for People with Substance Use Disorder

Authors
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What is your project or initiative?
Our initiative was to identify and meet the needs of emergency department health care providers (EDHCPs) to care for people with substance use disorder (SUD), and their families, through the use of inter-collaborative trainings.

Why did you develop this?
The emergency department is often the first point of contact for engagement in harm reduction practice and self-care management for people who use drugs. Since SUD is a chronic and relapsing brain disease, the EDHCPs often see individuals multiple times for issues related to their drug use. This experience can set the stage for future health care interactions. However, EDHCPs are confronted with increasing numbers of people with SUD accessing services and they often lack the training and resources to assist this marginalized population. Agencies working with people with SUD reported participant's refusal to seek health care services due to experiences of stigma and discrimination.

Who is the target audience?
Our targeted audience were EDHCPs in four Western Massachusetts emergency departments. Attendees included physicians, nurses, patient care technicians, security, and patient registration staff.

Is this based on established work, or does it draw from other existing work?
Our educational sessions drew from existing work from area resources and inter collaborative teams of individuals with the goal of decreasing stigma in the emergency department setting.

How does your project or initiative work?
We queried five EDHCPs to inquire about specific problems they were having caring for people with SUD. The myriad of responses ranged from a supportive tone to a stigmatizing and discriminating one. Themes were developed and tailored presentations based on the hospital responses were developed. Discussions were held with the unit manager to solicit feedback on present resources in the hospital. Five 60-90-minute educational presentations were held with EDHCPs at four hospitals in Massachusetts over a period of 8 weeks. An addiction certified Registered Nurse developed and led the informational sessions. Throughout the presentation, representatives from community agencies presented information on what they do and how they could help the EDHCPs to support the patient and family of those with SUD. Agencies included Hampshire Hope, local DART police officers, recovery coaches, and Tapestry Harm Reduction Services. The focus of the presentation was on recognizing addiction and supporting patients and their families throughout the addiction trajectory including recovery. EDHCPs were provided with information about trauma-informed care principles, the physiology of addiction, stages of change visual, the impact of stigma, recovery-focused language, their role in harm reduction education, state resources and area recovery supports for each hospital. The impact of stigma was delivered through the use of quotes of people who use drugs about the care they received in the hospital. The examples of the care included stigmatizing and supportive outcomes.

What are the results? If results are not yet available, what results do you hope to achieve?
All attendees were asked to complete an anonymous feedback sheet using a Likert scale to evaluate

how helpful they found the information in the presentation. The EDHCP written evaluations were positive with all but two reporting the information was “very useful,” and two reporting “helped me some.” Written comments included staff reporting an appreciation for hearing real patient experiences, the change in their mindset towards addiction, how to begin the conversation with an individual, and practical harm reduction education that they could incorporate into their practice. Many were unaware of local agencies targeting care for people with SUD and stated an appreciation of the knowledge of the area resources that could be shared with patients and families. All agencies were provided with a one-page resource and referral sheet to be able to provide referral to patients and their family members. This easy-to-use reference was identified as a welcomed tool for the clinicians. Lessons learned included an understanding that health care providers need ongoing SUD training, an easy and accessible community resource referral sheet, and institutional support to provide culturally sensitive care to people with SUD. Future research should include interviewing people with SUD post emergency department visit to evaluate changes in care.

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Keywords

care coordination, education, emergency medicine, person-centered language, training, trauma-informed, workforce

10. Collaborating with Community Partners to Develop a Harm Reduction and Stigma Curriculum for Primary Care Clinic Teams Distributing Intranasal Naloxone and Safer Consumption Supplies in the San Francisco Safety Net

Authors

Saundra Nguyen, MD, MPH; Jar-Yee Liu, BS; Tatyana Roberts, BS, MPH; Joanna Eveland, MD; and Members of the SF AIDS Foundation including Ro Giuliano, John Halifax, Seth Katz, Cassie Chichian, Kelani Clark, and Jen Jeffries

What is your project or initiative?

In response to sharp increases in mortality from opioid overdoses in the last few years, the San Francisco Health Network launched a pilot to distribute intranasal naloxone and safer consumption supplies (including safer smoking kits, safer injection kits, and fentanyl test strips) in safety-net primary care clinics with the goal of preventing overdose deaths, increasing safety around substance use, and overcoming barriers to access of substance use prevention and treatment services. Given the diversity of roles and experiences with harm reduction and substance use in our primary care clinics, our project aimed to develop a standardized harm reduction and stigma training that could be adapted to individual clinic sites and serve as a foundation for these pivotal patient interactions. We strived to include the voices of people with lived experiences in our trainings—both in the development of the curriculum and via narratives of their personal experiences with harm reduction, stigma, and overdose prevention.

Why did you develop this?

Stigma has long been recognized as a major barrier to accessing care and services and can take many forms, including stigma from individuals, self-stigma, and institutional stigma. Experiences of stigma in the health care setting can occur before the clinic encounter, starting at the front desk and waiting room. Therefore, interventions to raise awareness and reduce stigma within the clinic setting can positively impact patient experience and threshold to engage in care. We developed this training to accommodate for the varying levels of harm reduction experience across our different primary care clinic sites and to educate team members about the effects of stigma on people who use substances. We hope this will lead to a more non-judgmental and non-stigmatizing culture and environment.

Who is the target audience?

Any clinic staff member who will interact with patients who use substances, including front desk workers, medical assistants, nurses, behavioral health team members, social work, providers (MDs, NPs, trainees). Our pilot sites include Ward 86 (HIV Primary Care), Richard Fine People's Clinic, Castro Mission Health Center, Curry Senior Center, Family Health Center, and Tom Waddell Urban Health Center.

Is this based on established work, or does it draw from other existing work?

This work was developed in collaboration with our community partners at the SF AIDS Foundation who have significant experience in harm reduction, gave input on curriculum development, and lent their voices and personal narratives. We also drew from existing harm reduction and stigma materials available from the National Harm Reduction Coalition and the SF DOPE Project's Overdose Prevention training.

How does your project or initiative work?

Our training has three components:

1. The foundational Harm Reduction and Addressing Stigma session conducted either in-person or virtually at each clinic site,
2. A self-paced Overdose Prevention and Intranasal Naloxone module, and
3. Videos created by the SF AIDS Foundation reviewing the contents of the safer consumption supplies (safer smoking kits, safer injection kits, and fentanyl test strips).

Throughout the training, we include testimonials (text and video) from community members sharing their experiences with harm reduction, stigma, and overdose. For 1), we review harm reduction principles, effects of stigma, and ways to mitigate stigma in a discussion format. We meet with site champions at each clinic to assess the educational needs for each site including which team member roles will be distributing the supplies, the number of people being trained, and level of experience with harm reduction and patients who use substances. Based on these factors, the PowerPoint and discussion are adapted accordingly. We then identify a date for 1-1.5 hours of protected time to conduct the training either in-person or virtually. For 2) and 3), team members are asked to complete and review the modules on their own or as a group with support from their clinic site champions who can answer questions and provide on-site demonstrations for the intranasal naloxone and safer consumption kits.

What are the results? If results are not yet available, what results do you hope to achieve?
For the Harm Reduction and Stigma training, we are assessing the overall impact of the training by measuring pre and post levels of stigma using the Drug Stigmatization Scale (Palamar et al., 2011). We also want to look at how participants' perspectives and practices around harm changed after the training. For the Overdose Prevention and Safer Consumption modules, we are assessing competency for use of intranasal naloxone and the safer consumption supplies.

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Keywords

harm reduction, lived experience, training, workforce

11. Colliding Stigmas: Pain and Addiction in an Overdose Crisis

Authors
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What is your project or initiative?
National Pain Advocacy Center (NPAC), www.nationalpain.org, is a new non-profit that seeks to unite those affected by the stigmas of pain and addiction. Although NPAC's focus is on pain, our team includes experts in addiction, drug policy, stigma, racial disparities, and a diverse group of people with lived experience of pain as well as those in recovery from a use disorder. By giving everyone a seat at the table, we hope to foster understanding and a deeper recognition that both conditions are widely misunderstood, under-treated, and subject to considerable stigma. Together, we advocate for better drug policy choices. People with pain and people with addiction (and, especially, people with both) have long faced stigmas in society and the healthcare system. People with pain are often perceived as weak or malingering. People with use disorders are similarly shamed for weakness or indulgence. These biases exist not only in society at large but are also reflected and perpetuated by the language we use and the treatment systems upon we rely. Pain stigma is rooted partly in pain's subjectivity, the failure to understand of chronic pain as a disease, and religious notions of pain as punishment (the latin "poena" literally means punishment). Stigma surrounding use disorders relate to structural marginalization, poor cultural understanding of addiction, and punitive drug laws, their aggressive prosecution and related social norms around substance use. Systemic racism pervades our drug policy and informs the stigma that people with pain and people who use drugs experience. People of Color already wrongly have their pain rated as less severe by many clinicians and, because of the way we have waged the drug war disproportionately against communities of Color, are more often perceived as "drug seeking" and less likely to receive pain medication. The nexus between racism and drug regulation, legalization, and prosecution in the US is well documented and a primary source of stigma. Stigma and discrimination are intimately connected. Amidst a drug overdose crisis, stigma has caused the pain and addiction communities to be at odds with one another, when in fact they share many interests. Stigmas surrounding people who use drugs have begun to impact people who use opioids to manage physical pain. Some in the pain community have responded by lashing out against those with addiction, in effect doubling down on this stigma, while failing to recognize that they are simply perpetuating a stigma to which they are now subjected. A glaring example of this blame is the harmful hashtag #PatientsNotAddicts. Similarly, some in the addiction community blame a call to treat pain in the 1990s on the addictions and overdose deaths that flowed from liberalized prescribing, and indirectly, on people with pain. NPAC seeks to promote common interests in drug policy reform, anti-racism, and de-stigmatization.

Why did you develop this?
There was no group focused on advocacy that included the full spectrum of those affected by the opioid/overdose crisis and drug policy.

Who is the target audience?
Policymakers and the general public. Changing mindsets or public understanding goes hand in hand with changing policy.

Is this based on established work, or does it draw from other existing work?
Among our team members are scholars, like Daniel Goldberg, JD, PhD and Leo Beletsky, JD, MPH, who

are experts in stigma and the nexus between policymaking, stigma and discrimination. Our founder and others have deep expertise in anti-discrimination work. Our team also includes many involved in the Changing the Narrative group, www.changingthenarrative.news, which focuses on better education of the media and policymakers about addiction in the hopes of allaying stigma.

How does your project or initiative work?
Our project is primarily education and advocacy focused – but we are a large tent, including people with a variety lived experience as well as professionals who are clinicians, scientists, experts in pain, experts in addiction, and a significant cohort of drug policy and human rights experts. We work together to educate and develop better policy and learn from one another.

What are the results? If results are not yet available, what results do you hope to achieve?
We only very recently launched, https://nationalpain.org/press-releases.

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Keywords
awareness, chronic pain

12. Combating Stigma Surrounding Chronic Pain and Substance Use with Interprofessional Education

Authors

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What is your project or initiative?

A set of interprofessional education (IPE) trainings were developed to improve the treatment of patients with chronic pain who exhibit substance misuse behaviors. The IPE trainings incorporate case-based scenarios with video vignettes or simulation using live standardized patients to facilitate interprofessional (IP) discussions. During each training, participants practice use of person-first, non-stigmatizing language while working as part of an IP team to develop and prioritize holistic treatment options. The trainings are freely-available for adaptation by other institutions.

Why did you develop this?

Our IP team of university faculty identified a gap in education in chronic pain and substance use treatment. A key objective of this project was to teach health profession students and working clinicians how to recognize and avoid stigmatizing language and provide holistic, unbiased, and compassionate care for people with pain and substance use disorders. A team-based IP approach was chosen to diversify learners' perspectives, spark conversations, and encourage holistic treatment planning.

Who is the target audience?

The program targets team-based learning needs of health profession students (primarily medicine, nursing, pharmacy, social work, and physician assistants) and working primary care clinicians (including medical assistants and diverse clinic staff).

Is this based on established work, or does it draw from other existing work?

In response to the opioid crisis, our team was funded by the Washington State Department of Health in 2017 to develop an opioid education program focused on health science student learning needs. We subsequently received additional funding to expand the student training and develop a program for working clinicians. Further grant support led to the development of a third IPE training that builds on the original patient case to address improved access and reduced stigma regarding medications for addictions treatment.

How does your project or initiative work?

A two-part series of IPE trainings was implemented for health profession students from multiple institutions in Washington State. In the first 2-hour training, students are introduced to a longitudinal patient case of an older person who has developed opioid misuse behaviors after an accident resulted in chronic back pain. The case uses either video vignettes or a live trained standardized patient. Small IP teams are asked to meet and share perspectives from their unique discipline to create a holistic treatment plan for their patient. The case progresses for a second 2-hour session where the patient has increased their use of opioids and alcohol. During this second IPE session, students consider whether specific medications for addiction treatment are indicated.

What are the results? If results are not yet available, what results do you hope to achieve?

Since 2019, more than 1,400 health profession students have participated in one or both of the student

IPE trainings. Additionally, 12 rural clinics in Washington State have participated in the clinic-based trainings. Overall, the feedback on the trainings has been positive. Matched data from student pre- and post-surveys indicate improved confidence in utilizing non-stigmatizing language when caring for a patient with pain who takes opioids ($p<0.05$, paired student t-test). Narrative comments from the 2020 pilot suggest that students valued the content surrounding non-stigmatizing language. Additionally, students report improved understanding of their profession’s role and the roles of other healthcare team members in providing care ($p<0.05$, paired student t-test). We are currently investigating how learners respond to a longitudinal case through evaluation of the submitted holistic treatment plans.

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Keywords

chronic pain, education, interprofessional, person-centered language, training

13. Combating Stigma to Aid Reentry and Recovery (C-STARR): A Behavioral Intervention to Reduce the Stigma of Addiction and Criminal Involvement

Authors
Kelly E. Moore, PhD

What is your project or initiative?
Combatting Stigma to Aid Reentry and Recovery (C-STARR) is a brief group intervention designed to reduce the negative consequences of stigma among people with substance use disorders (SUD) who are currently or have previously been involved in the criminal justice system. The intervention involves learning new ways to cope with judgments and rejection experiences from other people, including family members, employers, healthcare/treatment providers, and criminal justice staff. In addition, the intervention focuses on how to cope with the judgments that justice-involved people with SUD often have toward themselves (i.e., self-stigma).

Why did you develop this?
People with SUD who have been involved in the criminal justice system are among the most highly stigmatized groups in our society. They experience stigma from the general public, when applying for jobs and housing, and also when engaging in treatment settings. Stigma has a significant impact on the way people think, feel, and behave. Stigma can be particularly harmful to this population when it interferes with engagement in substance use treatment because this has direct implications for staying out of the legal system. However, there are no current stigma-reduction interventions for justice-involved people.

Who is the target audience?
Justice-involved people who have SUD may be interested to hear about this new intervention that could help them better navigate stigma. In addition, mental health providers, particularly those who work in the criminal justice system, may find that this intervention would be beneficial for the clients they serve.

Is this based on established work, or does it draw from other existing work?
C-STARR was adapted for justice-involved people from an existing intervention designed to reduce addiction self-stigma (developed by Dr. Jason Luoma). Dr. Luoma's addiction self-stigma intervention was developed using the theory of acceptance and commitment therapy, which, in short, suggests that many of the emotional difficulties humans experience are a result of trying to avoid experiencing stress or pain. Research has shown that Dr. Luoma's intervention is effective in reducing substance use and shame, as well as improving substance use treatment retention (Luoma et al., 2012; Gul et al., 2020).

How does your project or initiative work?
Dr. Kelly E. Moore and her research team are currently pilot testing in-person and virtual C-STARR groups with adults enrolled in drug recovery court and probation-required substance use treatment settings in Northeast Tennessee. C-STARR involves 3 two-hour group sessions that involve clarifying one's values, understanding how stigma interferes with living a full life, committing to engage in valued action even when confronted with stigma-related barriers, and learning how to accept and cope with difficult thoughts and emotions that come up along the way.

What are the results? If results are not yet available, what results do you hope to achieve?
Dr. Moore's lab is collecting pre- and post-intervention data to determine whether C-STARR can improve levels of distress, coping with stigma, and engagement in treatment, among other outcomes. We are

also conducting qualitative interviews with people who complete the intervention to better understand how the intervention can address their experience with stigma. Qualitative interviews conducted thus far suggest that participants enjoy participating in C-STARR and find it helpful for coping with stigma. Broadly, we hope this intervention can help justice-involved people with SUD with successful recovery and community re-entry, and spark a bigger conversation about addressing the lack of stigma reduction efforts in the criminal justice system.

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Keywords

criminal justice, training

14. Creating Civic Engagement to Improve Healthcare Access for People who Use Drugs in Arizona: The Drug Policy Research and Advocacy Board

Authors
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What is your project or initiative?
The Arizona Drug Policy Research and Advocacy Board (DPRAB), is a civic engagement intervention involving the development and support of a statewide coalition of people with lived experience, research partners, harm reduction organizations, and providers of medication for opioid use disorder (MOUD). The key outcome is a sustained consumer-driven healthcare reform movement. The creation and development of this partnership emerged from funded research projects focused on MOUD system improvement (Vitalyst, FORE). Improving the MOUD system in Arizona is our initial focus. The co-chairs are Christopher Abert, Executive Director of the Southwest Recovery Alliance and Nick Stavros, CEO of Community Medical Systems. The DPRAB was modeled after a local drug user union, Community Health Advisory Committee (CHAC) located in Phoenix, Arizona.

Why did you develop this?
Our recent survey of people who use drugs in Maricopa County (Phoenix) conducted with the CHAC found that 40% of respondents avoided seeking medical care in the past year because they were afraid of being mistreated by healthcare providers. Those who did seek medical care at urgent care and emergency room settings reported three key experiences at the hands of healthcare providers:

1. medical maltreatment (wrong or denied treatment),
2. socially expressed stigma and discrimination, and
3. verbal or physical abuse.

Medical providers ignored healthcare complaints to instead fixate on illicit substance use, even when this was not the reason for healthcare seeking. A second study demonstrated the need for pharmacy practice change to reduce pharmacy staff enactment of stigma at the time customers request to purchase syringes without a prescription and for likely injection drug use. The confluence of COVID-19, HIV, Hepatitis C, and overdose pandemics has revealed systemic MOUD system inequities that must be corrected. Temporary policies to improve MOUD patient safety and treatment access during COVID-19 created a policy window of opportunity to examine the evidence of systems improvement from these key and temporary changes. The DPRAB has been designed and will be tested as a civic-engagement systems change model. The first focus is MOUD systems change in Arizona. Establishing the DPRAB, civically engaged community-provider-policy partnership will help assure future and lasting systems change, producing equity of access and improving community health by reducing overdoses, increasing overall health, and reducing incarceration in Arizona.

Who is the target audience?
Healthcare practitioners (MOUD initially), policy makers in local, state and federal settings (legislative, administrative), and people in the community with lived experience who want to develop and share their voice.

Is this based on established work, or does it draw from other existing work?
Yes on both counts.

How does your project or initiative work?
This DPRAB intervention involves:

- Recruitment and support of DPRAB members from across Arizona urban, rural, suburban and tribal communities with personal lived experience using illegal and/or stigmatized drugs and/or professional experience working in evidence-based drug treatment programs. Membership by professionals in other healthcare settings will be expanded in future years.
- Individuated group member training with focus on 1) community-driven research, 2) systems improvement evidence and 3) how to develop and engage in evidence-based policy communications.

What are the results? If results are not yet available, what results do you hope to achieve?
Key outcomes include:

1. improved member self-efficacy to engage in evidence-based policy communications to improve the health of people who use drugs through systems change,
2. improved perceptions of credibility among practice partners and policy makers (administrative and legislative) about evidence for systems change, and
3. development of community relationships with practice and policy partners to advance systems change.

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Keywords
harm reduction, lived experience, medications for opioid use disorder, policy and guidelines

15. Creating Long-Lasting Stigma Reduction among Community Pharmacists

Authors
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What is your project or initiative?
Creating Long-Lasting Stigma Reduction among Community Pharmacists

Why did you develop this?
Pharmacists have been shown to have significant stigma toward patients with opioid misuse behaviors. Stigma among community pharmacists is highly concerning and can have long term negative public health impacts because of the proximity of community pharmacies to all patients, the trusted nature of the profession, and the fact that every single opioid prescription must cross the hands of a pharmacist. Stigma reduction among community pharmacists is vital to provision of appropriate prevention, education, and follow-up care in order to address the opioid crisis. The Opioid and Naloxone Education (ONE Rx) program aims to equip pharmacists to screen patients for opioid misuse and overdose risk, to deliver key opioid-related interventions to patients based on their individual risk for misuse and overdose, and ultimately reduce opioid-related harms. It was implemented in 2018 along with a 3-hour educational training for pharmacists. From the outset, the researchers identified stigma of pharmacists as a potential barrier to implementation and maintenance of the program's pillars. Thus, components within the training to target stigma reduction were developed.

Who is the target audience?
The pharmacy workforce as well as the broader healthcare workforce network are target audiences as principles could be applied across disciplines.

Is this based on established work, or does it draw from other existing work?
It is based on established work with the integrative pedagogical perspective, known stigma reduction strategies, stigma-free language, and the social distance scale. It draws from other existing work related to the (Opioid and Naloxone Education) ONE Rx project. www.onerxproject.org

How does your project or initiative work?
The program works through delivery of stigma-reduction education simultaneously with opioid-related education that is directly connected to the work of the healthcare practitioner. Verbal explanation and diagram representation of information, application exercises, self- reflection/examination, drawing analogies, role-play, and video demonstration are used in stigma-reduction educational content delivery. Procedural information related to educating patients about naloxone, assessing patients for opioid-related risks, and other practitioner- specific on-the-job tasks is presented in conjunction with stigma-reduction content. In this way, reflections, examples, and analogies allow healthcare practitioners to directly apply and integrate stigma-reduction approaches and language into actions they perform regularly. Finally, the project involves measurement of attitudes and stigma (via the social distance scale) and practice behaviors at baseline, after the education, and 12 months later.

What are the results? If results are not yet available, what results do you hope to achieve?
This program is associated with significant reductions in negative attitudes and stigma among pharmacists immediately after the education and 12 months later. It is also associated with significant

practice behavior change. Compared with baseline, pharmacists in the program engaged in more frequent counseling on opioid misuse and overdose, discussion of medication take back programs, and naloxone prescribing 12 months after completion of the training. Thus, a significant reduction in negative attitude and stigma from baseline immediately after the training and 12 months later suggests a true and sustained adjustment in the pharmacists' willingness to engage with, form relationships with, and care for patients with opioid misuse.

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Keywords
education, pharmacy, storytelling, training, workforce

16. Culture Change in the Emergency Department Saves Lives: Reframing the Role of the Hospital in Addiction Treatment

Authors

Arianna Campbell, PA-C

What is your project or initiative?

CA Bridge saves lives by making it possible for people who use drugs to get treatment at any hospital in the state, wherever and whenever they need it. CA Bridge was officially launched in 2018 with a grant from the California Department of Health Care Services Medications for Addiction Treatment (MAT) Expansion Project. We are a program of the Public Health Institute, based in Oakland, California. The CA Bridge program's goal is to create 24/7 access to high-quality substance use treatment in every hospital in California by 2025.

Why did you develop this?

Over 21 million people in the United States require substance use disorder (SUD) treatment, however less than 4 million people receive treatment. When Arianna Campbell, one of the CA Bridge's Directors, supported her sister through a battle with addiction, she found herself with insider knowledge about the stigma held by many medical providers that were creating a barrier to her sister's treatment. When a medical institution gets addiction treatment wrong because of stigma that has permeated its walls, the stakes are high. CA Bridge aims to build a system that any patient or family member, like Arianna, can access. We know that it comes down to the smallest details, like how the family is greeted by the emergency department (ED) nursing staff. CA Bridge has set out to redefine 24/7 access to treatment in the ED so that patients and families can access high-quality resources whenever they are needed.

Who is the target audience?

This session will be relevant for anyone working to bring patient-centered and respectful treatment to people who suffer from addiction. Participants will receive links to our project toolkits so they may take action in their own communities.

Is this based on established work, or does it draw from other existing work?

CA Bridge is an ongoing program that is not only funded by the state of California to provide technical assistance but is also funded by the FORE Foundation and other sources to provide coaching on a national level.

How does your project or initiative work?

Programs in the model of CA Bridge have proved successful in diverse settings, including academic, non-academic, urban, and non-urban. Substance Use Navigators (SUN), who have been trained in CA Bridge model of care, are proven changemakers in these same hospitals and also serve as part of SUD infrastructure in California. These 200+ programs across California include rapid access to MAT and linkage support by substance use navigators while promoting a culture of harm reduction in the hospital setting.

What are the results? If results are not yet available, what results do you hope to achieve?

To date, hospitals supported by CA Bridge have led to the identification of over 22,000 patients with opioid use disorder and the initiation of over 12,000 MAT starts. SUNs have seen over 46,000 unique patients (data as of March 31, 2021.) Our initial cohort consisted of 32 sites, rapidly expanded to 52 and now stands at 208 acute care hospitals throughout California. Between April 2019 to June 2020, almost

12,000 patients were identified at CA Bridge sites, almost 8,000 of those patients accepted treatment and referral and almost 5,000 patients completed a follow-up visit. Through this scale and volume, we have found that EDs and hospitals serve as an important point for initiating treatment for substance use disorders. We have also centered on the importance of equitable access to care. In the recent article published in Drug and Alcohol Dependence titled “Voting with their feet: Social factors linked with treatment for opioid use disorder using same-day buprenorphine delivered in California hospitals”, the ED served as an important access point for those with socio-economic disadvantages.

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Keywords

education, emergency medicine, medications for opioid use disorder

17. Debunked: A Stigma Reduction Podcast

Authors
Jameen Fitzgerald; Katie Zaman, PhD; Cris Meier, PhD; Suzanne Prevedel, MEd; Sandra Sulzer, PhD

What is your project or initiative?
In 2019, the Tribal & Rural Opioid Initiative at Utah State University and Utah Public Radio launched an innovative evidence-based podcast. Season One was produced as a 15-episode podcast, “DEBUNKED,” which premiered in February 2020. Season One introduced lay audiences to harm reduction and substance use disorder (SUD) topics. Currently, Season Two is under production. Each episode discredits a myth that perpetuates stigma toward substance use, addiction treatment, and/or harm reduction interventions. Episodes feature conversations with harm reduction experts, scientists, members of Utah tribes, individuals in recovery, and local public health leaders.

Why did you develop this?
The Tribal and Rural Opioid Initiative (TROI) uses a community-based, participatory-action approach to creating local change around opioid use disorder treatment and recovery in rural and tribal communities in Utah. The TROI mission is to reduce stigma around harm reduction and SUD, and provide holistic wellness programs that promote healthier communities throughout Utah’s rural and tribal communities. DEBUNKED is a tool for changing perceptions of harm reduction, which often faces public opposition.

Who is the target audience?
We hope to reach a diverse audience of health care professionals, law enforcement, addiction and recovery specialists, and the general public through compelling stories of people who have experienced SUD and housing insecurity by providing insight into the myriad of stigmas they encountered on their journey.

Is this based on established work, or does it draw from other existing work?
Research shows reductions in negative public perceptions of drug treatment after exposure to people who were successfully helped by such interventions. Research on other populations, such as corrections officers, shows that explaining the science of harm reduction interventions may also lessen stigma.

How does your project or initiative work?
Season One was completed in March of 2021. The episodes are housed online at Utah Public Radio and YouTube to ensure the content is easily accessible. During Season One, and continuing in Season Two, we utilize an active promotion method to publicize and boost the visibility of this important work and resource to change the culture of the discussion around myths. Our current DEBUNKED season addresses myths related to substance use and homelessness, such as “people just need to pull themselves up by their bootstraps.” This season highlights the ways harm reduction principles can be mobilized to not only address the complexities of drug use among the ~33% of unhoused people with a chronic SUD but also highlight the ways harm reduction principles can be mobilized to assist in housing needs. Through a combination of live and produced episodes in Season Two, our target audience is exposed to evidence-based and personal experiences to dispel myths.

What are the results? If results are not yet available, what results do you hope to achieve?
We hope to build empathy and understanding among the general population towards people who use drugs and increase acceptance and knowledge of harm reduction strategies. Through stories and evidence, we hope that our audience will understand that the idea of harm reduction is a compassionate and effective approach to supporting people who use substances and face housing insecurity.

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Keywords

harm reduction, indigenous and tribal communities, lived experience, storytelling

18. Decreasing Student Nurses' Stigma toward People with Substance Use Disorder by Strengthening Therapeutic Commitment Skills

Authors

Kimberly Dion, PhD, RN, CNE, CARN; Stephanie Griggs, PhD, RN

What is your project or initiative?

Our initiative was to implement a four-hour training targeted anti-stigma training to first semester junior student nurses at a university in Massachusetts.

Why did you develop this?

An estimated 35 million people worldwide had a substance use disorder (SUD) in 2019. Nurses, including student nurses, report feeling poorly trained and have the least tolerant attitudes towards people with a SUD when compared to other health professions. Student nurses struggle with differences between their personal beliefs and professional expectations. Nurses have been known to stigmatize people with SUD. This is due to a common perception that drug use is under the control of the person with a SUD. Stigma has a negative impact on the person with a SUD's emotional and overall well-being.

Who is the target audience?

Student nurses are the target audience for this training but the training is appropriate for any health-related field.

Is this based on established work, or does it draw from other existing work?

This training is drawn from existing work and the development of an established curriculum for student nurses.

How does your project or initiative work?

We used a therapeutic commitment theory to guide our study with the intent of increasing practitioners' feelings of role adequacy, role legitimacy, and role support. We used a quasi-experimental, repeated measures survey design where all students (n=126) received a four-hour anti-stigma intervention that included the physiology of addiction, screening tools for SUD, intranasal naloxone training, and presentations by two individuals with a lived experience of SUD. All students received the training even if they did not participate in the study. The baseline survey was administered prior to the students' clinical practicum. A certified addiction physician provided the training on the physiology of addiction and focused the content on the role of the nurse. One individual with a lived experience was a mother who had lost her child to an opioid overdose. The other individual with a lived experience was a person in recovery. Both presenters shared their stories and illuminated how stigma impacted them and their loved ones. A special emphasis was placed on including their experiences with nurses and other health care professionals. Additionally, quotes from the experiences of people who inject drugs with nursing care in an acute care hospital were shared with the students. Students were instructed in the use of a variety of screening tools, the use of recovery-focused language, trauma-informed concepts, and were provided with electronic resources to utilize in their clinical setting.
We used the 20-item Drug and Drug Problems Perception Questionnaire (DDPPQ) (= 0.79), and the 8-item Perceived Stigma of Substance Abuse Scale (PSAS) (= 0.82) at baseline and post-intervention to measure stigma and attitudes toward those with a SUD.

What are the results? If results are not yet available, what results do you hope to achieve?
Following the four-hour educational intervention (n=109), there was a significant improvement in overall therapeutic attitudes (M=-14.8, $p < 0.001$) and perceived stigma (M=-0.87, p=0.014). Paired t tests were used to determine the mean differences in the total DDPPQ score (overall therapeutic attitudes) and in the total PSAS score. This intervention can serve to increase a student's awareness of the physiology of addiction, the impact of stigma and discrimination, and the importance of screening tools to identify those at risk for SUD. It is important for educators to develop strategies to increase student nurse engagement, motivation, and work satisfaction to improve care for people with SUD. Incorporating anti-stigma educational approaches may lead to more nurse involvement, compassionate connected care, and help to build therapeutic commitment in student nurses caring for people with SUD.

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Keywords

education, lived experience, storytelling, training, trauma-informed, workforce

19. Decreasing the Stigma of Addiction through the Integration of Medication-Assisted Treatment (MAT) Education into a Graduate Nursing Curriculum

Authors

Mary Beth Zeni, ScD, RN; Janet Baker, DNP, APRN; Martha Landolina, MEd; Joshua Hoffman, BA; Heather Marie Santa, MA; Jessica McCullough, MSN, PMHNP-BC, FNP-BC, PhD(c); Lisa Cowles, APRN, CNP; Sharon Sumansky, MS

What is your project or initiative?

This three-year SAMSHA-funded project integrates medication-assisted treatment (MAT) education into a Master of Science in Nursing Program so future advanced practice registered nurses (APRNs, also known as nurse practitioners) can obtain a DATA waiver to prescribe buprenorphine for the treatment of medications for opioid use disorder (MOUD) and provide ongoing recovery support for people living with opioid use disorder (OUD).

Why did you develop this?

There is a shortage of MOUD providers available to treat people living with OUD. APRNs, in collaboration with MAT prescribing physicians, can increase the number of qualified providers and improve access to MAT services for people living with OUD, particularly in rural areas. Providing MOUD treatment in a variety of settings, including primary care, will increase access to OUD treatment.

Who is the target audience?

The project involves graduate nursing students at Ursuline College in Cleveland, Ohio, a liberal arts college with a well-established and highly ranked graduate nursing department. The goal is to educate 230 graduate nursing students during the three-year grant period (September 2019 – September 2022).

Is this based on established work, or does it draw from other existing work?

The project draws upon existing education models developed by the Program Evaluation and Research Unit (PERU) at the University of Pittsburgh School of Pharmacy. This is the first collaboration between PERU and a graduate nursing program. PERU is an established provider of healthcare systems technical assistance, evaluation, and research in the areas of substance use disorder (SUD) prevention and veteran health. Initiatives include integration of patient SUD screening in multiple public health and safety settings and use of the Systems Transformation Framework (STF) to optimize healthcare service quality, patient outcomes, and cost savings. The STF utilizes standardized real-time data collection and analysis to drive continuous quality improvement. PERU collaborates with academic institutions to increase SUD education with a variety of healthcare professionals in the medicine, nursing, pharmacy, physical and occupational therapy, clinical rehabilitation and mental health counseling, counseling psychology, and social work disciplines.

How does your project or initiative work?

MAT includes more than prescribing and monitoring medications for OUD. A relationship based upon therapeutic communication skills and trust is needed between the provider and client. Stigma related to people living with OUD is a barrier to establishing this therapeutic relationship. APRNs experiencing stigmatizing attitudes towards patients using substances are less likely to obtain a DATA waiver and may avoid working with this population. The MAT educational intervention includes 24- hours of online MAT education, in-classroom case studies with a faculty champion with expertise in psychiatric/mental health nursing and OUD, and clinical observations with addiction medicine physicians in a variety of SUD/OUD treatment settings at a major medical center. Educational content focuses on stigma related to people living with OUD and aims to correct common misperceptions and judgmental attitudes. In addition to measuring pre- and post- intervention changes in knowledge and perceived competence, attitudes and perceptions are measured to ascertain changes related to stigma. Upon completing the MAT education, graduates are prepared to apply for a DATA waiver once they are licensed to practice as advance practice nurses.

What are the results? If results are not yet available, what results do you hope to achieve?
Results to date are based on analysis of 67 graduate nursing students representing the first five cohorts of students in Year 1 of the grant. Significant increases in perceived competence and significant increases in improved attitudes/perceptions (decreased stigma-related attitudes and perception) toward individuals living with SUD were noted based on the results of paired sample t-test ($p<0.05$). Changes in knowledge were favorable, but not significant. Knowledge questions were examined to determine possible content revisions during classroom and clinical observation experiences. The pre- and immediate post-test measures provide an opportunity for continuous quality improvement.

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Keywords
education, medications for opioid use disorder, training, workforce

20. DestigmatizER: A Simulation-Based Curriculum Advancing Patient-Centered Care for Chronic Pain and Opioid Use in Emergency Medicine

Authors

Timothy Ibrahim, MD; Lori Karan, MD; Adley Dason, MD; Ellen Reibling, PhD; Sharmin Kalam, MD; Wonha Kim, MD, MPH

What is your project or initiative?

The objectives of this project are to:

- identify the evidence-based best practices and communication techniques that most effectively address issues surrounding chronic pain and opioid use in the emergency department (ED), and to
- create and disseminate an innovative simulation-based educational framework intended to develop skills in these practices and techniques among emergency medicine residents.

Why did you develop this?

Despite the prevailing proportion of ED visits by patients with chronic pain and long-term opioid use, both patients and clinicians at all levels of training commonly rate these encounters amongst the most difficult and dissatisfying. Physicians across specialties, including emergency medicine, overwhelmingly report being uncomfortable managing patients with chronic pain and opioid dependence and feel that their training in this domain is poor. In addition, the direct and indirect stigmatization of patients with opioid use is common, impairing the care of these patients and contributing to several missed opportunities for the primary, secondary, and tertiary prevention of opioid-related harm especially in the ED. Although we have seen exciting growth, major gaps remain in the education of these pathologies as human issues deserving of empathic, stigma-free care, especially in post-graduate training. Communication-focused chronic pain management modules are growing in number and scope, but are primarily in the form of lengthy online lecture-based video modules. When compared to standard didactics, simulation in healthcare education has been shown to be more effective in teaching empathy skills. However, no simulation-based curriculum targeting the patient-centered care of patients with chronic pain and opioid use has been developed for emergency medicine graduate and post-graduate training. The resulting training paradigm is expected to become a powerful tool for reducing stigma of opioid users and increasing overall competence in their care, thereby leading to the elimination of barriers to the effective treatment and prevention of opioid misuse, addiction, and overdose.

Who is the target audience?

This curriculum will be developed for dissemination to emergency medicine training programs across the United States and the world. The intended audience is therefore composed of emergency medicine program directors, assistant program directors, directors of simulation, department directors, and other agents of change in EDs globally.

Is this based on established work, or does it draw from other existing work?

There is exciting promise of case-based education surrounding opioid-related humanistic issues, although none is intended specifically for the acute care-minded emergency medicine resident. In that vein, we believe the project proposed is innovative because it focuses on the setting-specific issues in management of chronic pain and opioid-related problems in the ED and simulation-based training of specialized skills in effective communication, intervention, and harm reduction for new emergency physicians.

How does your project or initiative work?
We plan to develop simulated patient cases and focused debrief frameworks that promote self-efficacy and skills vital to the unbiased patient-centered care of patients with opioid use and chronic pain among emergency medicine trainees. This will involve intensive review of available guidelines supporting best practices of chronic pain management in the emergency room as well as the literature analyzing psychosocial aspects of the pain experience that influence the clinician-patient relationship. We will conduct further review of the primary literature surrounding principles of simulation in medical training, then create and launch the simulation-based curriculum at our institution, incorporating feedback prior to reformatting for dissemination.

What are the results? If results are not yet available, what results do you hope to achieve?
Upon achieving the aims of this project, we will have produced an embeddable simulation-based curriculum that can be used by any emergency medicine training institution. An instructional module will be launched for emergency medicine residents who will complete online surveys prior to participation, immediately after completion, and at a delayed point after completion. The surveys will examine perceptions including: their performance, the effect on topical knowledge, the effect on self-efficacy, the likelihood that they will change their future clinical practice, and the barriers to making any expected changes. Trainees will also be asked to contribute any suggestions for improvement.

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Keywords
chronic pain, education, emergency medicine, simulation, training, workforce

21. Destigmatizing Harm Reduction and Medication Treatment Interventions: Curricula for Tribal and Non-Tribal Substance Use Treatment Professionals in Rural Utah

Authors

Sandra H. Sulzer, PhD; Erin Fanning Madden, PhD, MPH; Suzanne Prevedel, MEd; Cassandra Manning; Claire Warnick; Michelle Chapoose, LSUDC

What is your project or initiative?

Our Utah-based team created novel educational curricula that integrated evidence-based strategies for reducing stigma toward medications for opioid use disorder and harm reduction interventions. We partnered with a rural community advisory board and members of the Ute tribe to create culturally-centered curricula tailored to tribal and non-tribal substance use treatment professionals.

Why did you develop this?

A large body of research shows medication treatment for opioid use disorders and harm reduction interventions, such as safe consumption facilities, reduce overdose and other health risks. Despite this scientific support, significant stigma exists toward medication treatment and harm reduction interventions among the general public, as well as health professionals, and even addiction treatment professionals in the U.S., including in Utah. Such stigma can deter people with opioid and other substance use disorders from accessing medication or harm reduction programs, promote discrimination by abstinent treatment programs toward patients using medication and harm reduction interventions, and limit support for legalizing and funding life-saving harm reduction interventions. This stigma is driven in part by inadequate exposure to the evidence base for these interventions and limited contact with people who use or provide these services.

Who is the target audience?

Professionals working in Utah's rural tribal and non-tribal substance use treatment settings, including physicians, nurses, therapists, and reception staff.

Is this based on established work, or does it draw from other existing work?

This project was based on a systematic review conducted by the study team of the literature on stigma toward harm reduction and treatment interventions, but this systematic review and the resulting training were both novel efforts.

How does your project or initiative work?

The training has been delivered in face-to-face, synchronous online, and asynchronous online formats. Each training lasts four hours. All trainings are co-taught by an academic harm reduction researcher and a community harm reduction practitioner with lived treatment and recovery experience. Face-to-face and synchronous trainings include interactive components, including case studies, small group discussion, and open large group discussion. The asynchronous format delivers the training via video modules. All formats are assessed using pre- and post-training surveys asking about dimensions of stigma. These surveys included questions about factual knowledge of intervention efficacy, changes in attitudes towards interventions, and changes in intended actions, such as intention to refer people to syringe services.

What are the results? If results are not yet available, what results do you hope to achieve?

Initial analyses of face-to-face and synchronous online training data from 110 participants who completed surveys indicate the training significantly decreased the total stigma score toward medication treatment and harm reduction. At the individual survey item level, 6 of the 22 items showed significant change.

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Keywords

education, indigenous and tribal communities, medications for opioid use disorder, training, workforce

22. Do Licensure Questions Affect Stigma and Help-Seeking Behaviors for Physician Assistants?

Authors

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What is your project or initiative?

We analyzed initial licensure (n=51) and license renewal (n=47) applications for physician assistants (PAs) with regard to questions about physical and mental health. Applications that asked questions about current or recent impairment were considered consistent with the Americans with Disabilities Act (ADA), while applications that asked about remote history (e.g., “have you ever been diagnosed with a mental health condition?”) or were speculative in nature (e.g., “...could possibly cause impairment”) were considered not to be consistent with the ADA. We also surveyed practicing PAs to explore the relationship between these questions and concern about seeking help for health concerns.

Why did you develop this?

Analysis of the licensure applications for physicians revealed that 2/3 of states had physician licensure applications that were NOT consistent with the ADA with regard to mental health. The same study found that almost 40% of physicians would be reluctant to seek help for a mental health issue due to concerns about licensure repercussions. We sought to explore these questions with practicing PAs.

Who is the target audience?

Practicing clinicians, members of licensing boards, and leaders within the health professions.

Is this based on established work, or does it draw from other existing work?

This is based upon existing work published about physicians.

How does your project or initiative work?

Phase 1 involved the analysis of state licensure applications and renewal applications. Phase 2 involved a survey of over 1,500 PAs from nationwide survey administered by the American Academy of PAs.

What are the results? If results are not yet available, what results do you hope to achieve?

Only 18 states were consistent with the ADA for both initial and renewal licensure applications. The results of our survey found that 35% of PAs would be reluctant to seek help for a mental health or substance use issue due to concerns about licensure (only 12% were reluctant regarding physical ailments). PAs in states with licensure language that was inconsistent with the ADA were significantly more likely to be reluctant to seek care due to concerns about repercussions on licensure – this was true for both physical ailments as well as mental health and/or substance use concerns. Our results show considerable stigma with regard to mental health and substance use within our professional lives, and state licensure questions seem to adversely influence this. We can do better.

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Keywords

mental health, policy and guidelines, workforce

23. Effect of Implementation of a Medication Assisted Treatment and Education Program on Perceived Stigma of Healthcare Providers in an Emergency Medicine Department

Authors
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What is your project or initiative?
This project is designed to evaluate stigma of healthcare providers towards those with opioid use disorder (OUD) and whether or not stigma is affected by educating healthcare personnel about OUD and stigma. This project also will measure the impact of a Medication Assisted Treatment (MAT) Pilot Program on healthcare providers' perceived stigma towards individuals suffering from OUD.

Why did you develop this?
Stigma towards various populations has been shown to negatively impact healthcare outcomes. This specific project has been developed in order to see if stigma can be improved with education and understanding of a population (those with OUD) through adopting a new MAT pilot program directly addressing the unique medical needs of this population.

Who is the target audience?
The target audience is emergency department (ED) staff: physicians, pharmacists, residents, nurses.

Is this based on established work, or does it draw from other existing work?
This project draws from other existing work.

How does your project or initiative work?
In conjunction with the initiation of our MAT pilot program, there are educational grand rounds, discussions at shift change, educational presentations in weekly resident conference, and integrated meetings at an administrative level concerning ED protocols.

What are the results? If results are not yet available, what results do you hope to achieve?
Results are not yet available as we are in the data collection phase. We hope to see a progressive improvement in scores on the Perceived Stigma of Substance Abuse Scale (PSAS: validated stigma questionnaire) with increased amount of stigma education, awareness, and familiarity with MAT protocols.

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Keywords
education, emergency medicine, medications for opioid use disorder, training, workforce

24. Ending Self-Stigma for Justice-Involved Populations Being Treated with Medications for Opioid Use Disorder

Authors

Shannon Gwin Mitchell, PhD; Alicia A. Lucksted, PhD

What is your project or initiative?

We plan to modify an existing evidence-based treatment for adults with serious mental illnesses (Ending Self Stigma, ESS) so it can be used to reduce internalized stigma (IS) and problematic anticipated stigma (PAS) for justice-involved people being treated with or considering the use of medications for opioid use disorder (MOUD).

Why did you develop this?

Stigma has been specifically identified as a barrier to providing MOUD to justice-involved populations. Such people often experience multiple intersecting stigmatized identities, including their justice involvement as well as their histories of substance use. Courts/judges, correctional and community supervision agents (as well as family, neighbors, peers and others) may hold negative views of MOUD; views that the justice-involved populations may seek to avoid and are susceptible to internalizing, creating additional barriers to treatment entry and continued engagement. Unfortunately, despite these myriad harms to the core goals of addiction treatment, and to MOUD adherence specifically, there are no evidence-based interventions available to help justice-involved individuals using MOUD avoid or resist PAS and IS.

Who is the target audience?

Justice-involved people with OUD who are engaging in recovery treatment either during their incarceration or while on probation or parole are the target audience.

Is this based on established work, or does it draw from other existing work?

The proposed project builds on Dr. Lucksted's existing evidence-based intervention, Ending Self-Stigma (ESS). ESS is a 9-session, manualized, group-delivered intervention designed to help adults with serious mental illnesses gain tools and strategies to effectively cope with societal stigmatization and to reduce IS and PAS. To date, it has been tested in two large randomized clinical trials, one in community-based psychosocial rehabilitation programs and one in Veterans Administration outpatient mental health programs. Additionally, the project builds upon our team's extensive research with MOUD for justice-involved people, including studies of interim methadone, methadone, buprenorphine, extended-release naltrexone, and extended-release buprenorphine. Successful initiation of MOUD during incarceration may still result in rapid treatment drop-out or failure to engage in care upon release. Perceived stigma is often noted as a reason for either not initiating MOUD treatment or discontinuing care.

How does your project or initiative work?

This three-phase project will occur over the course of a year and involve the following activities:

1. Conducting a series of stakeholder focus groups and individual interviews with clients, clinicians, and community corrections staff in order to gather diverse input regarding modifications for the original ESS to make it better suited to the stigma experienced by justice-involved populations receiving MOUD. The findings will be used to generate a first version of the new intervention (Ending Self Stigma: Medications for Justice-involved People; ESS-MJP).
2. Refining the intervention via serial, iterative pilot administrations of ESS-MJP. This will comprise two group treatment cycles of approximately 8 participants each, with participant feedback

following each session-by-session to refine the intervention and assess feasibility and acceptability in the intervention's content.

3. Finalizing the ESS-MJP intervention manual and materials based on the pilot testing phase, to be tested in a larger trial.

What are the results? If results are not yet available, what results do you hope to achieve?
It is our hope that the project will successfully develop an intervention with the potential to build resiliency among justice-involved people who could benefit from MOUD and enhance their treatment outcomes. Modifying ESS for justice-involved populations with OUD has the potential to improve outcomes in two important ways:

1. by increasing receptivity to MOUD for incarcerated populations not currently receiving medication (e.g., engaged in drug counseling programs following detox), and
2. by improving treatment compliance and retention for justice-involved people on MOUD programs in the community.

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Keywords
criminal justice, medications for opioid use disorder, mental health, training

25. Exploring the Effect of Personal Narratives of People Who Use Drugs

Authors

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What is your project or initiative?

This project intends to expose participants to a documentary produced by Tapestry Health Systems that includes personal portrayals of people who use drugs to assess their effect on community members' stigma toward people who use drugs. To create this documentary, Tapestry has engaged local participants and community members to provide context into the lived experience of people who use drugs. Anonymity has been maintained for those who wish without altering the message of the insights they have to share. The documentary, which is currently still in production, will be about an hour long and is set to be completed by late spring of 2021. The film is a portrayal of the experiences of people who use drugs and their experiences of perceived and societal stigma. Exploration of the significance of harm reduction is another film component and is presented via the voice of the client, as well as harm reduction workers. Stigma is addressed from both personal perspectives, reflections, and observations throughout the documentary. Perceived stigma will be measured pre- and post-survey using the Perceived Stigma of Substance Abuse Scale (PSAS) and reflection will be used with willing view participants to assess the effect of the documentary on stigmatic tendency.

There are three specific aims for this project, namely:

1. To determine if the participant's perceived stigma changed over time (pre/post-intervention),
2. To explore differences in perceived stigma by age, race, religion, educational level, experience with persons with substance use disorder, and
3. To explore the impact of this documentary on the participants' intent to change their attitudes or behaviors towards persons who use drugs.

Why did you develop this?

Substance use is identified as a leading health indicator by the US Office of Disease Prevention and Health Promotion. Substance use disorder (SUD) is not only a health-related problem but a financial one as well, including lost productivity and crime-related costs estimated to exceed $600 billion annually (Healthy People, 2030). The US Office of Disease Prevention and Health Promotion also details how community and legal responses to substance use complicate the public health issue. Evidence indicates that current stigmatization of persons who use drugs inhibit the ability to promote health in this population. People who use drugs often delay health care, don't disclose their drug use, and seek alternative ways to manage their health care issues than to seek care. Societal stigma exists toward people who use drugs. A change of mindset, including embracing concepts such as pragmatism, in that none of us have perfect health behaviors, and incremental improvements of decreased stigma can take years. Common themes among community members' perspectives and attitudes toward people who use drugs include "being dangerous and self-destructive", and "the tendency to want to avoid 'these people'". Evidence to support self-stigma exists, which may explain why persons who use drugs are hesitant to seek healthcare for fear of being judged or treated poorly. The use of personal narratives, especially those who incorporate barriers to treatment, may be useful in decreasing stigma and increasing public support for improving access to services and healthcare for people who use drugs.

Who is the target audience?
Participants for this initial project will be local community members. However, the documentary may also serve to be effective for other specific groups in the future such as healthcare providers.

Is this based on established work, or does it draw from other existing work?
This project draws from existing work. Evidence exists to support the idea that the use of personal narratives has the potential to affect mindsets.

How does your project or initiative work?
Participants in the project will be asked to complete the PSAS via an anonymous online survey immediately prior to viewing the documentary. Then, immediately following, participants will be asked to complete an anonymous survey of open-ended reflection questions and the PSAS. The open-ended questions ask about the participant's intent to change behaviors as a result of viewing the documentary. The results of the survey will be analyzed to determine if participants' perceived stigma changed as a result of viewing the documentary.

What are the results? If results are not yet available, what results do you hope to achieve?
Because the project will commence when the documentary is debuted in September 2021, we do not have results to share at this time. However, our analysis will include both qualitative and quantitative methods and it is our hypothesis that participant's perceived stigma will decrease following the intervention.

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Keywords

lived experience, storytelling

26. Exploring the Impact of Intersecting Prescription Opioid and Chronic Pain Stigmas on Pain Management in Cancer Survivors

Authors
Hailey Bulls, PhD

What is your project or initiative?
Development of a multi-level intervention to mitigate the negative consequences of intersecting stigmas associated with opioids and chronic pain in cancer survivors.

Why did you develop this?
Cancer survivors experience high rates of chronic pain, with up to 40% of cancer survivors reporting pain months or years after the completion of their curative treatment. Though a high proportion of patients are exposed to opioid pain medications during active treatment, less is known about the safety and efficacy of opioid pain medications for cancer survivors with chronic pain. Thus, survivors and their clinicians are stuck between two worlds – cancer pain, in which opioids are standard of care, and chronic pain, in which long-term opioids are known to carry significant risk, including opioid misuse, addiction, and death. This challenge is particularly impactful amid the opioid epidemic, in which negative attitudes towards opioids and addiction are prevalent. Cancer survivors with chronic pain may be at particularly high risk for intersectional stigma arising from addiction stigma (associated with prescription opioids) and chronic pain stigma. Unmitigated stigma is associated with worse health outcomes and may result in undermanaged pain and worse quality of life in cancer survivors. As the population of cancer survivors on long-term opioid therapy continues to increase, understanding and mitigating stigmatizing experiences in this group is a time-sensitive, critical need.

Who is the target audience?
Cancer survivors who report chronic pain, their caregivers/family supporters, and clinicians who treat cancer survivors as part of their practice (oncologists, primary care physicians, pain management specialists, and palliative care physicians, among others.) Each group will be included in the study and resulting multi-level intervention to mitigate stigma in cancer survivors.

Is this based on established work, or does it draw from other existing work?
Prescription opioid and chronic pain stigmas are emerging areas of literature and have been described in other patient groups. For example, our prior pilot work in patients with active disease indicated that a majority of survey respondents reported experiencing at least one aspect of opioid stigma (most commonly, fears of addiction and difficulty discussing opioid pain management with healthcare providers), and over a quarter reported potentially maladaptive behaviors as a result (most commonly, taking less medication than needed, resulting in excess medication available in the community). However, there is little literature that explores how prescription opioid and chronic pain stigmas may intersect to affect pain management and quality of life in cancer survivors. Encouragingly, prior literature in other medical (e.g., HIV) and mental health populations suggests that stigma can be effectively addressed and mitigated.

How does your project or initiative work?
This is a qualitative study to understand the experience of co-occurring prescription opioid and chronic pain stigmas in cancer survivors. Guided by the Health Stigma and Discrimination Framework, we will design and conduct in-depth qualitative interviews exploring prescription opioid and chronic pain stigma with 20 cancer survivors with moderate-to-severe pain, 20 caregivers, and 20 clinicians

who treat chronic cancer pain in outpatient settings. Recruitment will begin with clinicians, including oncologists, primary care physicians, pain management specialists, and palliative care physicians. Eligible patients will be cancer survivors who are prescribed opioids for moderate- to-severe cancer pain (4+/10 for the past 3 months). Participating patients will be asked to identify a caregiver who meets study eligibility criteria. Upon completion of the interviews, we will conduct thematic analysis to identify modifiable contributors to stigma in cancer survivors, with an emphasis on potential targets of future interventions. We will also explore long-term health outcome that we anticipate will be associated with stigma in survivorship.

What are the results? If results are not yet available, what results do you hope to achieve?
The results of this work will provide foundational information for the development of a multi-level behavioral intervention to mitigate the impact of stigma and improve pain management in cancer survivors with chronic pain.

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Keywords
chronic pain, lived experience, storytelling

27. Healing Stigma through Equity-Informed Hiring, Training and Quality Practices

Authors
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What is your project or initiative?
Our overarching project was to create a company culture from scratch that is entirely based on equity and empowers all staff from all areas to create an equitable culture. We sought to build an intentionally diverse, stigma-reducing workforce that has skills for increasing equity, reducing disparities, and using affirmative instead of stigmatizing language.

Why did you develop this?
First, to provide lasting, effective care, our team members need to be able to develop deep and trusting relationships with our community members. Having staff skilled in stigma reduction and equity conversations are core for achieving these relationships. Second, it's the right thing to do. Corporations have a lot of power to health stigma and ameliorate inequity with intentional policies, procedures, and outcomes. Third, it's pragmatic. To compete in a competitive market, we need to offer people something that they believe in and want to be part of. Candidates want places where they feel at home and where "there are people who look like me here." We don't just have a website with diverse pictures, our team has diverse leaders in material roles that are high performing, highly placed role models.

Who is the target audience?
Mental health and addiction boards, executive teams, operational leadership, human resources (HR), and quality leaders.

Is this based on established work, or does it draw from other existing work?
The importance of creating healthy, trauma-informed cultures has been proven to help people with addiction recover more successfully. We are innovative in seeing racism is a trauma that should be explicitly addressed and applied to a people/HR framework. We are also innovative in our investment in language, stigma reduction, and equity training. Many companies do not train all team member roles in these things, including independent contractors. We are also innovative in our data transparency. Achieving racial, ethnic, and LGBTQIA+ equity for our people processes and for our clinical outcomes requires transparent measurement and communication.

How does your project or initiative work?
To meet our project goals, we implemented several interventions. The first is equity-informed hiring. Our diverse recruiters use data to intentionally recruit from under-represented hiring areas. We screen for stigma while screening, asking, "Do you embrace the core principles of whole person care, de-stigmatization, equity?" Equity-informed team member data tracking. We transparently look at racial diversity, LGBTQIA+ diversity, and other factors -- by all team members, by managers, and by directors and above. All new team members, whether in information technology or HR, receive equity and stigma-informed training and gain skills for practicing affirmative language. Our culture is a profound conversation about stigma and equity that sets our cultural tone.

The second is affirming corporate language. Reducing stigma is a core value, and our team members are trained to treat community members as humans worthy of respect.

The third is team member affiliation groups. For instance, we have Black Eleanor (an affiliation group specific to our organization) and Black Lives Matter employee relation groups. Executive-driven equity leadership addresses every significant stigma/racial injustice event through internal communication, and, when possible, external communication. We developed reporting that disaggregated our outcomes by rate to determine whether we were meeting our equity goals for high quality care for all of our community member groups.

What are the results? If results are not yet available, what results do you hope to achieve?
For overall team members, 70% are white, 18% are black and 12% are IPOC/H. For our directors and heads of divisions, 71% are white, 10% are Black, and 19% are IPOC/H. For our managers and above, 63% are white, 20% are Black, and 17% are IPOC/H. For LGBTQIA+ members, 4% are LGBTQIA+ overall, 10% are Directors or heads of department, and 9% are Managers and above.

For our mental health improvement outcomes, Black Eleanor members with insurance that covered peer support services had a 23% higher depression improvement rate than white members. Black Eleanor Members without these services covered by their insurer experienced improvement (70%), but it was slightly lower than white members (74%). For our social determinants of health outcomes, 88% of our Black Eleanor members and 81% of white Eleanor members receiving Care+ services improved at least 5 points on their Recovery Capital Scale. For those whose insurer didn't cover peer specialist or nurse care management services, 57% of Black Eleanor members and 74% of white Eleanor members improved without Care+ services.

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Keywords
person-centered language, training, trauma-informed, workforce

28. Hot Button Topic: Combating Opioid Use Disorder Stigma with White Coat Lapel Pins at the University of Colorado Anschutz Medical Campus

Authors
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What is your project or initiative?
The “X Waiver” authorizes medical providers to prescribe buprenorphine to treat patients with opioid use disorder (OUD). Our project is the design, development, and dissemination of white coat lapel pins with an “X” design on them – a nod to the X Waiver – to students who complete 8 hours of X Waiver training. The pins are supported as part of a SAMHSA-funded initiative to integrate the buprenorphine waiver training in the curricula for MD, NP (nurse practitioner), and PA (physician assistant) students at the University of Colorado Anschutz Medical Campus. The pin signifies completion of federally-approved buprenorphine waiver training and displays the wearer’s interest in talking openly about and treating OUD. The “X” pin design is gold and black to reflect our school colors – Go Buffs! – and could be modified to other colors for use at other health professions schools. The pin is intended to be displayed to both patients and colleagues alike.

Why did you develop this?
We developed this project to combat OUD stigma among healthcare professionals at the outset of their careers. Negative attitudes of health professionals towards patients with substance use disorders are common and contribute to suboptimal health care for these patients. Coupling the buprenorphine training with a lapel pin provides an opportunity for a conversation about OUD treatment when someone asks, “What’s that pin on your coat?” This type of messaging and advocacy can help to engage “fence sitters”—people who have some investment in OUD stigma change but limited knowledge about how to translate their beliefs into action.

Who is the target audience?
The target audience is current and future clinical healthcare providers. Our secondary audience is patients cared for by pin wearers.

Is this based on established work, or does it draw from other existing work?
Pins and buttons have messaged social change for over a century. In “Button Power: 125 Years of Saying It with Buttons,” Christen Carter details the role of buttons in messaging on topics including pacifism, racism, gentrification, pop culture, and politics. Buttons represent a low-cost, high-visibility medium for engaging colleagues and patients about hot button topics. Doctors began wearing white coats in the 19th century as a symbol of cleanliness; today, the white canvas of a healthcare provider’s coat provides a distinctive backdrop against which to showcase an attractive, understated button about an important public health issue.

How does your project or initiative work?
Students in the MD, NP, and PA degree programs at the University of Colorado receive federally-certified buprenorphine waiver training using the Providers Clinical Support System (PCSS) curriculum delivered by addiction experts. Upon completion of the training, learners receive X pins. The X pin design is understated; our goal was to create an attractive button that could be a neutral conversation starter in a clinical setting. Each ¾” button costs $2.19.

What are the results? If results are not yet available, what results do you hope to achieve?
The first wave of pins will be distributed to students in Spring 2021. To date, 230 learners have completed at least the first 4 hours of the buprenorphine waiver training through this grant effort, and at least 120 learners have completed 8 hours of the training. The pins have also been distributed to approximately 10 attending physicians on the University of Colorado Hospital Addiction Medicine Consult Service. The pins are one piece of the SAMHSA grant project's activities. The grant has also supported the creation of the Interprofessional Addiction Medicine Student Interest Group at University of Colorado Anschutz Medical Campus, which has held multiple events with overwhelming interest. These events have included a virtual Narcan training to over 70 students with in-person distribution of Narcan kits, as well as a virtual panel discussion about careers in addiction medicine. Future events will include field trips to county drug court and the Harm Reduction Action Center. We hope to spread the effort to other health professions programs that can use their school colors for the pin. We plan to develop and distribute a blueprint to schools to promote interprofessional addiction medicine activities for their student bodies.

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Keywords
education, medications for opioid use disorder

29. "I Do Love My Baby", Stories of Mothers with Addiction and Recovery

Authors
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What is your project or initiative?
The project was to give voice to mothers (pregnant or parenting) who have substance use disorder (SUD) to share their stories with the world. Stigma for having SUD during pregnancy is often expressed by blame and shaming the mother for the misconception that the mother does not care for their infant or child. The stories depict the prior trauma experienced by these women and how their child(ren) are strong motivators for their recovery. A book titled "I Do Love My Baby": Stories of Mothers with Addiction and Recovery was published on Amazon to share their stories as promised in the qualitative research to promote empathy and caring by the public. At the end of each chapter are reflection questions for the reader to consider with the overarching goal to reduce stigma to the marginalized population of mothers with SUD. The innovation of this project to address stigma for mothers with addiction was multifaceted. University undergraduate research students were included in the data collection and had the opportunity to reflect and contribute each chapter of the book. The students' reflections of the experience are included in the book and demonstrate increased awareness and compassion ignited by the stories of the mothers.

Why did you develop this?
As nurse practitioners, we have heard the language and attitudes expressed to and about women who are mothers and have SUD, both in the clinical setting and in public. Mothers with SUD feel reluctant to disclose their use and their concerns due to the anticipation of judgment and condemnation. Giving voice to the stories of the mothers we hope will bring a new understanding that includes trauma-informed care and inviting these mothers to engage in healthcare services that are supportive to their journey to recovery. We hope the stories inform public policy that addresses SUD to create opportunities for recovery instead of punishment.

Who is the target audience?
The target audience of this project is anyone who comes in contact with mothers with SUD, which is everyone. The target audience includes anyone who speaks about mothers with addiction and how the language they use can inflict harm on the mother and reduce her likelihood of seeking recovery. Included in the audiences are not only healthcare professionals, but families, friends, neighbors, public policymakers, members of the press, and the settings of churches, schools, public gathering places and social service agencies.

Is this based on established work, or does it draw from other existing work?
The project is a result of an original qualitative research study created by our team. One of the research deliverables was the publication of this collection of stories of mothers in book form. The mothers were excited at the possibility that their story could be influential on the attitudes and beliefs of others toward women with substance use disorder. The identifiers of the stories are removed or changed so that the mothers' stories remain anonymous. In the book are stories of a grandmother, foster mother, pregnant woman, and parenting women.

How does your project or initiative work?
The book is available on Amazon. The majority of the proceeds are going to establish a research fund

to award to research projects that address pregnant or parenting women with SUD or their infants/children through the Clemson University Research Foundation. We hope reading the book provides a platform for discussion, education and reflection on how to create a better environment for mothers with addiction that removes stigma and condemnation.

What are the results? If results are not yet available, what results do you hope to achieve?
The themes of the qualitative study include:

1. prior trauma for the women in circumstances such as domestic/interpersonal violence, history of experiencing maltreatment as a child and loss of loved ones,
2. multiple prescribed and non-prescribed substances used,
3. stigma and judgement from healthcare providers during the perinatal period,
4. positive social support from multiple sources co- occurring with recovery for the mothers, and
5. the children as motivators for recovery.

The qualitative study is in press in the Journal of Maternal Child Nursing (MCN).

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Keywords

lived experience, trauma-informed, women's health

30. Improving Behavioral Health Patient Experiences and Healthcare Worker Wellness Through Empathy-Grounded Training in Health Professions

Authors

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What is your project or initiative?

Patients with addiction, mental illness, and developmental disorders (AMD) often feel misunderstood by healthcare providers. Stigma and bias toward patients with AMD has been shown to lead to poor patient care experiences. Empathy, the process by which a person comes to better understand and respond to another person's needs, reduces stigma and bias. Our project aims to better support empathy-grounded care for patients with AMD, identifying, prioritizing, and innovatively addressing empathy training needs of future healthcare providers to reduce the effects of stereotyping and bias negate.

Why did you develop this?

While it is widely accepted that reducing stigma and increasing empathy toward patients with AMD is desired, little is known regarding how to develop and sustain the requisite knowledge, skills, and attitudes among current and future healthcare workers, so that they are better prepared to face challenges encountered in practice. We developed this project because there is a gap in interprofessional and innovative approaches to educating frontline healthcare professionals on how to provide empathy grounded care to patients with AMD. This project will support identification of gaps and approaches to innovate training to address behavioral health knowledge, empathy skills, attitudes, and resilience.

Who is the target audience?

We will focus on students enrolled in four health profession programs: nursing (RN), nurse practitioner (NP), physician assistant (PA), and pharmacy (PharmD).

Is this based on established work, or does it draw from other existing work?

Our project is based on what is currently known and draws from our previous existing work. Research has shown the benefits of empathy and related relationship-building activities on health outcomes of patients managing chronic illness. Our prior research, a survey of 230 nurses, found that being motivated to know what a patient is thinking and feeling is positively linked to nurses' emotional wellness at work. We found that clinicians who were successful at managing agitated or aggressive patients described an attitude of empathy as being critical to their approach; however, there is little guidance to prioritize training needs of different healthcare providers and even less information on the needs of different healthcare students.

How does your project or initiative work?

Enhancing empathy toward patients can improve patient outcomes and healthcare worker emotional wellness. There is little guidance in the form of defined competencies or recommended approaches to educating and training healthcare workers. The proposed project will enhance understanding, prioritize training needs and employ innovative approaches to ensure students develop, apply, and sustain appropriate empathy skills to support patients with AMD. Applying a consensus building process (Delphi process), we will prioritize unmet training needs, gaps, and opportunities for innovation, developing an empathy-based training program with directors, faculty, students/alumni, and patients with AMD. We plan to collect preliminary data to assess, tailor, and refine the empathy-grounded training intervention, addressing profession specific, and patient specific needs.

What are the results? If results are not yet available, what results do you hope to achieve?
This planned process will generate prioritized lists of research questions, training needs, and innovation opportunities for enhancing empathy in the target health professions for patients with AMD. The team will use these findings to inform future training programs and research.

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Keywords

education, interprofessional, mental health, training

31. Innovation and Inclusion: Using Experience Based Co-Design to Improve Care for Patients with a Substance Use Disorder

Authors
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What is your project or initiative?
We used a modified experience based co-design (EBCD) methodology to work in partnership with patients who currently use or have a history of using drugs and alcohol to first identify “pain points” and then develop solutions to improve healthcare delivery and experience in rural, acute care hospitals.

Why did you develop this?
Programs and initiatives are often created for people with substance use disorder (SUD) but not with them. The exclusion of lived experiences is a stigmatizing action and risks creating programs that do not address the specific needs of those with seeking care whether for their SUD or other medical needs. The lack of including the lived experience results in initiatives that are less likely to succeed, resulting in patients leaving care against medical orders, facing stigma, and not receiving effective care for their SUD and other medical conditions. Additionally, staff and clinicians who do not specialize in SUD treatment find that they do not have enough understanding of the disease process and the experience of patients to be able to provide care that is truly patient centered.

Who is the target audience?
Inpatient individuals with SUD and the staff and clinicians who work with them.

Is this based on established work, or does it draw from other existing work?
EBCD was developed in the United Kingdom but was modified to be used with individuals who have used drugs or alcohol. Due to COVID-19, we re-designed the process to be used in virtual settings. This adaptation provided greater access for patient participants and a layer of security for confidentiality and nervous participants.

How does your project or initiative work?
Our project is using the EBCD model to assess the current landscape and enhance the inpatient management of SUD in acute care rural hospitals in New Hampshire.

The EBCD methodology consists of the following steps:

1. Convene focus groups for patients and staff and clinicians to identify “pain points”. Staff representatives come from all areas of the hospital that interact with patients or provide patient care, including but certainly not limited to bedside nurses, medical technicians, certified nursing assistants, pharmacy, intensive care unit, obstetrics, dietary, and other providers. Patients are recruited who have had an inpatient stay in a New Hampshire hospital and have a history or currently use drugs or alcohol. Human-centered design strategies are used to encourage creative and out of the box thinking for all participants.
2. Analysis of focus groups. Qualitative analysis of focus group information allows for the identification of thematic areas of priority.
3. The Co-Design meeting will bring together patients, staff and clinicians to prioritize the items from the initial focus groups and generate solutions. Strategies will be identified for implementation and evaluation in quality improvement cycles.
4. The Co-Design workgroup consists of staff, clinicians and patients from the initial focus groups

and additional staff as needed. The work group designs, implements and evaluates the identified solution(s).

What are the results? If results are not yet available, what results do you hope to achieve?
Full results from the co-design meetings and workgroup are not yet available. The findings from the project so far are the following:

1. Recruitment was most successful when using peer champions, defined as individuals with lived experience within specific communities or populations who can help reach out to individuals who tend to distrust healthcare. This method provided opportunities to include individuals who were not in recovery or treatment programs.
2. Themes from the focus groups demonstrated that the primary pain point for patient participants was the stigma and inequity of treatment associated with using or having used drugs and alcohol. Staff focused on patient behavior. However, statements such as “Patients lie about substance use” were seen as the part of the same problem as “They treat me differently when I disclose my drug use.” These statements show the urgent need to bring patients and professionals together not only to identify problems but to work together towards solutions. Though not yet completed this project is providing specific insight into how stigma, judgement and lack of understanding of addiction as a disease is negatively impacting patients seeking help as well as the professionals who want to provide effective, compassionate care.
3. This project is being piloted in four rural, acute care hospitals.

When completed each hospital will implement initiatives that have been designed, implemented, and evaluated with those with lived experience.

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Keywords
lived experience, training, workforce

32. Insights Into Recovery Veteran Video Series: A Veteran-Centered Resource to Support a National Quality Improvement Project to Improve Access to Opioid Use Disorder Treatment in the Veterans Health Administration

Authors
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What is your project or initiative?
Our project is a series of educational videos that document the real stories of veterans with opioid use disorder (OUD) and their experiences seeking treatment. They also highlight a primary care physician's journey in treating this population. The video series will be disseminated as a resource for clinicians and staff in the Veterans Health Administration (VHA) as part of a national quality improvement project, the Consortium to Disseminate and Understand Implementation of OUD Treatment (CONDUIT).

Why did you develop this?
We developed this tool to educate clinicians on experiences of stigma in VHA clinics. We hope to change some of the culture in the way medications for opioid use disorder treatment are perceived.

Who is the target audience?
The target audience are clinicians and veterans within the VHA.

Is this based on established work, or does it draw from other existing work?
This video series builds on a prior collaboration between an experienced video production team and VHA researchers. These videos draw on the expertise and lived experience of members of the VHA's Opioid Addiction & Recovery Veteran Engagement Board. We consulted literature on stigma around OUD treatment when creating the interview talking points. We relied on the expertise of the video production team in interviewing, recording and editing the materials.

How does your project or initiative work?
In April 2021, the video series was disseminated to implementation teams to support educational efforts and to facilitate practice change among VHA clinicians and staff. We created a Microsoft Stream page to house the videos and created a technical guide to support broad dissemination in meetings, presentations and email outreach.

What are the results? If results are not yet available, what results do you hope to achieve?
We began dissemination in April 2021 and do not yet have results. We hope our results will improve understanding and prompt important conversations about veterans' lived experience with OUD and its evidence-based treatment. Overall, we hope our results will improve access to treatment for OUD and thereby save lives.

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Keywords
lived experience, medications for opioid use disorder, story-telling

33. Life Unites Us: A Statewide, Evidence-Based Effort to Eliminate Opioid Use Disorder Stigma

Authors

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What is your project or initiative?

The Douglas W. Pollock Center for Addiction Outreach and Research at Penn State Harrisburg, The Public Good Projects, and Shatterproof partnered with the Pennsylvania Department of Drug and Alcohol Programs to implement an interdisciplinary project that uses the collective impact model to reduce opioid-related stigma. Life Unites Us (LUU) addresses stigma by pairing a digital media campaign with stakeholder involvement, providing resources and assistance to target audiences and community-based organizations. It further addresses the needs of treatment and recovery providers through delivery of a web portal that contains webinar trainings, mapping tools, statewide survey results, and stigma-related health indicators.

Why did you develop this?

The opioid epidemic is the deadliest drug crisis in the nation’s history. From 2019-2020, Pennsylvania had the third highest number of deaths due to drug overdose in the country. Public awareness of the opioid epidemic has increased over time, but stigma surrounding opioid use disorder (OUD) remains a significant barrier to treatment and recovery.

Who is the target audience?

Targeting Pennsylvanians with stigma toward OUD, LUU uses statewide contact-based approaches, providing the public with educational stigma messaging and personal testimonials of individuals with lived experiences.

Is this based on established work, or does it draw from other existing work?

Research has demonstrated that effective stigma reduction efforts normalize substance use disorder diagnosis, treatment, and recovery. Successful education and contact-based strategies work to change critical influencers’ and institutions’ behaviors by educating the public about stigma and showing targeted success stories of people who have achieved recovery.

How does your project or initiative work?

Life Unites Us merges evidence-based digital strategies with a collective impact model that relies on community networks and individuals as a key component of the program. The campaign utilizes local voices to highlight how specific groups across Pennsylvania understand OUD and stigma. Importantly, this project employs rigorous evaluation methods to determine effectiveness. Community-based organizations across the state and an advisory board are engaged to support the campaign and provide connections to individuals who could provide testimonials; LUU in turn provides content that organizations can use to reach their own specific audiences. Diverse audiences are reached not only through these channels but also through various social media platforms. Social media engagement is accomplished through organic reach, paid advertising as well as the use of influencers with a personal connection to OUD. The campaign represents an updated approach to current strategies to reduce OUD stigma and holds promise for scaling and applying to other locations.

What are the results? If results are not yet available, what results do you hope to achieve?
The baseline and six-month surveys were conducted in June and July of 2020 and February and March 2021, respectively. Both surveys used a quota-based invitation system to produce a final dataset that is representative of Pennsylvania's population by region, and separately, by age/sex combined categories. Overall, the campaign has already produced exceptional results. 26.2% of a representative sample of Pennsylvanians (n = 1,034) recalled viewing the campaign over the past six months, equating to approximately 2.7 million adult Pennsylvanians over that period; 46.7% of those who viewed the campaign (n = 270) feel more prepared to talk with others about stigma against OUD, equating to approximately 1.2 million adult Pennsylvanians. Compared to those not exposed to the campaign (n=764), we found that more people exposed to the campaign (n=270) strongly agreed that people with OUD will, with effective treatment, get well and return to productive lives (35.8% vs. 26.7%); agreed that buprenorphine is an effective treatment for OUD (42.9% vs. 21.2%), and agreed that they would be willing to have a person with OUD as a neighbor (52.2% vs. 38.3%).

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Keywords
education, lived experience, policy and guidelines

Disclosure statement
Victoria Bosman from the Department of Drug and Alcohol Programs is on the Stigma of Addiction Summit Planning Committee and is involved in the Life Unites Us project and provided edits for the abstract. Shatterproof is a partner in the Life Unites Us project and did not have involvement in the abstract submission.

34. Measuring Arab American Public Stigma towards Substance Use

Authors
Cynthia Arfken, PhD; Mona Hijazi, MBA, MHA; Hala Mallah, LLMSW; Ahmad Ballout, AA

What is your project or initiative?
To develop a reliable and valid measure of public stigma to substance use for the Arab American community to guide and monitor as an outcome for interventions.

Why did you develop this?
Although substance abuse is a costly public health burden in all racial and ethnic groups, not much is known about it among Arab Americans (defined as individuals who self-identify as having roots in countries of the Middle East and North African where Arabic is spoken). From medical examiner, treatment admission, and arrests data, it is clear that substance abuse is present and growing among the local Arab American community. An overwhelming barrier to community activities to lower the burden of substance abuse among Arab Americans is stigma by the public towards people who use and misuse alcohol and drugs. Due to this stigma, people do not want to talk about substance use. Reluctance to speak about it by people in the community exists across different cultures but is very strong among Arab Americans.

Who is the target audience?
Arab American community.

Is this based on established work, or does it draw from other existing work?
Research has demonstrated that effective stigma reduction efforts normalize substance use disorder diagnosis, treatment, and recovery. Successful education and contact-based strategies work to change critical influencers' and institutions' behaviors by educating the public about stigma and showing targeted success stories of people who have achieved recovery.

How does your project or initiative work?
To address this barrier, our initial focus is to validate a reliable public stigma measure that can guide and monitor the impact of interventions. We are leveraging an ongoing federally-funded Arab American Substance Abuse Program Community Coalition by a social service agency and the experience of an academic researcher who has published on alcohol and drug use among Arab Americans. To date we have identified over 50 possible items for the scale using existing validated scales, had a panel of Arab Americans with expertise in behavioral health reduce the number of possible items to 19 based upon the utility and acceptance of the wording, and began interviewing people in the community. The interviews will address comprehension (do you understand the question) and if so, their response. None of the items identify personal or family use. The community group will be recruited to provide equal numbers by gender, religion, and nativity (i.e. born in the U.S. or an immigrant). From this we intend to develop a scale with high internal consistency across demographic groups. Then we intend to replicate the findings in an independent sample along with test-retest reliability. Finally, we intend to use the scale with parents at a local school to assess the need to tailor prevention activities.

What are the results? If results are not yet available, what results do you hope to achieve?
We are in the field interviewing community members. We hope to develop a useful scale that is reliable

and valid for measuring public stigma for the Arab American community to guide our prevention interventions and harm reduction activities.

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Keywords

awareness, young adults

35. Medication-Assisted Treatment of Substance Use Disorder at Brigham & Women's Primary Care

Authors

Brendan McKenna; Janna Levi, LICSW; Salah Alrakawi, MD

What is your project or initiative?

Providing increased screening for opioid and other substance use disorders (SUD) and medication-assisted treatment (MAT) in an integrated primary care setting.

Why did you develop this?

The goal is to eliminate the stigma of SUD by treating them like any other chronic condition. Increased screening will help identify more patients who are living with SUD and subsequently provide them with an opportunity to seek treatment. The trusting relationship patients build with their primary care physicians promote their comfort in accepting medical recommendations. Offering MAT in the primary care setting offers more alternatives for intervention and reduces the stigma associated with having to receive treatment from specialized services. Increased screening and reduced stigma will allow for more compassionate care as well as decreased mortality and morbidity from SUD.

Who is the target audience?

All primary care patients in the Brigham & Women's Hospital network. Population statistics would suggest that there are many undiagnosed cases of SUD that are not captured by current measures. Many patients likely fail to disclose or minimize their use due to the fear and stigma of seeking substance use treatment.

Is this based on established work, or does it draw from other existing work?

This program draws on established literature showing the significantly higher success rates of MAT over treatment with no medication or with placebos. It also draws on the improved medical outcomes shown with integrated primary care approaches in other chronic diseases and integrated behavioral health in primary care. Providing MAT at Brigham and Women's Primary Care is a new initiative, but it builds on the extensive SUD experience and programming within the hospital's network.

How does your project or initiative work?

Beginning with a pilot at four primary care sites connected to the Brigham & Women's Hospital network, the program has begun additional routine screening of patients for alcohol and SUD by administering the Audit-C and DAST-1 questionnaires at each annual visit. Patients who display increased risk of alcohol or substance use are educated on the options for care that include MAT, counseling, partial hospitalization, and treatment referrals, or other resources for intervention. As we work to ensure every primary care physician is waivered to administer buprenorphine prescriptions, providers are continuing to be educated about language to use to reduce the stigma of substance use treatment, the importance of frequent and routine screening, the benefits of offering MAT within a primary care setting, the protocols for managing withdrawal, and the processes for in-office and at home induction of MAT. Providers manage patients' substance use treatment along with social workers who provide emotional and behavioral support and nurses who help administer the medication. Medical assistants and support personnel are trained to administer initial screenings and flag positive results for provider follow-up. The entire primary care site is educated about the integrated model of substance use treatment and stigma reducing messages including person-first language and language that fosters self-efficacy and self-worth, the avoidance of jargon to promote clinically accurate terminology in the same way it is used for other medical conditions, and the power of connection, community, hope and change.

What are the results? If results are not yet available, what results do you hope to achieve?
The program has started at four pilot sites with a task force of physicians, nurses, pharmacists, support staff, and behavioral health experts to develop the appropriate treatment protocols and workflows. The task force is providing educational workshops for primary care clinics to ensure buy-in for the initiative among all staff at the sites. Since the beginning of the program, additional providers have been waivered to administer buprenorphine prescriptions and patients have been successfully screened, identified and started on medication-assisted treatment. Ultimately, integrating SUD treatment in primary care will reach an additional 150,000 patients with increased screening and identification of alcohol, marijuana, tobacco, opioid and other substance use disorders. Along with the increased screening will come additional treatment options that will reduce the potential barriers to treatment, including allowing patients to detox at home and receive prescriptions at their primary care office.

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Keywords
mental health, person-centered language, training, womens health, workforce

36. Multiply Stigmatized: The Intersection of Disability, Addiction and Other Identities

Authors
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What is your project or initiative?
INROADS – Intersecting Research on Opioid Addiction and Disability Services – is a NIDILRR-funded project that uses mixed methods to examine opioid addiction and treatment among people with disabilities, peer support at this intersection, and qualitative work with people with lived experience of both disability and opioid use disorders.

Why did you develop this?
People with disabilities are often overlooked when considering other conditions, and evidence about substance use disorders (SUD) and treatment in this population is still nascent. Stigma plays a large role for both disability and addiction. It further plays a role in many resulting conditions for both disability and addiction (e.g., unstable housing, mental disorders, poverty) and with other identities (e.g. race/ethnicity, LGBT+). These overlapping circles of stigma become additive and can have deep impact on the people themselves and on their ability to access services.

Who is the target audience?
Treatment and social service providers and policymakers are the most likely audience, but also peers and people with disabilities and/or opioid use disorders.

Is this based on established work, or does it draw from other existing work?
This work stems from our broader project including interviews with people with lived experience, and draws upon the extant literature about stigma, critical disability theory, addiction recovery, and intersectionality. Critical disability theory is an essential framework to understand the complex relationship of disability with other identities. People with both disability and addiction are likely to face unique barriers and stigma.

How does your project or initiative work?
The conceptual approach came from literature reviews, research team and advisory board input, and feedback as we have presented on this project. We conducted interviews and focus groups with people self-identified with a disability and problems stemming from opioid use. We engaged with experts in peer supports at the intersection of disability and SUD and with people living with disability who are contributing to our knowledge translation efforts.

What are the results? If results are not yet available, what results do you hope to achieve?
Addiction treatment is often not fully accessible for people with disabilities (PWD) despite the Americans with Disabilities Act (ADA). The literature also demonstrates that PWD experience stigma and stereotypes that complicate SUD treatment quality and access. Examples of these stigmatizing experiences are, “too difficult” to serve, not able to “comply” with treatment or maintain recovery, or deserving of pity rather than support. Our qualitative work highlights numerous challenges. Some are systemic such as the need for specialized programs for people with multiple and often-complex conditions, disability-specific accommodations, transportation, and affordable quality care. Stigma about disability in the context of SUD treatment included concerns about inconveniencing people,

being a burden, not wanting to ask for help or bring personal care attendants to sessions, feeling too much shame to seek help, or being seen as less of a person. Respondents from other marginalized groups expressed further challenges that racism and health inequities bring to treatment and recovery. Treatment-specific challenges included the need for trauma-informed care since PWD have higher rates of trauma, making use of technologies, or considering disability- friendly alternatives when discussing relapse prevention strategies. We also heard suggestions for how to reduce this intersectional stigma. Sharing stories about recovery is an anti-stigma approach for people with addiction, and can be extended to disability populations in recovery. It can reduce shame and increase help-seeking among people currently in need and highlights the benefits of peer support. Education in the disability community about addiction as a chronic disease, support for addiction medications and other SUD care, and open discussion of relapse and recovery would also reduce stigma. Efforts are underway by some practitioners and researchers to improve SUD treatment for PWD including mental illness and traumatic brain injury. This may include adjustments to traditional modes of treatment, alternative treatments, accommodations, and training for clinicians. With this work, we have begun to delve into the challenges stemming from stigma and structural barriers to SUD treatment for people with both disability and addiction. With the critical disability theory lens, and ongoing efforts beyond this project to reduce stigma around addiction, we are moving forward in the holistic support of people with disabilities in their addiction recovery journeys.

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Keywords

lived experience, trauma-informed

37. Online Course “Stigma and Mental Health: Challenges to Building Quality Care,” an Innovative Practice from Mexico

Authors
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What is your project or initiative?
Implementation of the online course “Stigma and Mental Health. Challenges to building quality care” in Mexico.

Why did you develop this?
The stigma and discrimination of people with substance use disorders (SUD) and other mental health problems (MHP) produce social inequities that hinder timely care. Research in Mexico shows that healthcare personnel are among the leading groups that stigmatize people diagnosed with a severe mental disorder or SUD, second to only the family members of affected individuals. Previous projects focus on the stigma produced by family members; hence there was a need to implement a strategy to address the stigma of health professionals towards people with mental health problems and SUD.

Who is the target audience?
The target audience is healthcare professionals who provide clinical and social services to individuals affected by MHP and SUD.

Is this based on established work, or does it draw from other existing work?
This project stems from the line of research on stigma and mental health, developed by Jazmin Mora-Rios in Mexico’s National Institute of Psychiatry.

How does your project or initiative work?
Mexico’s National Institute of Psychiatry manages this project through an e-learning platform. The online course consists of five modules, built from the research outcome on the experience of people with MHP and SUD, family members, healthcare personnel, and the general population. The course encourages nationwide healthcare professionals to apply various strategies to foster interpersonal contact with people affected by mental health problems and SUD.

What are the results? If results are not yet available, what results do you hope to achieve?
Mexico’s National Institute of Psychiatry delivered this free course from July 20 to October 20, 2018. A total of 166 healthcare professionals between 21 and 61 years of age participated, the average age being 31 years (SD=9.75). Most of the participants (72%) were women from different professions (psychology, social work, medicine, and nursing). Four specialized graduate-level tutors supported the students’ learning process. Three questionnaires were applied (pre and post-test), including the version adapted to Mexico of the Opinion Questionnaire towards Mental Illness (OMI) and qualitative indicators to evaluate the course’s effect on the participants’ attitudes. The course had an adequate terminal efficiency (65%) and high acceptance by graduates. Lack of time caused most dropouts. The Cohen’s D statistical analysis found significant differences in some attitudes measured with the OMI questionnaire after taking the course. In another mixed-method assessment that incorporated qualitative indicators, the participants mainly reported the following changes after taking the course:

1. Greater willingness to help,
2. Acknowledge their stigmatizing attitudes, and

3. Identify actions to deal with them.

Additionally, participants reinforced positive attitudes. These findings provide preliminary evidence of the positive impact of the online course in reducing stigmatizing attitudes of healthcare personnel. However, it is necessary to incorporate follow-up studies at three, six, and twelve months, establishing control groups to provide evidence on the course's long-term effectiveness.

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Keywords

education, mental health, training

38. Operation Lighthouse: Bringing the Challenges and Stigma Associated with Substance Use Disorder to Light for Startup Companies and Their Employees

Authors

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What is your project or initiative?

In collaboration with venture capital firm QED Investors and Shatterproof (SP), Operation Lighthouse (OL) provided 3 startup companies in QED's portfolio SP's "Just Five" program, a series of six brief videos about prevention, recognition and management of substance use disorder (SUD) along with supplemental content tailored to each lesson to further engage those working in startup companies. Access to additional resources on the OL website, including a link to SP's self-assessment tool and information regarding evidence-based treatment was provided.

Why did you develop this?

In 2018 we lost Greg Mazanec after a long battle with SUD. Greg was a son, brother, father, friend, and colleague who loved guiding startups through unexpected challenges. OL was created in his memory to provide startup leaders and employees with a pathway to personal and corporate health by providing SUD education and catalyzing informed discussion to reduce stigma. Entrepreneurs and those who work in small startups represent a high risk group for SUD and mental health disorders. SUD are most prevalent in people under 30 years of age, matching the demographic of more than 50% of startup employees. 15% of persons under 25 have a SUD and another 10% an alcohol use disorder, twice the risk of persons over 30. Startup founders are 10 times more likely to have a bipolar disorder. Risk in the startup environment is compounded by stressors such as long, irregular work hours. The very success of the business may be affected if a key employee is struggling with a SUD. Unfortunately, startups often lack the resources to assist employees seeking help. Further, stigma remains a significant barrier to addressing SUD affecting startups.

Who is the target audience?

Entrepreneurs, employees and investors in venture-backed startups.

Is this based on established work, or does it draw from other existing work?

SP developed, in collaboration with experts, educational videos as well as a self-assessment tool (Addiction Treatment Needs Assessment ATNA) and guide to treatment (Addiction Treatment Locator Assessment and Standards platform ATLAS). These have been adopted by several larger national employers. We sought to reach a distinctly different target audience - the smaller startup business.

How does your project or initiative work?

Over the course of three months, OL and QED systematically rolled out educational and informational content to the three startups participating in the pilot study and to QED's own team. The program was easily accessible online at no cost to the company. SP's Just Five videos, which served as the outline and anchor of the informational content, were supplemented with links to videos, articles, quizzes, and blogs surrounding issues of SUD and other timely topics such as the effect of COVID-19 and stress of the holidays. The program was self-paced, anonymous, and voluntary. SP tracked participation and duration of engagement with the videos and pilot program landing page using anonymous analytics. At the conclusion of the program, QED administered SP's Just Five feedback survey and a supplemental impact survey developed by QED and OL. The objective of the pilot was to determine if this educational initiative was accessible, engaging and valuable to the participating startups and to assess the scalability to a larger group of QED portfolio companies and other venture capital firms.

What are the results? If results are not yet available, what results do you hope to achieve?
35 participants from the four companies responded to the feedback surveys; 18 (51%) viewed 4 or more videos. 25 (71%) agreed/strongly agreed the program made discussion of SUD easier. 18 (51%) agreed/strongly agreed the company's culture became more open to mental health discussions. 25 (71%) were very/extremely likely to recommend the program to a colleague. Anecdotal comments were notable for surprise at the extent of the problem and impact of stigma. Respondents felt more likely to seek help if needed.

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Keywords
awareness, education, mental health, person-centered language, workforce

Disclosure statement
Shatterproof is the creator of the Just Five educational module used by the Operation Lighthouse project and did not have involvement in the abstract submission or the project itself other than the initial technical support provided at launch.

39. Opioids and our Community. Stop the Stigma. Save a Life. Collaboration to Educate University Campus Students to Identify and Intervene for an Opioid Overdose

Authors

Kimberly Dion, PhD, RN, CNE, CARN; Cherry Sullivan, MPH; Ann Becker, DNP, RN

What is your project or initiative?

A training aimed at the university student to decrease stigma against those with a substance use disorder (SUD), incorporation of harm reduction strategies, and to educate about prevention, recognition, and treatment for opioid overdose.

Why did you develop this?

Young adults between the ages of 18-25 are at an increased risk for opioid misuse. Stigma and misunderstanding campus policies have been shown to be barriers to disclosure of substance use and SUD. There have been national media results of students dying as a result of substance use in campus. Through formal and informal conversations with students at our university, we found that students had many concerns regarding their friends and family member's drug use. Shared stories included students not calling 911 due to fear of repercussions from parents, peers, and the university. Members of our inter collaborative team also learned that there was confusion regarding the university campus policies for reporting an overdose and the consequences of this action as a result of residential directors and assistants interpretation of the campus substance use policy.

Who is the target audience?

Targeted groups included residential assistants, general student body, sorority and fraternity leaders.

Is this based on established work, or does it draw from other existing work?

This project drew from existing work but was a multidisciplinary collaboration between university health nurses, state police officers, and community partners.

How does your project or initiative work?

Trainings were held during residential assistant orientation, for fraternities and sororities, and across campus for general students. A one-hour training was developed that consisted of the physiology of addiction, the impact of stigma, recovery-focused language, how to recognize and intervene for an opioid overdose, harm reduction strategies, and campus and community resources. In addition, students were educated about fentanyl contamination of commonly used drugs such as counterfeit pressed pills, cocaine, MDMA, and ecstasy. Students were provided with intranasal naloxone, resources, and refrigerator magnets that outlined how to recognize and intervene for an opioid overdose. Incorporation of myth busting by campus police, health care providers, and residential administration were incorporated into the training with a focus on putting the safety of their peers first. Resources were put together and distributed at the trainings in addition to a number of campus websites.

What are the results? If results are not yet available, what results do you hope to achieve?

Over 400 students have received the training. Students reported an appreciation and need for the information but voiced concern regarding a campus medical amnesty policy that appeared to be in conflict with information provided in their orientation and undergraduate handbook. Presenters worked with administration to revise the medical amnesty policy to revise language that was being misinterpreted by students. Additionally, the campus undergraduate handbook was examined and suggested language was provided to administration to align with a harm reduction approach that did not increase perceived stigma. In addition, union policies interfered with residential assistant students being able to carry and use intranasal naloxone. Student involvement throughout the training encouraged information exchange that led to misperceptions of campus policies that served as barriers to students accessing campus resources or emergency services. There was an increase in the number of students requesting the presentation for their dormitory floor, sorority or fraternity. It was also determined that focus groups should be held in advance with key stakeholder students to understand barriers and facilitators to implementing the presentation strategies. Acting as a liaison between students and residential directors and administration was critical to allow for open communication and understanding.

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Keywords

awareness, education, harm reduction, young adults

40. “Original Body of Pain” Documentary Film of Mothers with Substance Use Disorder

Authors
Stan Wright; Dominic Silva

What is your project or initiative?
The project was the creation of a documentary film that captured a three year ethnography of two mothers experiencing substance use disorder (SUD) during pregnancy and parenthood. Original Body of Pain captures the intense and often generational nature of adduction through portraits of two women in recovery. As their stories unfold the mothers navigate recovery, care for their infant’s substance withdrawal, raise their children, redefine their goals in life, family relationships, experience recurrence of use, and even face incarceration. The film demonstrates the testing of their resolve to seek recovery. The film also features a program with a home health nurse visiting mothers and families affected by SUD and assists in their care of themselves and their infant.

Why did you develop this?
Stigma and judgement surround the social and healthcare environment for women, particularly mothers with SUD. The purpose of the documentary was to bring the stories to life of women navigating their recovery journey while being mothers of small children. The documentary title came from the expression of one of the women of her prior traumas in life that contributed to her use. She states you have an original body of pain from which you never recovered. The focus on the multiple dimensions of the mother with SUD that includes prior trauma, stigma, and the challenges of recovery are depicted as the women share their stories.

Who is the target audience?
Anyone interested in learning more about SUD with a special focus on mothers and developing families is the target audience for the documentary film. The creators and associate producer of the film want to make the documentary available to healthcare professionals to use as another way to present the challenges and successes of mothers with SUD to promote the creation of a more caring environment. The film has been shown at national nursing professional organizations, film festivals, and community presentations regarding substance exposure and now we would like to share it with this forum to invite further sharing of this valuable presentation.

Is this based on established work, or does it draw from other existing work?
The documentary is an original creation, inspired by the associate producer, a nurse practitioner and nurse researcher who wanted to have more information go to healthcare providers and the public regarding mothers with SUD in an attempt to decrease stigma and poor treatment for these women and their families. The filmmakers were graduate documentary film students when they started to create the film and have gone on in their profession as documentary filmmakers. The filmmakers spent three years filming the two women, the healthcare surrounding them the women’s families and their recovery to longitudinally show the changes through pregnancy into motherhood.

How does your project or initiative work?
The documentary film is complete and available by request for other healthcare professionals to use for education or sharing to make changes in systems to support mothers with addiction. The use of the film is free for those purposes with the only stipulation that it cannot be sold by the person showing the film or money charged to view the film.

What are the results? If results are not yet available, what results do you hope to achieve?
In a recent study of over 300 participants viewing the film in a pre- and post-survey design, there were significant differences ($p<0.05$) in knowledge, attitudes and beliefs regarding SUD in pregnancy. Manuscript preparation is underway for publication in a peer-reviewed journal.

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Keywords
awareness, lived experience, womens health

41. Overcoming Stigma: Practical Strategies and Approaches to Form Effective Community Partnerships

Authors
Sy Demsky; Andrew Rosenblum, PhD

What is your project or initiative?
The project utilizes practical strategies and approaches to form effective community partnerships. Specifically, our project is a multilevel continuous community intervention that addresses the deep social and structural elements that stigma directs against people with opioid use disorder (OUD), especially those who are receiving (or could benefit from) medications for opioid use disorder (MOUD).

Why did you develop this?
The project was developed to further the mission of Stop Stigma Now (SSN), to change prevailing stigmatizing attitudes towards people suffering from OUD. SSN is a 501(c)(3) founded in 2007 by a group of professionals with many years of experience in the field of substance abuse and opioid treatment who have been working to end the stigma that has hampered medication-assisted treatment (MAT) and MOUD for opioid addiction for much too long. SSN includes a board of directors' with an average of more than 30 years' experience addressing stigma in communities where they directed and worked with opioid treatment programs (OTPs), Despite the escalating opioid addiction crisis in the U.S., most persons with OUD are not in treatment and, among those who are, most are not exposed to the modality with the strongest evidence-base: MOUD (especially the agonist medications buprenorphine and methadone). Stigma against people with OUD imposes a barrier to enrolling in and remaining in MOUD. Stigma is a complex social phenomenon based on a relationship between an attribute and a stereotype that assigns undesirable labels, qualities, and behaviors to a person with that attribute. Labeled individuals are then socially devalued, which leads to inequality and discrimination (National Academies of Sciences, Engineering, and Medicine, 2016). In the case of stigma against MOUD, patients (and their providers and families) have to deal with the dual stigmas of a person who uses opioids and a person treated with agonist medications.

Who is the target audience?
Counselors, social workers, physicians/nurses, clinicians/pharmacists, treatment program administrators, public officials.

Is this based on established work, or does it draw from other existing work?
Our activities are based on consensus practices and original work developed by members of SSN.

How does your project or initiative work?
SSN's activities include community organizing, transparency practices, education, and sustainable and ongoing relationship building to address public, structural, and social stigmas of OUD and the use of MOUD and (as needed) other services such as medical care, counseling and other psychosocial interventions.

What are the results? If results are not yet available, what results do you hope to achieve?
Over the many years that SSN members have been addressing stigma (both in their professional roles and as SSN member) we have conducted effective community outreach that involved developing relationships with a wide spectrum of stakeholders including business owners, neighborhood advocacy groups, schools, law enforcement, real estate, public and private schools, public health and safety

agencies and elected officials. Results from this community outreach have included public/private partnerships, engagement of key players in host communities, dissemination of education materials, which have been used to establish sustainable long-term working relationships with community representatives, methods to develop transparency practices that have helped communities understand how OTPs function and how MOUD is used to stabilize people with OUD in community settings. Results also include a quarterly electronic newsletter that is distributed to more than 3,000 people on our mailing list, a radio program (Steppin' Out Radio), a speakers bureau (where SSN members speak to various organizations about how MOUD works and address concerns that participants might have), and a research department that has conducted an investigation in how the COVID-19 pandemic spurred changes in MOUD distribution and telehealth and how these changes have impacted OTPs and their patients (and might inadvertently reduce stigma experienced by MOUD patients).

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Keywords

awareness, medications for opioid use disorder

42. Peer Story Telling to Shift Perceptions in Overdose Response Professionals

Authors
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What is your project or initiative?
Our initiative creates a lens through the power of storytelling into the world of active addiction. Jennifer Wolfe, CPS, is a Peer Support Specialist who struggled with addiction for numerous years. She uses her story to increase understanding about the toll of addiction and how it becomes completely life-changing.

Why did you develop this?
We developed this presentation after having many discussions with local first responders around their needs in overdose response. In Kansas City, numerous evidence-based practices are being rolled out (take home naloxone, connection to peer support specialists, etc.) but many are not being utilized because of the stigma held by the first responder work force. A common piece of feedback we received was that it was challenging to continue to have empathy for people who overdose, when there is no way to know if they are successfully connected to treatment, especially when they are overdosing again and again. This presentation is meant to assist in creating a feedback loop, to show that even from the lowest points in addiction, recovery is possible.

Who is the target audience?
This presentation was developed for first responders but has been expanded for any professional who works in the addiction workforce.

Is this based on established work, or does it draw from other existing work?
This presentation was created from requests of local first responder stakeholders and drew from the work of the DOTS Project out of the Missouri Institute of Mental Health, and the Take ACTION Naloxone Training Program from the University of Michigan.

How does your project or initiative work?
By the time of the summit, we will have presented this material to at least one (possibly two) first responder agencies, one national webinar, and two medical professional organizations. It is an hour-long presentation that presents Jennifer's story of addiction, with pauses throughout to discuss how addiction is a chronic relapsing brain disease, stigma in the workforce, and Evidence Based Practices (EBPs) in overdose response. The presentation is evaluated by a pre- and post-test.

What are the results? If results are not yet available, what results do you hope to achieve?
The results are not yet available, but our short term goals are to shift initial attitudes towards people who use drugs to be less stigmatized, and our long term goals are to see an increase in first responders connections to EBPs and an increase in local treatment referrals and intakes.

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Keywords
awareness, lived experience, storytelling

43. Project Empower: Engaging Medicine Providers on Ways to Enhance Recovery

Authors

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What is your project or initiative?

Project EMPOWER (Engaging Medicine Providers on Ways to Enhance Recovery) is a collaborative effort funded by SAMHSA, including Clemson University School of Nursing, University of South Carolina Medical School Greenville, Prisma Health Addiction Research Center and the FAVOR Greenville Recovery Center to provide education on opioid use disorder (OUD) for nurse practitioner and medical students. The purpose of the project is to educate students about substance use disorders (SUD)/OUD, culminating in obtaining the DATA waiver to prescribe medications for opioid use disorder (MOUD) upon completion of the program and graduation. A major innovative feature of this educational program is the enhanced case discussions that are part of the waiver training. After completing all of the PCSS DATA waiver modules, we began case discussions in both a large and small group format. Each small group of 10 included both nurse practitioner and medical students, a peer recovery coach and a MOUD provider. The peer recovery coaches provided the patient experience and enhanced the discussion around the stigma and the barriers they have encountered in the health care system as they have sought treatment and recovery. The MOUD provider guided the discussion and brought in a variety of perspectives. Discussion points were intermittently brought to the large group.

Why did you develop this?

The American Society of Addiction Medicine (ASAM), the American Association of College of Nursing (AACN), and the American Association of Medical Colleges (AAMC) have identified a need for increased education on SUD. Adding in the patient experience and working in interprofessional teams were components that we believed would enhance the education and help to reduce stigma toward persons with OUD.

Who is the target audience?

The target audience is nurse practitioner and medical students participating in our Project EMPOWER training.

Is this based on established work, or does it draw from other existing work?

The educational program offered is through the PCSS MAT national waiver training is supported by the SAMHSA training that is used for certification for clinicians to receive a waiver to prescribe MOUD. We expanded upon this training by enhancing case discussion by creating groups of 10 students (NP and MD students together) with a peer recovery coach and MOUD provider. This allowed for true interprofessional conversation. The outcome measure of the Substance Use Disorder Knowledge, Attitudes and Beliefs Survey was original to the project and based on modification of prior tools, plus original content. The Cronbach alpha of the survey in the study was pre-training coefficients ranged from .764 to .974 and post-training coefficients ranged from .843 to .988.

How does your project or initiative work?

Nurse practitioner students and medical students were and are required to participate in the educational program as part of their academic programming. The students participated in a pre-program and post-program survey and a sample of the participants also participated in focus groups regarding the experience of the educational program on SUD/OUD.

What are the results? If results are not yet available, what results do you hope to achieve?
The presented research on the first iteration of the PCSS training demonstrated significant positive changes ($p<.05$) in 33 out of 44 items for the nurse practitioner students and 24 out of 44 items for the medical students on the Substance Use Disorder, Knowledge, Attitudes and Beliefs Survey. For the new and enhanced experience, preliminary analysis of the qualitative data indicates the peer recovery coaches and MOUD providers as an active part of the training provided value to the training. One student stated, “Excellent! So important to include their voice. I was very impressed with their willingness to speak up and also really appreciated how the providers asked their opinions. A true team-based approach.” Further analysis of the outcomes are currently underway. A quote from a medical student summarizes the themes of the sentiments expressed in the focus groups “I learned that this is why I went into medicine; treating this population is the closest you get to humanity”.

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Keywords
education, lived experience, medications for opioid use disorder

44. Recovery Ally Training: Building Self-Efficacy in Campus Communities to Support Students in Recovery and Students with Substance Use Disorder

Authors
Sierra Castedo de Martell, MPH; Ananya Roy, BA, BSA; Tiffany Cunningham, BA; Larkin Cummings, MEd

What is your project or initiative?
The Recovery Ally Training at the University of Texas at Austin's Center for Students in Recovery.

Why did you develop this?
To lower stigma toward students with substance use disorders (SUD) and to empower allies to support and advocate for students with SUD.

Who is the target audience?
Students, staff, and faculty at the University of Texas at Austin.

Is this based on established work, or does it draw from other existing work?
This is not the first Recovery Ally Training created, so it builds off of existing recovery ally training programs at other collegiate recovery programs, as well as building on the work of other types of campus ally programs, including the excellent work of LGBTQ+ Ally Programs.

How does your project or initiative work?
Participants attend either a full 2-hour training or a 1-hour in-class training. Full trainings include a knowledge component with guided practice and role playing exercises. The in-class trainings are primarily knowledge-based. The training targets the common misperceptions about substance use disorder that underlie stigma, increase self-efficacy to support students with SUD, and raise awareness about the underserved population of students in recovery on campus.

What are the results? If results are not yet available, what results do you hope to achieve?
Recovery ally trainings lead to significant increases in perceived self-efficacy (0.47, $p = 0.000$). While SUD misperceptions related to stigma did not change, this may be due to selection bias, where trainees already low in stigma toward SUD self-select as participants.

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Keywords
education, young adults

45. Reducing Opioid Use Disorder-Related Stigma among Pharmacy Students Using Contact-Based Education

Authors

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What is your project or initiative?

The University of Houston College of Pharmacy (UHCOP), in collaboration with the University of Texas Health Science Center at Houston School of Biomedical Informatics will implement a contact-based educational intervention addressing stigma against patients with opioid use disorder (OUD). This intervention will feature a speaker who is in long term recovery from OUD. The intervention consists of a single session, one-hour long interactive lecture that will cover different topics both from lived experience with addiction, and from the perspective of a peer recovery support specialist or recovery coach. Prospective data collected from students will be used to assess and evaluate the effectiveness of the intervention in reducing OUD related stigma among pharmacy students. Such data includes: demographics including age, race, gender, and pre and post test data from a modified version of Brief Opioid Stigma Scale (Yang et al., 2019).

Why did you develop this?

This project was developed to reduce stigma among future pharmacists through contact-based education. Pharmacists are in a ubiquitous and unique position to facilitate access to short-term and long-term treatment as well as to screen for prescription opioid dependence. While previous studies have focused on barriers to access of medical management for OUD among physician and nurse-based practices, few interventions have addressed barriers to access in pharmacy settings. Stigma held by pharmacists against those on medical management for OUD can limit access to medication assisted treatment, such as methadone and buprenorphine-naloxone. Studies have shown that community pharmacists do not feel adequately prepared to address issues related to substance misuse due to a reported lack of education on this topic during professional training. While previous interventions addressing stigma among healthcare students have been studied, there is limited research on contact-based education using a facilitator who is in long term recovery from OUD.

Who is the target audience?

The target audience for this intervention is third year pharmacy students enrolled in the Psychiatry Integrated Course during the Spring semester of 2021 at the University of Houston College of Pharmacy. Beyond the direct intervention with pharmacy students, other health system stakeholders will benefit from the data and outcomes.

Is this based on established work, or does it draw from other existing work?

Previous literature has examined the efficacy of didactic instruction combined with interactive presentations from individuals in recovery from OUD. The results of these studies have shown that this combined approach can be effective in changing stigmatizing beliefs. However, the outcomes do not specifically focus on measures of stigma or are not generalizable to a broad range of healthcare professionals.

How does your project or initiative work?

Our intervention consists of a single, one-hour long lecture that will cover different topics both from lived experience and from the perspective of a recovery coach. The intervention took place in April 2021 with 125 students. The recovery coach covered topics relating to how individuals start to use drugs, barriers to accessing healthcare, challenges to accessing treatment, facing stigma on a personal basis, recovery and success stories, and challenges of long-term recovery. Students completed an anonymous online pre-survey and post-survey that included measures of demographic data and a modified version of the Brief Opioid Stigma Scale.

What are the results? If results are not yet available, what results do you hope to achieve?
Both quantitative and qualitative results from this intervention are in the process of being analyzed. We hope to observe that the intervention succeeds in decreasing opioid use related stigma as measured by the Brief Opioid Stigma Scale. Our aim is that this method of delivery of OUD and stigma education by an instructor in long-term recovery is an effective tool to decrease stigma among pharmacy students. We hope that this intervention can be replicated on a larger scale in other pharmacy schools, as well as other healthcare education settings.

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Keywords

education, lived experience, pharmacy, storytelling

46. Reducing Stigma of Individuals with Opioid Use Disorders Through Art in Rural Appalachia

Authors

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What is your project or initiative?

University of Rochester Medicine Recovery Center of Excellence's (RCOE) stigma campaign applies the practices of education and contact through a combination of art and workshops in rural Appalachian communities. The art and workshops were developed to provide an innovative way to capture the lived experiences of individuals with opioid use disorder (OUD) to inform providers and other community members about the impact of stigma and OUD, that recovery is possible and there are effective treatments available.

Why did you develop this?

Stigma about individuals with OUD is a critical barrier to accessing evidence-based OUD treatments. Negative beliefs about individuals with OUD and about the effectiveness of treatments often lead to suboptimal care. If individuals with OUD are treated poorly because they are stigmatized, it impacts how a person with OUD experiences treatment and reduces the likelihood a person will return. Stigma is associated with poorer mental and physical health, and increased involvement in risky behaviors. People with OUD who are stigmatized will often isolate from others, which also leads to further opioid use.

Who is the target audience?

The target audience is for rural community members, and healthcare providers and systems.

Is this based on established work, or does it draw from other existing work?

Education and contact to people with OUD appear to have the strongest evidence of reducing provider stigma. This project combines these approaches to reducing stigma and does so through a captivating vehicle that has the potential for a longer-term impact. Reducing stigma through art has been utilized for other stigmatized populations including those with HIV and those with mental health challenges. We are seeking to expand its utility to reduce stigma among individuals in rural communities with OUD.

How does your project or initiative work?

We are developing a training program centered around artwork depicting the lived experience of individuals with OUD. The program uses watercolor portraits of the individual with their own words on their experiences with stigma and successes during recovery through evidence-based treatments for OUD surrounding their image. This artwork will be disseminated throughout areas of communities and healthcare systems and will be paired with workshops to elicit discussion of and reflections on the artwork to digest the materials. This approach marries education and contact—evidence-based approaches of reducing stigma.

What are the results? If results are not yet available, what results do you hope to achieve?

This project is currently being implemented and results are not yet available. We hope that this project raises awareness about stigma, lived experience of people with OUD, that successful recovery is possible, particularly through evidence-based approaches for OUD. We hope that this awareness changes stigmatizing beliefs, promotes an accepting culture, and improves provider care behaviors that help ensure that individuals with OUD receive compassionate care and have access to evidence-based treatments for OUD (e.g., referral to treatment, distribution of naloxone, initiation of evidence-based medications for OUD).

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Keywords

awareness, lived experience, storytelling

47. Reducing the Stigmatizing Beliefs and Behaviors of Inpatient Nurses Towards Patients with Substance Use Disorders: The Design of a Blended Learning Program

Authors

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What is your project or initiative?

A blended learning program for inpatient nurses, intended to reduce stigmatizing beliefs and behaviors towards patients with substance use disorders (SUD).

Why did you develop this?

At an urban hospital in Kentucky, 22% of patients admitted for conditions related to substance misuse had left the hospital against medical advice (AMA). In addition, this population had a high rate of dissatisfaction with the care provided by inpatient nursing staff. We identified the need to reduce the stigmatizing beliefs and behaviors of inpatient nurses towards their patients with substance use disorders. This blended learning program was developed in response.

Who is the target audience?

Inpatient nurses and healthcare administrators are the target audience.

Is this based on established work, or does it draw from other existing work?

It draws from other existing work.

How does your project or initiative work?

The blended learning program consists of a series of vodcasts with supplemental materials and knowledge assessments, covering topics such as the principles of harm reduction, understanding the harmful effects of stigma on patients, safer injection education, behavior change principles, and improving communication between the patient and inpatient nurse. In phase two of the study, inpatient nurses will take part in a series of lunch and learns led by a harm reduction specialist, providing them the opportunity to ask questions about what they learned in the vodcasts and discuss in more detail these topics with other nurses. In phase three, we will disseminate a similar blended learning program to a wider audience of healthcare providers that is customizable across a variety of settings, such as federally qualified health centers and hospital emergency departments

What are the results? If results are not yet available, what results do you hope to achieve?

In the short term, we hope to reduce inpatient nurses' stigmatizing beliefs and behaviors towards their patients with SUD. In the long-term, we hope to increase patients with SUD's satisfaction with healthcare services and reduce the percentage of these patients leaving care AMA.

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Keywords

education, harm reduction

48. Refinement of a Provider-level Substance Use Stigma Reduction Intervention

Authors

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What is your project or initiative?

We have developed and aim to refine a provider-level intervention targeting barriers to care for individuals with substance use disorders (SUDs), specifically provider-level substance use stigma. The intervention leverages an innovative combination of carefully selected evidence-based strategies including:

1. empirically supported stigma-focused strategies such as didactics and social contact,
2. evidence- based acceptance and compassion-focused techniques to decrease the impact of stigmatizing beliefs and increase compassionate, flexible behavior in providers (from Acceptance and Commitment Therapy, Mindful Self-Compassion, and Dialectical Behavior Therapy), and
3. recent advances in affective science to improve provider awareness of and attunement to patients experience of substance use stigma.

We are planning to refine this intervention to be delivered virtually based on stakeholder feedback, and then pilot the refined virtual version to assess feasibility and acceptability and subsequently effectiveness.

Why did you develop this?

People with SUD underutilize primary and psychiatric care and are disproportionately high utilizers of costly emergent and inpatient hospitalizations. Additionally, substance use stigma, or the negative and devaluing beliefs about individuals with SUD, is thought to be ubiquitous in the U.S., including among healthcare providers. A systematic review indicates that primary care and psychiatry providers have generally negative views about people with SUD and are reluctant to work them, resulting in suboptimal healthcare. Consistently, people with SUD report anticipated and enacted substance use stigma from providers as reasons for not attending primary care and mental health appointments. Given the high prevalence of health and psychiatric comorbidities among people with SUD, substance use stigma is a substantial and costly barrier to meeting the needs of people living with SUD. Decreasing substance use stigma among primary care and psychiatry providers may ultimately increase utilization of primary care and psychiatric services and decrease emergent and inpatient hospitalizations among people with SUD.

Who is the target audience?

Healthcare providers, administrative staff, hospitals and clinics who care for individuals with SUD.

Is this based on established work, or does it draw from other existing work?

Several didactic and contact-based didactic strategies have been documented in the literature, including mental illness and HIV stigma reduction provider interventions, resulting in moderate improvements on stigma-related knowledge, attitudes, and intended behavior. However, there is limited evidence for behavioral changes or lasting impact of these short-term didactic and contact-based interventions. This project builds on our previous intervention development work that leverages evidence-based content to create a virtual platform to facilitate provider engagement. We hypothesize that refining our existing intervention for a virtual platform will facilitate providers to not only utilize the intervention but also improve their treatment of patients with SUD and improve engagement in medical and psychiatric care among people with SUD.

How does your project or initiative work?
Through interactive didactics, experiential exercises, and skills practice, the refined version of our novel intervention will influence change by:

1. enhancing providers' empathy and compassion for patients with SUD,
2. increasing non-stigmatizing provider behaviors (e.g. use of non-stigmatizing language in documentation), and
3. training providers to more compassionately identify and respond to verbal and non- verbal communications of perceived stigma and related emotions (e.g., shame and guilt).

What are the results? If results are not yet available, what results do you hope to achieve?
Given the ubiquity of substance use stigma, the prevalence of SUD among patients living with comorbid health challenges, and the dearth of evidence-based behaviorally influential stigma reduction provider level interventions, we foresee wide public health implications for the refined virtual version of our intervention. In addition to changing providers' behaviors in caring for individuals with SUD, this intervention may lead to reductions in patients' anticipated substance use stigma, potentially increasing engagement in primary and psychiatric care and decreasing costly emergent and inpatient care.

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Keywords
education

49. REMIND: Recognizing and Engaging Mental Health in Indigent Defense

Authors
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What is your project or initiative?
REMIND: Recognizing and Engaging Mental Health in Indigent Defense

Why did you develop this?
REMIND seeks to improve the experience and outcomes of indigent persons with substance use and mental disorders who are involved with the criminal justice system by training defense attorneys to overcome stigma to better communicate with and advocate for them. In the U.S., over 70% of women and 55% of men in prisons and jails have at least one mental health or substance use problem. Those experiencing substance use and mental health issues face misunderstanding, mistreatment, and worse outcomes than their counterparts in the criminal justice system. Prisoners with substance use and mental disorders are less likely to receive proper medical treatment, more likely to be victimized while incarcerated, and more likely to reoffend. But strong advocacy at every stage of the criminal defense process can reduce exposure to these threats, and trusting client-attorney relationships produce the highest quality representation. We developed the initiative as a (now-completed, 18-month) 2018 Open Society Institute-Baltimore Community Fellowship project awarded to Jennay Ghowrwal. REMIND developed in close consultation with the Maryland Office of the Public Defender, with a particular focus on attorneys practicing in Baltimore City. However, we have drawn input and direction from a variety of resources based throughout the country, and intend to extend REMIND as a resource for indigent defense agencies across the U.S. Because of COVID-19, REMIND has not yet fully rolled out in Maryland, and we plan to resume its activities by the fall of 2021.

Who is the target audience?
REMIND specifically engages public defenders as trainees - to build their capacity as advocates for clients facing substance use and mental disorders primarily through the strength of their relationships with these clients. In the first week after arrest, a person with mental health or substance use issues is likely to encounter about a dozen police officers, corrections officers, and court representatives. None of these people are their advocate. Criminal defense attorneys, particularly public defenders and other court-appointed counsel, are different. They are the only actor within the system fighting for the stated interests of a defendant.

Is this based on established work, or does it draw from other existing work?
No such comprehensive, universal program exists to equip attorneys to represent clients experiencing substance use and mental disorders. Many indigent defense agencies employ Gideon’s Promise, a nationally-renowned training that emphasizes client-centered representation. However, Gideon’s Promise does not have a component related to identifying and addressing the role of client mental health and substance use issues. REMIND’s philosophy, curriculum, and format draw both from extensive consultation with indigent defense experts, including those with lived experience as public defender clients, and from academic and policy literature on the intersection of public mental health, addiction medicine, and criminal justice.

How does your project or initiative work?
REMIND consists of an interactive, workshop-format curriculum for public defenders. We offer

three comprehensive, half-day modules: developing client relationships; doctrine and strategy; and advocating for and with ourselves. Broadly speaking, the curriculum and its structure draw heavily from critical criminology; harm reduction; social therapy; positive psychology; antiracism organizing; and trauma- focused therapeutic analysis.

What are the results? If results are not yet available, what results do you hope to achieve?
REMIND will transform the experience of indigent defendants with mental health and substance use concerns by ensuring that their legal advocates are prepared to understand their needs and potential outcomes. In discrete terms, the anticipated impact is twofold: improved experience (defined generally as satisfaction with representation) and better outcomes (in terms of clinical continuity and sentencing or diversion) for indigent defendants. Anecdotally, we have already observed these outcomes, along with attorney enthusiasm for applying and reproducing the training process.

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Keywords
awareness, criminal justice, education, training

50. Shared Stories - Vulnerability in Health Care

Authors
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What is your project or initiative?
Over the past few years, we have facilitated “shared stories” focus group discussions via Zoom with physician assistant (PA) students at various stages of training and across multiple PA programs. These have been embedded in different formats and courses, but all stem from the idea that you are not alone in whatever you are dealing with. We have those is ‘powerful’ positions such as faculty members, clinical PAs, etc., share their vulnerabilities with mental health, including substance use disorders (SUD), with students and then lead discussions around vulnerability and stigma in healthcare. We hope to continue to grow this experience and training to more programs.

Why did you develop this?
Out of our own experiences with shame and stigma as PAs with lived experiences and as we are PA educators, we are seeing this cycle propagate so aim to challenge the infallible role our students are cast in.

Who is the target audience?
PA students at any stage of training. We have worked with those in early didactic, late didactic and clinical year.

Is this based on established work, or does it draw from other existing work?
This is based on prior work that Stephanie first did with a primarily MD research team with medical students from the University of Tel-Aviv. This was adapted to bring to PA students across 3 programs as a standalone project. Given the success, it was then built into a 16 week well-being course that is being delivered to 4 PA programs (N = 185) concurrently and another 2 programs will take the course starting in June.

How does your project or initiative work?
This project has been run a few different ways, but for live sessions, the core framework is to have 1-2 PAs who are seen as superiors and a group of students. The session begins with each PA telling their story in detail to the students (we have done SUD, serious mental illness, anxiety/depression) and then opening the floor for discussion around mental health, help seeking behaviors, stigma, the hidden curriculum in medicine, shame etc. Many students opt to share their own stories as well through this discussion. We have also done this with recorded versions of our shared stories and students watch on their own then participate in a discussion forum with prompts on vulnerability.

What are the results? If results are not yet available, what results do you hope to achieve?
For the live sessions, we have shown great success with reducing stigma and improving help seeking behavior of mental illness as measured by the OMS-HC and the SSOSH surveys. We do not tease out by diagnosis so do not have specific data on SUD, only SUD as included with other mental illness. For the recorded version with discussion forums, this is underway currently and the forum participation is incredibly rich but we do not have the supporting pre-post survey data at this time. This will be available in late May 2021.

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Keywords
awareness, education, lived experience

51. Stigma Reduction and Prevention in Healthcare: An OPEN Partnership with Shatterproof

Authors

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What is your project or initiative?

The Opioid Prescribing Engagement Network (OPEN) has partnered with Shatterproof to raise awareness on stigma toward individuals with substance use disorder (SUD) in the healthcare setting. Through a summit, online workshops, and self-paced programs, we seek to provide healthcare systems with the tools necessary to reduce stigma through evidence-based interventions.

Why did you develop this?

Stigma from providers adversely impacts the care, treatment, and recovery of their patients. When subject to stigma, patients are isolated and shamed which creates added barriers to care and impedes recovery. Recognition of how stigma manifests in different settings will lead to better development of interventions that support the needs of all patients, including those struggling with addiction.

Who is the target audience?

Our initial learning series will focus on the unique needs of obstetrics and gynecology. Our targeted audience will encompass a wide range of demographics including healthcare professionals and family members of pregnant women with SUD.

Is this based on established work, or does it draw from other existing work?

OPEN has spent the last five years combatting the opioid epidemic in Michigan and beyond, beginning first with a preventative approach to the opioid crisis through the introduction of prescribing guidelines for postoperative and acute care opioid prescribing. OPEN also provides multitude of educational resources for providers, patients, and communities on opioid risk assessment and proper medication disposal. Through data driven research, policy suggestions, and community outreach, OPEN is an established stakeholder in work done to end the opioid epidemic.

How does your project or initiative work?

OPEN has proven networks of partners that will be leveraged to reach providers spanning a number of specialties. Specifically, the Blue Cross Blue Shield of Michigan Value Partnerships Program consists of over 20 different Collaborative Quality Initiative (CQI) programs that provide a cooperative approach to population-based quality improvement, financial support and infrastructure to establish collaborations among hospitals and healthcare centers. We will first introduce our Stigma Learning Series to the Obstetrics Initiative (OBI) Collaborative to garner interest and participation from providers within their 73 maternity hospitals. Providers will learn about initiatives taking place nationally to reduce stigma, participate in an OB/GYN focused panel session, and finally, they will be offered an opportunity to workshop skills on providing non-stigmatizing within virtual case study session. By sharing lived experiences, Shatterproof and OPEN will connect with healthcare professionals and formulate ways to reduce stigma and implement interventions in clinical settings. In addition to working with providers, families and loved ones of individuals with SUD will have an opportunity to participate in self-paced, online programs.

What are the results? If results are not yet available, what results do you hope to achieve?
Though the project is ongoing, the interventions created by OPEN and Shatterproof are a promising step in addressing stigma toward individuals with SUD. By creating spaces for healthcare professionals to discuss and be educated on stigma, we hope that providers will be better equipped to support patients with SUD, including expectant mothers through our obstetrics initiative.

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Keywords

policy and guidelines, womens health

Disclosure statement
Shatterproof is a partner in the Stigma Reduction and Prevention in Healthcare project and did not have involvement in the abstract submission.

52. Stigma Reduction as a Consideration for Choosing Telehealth Care for Substance Use Disorders

Authors

Stephen A. Martin, MD, EdM; Jordon Bosse, PhD, RN; Katharina Wiest, PhD; Dennis McCarthy, PhD; Kim Hoffman, PhD; Ximena Levander, MD; Brian Chan, MD, MPH; P. Todd Korthuis, MD, MPH

What is your project or initiative?

Boulder Care is a mobile application treatment solution offering long-term support for people with substance use disorders (SUD) by delivering access to medical and psychosocial services via telehealth. Our interdisciplinary Care Teams (a team clinician, care advocate, and peer coach) provide comprehensive, evidence-based, interdisciplinary care for each of our participants.

Why did you develop this?

SUD are a problem of national concern. In the case of opioid use disorder (OUD), medications such as buprenorphine reduce opioid use, opioid use associated risks, and death. Despite the evidence supporting medications for opioid use disorder (MOUD), more than half of US counties (predominantly rural) have no prescribers. Patients travel long distances, join waitlists, or go without treatment. Additional barriers to care include lack of transportation, competing demands (e.g., work, childcare) and stigma. Combined, this lack of access and additional barriers leave millions without treatment. The National Institute of Drug Abuse (NIDA) emphasizes how the complex nature of SUD requires long-term care. NIDA supports a multi-faceted approach with adequate treatment time and dynamic, individualized treatment based on a person's unique goals. Given the escalating scale of the epidemic, a highly accessible, innovative solution is critical to closing the treatment gap. Telehealth is one such solution.

Who is the target audience?

Our target audience consists of people who have one or more SUD, are seeking care, and are amenable for care to be provided via telehealth.

Is this based on established work, or does it draw from other existing work?

Our research is based on pioneering interviews -- made possible by a NIDA Small Business Innovation Research (SBIR) grant awarded in 2019 -- with people who would be candidates for Boulder Care. These interviews sought to understand people's experiences and thoughts as to why telehealth might be, or might not be, a reasonable approach for themselves. The potential for stigma to be in a telehealth setting was a significant consideration for a number of study participants. The presented work will be an initial qualitative analysis of how past experience with stigma and efforts to reduce ongoing exposure to it may influence people's decisions regarding telehealth-based care.

How does your project or initiative work?

Boulder Care is a mobile application treatment solution offering long-term support for SUD by delivering telehealth access to medical and psychosocial services. Our virtual treatment platform ensures the provision of critical components of SUD care with less burden on both the participant and caregivers. Care is mediated by a HIPAA-compliant smartphone app which patients download to their phones. Effective treatment for SUD includes multiple components tailored to meet the needs and schedule of an individual. Our solution to reduce the burden of care on prescribing providers is to use a care team, combining the skills of care advocates, peer coaches, and team clinicians. The focus of the care team is to develop a therapeutic clinical relationship with each patient, led by the patient's recovery goals. From the participant's initial contact with Boulder Care, our comprehensive services are provided virtually. In the COVID-19 pandemic, telehealth has become indispensable for outpatient health care, including care for SUD. In a recent review of telemedicine interventions for SUD, telehealth was effective and appreciated; over 75% of patients reported high satisfaction. Provision of buprenorphine via telehealth also appears to improve retention at one year compared with in-person treatment.

What are the results? If results are not yet available, what results do you hope to achieve?
We are actively analyzing data from our interviews. By the time of the Summit, we will have a refined understanding of study participants' consideration of stigma and how it influences their preference for traditional care or that provided via telehealth.

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Keywords

lived experience, technology

53. Stigma towards People Who Use Drugs: An Study of Police Officer Perspectives and Their Effects

Authors

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What is your project or initiative?

Our project is a study to survey police officers to better understand their knowledge, beliefs, and attitudes about people who use drugs (PWUD) including stigma held towards them, and responses to PWUD including treatment and harm reduction strategies. In addition, it will explore what shapes decision making about, and planned behavior towards, PWUD. We will further explore differences in responses based on officer demographics. The study looks at data from Illinois, Indiana, and Massachusetts. There is limited prior research in this area and this study can gain information directly from officer's unique perspectives.

Why did you develop this?

Over 20 million Americans struggle with substance, use and PWUD are highly stigmatized. Stigma affects PWUD decisions to seek help or share with others and harms their psychological well-being. Stigma negatively affects police encounters with PWUD, and leads officers to exercise the prerogative to arrest when a referral to effective treatment would have in fact decreased recidivism and reduced the overdose risks a suspect faces as a result of incarceration. As seen in the Derek Chauvin defense's case in the murder of George Floyd, stigma against PWUD, particularly people of color, can be used to justify use of force. Ultimately, stigma against PWUD negatively affects their overall public health and criminal justice outcomes. We need to be able to measure this stigma, systematically understand what shapes officer behavior, and develop interventions to constrain and redirect the negative outcome of stigma-based decisions by police.

Who is the target audience?

Criminal justice practitioners, public health practitioners, healthcare practitioners, researchers and academics.

Is this based on established work, or does it draw from other existing work?

There has been limited prior study of police officer attitudes toward PWUDs. This is original research that adds to what is known on this subject.

How does your project or initiative work?

We are distributing an online survey on stigma and the Theory of Planned Behavior using stratified random sampling of police departments in Illinois based on characteristics of department jurisdictional area type (rural/urban) and department size (number of officers). This strategy is done to ensure diverse departments and officers participate in the study and to increase response rates. They are accompanied by pre-training surveys that ask an overlapping battery of questions in Indiana and Massachusetts. (Present N=approx. 315)

What are the results? If results are not yet available, what results do you hope to achieve?

We have not concluded recruitment for the Illinois arm of the study, but we can share preliminary findings if selected. Some of them follow here. To date, we have a sample size of approximately 315 officers. We will use descriptive statistics and perform statistical tests to explore the strength of the associations between officer and department demographics and survey responses. To date, we have

found that police perceive they have high levels of control over their decision to arrest a PWUD or not, that the attitude of the suspect strongly influences their decision (with perceptions informed by stigma), that the expectations of their immediate supervisor figure prominently in their decisions, and they will take effective alternatives to arrest into account. Officers also believe people who use drugs will lie to them as necessary, and have reduced control over their actions, but recovery is possible, although tapering and sobriety should be the ultimate goal. Our research suggests training on the effectiveness of MOUD and the effects of addiction on behavior, and policies that set supervisor expectations about deflection will likely limit and reduce the effects of stigma against PWUD in the course of police encounters.

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Keywords

criminal justice, medications for opioid use disorder

54. Strategic Teaching to Transform Language

Authors
Alëna A. Balasanova, MD

What is your project or initiative?
My initiative is to transform the language of addiction to reduce the stigma of substance use disorders (SUD). My goal is to strategically teach the next generation of healthcare leaders clinically accurate, non-stigmatizing addiction terminology aligned with the Surgeon General's lexicon for SUD. Learners then have curated opportunities over 1-4 weeks to practice using non-stigmatizing language in a clinical setting with faculty feedback.

Why did you develop this?
Research shows that stigmatizing and pejorative addiction language negatively impacts patient care and adversely affects clinician wellness. This is a major driver of stigma that can be remedied if clinicians are taught, supervised, and encouraged to use clinically accurate non-stigmatizing terminology.

Who is the target audience?
Those in clinical service and care delivery and in particular, our future generations of healthcare leaders: medical and health professions students, resident physicians, fellows, and medical staff colleagues and peers.

Is this based on established work, or does it draw from other existing work?
To my knowledge there is no established framework for strategic teaching of non-stigmatizing addiction terminology to healthcare learners.

How does your project or initiative work?
This initiative is through the University of Nebraska Medical Center Department of Psychiatry Addiction Psychiatry Consultation-Liaison (APCL) Service, an interdisciplinary medical team providing consultations to patients with substance use who are medically and surgically admitted to our hospital. APCL is a teaching service with learners across the spectrum of medical education. As part of their experience on APCL, learners receive a comprehensive orientation including teaching about the stigma of addiction language, an overview of the literature surrounding how language impacts patient care, and a lexicon of clinically accurate substance use terminology published by the U.S. Surgeon General. Special emphasis is placed on the role that healthcare workers have in propagating or reducing stigma. Learners are empowered with the knowledge that pejorative language jeopardizes patient care and are taught skills needed to reverse this stigma. Throughout their time on APCL, learners practice using non-stigmatizing language and begin to incorporate it into their general medical discourse. Learners are supervised by expert faculty who provide formative feedback through encouragement and gentle correction as well as summative feedback through formal evaluations.

What are the results? If results are not yet available, what results do you hope to achieve?
Anecdotally, nearly all learners report a change in their perception of patients with SUD by the end of their APCL rotation. They also report beginning to notice just how many peers and healthcare workers use stigmatizing addiction language since it now sounds foreign to them. In trying to quantify these findings I plan to administer an anonymous survey at the beginning and end of the APCL rotation to assess changes in stigma and attitudes towards patients with SUD.

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Keywords
education, person-centered language

55. Substance Use Narratives in a Contact-based Stigma Reduction Program

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What is your project or initiative?

The elimination of stigma surrounding behavioral health conditions has been a public health priority internationally since 1996 with the World Psychiatric Association's Global Program to Fight Stigma and Discrimination, "Open the Doors" (Sartorius & Schulze, 2005) and since 1999 in the United States (Corrigan & Kosyluk, 2013; Hinshaw & Cicchetti, 2000). Over the past two decades, multiple common stigma-reducing approaches have been utilized—protest (e.g. campaigns telling the public not to endorse negative stereotypical beliefs about individuals living with behavioral health conditions), education (e.g. providing the public with accurate information about behavioral health), contact (e.g. personal interaction with individuals living with a behavioral health condition), legislative reform (development and enactment of protective legislation), advocacy (use of multiple strategies to increase prioritization of behavioral health by decision makers), and stigma self-management (peer and recovery-oriented services) (Arboleda-Flórez & Stuart, 2012; Corrigan et al., 2012; Sartorius & Schulze, 2005)—with research supporting contact-based approaches as superior at changing stigma (Corrigan et al., 2012; Sartorius & Schulze, 2005). Common contact-based interactions involve individuals sharing their stories of lived experiences with mental illnesses and corresponding symptoms and struggles as well as their path to wellness and hope. This Is My Brave (TIMB) is a contact-based stigma reduction program where stories are delivered in theaters, live and on-stage (or on virtual stages during COVID-19), guided by key ingredients for contact-based stigma change programs put forth by Corrigan and Kosyluk (2013). Individuals who participate in a TIMB production (cast members) consist of people with lived experience with behavioral health conditions including mental illness and substance use disorders. They creatively share not only their lived experiences and struggles but also their path to wellness, which conveys messages of recovery and hope. Cast members communicate their experiences on-stage through a medium they choose that can include poetry, essay, comedy, or original music (https ://thisismybrave.org). Kosyluk et al. (2018, 2020) have completed two studies examining the effectiveness of TIMB and found the program to be a promising stigma reduction program, resulting in audience members experiencing a decrease in public stigma, improvements in beliefs about recovery and empowerment, and greater willingness to seek treatment.

Why did you develop this?

Our research team has developed a line of scholarly inquiry using the archival recordings of TIMB performances (all performance are recorded and placed online for viewing by an international audience). We are qualitatively analyzing these videos to answer a variety of research questions. For the purpose of this conference we will report on narratives around substance use and stigma in TIMB performances.

Who is the target audience?

The target audience of this presentation ranges from other scholars, behavioral health practitioners, people living with behavioral health conditions and their friends and family members.

Is this based on established work, or does it draw from other existing work?
The research question, “How do TIMB performers communicate about substance use?” is a new approach to this data.

How does your project or initiative work?
Our team members will independently code the videos from 14 TIMB performances where substance use is discussed and come together to agree on a set of themes.

What are the results? If results are not yet available, what results do you hope to achieve?
Examples of themes we expect will emerge from the data include the language used to describe experiences with substance use, coping strategies used to replace substance use behaviors, and emotions and thoughts surrounding substance use and recovery.

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Keywords
mental health, storytelling

56. Teaching Undergraduate Substance Use Courses through a Person-First Lens

Authors
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What is your project or initiative?
The initiative described here is an undergraduate substance use, dependency and addiction course which has as one of its learning objectives to describe the social effects of substance use, and the stigma associated with people who use substances. However, from beginning to end, this course, its instructor, teaching methods and assignments recognize and call out stigma.

Why did you develop this?
I inherited this course in 2015, and since then, have made it my own, highlighting what I feel to be injustices in the treatment of persons who use substances and who may have substance use disorder. Because this is a popular course enrolling 50 to 100 students each semester, it allows dissemination of new ideas which change mindsets. In immediate and later feedback (e.g., emails) students share the impact. If I remember correctly, it was one my guest speakers who suggested I check out the Narcotica Podcast, which lead me to resources such as the Recovery Research Institute, the Truth in Justice Lab and Changing the Narrative. Now these resources and more, inform the programming for this course.

Who is the target audience?
A diverse group of undergraduate students (i.e., demographically and by major) at a large NE urban university (we are near Kensington in Philadelphia). Course runs twice a year.

Is this based on established work, or does it draw from other existing work?
The course has been revised but builds on my past teaching of the course and new information from many of the aforementioned groups.

How does your project or initiative work?
The course is taught in a flipped style, such that students read, listen, view content prior to meeting live once a week (currently via Zoom). The first two weeks set the stage for the person first lens used throughout the semester. For example, students read T*he AP Learns to Talk about Addiction: Will Others Follow?* (Szalavitz, 2017); *Why I Stopped Calling Myself an Alcoholic* (Whitakar, 2019); and review the *Changing the Narrative* website. In class, the students review the Addictionary and note which words have stigma alerts, while also considering which ones surprise them and which ones might be missing. Students also listen the Narcotica podcast #22 which discusses stigma around substance use and also some phrases (epidemic) that do not capture the nature of the overdose crises. Throughout the semester we work on using person-first language in our exchanges and pay particular attention to stigma and injustice when discussing drug control policy; this year, we were able to explore stigma used by the defense team in the Derek Chauvin murder trial. The final project for this class is a PSA or Zine that focuses solely on harm reduction (examples available).

What are the results? If results are not yet available, what results do you hope to achieve?
The goal is for graduates of this course to lead by example in their exchanges with others when discussing substance use. As I tell them, it takes a long time to change the language we use to talk about persons who use substances, but it must start somewhere, and it should start with them. Anecdotally, it is working. Students say: “I’ve found myself changing the language that I use and

becoming more conscious about how I approach discussions surrounding substances and those who use them. I feel like this will definitely benefit me as I continue my education around healthcare." "It has made me aware of harmful language that we use about people with substance use [disorder] on the daily. I had to do a trauma population presentation in another class surrounding "drug use in the family" and made sure to use no stigmatizing language."

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Keywords
education, person-centered language, young adults

57. The Implementation of an Anti-Stigma, Outreach-Based Naloxone Training Program

Authors
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What is your project or initiative?
The REACH Project, Inc., a 501(c)3 non-profit organization, is an independent medical practice. REACH–an acronym for Respectful, Equitable Access to Compassionate Healthcare–opened in February 2018 with the goal of building health equity in the Southern Tier region of New York State (NYS) by providing access to high quality, evidence-based, stigma-free healthcare to commonly marginalized populations through a harm reduction model. REACH offers low threshold, integrated services including medication for opioid use disorder (MOUD) with buprenorphine for opioid use disorder (OUD), comprehensive primary care, behavioral health services, and Hepatitis C and HIV testing and treatment. In the Fall of 2020, REACH launched outreach-based naloxone training in Ithaca, NY. Naloxone (also known as Narcan) is an opioid overdose reversal medication that is available in an easy to use intranasal form, commonly distributed to the public. As a mechanism to educate the community on harm reduction practices, naloxone training can assist in the reduction of stigma and opioid overdose death. These virtual and in-person trainings are delivered by certified REACH staff with experience in outreach service delivery, community health work, and emergency medical response.

Why did you develop this?
In response to the COVID-19 pandemic, REACH implemented outreach services to ensure that people experiencing homelessness or housing insecurity in our local community had adequate and safe access to healthcare services. In conjunction with facilitated telemedicine, COVID-19 testing, and COVID-19 vaccine administration, outreach-based naloxone training offers an additional level of life-saving support to vulnerable populations that access outreach services. A reported increase of opioid overdoses in Ithaca, particularly within the homeless population REACH serves, led REACH to expand naloxone training and distribution through outreach.

Who is the target audience?
The target audience for this project is everyone in REACH's community. The availability of naloxone during an opioid overdose can be life-saving. Through outreach-based trainings, REACH was able to specifically engage people experiencing homelessness or housing insecurity and those that work closely with this population. By promoting and empowering community members, REACH can help to prevent overdose deaths and can help people who use drugs feel safe. Furthermore, the expanded availability of naloxone promotes reductions in the stigma surrounding substance use.

Is this based on established work, or does it draw from other existing work?
As a designated New York State Opioid Overdose Prevention Program (OOPP) site, REACH provides free naloxone to patients and naloxone training participants. To continue providing naloxone trainings during the COVID-19 pandemic, REACH has adapted their training to be delivered virtually.

How does your project or initiative work?
As a certified OOPP site, REACH is able to coordinate the distribution of naloxone kits. These kits include two doses of intranasal naloxone, a face shield for rescue breathing, and a quick-reference opioid overdose identification and naloxone administration sheet. Trainees receive a certification of completion card with resources, such as the Office of Addiction Services and Supports (OASAS)

HOPEline. Due to regulatory changes during the pandemic, REACH is able to mail or deliver these kits in-person to virtual or in-person training attendees. Finally, REACH developed a voluntary post-training survey that is sent via email to all participants for data collection and quality improvement purposes.

What are the results? If results are not yet available, what results do you hope to achieve?
Since the start of the outreach-based training program in October of 2020, REACH has trained 73 individuals in seven unique trainings on opioid overdose awareness and naloxone administration. These individuals include local social service organizations, local businesses, REACH clinical staff and Peer Advisory Board members, and the general community. In the post-training survey, participants reported an average confidence score of 6.6 on a scale from 1-10 (1 being the least confident, 10 being the most confident) in their ability to administer naloxone prior to receiving the training. After receiving the training, participants reported an average confidence score of 9.7 in their ability to administer naloxone in the event of an overdose. Moving forward, REACH aims to increase the number of individuals trained and unique trainings delivered. In order to empower the community and reduce stigma, REACH will continue to provide harm reduction services in its low-threshold, integrated setting.

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Keywords

harm reduction

58. The Mind Mirrors the Clinic: Destigmatizing Behavioral Health through Integration

Authors

Amy Etzel

What is your project or initiative?

The Robert Bree Collaborative (the Collaborative) was established in 2011 to provide a forum in which public and private health care stakeholders in Washington State can work together to develop evidence-based clinical guidelines in order to improve health care quality, outcomes, affordability, and equity. The number of people in Washington with substance use disorders and who experience variation in whether they are screened, receive any intervention and/or access to treatment, and a lack of coordination and communication between primary care, emergency rooms, and treatment centers were identified by the Collaborative as a priority area for improvement in 2014 and the Collaborative developed clinical, community standards to improve care. Guidelines are based on published evidence, stakeholder input and expert opinion, and examine methods of improving the ways that those with substance use disorders interact with the health care system. The Guidelines are framed around five focus areas and apply to those 13 years of age and older: Reduce Stigma; Increase Appropriate Screening; Increase Capacity for Brief Intervention and Treatment; Decrease Barriers for Referrals to Treatment Facilities; Address the Opioid Epidemic. Building off this last focus area and recognizing the growing opioid epidemic, the Collaborative developed guidelines in 2017 to address lack of access to appropriate, evidence-based opioid use disorder treatment. The goal is a health care system that identifies people with opioid use disorder and facilitates access to comprehensive, evidence-based treatment with the patient at the center of care. The workgroup identified the following three focus areas to improve outcomes for this population: Access to evidence- based treatment (e.g., medication-assisted treatment, reduce stigma); Referral information (e.g., inventory of medication treatment prescribers, supportive referrals); Integrated behavioral and physical health to support whole-person care (e.g., treatment of comorbid conditions). The Collaborative has since built a suite of implementation resources to facilitate broad adoption of these guidelines by delivery sites, health plans, and others. Resources include: implementation checklists; core process measures; self-assessment to measure implementation; topic specific webinars related to substance use disorders; and an online resource library.

Why did you develop this?

The Collaborative recognizes that full adoption of our guidelines requires a strong foundational system that not all delivery sites may have the funding, resources, or staff to build. These resources are meant to be a roadmap toward successful implementation, outlining incremental and actionable steps without being overly prescriptive so as to feel overwhelming or impossible to implement.

Who is the target audience?

Our Implementation Checklist and Core Process Measures are meant for outpatient delivery sites. Our webinars and online resource library are meant for anyone within our broader community that is working to reduce stigma related to addiction and dependence and improve outcomes for people living with a substance use disorder.

Is this based on established work, or does it draw from other existing work?

These resources are based on the recommendations written by our workgroup members. A list of workgroup members is included in our full reports.

How does your project or initiative work?
These Implementation resources are open access, available to all within the health care community. The initiative is structured to be made of two levels, a more intensive pilot group of out-patient primary care delivery sites working toward integrating behavioral health into care and a state-wide learning community. This pilot group completed a baseline Bree Collaborative Assessment measuring implementation of our Addiction & Dependence Treatment and Opioid Use Disorder Treatment guidelines, and a follow-up assessment in January/February 2021. Based on identified gaps within this Assessment, each clinical team created an Action Plan of three to four quality improvement items to move toward full adoption of recommendations, and ultimately improved care for their substance use disorder patients.

What are the results? If results are not yet available, what results do you hope to achieve?
Data reflecting six clinics showed improvement in the 11 assessment question scores related to our Addiction and Dependence and Opioid Use Disorder treatment guidelines, with an overall average improvement of 18.4% from 2020 to 2021. The assessment question specifically related to training and education for staff on stigmatizing language and perceptions about alcohol and drug misuse showed a 25.5% increase.

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Keywords
policy and guidelines

59. Training Child Welfare and Legal Professionals to Effectively Address and Support Families Impacted by Parental Substance Use

Authors

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What is your project or initiative?

The Philadelphia Coalition on Children and Opioids ("the Coalition") is a stakeholder group of organizations at the intersection of child welfare and substance use treatment in Philadelphia. A major initiative of the Coalition is development and implementation of a series of trainings for child welfare staff (case managers, supervisors, and child investigators) and legal professionals (judges, attorneys, child advocates, and related staff) on how to effectively address and support families affected by parental substance use. The trainings include topics ranging from using non-stigmatizing approaches, understanding the context in which a parent is using substances, addressing the parent's needs, engaging the parent in treatment and services, and promoting a positive child-parent visitation experience.

Why did you develop this?

The Coalition developed these trainings to correct common misperceptions that child welfare-related and legal professionals may hold related to parents who use substances. Key informant interviews with child welfare case managers in Philadelphia revealed that the current trainings do not equip child welfare workers with the knowledge and skills to work effectively on opioid-involved cases. They also revealed that a case manager's bias towards substance use can hinder effective case management, and that a judge's bias can prevent reunification. In conversations with previously involved parents who use substances, parents indicated feeling stigmatized and treated in a punitive approach, especially in court, which may hinder their recovery and reunification with their child(ren).

Who is the target audience?

The target audience of the child welfare-related training series include child welfare case managers and supervisors, child welfare investigators, and any other staff who work directly with parents. The target audience of the legal professionals training include family court judges, child welfare attorneys, and child advocates.

Is this based on established work, or does it draw from other existing work?

While our trainings draw from similar trainings by the National Center on Substance Abuse and Child Welfare, our trainings are focused on and tailored to Philadelphia's child welfare system and culture.

How does your project or initiative work?

The Coalition collaborated with Philadelphia's Department of Human Services to host mandatory live training sessions for child welfare workers in addition to building online training modules that are available to all staff. The Coalition is offering live training sessions for legal professionals in partnership with Philadelphia area legal agencies and organizations.

What are the results? If results are not yet available, what results do you hope to achieve?

Pre- and post-training evaluation results for initial training sessions will be available by the Summit. We hope that these trainings will: (1) increase the knowledge and skills of those who work with child welfare-involved parents who use substances; and (2) allow staff to recognize how their personal beliefs and attitudes may affect how they relate to families. Ultimately, we hope that trainings will reduce stigma related to parental substance use and treatment, that families experiencing or impacted by substance use will be treated compassionately and supported, and that substance use-related cases will be navigated equitably and effectively.

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Keywords

awareness, criminal justice, education

60. Understanding How Peers Can Shift Stigma to Retain Low-Income, Minority Individuals in Opioid Treatment

Authors

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What is your project or initiative?

Our team is evaluating whether and how a peer recovery specialist (PRS), a person with lived substance use experience currently in sustained recovery and trained to support others with substance use disorders (SUD) may shift multiple intersecting stigmas, and whether changes in stigma translate into improvements in methadone treatment retention. This work is a part of a larger parent award evaluating a PRS-delivered behavioral intervention to improve retention in methadone treatment. Our stigma initiative employs qualitative and quantitative methods to evaluate how a PRS may shift substance use and methadone stigma among individuals with opioid use disorder (OUD).

We conducted qualitative research with patients, PRSs, staff, and other key stakeholders to understand:

1. how stigma manifests among low- income, minority individuals in methadone treatment, including internalized methadone and substance use stigma, and
2. how a PRS may reduce stigma barriers and improve retention in care, including barriers and facilitators to the PRS role in shifting stigma.

Why did you develop this?

Retention in methadone treatment is a persistent challenge, with six-month retention rates below 50% nationally, and even lower retention rates among low-income, ethnoracial minorities. Stigma is a known barrier to methadone retention, particularly within ethnoracial minority communities. The PRS workforce has rapidly expanded in the U.S. in order to increase access to treatment for substance use, particularly in historically underserved low-income, ethnoracial minority communities. Given PRS' unique shared experience, PRS-led interventions may be well suited to shift stigma and improve retention in methadone care. However, this has yet to be empirically tested.

Who is the target audience?

The target audience includes those involved in PRS funding, training and services, as well as methadone treatment. We hope this initiative will build empirical support for understanding how PRSs may shift stigma, and whether these changes in stigma can improve methadone retention and other treatment outcomes.

Is this based on established work, or does it draw from other existing work?

This study is a stigma supplement within a larger parent award funded by the NIH HEAL Initiative, which aims to understand the effects of a PRS-led behavioral intervention, behavioral activation, on retention in methadone care and other treatment outcomes.

How does your project or initiative work?

We have developed a training model to train PRS's in an evidence-based intervention, behavioral activation, which weaves in one's lived experience. We are conducting qualitative work to inform ongoing adaptation of the PRS approach, as well as to understand specifically how stigma is a barrier to methadone treatment, and how a PRS's lived experience can be integrated into the behavioral activation intervention to further amplify potential effects on internalized stigma. Semi-structured qualitative interviews and focus groups were conducted (Phase I) with participants (N=32) including: patients currently enrolled in methadone treatment, treatment center staff, and PRSs working in a range of substance use treatment settings. Interviews were transcribed, and a codebook was iteratively developed to allow for thematic, rapid qualitative analysis. Qualitative results informed a subsequent open-label pilot trial (Phase II), in which participants thus far (N = 4) have completed semi-structured exit-interviews, which have been transcribed and are being analyzed.

What are the results? If results are not yet available, what results do you hope to achieve?
Several themes emerged from the Phase I interviews and focus groups. Participants described internalized as well as enacted methadone and substance use stigma at various levels, such as institutional and societal levels, as barriers to reaching successful treatment outcomes, as well as other forms of stigma. Participants expressed that a PRS-led intervention may reduce stigma and improve retention in care through qualities unique to the PRS role, such as shared experience and being seen as a role model, as well as PRS actions/behaviors, such as supporting clients and shifting organizational stigma. However, it was noted that the PRS having a different recovery pathway may result in stigmatizing the patient, and, thus, may act as a barrier to a PRS-led intervention reducing stigma. Exit interviews to date indicate that, as a result of engaging in a PRS intervention, participants felt a shift in internalized methadone and substance use stigma.

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Keywords
lived experience, medications for opioid use disorder

61. Understanding Stigmatizing Healthcare Experiences of Individuals in Recovery from Opioid Use Disorder

Authors
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What is your project or initiative?
Understanding Stigmatizing Healthcare Experiences of Individuals in Recovery from Opioid Use Disorder

Why did you develop this?
To understand stigmatizing language and actions that people with lived experience of opioid use disorder (OUD) have experienced in different care settings to inform a flipped simulated patient experience.

Who is the target audience?
Trainees.

Is this based on established work, or does it draw from other existing work?
Based on established work.

How does your project or initiative work?
18 individuals who identified as being in recovery from OUD were recruited via flyers and word-of-mouth at a local community recovery organization. Three focus groups were held with six participants each. Groups lasted up to 90-minutes and were led by a trained facilitator using a semi-structured interview guide that allowed participants to guide the conversation flow.

What are the results? If results are not yet available, what results do you hope to achieve?
Preliminary analysis of qualitative interviews using applied thematic analysis elicited the following main emergent themes:

1. provider language use and self-identifying language;
2. provider body language and behavior;
3. fear and avoidance of the healthcare system;
4. infrequency of honesty, open communication, and trust between provider and patient; and
5. inadequate medical care including undertreating pain or overprescribing without inquiring about opioid use history.

Participants noted that characteristics of positive interactions with providers included:

1. providers educating patients about OUD including harm reduction;
2. providers explaining to the patient what their care entailed;
3. collaborative decision-making; and
4. compassion and empathy.

These characteristics were viewed as helping to build trust and an open line of communication between the provider and the patient.

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Keywords

education

Disclosure statement

Richard Bottner, member of the Stigma of Addiction Summit planning committee, is a partner in this project and did not have involvement in the abstract submission.

62. Underutilization of Buprenorphine and Opioid Use Disorder Stigma in Primary Care: A Pilot Intervention for Registered Nurses

Authors

Anina Terry, MSN, FNP-C, ARNP; Richard Waters, MD, MSc; Phyllis Sharps, PhD, RN, FAAN

What is your project or initiative?

This quality improvement (QI) project piloted an evidence-based buprenorphine-specific anti-stigma intervention that aimed to reduce registered nurses' (RNs) stigmatizing attitudes towards persons with opioid use disorder (OUD) and to increase their participation in providing buprenorphine, a medication for OUD, in a primary care community health setting. The organization's goal was to increase buprenorphine prescribing rates and access to care for persons with OUD. The intervention was piloted for primary care RNs as non- prescriber members of the primary care team intended to support prescribers and patients in buprenorphine management.

Why did you develop this?

Underutilization of buprenorphine in primary care and OUD stigma are two factors that have hindered the expansion of access to medications for OUD. Primary care buprenorphine prescribers reported lack of clinical support from care team members, specifically RNs, and OUD stigma to be common barriers. However, recent published buprenorphine education interventions for primary care, designed to increase participation in buprenorphine management, did not include anti-stigma curricula and few actively included the participation of RNs.

Who is the target audience?

Those in clinical service, including management of direct care delivery, and academia. This feasible low-cost intervention provides a framework for creating and providing anti-stigma training in the context of primary care OUD management and merits further evaluation with larger studies.

Is this based on established work, or does it draw from other existing work?

The buprenorphine-specific anti-stigma education intervention combined a validated anti-stigma model and evidence-based methods most commonly used for post Drug Enforcement Administration X-waiver buprenorphine training in primary care. The anti-stigma model consisted of six elements: the significance of recovery, multiple forms of contact, setting the tone, inclusion of personal testimony, skill building, and myth busting. The buprenorphine training methods included interactive case studies, communication training, and peer mentoring or support.

How does your project or initiative work?

A pre-test and post-test design was used to evaluate changes in stigmatizing attitudes about persons with OUD after a two-hour virtual buprenorphine-specific anti-stigma education intervention. Stigmatizing attitudes were measured with a modified Opening Minds Stigma Scale for Health Care providers (OMS-HC). The scale was modified by substituting "opioid use disorder" for the term "mental illness". RNs' self-reported change in participation with buprenorphine management was evaluated two months after the intervention with a novel buprenorphine participation scale created for this project. The organization's rate of unique patients receiving buprenorphine prescriptions was calculated over a two-month timeframe before and after the intervention.

What are the results? If results are not yet available, what results do you hope to achieve?

Results from this small (n=12) QI project showed a 4% reduction in stigmatizing attitudes post intervention. A Wilcoxon matched-pairs signed rank test indicated that this decrease was not statistically significant (Z = -1.77, p = 0.15). A Cohen's d effect size statistic showed this decrease had an intermediate effect, d = 0.62. While not statistically significant in this project, the 4% reduction magnitude was consistent with the magnitude of change observed in larger studies addressing general mental health stigma using a similar design to measure change in OMS-HC after implementing the same anti-stigma model. Two months post-intervention, there was no statistically significant change in buprenorphine participation (Z= -1.74, p=0.08) or association between the rate of patients receiving buprenorphine prescriptions and the intervention (x2 = 2.10, p=0.15), but prescribing rates did increase by 36%. Data collection continues to further evaluate the long-term impact of the anti-stigma training. Additional data collection is underway to measure the clinical impact from a reduction in healthcare team members' OUD stigma and the project has been expanded by incorporating the anti-stigma model in buprenorphine trainings for other primary care team roles (both prescriber and non-prescriber).

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Keywords

medications for opioid use disorder

63. Using Patient Narratives to Reduce Stigma among Primary Care Clinicians towards People with Opioid Use Disorder

Authors

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What is your project or initiative?

Our team has created a clinical decision support (CDS) tool in the electronic health record designed to help primary care providers identify, screen, diagnose, and treat opioid use disorder ("OUD CDS"). As part of this project, we are conducting a clinical trial to examine whether an online training for the OUD CDS infused with patient narratives reduces stigma towards people with opioid use disorder among primary care clinicians compared to a basic training.

Why did you develop this?

In our preliminary work, we interviewed primary care clinicians about treating patients with opioid use disorder, and we heard many common stigmatizing beliefs from those clinicians. In reviewing the literature, we learned there is little research on the topic of stigma towards patients with opioid use disorder among primary care clinicians. Interventions to address stigma among healthcare providers are rare; however, limited research suggests that contact with people who have opioid use disorder is one of the best approaches to reduce stigma.

Who is the target audience?

The intervention is targeted towards primary care clinicians.

Is this based on established work, or does it draw from other existing work?

This is a clinical trial of a new intervention founded in previous research.

How does your project or initiative work?

In the intervention group, clinicians complete an online training where they are presented with four patient scenarios of when they might use the OUD CDS. In collaboration with a medical historian, we wrote patient narratives that tell true stories of patients with OUD (all identifying information was changed to protect the patients' confidentiality); we hired actors to portray those patients. Clinicians watch videos of these patients telling their stories while simultaneously learning how they might use the OUD CDS in this scenario. The patient narratives are designed to humanize the patients, demonstrate appropriate person-first language, reduce the use of labels ("addict"), and encourage clinicians to learn a patient's story before making assumptions (e.g., that the patient is "drug-seeking"). Further, the videos try to dispel stigma of using buprenorphine to treat opioid use disorder by showing patients who have successfully been treated using the medication. The attention-control training simply walked the clinicians through the same four scenarios on which they might use the OUD CDS; however, they did not see the patient videos or hear their stories.

What are the results? If results are not yet available, what results do you hope to achieve?

The intervention is currently in the field and preliminary results are expected in Summer 2021. We hope that the intervention, compared to an attention-control training without patient narratives, reduces stigma towards people with opioid use disorder among primary care clinicians. Further, we hope that those primary care clinicians are more likely to use the OUD CDS tool and ultimately treat patients with OUD.

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Keywords
storytelling, technology

64. Utilizing the Project ECHO Model to Reduce Stigma toward Patients Receiving Medication for Opioid Use Disorder (MOUD)

Authors

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What is your project or initiative?

Arizona State University (ASU), in partnership with Blue Cross Blue Shield of Arizona, HonorHealth, and Arizona's Medicaid program developed the Medication-Assisted Treatment (MAT) ECHO program.

Why did you develop this?

Although there have been tremendous efforts to increase the numbers of buprenorphine-waivered providers across Arizona, the shortage of providers integrating MAT practices into their clinic persists. The results of provider shortages is catastrophic to population health, as nearly 90,000 overdose related deaths occurred in 2020 alone. Common barriers to practice integration include stigma associated with both opioid-use disorder (OUD) as well as MAT practices, lack of organizational or ongoing support for MAT services, and the inherent complexity of patient cases. Thus, the MAT ECHO program addresses these barriers by integrating education around stigma, sharing of best-practices, normalizing the use of MAT in standard medical practices, and ongoing clinical and technical consultation to providers across the state.

Who is the target audience?

The target audience for this program are buprenorphine-waivered medical providers, those who are considering becoming waivered, and supportive staff involved in direct patient care. This includes physicians, physician assistants, nurse practitioners, psychiatrists, pharmacists, behavioral health providers, social workers, community health workers, peer support, and more.

Is this based on established work, or does it draw from other existing work?

First established in 2003 at the University of New Mexico (UNM), Project ECHO (Extension for Community Healthcare Outcomes) is a proven adult learning model for delivering high-quality continuing medical education to the current healthcare workforce. To date, there are over 3,400 unique ECHO programs operating in 49 countries around the world. These programs have combined to deliver 2.8 million learning hours to nearly 500,000 unique participants. ASU became an official replicating partner in 2018. To date, ASU has built and is currently operating ten ECHO programs including the MAT ECHO, which launched in February 2020. This program meets on a biweekly basis and will operate indefinitely so long as there is a need improve clinical skills in MAT.

How does your project or initiative work?

The primary goal of this project is to establish a state-level collaborative partnership to scale evidence-based education and practice in the management of patients with OUD. The MAT ECHO program is designed to provide the knowledge, support, and resources necessary to increase the capacity and confidence of medical providers to effectively provide MAT. By leveraging video-conferencing technology, the MAT ECHO program uses a hub-and-spoke model, connecting teams of subject matter experts ('hub') with medical providers ('spokes') through live, virtual, teleECHO clinics. This provider network creates a platform for lifelong learning and guided practice for increasing local capacity to treat patients and reduce stigma associated with OUD. The MAT program meets virtually, via teleconferencing technology, on a biweekly, ongoing basis. Each 60-minute session includes an introduction on reducing stigmatizing practices (i.e., 'word of the day'), a brief didactic presentation, followed by discussion of a patient case (scrubbed of PHI prior to the teleECHO clinic). The curriculum is developed annually by the subject matter experts but retains flexibility to account for the needs of the community. Programming is provided free to participants and CME credits are provided at no charge to those who qualify.

What are the results? If results are not yet available, what results do you hope to achieve?
Since February 2020, the MAT ECHO program has delivered 28 sessions to 292 unique participants, for a total of 8,176 learning hours. A six-month retrospective survey was sent by email to all teleECHO participants in November 2020. Across all sessions, 97% of participants report being ‘satisfied’ or ‘extremely satisfied’ with program content. When asked about “providing excellent care when working with patients that have OUD,” participant confidence increased from 3.85 at baseline to 4.33 at six months and job satisfaction increased from 3.83 to 4.33 among those who regularly attended the MAT ECHO program (5 = strongly agree; 4 = agree; 3 = neutral; 2 = disagree; 1 = strongly disagree).

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Keywords

education

65. Virtual Simulation Focused on Stigma Awareness and Opioid Use Disorder

Authors

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What is your project or initiative?

An immersive virtual simulation about opioid use disorder (OUD) was designed to provide participants with the opportunity to experience challenges associated with navigating life as a pregnant mother in active addition and to feel the impact of stigma associated with OUD. The Opioid Simulation is an experiential learning opportunity to help participants view OUD as a chronic disease for which there is treatment and recovery, experience the role of stigma in the disease of addiction, and understand the role of resilience in OUD.

Why did you develop this?

OUD is a treatable medical condition with appropriate access to care. Despite advancements in treatment and the availability of life-saving medications, provider stigma remains a barrier to reducing OUD and decreasing the number of opioid- related deaths. Creating ‘OUD competent’ and sensitive healthcare providers will require incorporating OUD education and stigma training into program curricula and continuing education. Simulation provides an opportunity for participants to experience challenges presented in the virtual realm and promotes introspection in response to these personalized experiences.

Who is the target audience?

The simulation is intended for a broad audience of healthcare workers and students in health professions programs.

Is this based on established work, or does it draw from other existing work?

First established in 2003 at the University of New Mexico (UNM), Project ECHO (Extension for Community Healthcare Outcomes) is a proven adult learning model for delivering high-quality continuing medical education to the current healthcare workforce. To date, there are over 3,400 unique ECHO programs operating in 49 countries around the world. These programs have combined to deliver 2.8 million learning hours to nearly 500,000 unique participants. ASU became an official replicating partner in 2018. To date, ASU has built and is currently operating ten ECHO programs including the MAT ECHO, which launched in February 2020. This program meets on a biweekly basis and will operate indefinitely so long as there is a need improve clinical skills in MAT.

How does your project or initiative work?

During this simulation, participants play the role of a pregnant mother with an OUD navigating the challenges of everyday life such as obtaining healthcare, childcare, and finding a job. Participants are presented with opportunities to make decisions based on their previous experiences, current resilience, and pain levels. All participants progress through active addiction and treatment. After completing the simulation, there is a structured virtual debriefing during which participants share reactions to participating in the simulation and reflect on their experiences they encountered throughout the simulation, including how resilience impacted their decisions, how stigma effected them, and how participating in the simulation demonstrated that OUD is a chronic, relapsing disorder for which there is treatment and recovery.

What are the results? If results are not yet available, what results do you hope to achieve?
Results are not yet available. We hope to demonstrate that participation in this virtual simulation reduces provider stigma towards pregnant women with OUD. We also hope to expand the simulation to provide more education on treatment options for women with OUD and to develop more storylines for the virtual simulation, allowing participants to play addition roles in the simulation.

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Keywords

simulation, womens health

66. Your Rights in Recovery: A Toolkit

Authors

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What is your project or initiative?

The “Your Rights in Recovery Toolkit” explains varied treatment options, including clinical interventions, peer-based recovery support, and harm reduction for people with opioid use disorder (OUD). It also includes facts about an individual’s legal rights, self-advocacy tips and resources on the topics of families, housing, education, employment, and the justice system that are important to understand. Each chapter addresses a social determinant of health that impacts an individual’s recovery from OUD, as well as their overall well-being. For example, the employment chapter explains that most individuals have the right to take up to 20 weeks off work to get treatment for OUD without losing their job. The “Your Rights in Recovery Toolkit” was developed through RIZE’s Together in Recovery: Supporting Informed Decisions initiative that was launched in April 2019 to foster an accessible, integrated treatment and recovery network in Massachusetts that champions evidence-based approaches, supports multiple pathways to recovery, and puts people in charge of their treatment choices. The Together in Recovery Advisory Committee, comprised of advocates, clinicians, and public officials, helped create the “Your Rights in Recovery Toolkit” as a means to improve support for individuals living with OUD. The toolkit was launched on April 7, 2021 and in the last two weeks, there were over 500 unique views and the average time spent on the toolkit is 4 minutes.

Why did you develop this?

The current system of substance use disorder treatment often perpetuates stigma, bias, and a power imbalance that keeps vulnerable people stuck in punitive and ineffective cycles of care. It is afflicted by antiquated policies and procedures, a payment structure that discourages equitable access to treatment, and divisive ideological debates that cloud patients’ decisions. In response to these challenges, RIZE created and disseminated a toolkit that addresses the rights and protections of people with opioid use disorder. Because many people are unaware of the types of treatment available, and the rights afforded to them, only 11% of people who needed substance use treatment received care at a specialty facility, according to SAMHSA’s 2018 National Survey on Drug Use and Health.

Who is the target audience?

The audience is people who suffer from OUD and their loved ones; case managers, especially those who assist with discharge planning and treatment plans; prescribers of medication for opioid use disorder; criminal justice professionals, including probation officers and law professionals; advocates; housing specialists; etc.

Is this based on established work, or does it draw from other existing work?

The toolkit pulls information from public sources from the Massachusetts treatment and legal system but this is new product developed by RIZE.

How does your project or initiative work?

The “Your Rights in Recovery Toolkit” is designed to empower individuals who may not have access to accurate information – often through no fault of their own – to manage their addiction and begin to recover safely. It is accessible online at www.rizema.org/yourrights, prints easily, and is available in English and Spanish.

What are the results? If results are not yet available, what results do you hope to achieve?
RIZE is dedicated to highlighting the stigma and inequities in the addiction treatment system and making resources accessible to all people and communities to promote equity. We envision a world where all people who use drugs and those who have addiction are treated with care, respect, and dignity. Stigma associated with drug use or addiction must end. We hope this toolkit provides the building blocks needed for this kind of future.

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care coordination