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Health Care Professionals' Stigma Toward People with An Opioid Use Disorder: Preliminary Findings on The Effect of Amount of Contact Has on Stigma

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Introduction

Opioid-related deaths are the leading cause of injury and death in Utah (Dube & Doom, 2020). Professionals working in the public, behavioral, or physical health sector provide an array of treatment and preventative options in efforts to combat high rates of opioid misuse, which can become diagnosed as an Opioid Use Disorder (OUD) when there is a pattern of misuse that leads to significant impairment and distress in an individual (Elliott & Jones, 2019). The contributors to OUD rates are complex and largely stem from a myriad of community and societal influences, including environmental supports, stigma, and socioeconomic status (Degenhardt et al., 2019; Florence et al., 2021; Witkiewitz & Vowles, 2018).

Given the complexity and prevalence of OUD, it is beneficial to have various accessible holistic treatment and prevention options that are compassionate, supportive, and delivered by trained professionals (Carney, 2018). Despite this need, not all health professionals undergo training related to stigma nor are they trained in strategies to effectively work with people who use opioids. When health professionals have not received training related to stigma nor do they personally have an awareness of stigmatizing behaviors, they may impact the services they provide to persons and also reduce healthcare seeking among persons who have been impacted by OUD (Mackey et al., 2020). Such barriers experienced by persons who use opioids could lead to avoiding or postponing treatment and therefore exacerbating and elongating the effects of opioid misuse, including chronic conditions and infections.

Prolonged opioid misuse is shown to exacerbate an existing chronic condition, such as cancer, stroke, or obesity (Rajbhandari-Thapa et al., 2019). The researchers analyzed data of hospitalizations from 2011-2015 and found that individuals with at least two chronic conditions made up more than 90% of opioid-related hospitalizations. Prolonged opioid misuse is also

correlated with an increase in bacterial, viral, and sexually transmitted infections such as hepatitis C, human immunodeficiency virus (HIV), and endocarditis, leading to hospitalizations, specifically in people who inject substances (Farnsworth et al., 2020; Infectious Diseases Society of America, 2018).

Those seeking treatment for opioid misuse have reported stigma as the leading barrier to accessing treatment from health professionals, including primary care physicians, social workers, and therapists (Leshner & Macher, 2019). Stigmatizing views include the labeling, stereotyping, separation, status loss, and discrimination placed on an individual (Link & Phelan, 2001). Stigma not only reduces treatment seeking among persons using opioids, but it also leads to poorer patient care (Olsen & Sharfstein, 2014; Van Boekel et al., 2013) which can contribute to insufficient or inappropriate treatment based on a misunderstanding of the complexity of the disorder. Additionally, stigmatization can lead to aggravated physiological and psychological disturbances and increased feelings of isolation, all of which can prolong treatment (Leshner & Mancher, 2019). However, it is important to recognize that not all providers delivering OUD treatment are insufficiently trained or hold stigmatizing views of people who use opioids.

Healthcare providers are one group of professionals who receive training, either through higher education or continuing education efforts. Specifically, previous research has shown that those who have increased contact with persons diagnosed with an OUD have been shown to have less stigma towards those with such a diagnosis, thereby increasing the quality of care (Livingston et al., 2011). A systematic review conducted by Van Boekel and colleagues (2013) similarly found that health professionals who had contact with patients diagnosed with a substance use disorder (SUD), including OUD, reported more positive attitudes towards the diagnosed individual. While this supports the notion that contact between health professionals

and individuals with an OUD decreases stigmatization, there is limited research determining the amount of contact needed and how this impacts the professional's level of OUD-related stigma.

Based on the aforementioned OUD-related issues, it is clear that OUD is a complex and highly nuanced public health issue. The present exploratory project seeks to provide additional context to the relationship between contact of health providers, diagnosed OUD patients, and stigma. More specifically, our project attempts to bolster information on the amount of contact needed to reduce OUD-related stigma. In the current study we examine the relationship between frequency of contact and stigma among healthcare professionals in Utah. We specifically hypothesize that an increase in previous contact with persons diagnosed with an OUD will be associated with decreased stigma towards such individuals. Finally, we utilized the results of this study to inform the development of a community based opioid education program.

Method

Participants and Sample Selection

Data were derived using a one-time survey that was administered via Qualtrics. The survey targeted professionals in the health sector in Utah and was distributed using convenience sampling methods. To recruit participants, the research team utilized their contacts from coalitions, county public health agencies, and other collaborators to send an email inviting health professionals to participate in the survey. In total, three emails were sent over a three-week period in the spring of 2021.

Since this study aimed to inform the development of a professional development seminar targeting health or behavioral professionals, participants were required to: a) work in healthcare or behavioral health fields and b) practice in the state of Utah.

Procedures

The survey took 10-15 minutes to complete and participants (N = 88) were able to skip any questions they preferred not to answer. This study was approved by the project team's Institutional Review Board prior to collecting any data and informed consent was attained at the start of the survey. If the participant consented and completed the survey, their name was entered into a drawing for one $50 Amazon gift card.

Measures

The dependent variable was the stigma scale (Cronbach's alpha = 0.65; for current study), from Yang et al. (2019), and included four items asking about the participant's beliefs about persons who misuse opioids (e.g., cannot be trusted, is dangerous; see Table 1 for questions). While the question's themselves were part of a larger scale (Brief Opioid Stigma Scale), we elected to utilize only one of the three subscales (Yang et al., 2019). Opioid misuse was not defined for participants. Response options for each question ranged from strongly disagree to strongly agree. The composite measure scores ranged from 0-5 with higher scores indicating higher levels of stigmatizing views.

The independent variable of interest was the frequency of contact the professional had with people who misuse opioids. Response options included: I do not interact with clients who are impacted by opioid misuse, daily, more than once per week, weekly, monthly, every few months, and a few times per year.

Participants' roles within the health profession were assessed by asking, "which of the following best describes your role in the healthcare profession?" with seven response choices (e.g., nurse, physician, social worker). After reviewing the data, there was a large number of "other" responses with open-ended text. The original categories were then recoded, collapsed, or

created (e.g., social worker and therapist became mental health) based on the effort to combine categories with emergent new categories from open-ended text responses. Additional survey items included demographic questions including the participants' age, race, gender, role within the health profession, and years in their role.

Data Analysis

All data analysis was completed in Stata 15 (STATA Press, 2017). First, descriptive statistics were conducted to understand the distribution of responses across the sample. Next, an Ordinary Least Square (OLS) regression was conducted to examine the relationship between stigma and frequency of contact of the participant while controlling for select personal and professional demographics.

Results

Univariate statistics for the sample are presented in Table 2. Participants (N = 86) most often came from the health care field (36.1%). Participants reported interacting often (39.5%), defined as weekly to monthly, with someone misusing opioids in their professional practice. Overall, participants were most often 45 years of age and older (54.6%), white (66.7%), and identified as female (79.6%).

Results for the OLS regression models predicting stigma among professionals working in the health sector are reported in Table 3. As hypothesized, professionals with increased contact with a person misusing opioids had less stigma (β = -0.69, SE = 0.24, p = 0.05), compared to professionals in the health sector who did not have any contact with someone misusing opioids. Specifically, daily contact with someone who was misusing opioids significantly predicted decreased stigma among participants. Interestingly, all other frequency of interactions did not significantly predict a reduction in stigma. An unexpected result was that regardless of the

amount of contact with persons misusing opioids, behavioral healthcare providers had significantly decreased stigma ($\beta = -0.35$, $SE = 0.17$ $p < 0.001$) compared to healthcare providers. No additional factors significantly predicted stigma.

Discussion

The results of this study suggest that increased contact between health professionals and those who misuse opioids is correlated with decreased levels of stigma. Our preliminary findings affirm that the more contact a health professional has with an individual who misuses opioids, in this case daily contact, the less stigma they have towards persons who misuse opioids. The results of our study are consistent with the findings of previous studies (Livingston et al., 2011; Van Boekel et al., 2013) denoting that the amount of contact or exposure to persons who misuse opioids can reduce stigmatizing views.

However, our results are unique in the sense that behavioral healthcare providers reported significantly less stigma compared to their health care provider counterparts; suggesting that contact alone does not necessarily result in a decrease of stigma (Bielenberg et al., 2021). Rather, intervention components such as motivational interviewing and education or training centered around caring for patients with a SUD in concert with contact may result in decreased stigma over time (Bielenberg et al., 2021). Content provided in education and training includes using person-first language, focusing on protective factors that help decrease the risk of developing a SUD, promoting harm reduction strategies to mitigate consequences of a SUD (e.g., infections, overdose), and sharing positive stories of recovery (Atisme et al., 2019). Behavioral healthcare providers may be more likely to take part in such programs focused on SUD patients due to the nature of their work, whereas general healthcare providers' continuing education may focus on

traditional medicine such as detoxification and medication management (Gold & Wong, 2018). Future research should examine the disparity in stigma attitude across professions.

The results of the current study also suggest that healthcare providers may not be getting the same level of education and training that behavioral healthcare providers are and that amount of contact may be a proxy for education and training. Based on the work of Gold and Wong (2018), traditional medicinal practices for treating OUD are not as effective without the integration of behavioral health treatment. Therefore, holistic education and training requirements that encompass health and behavioral health are encouraged for all providers who treat OUD. We suggest that evidence-based trainings such as motivational interviewing and other educational programs (e.g., Reducing Stigma Education Tools [ReSET] and harm reduction practices) should be contact-based and a training that providers who interact with those with a SUD receive (Livingston et al., 2011; Substance Abuse and Mental Health Service Administration, n.d.; University of Texas at Austin, n.d.).

Development of a Community Opioid Education Program

The results from the current study were used to inform the project team's creation of a one-time one-hour virtual workshop for healthcare and behavioral health professionals' treatment of OUD. The workshop specifically targeted healthcare professionals in Utah, with an aim to reduce stigma and increase provider knowledge about opioid use and stigma. In the workshop, participants were presented information about the basics of opioids, how opioid dependence occurs, identifying and responding to a suspected OUD, alternative non-medication treatments, types of stigma and stigma reduction strategies, and local and state resources for professionals to gather more information. It was piloted with behavioral health professionals in Utah and San

Juan counties in August 2021 and preliminary findings suggested that the workshop met its aims (Murza et al., 2023).

Since the pilot, the content has been presented to public health professionals as professional development trainings, or shared with them so they can train their staff. This helps familiarize them with OUD and related topics as they work with the public, including those in recovery and treatment.

Limitations

Several limitations should be considered when interpreting our results. First, it is possible that the contact measure we used may be a proxy for the amount of training received. While we did control for health role as a confounder, we collapsed categories of health professionals due to small cell sizes. Future studies should examine the effects of both contact and training regarding SUD/OUD treatment and stigma as it is possible that they mediate the relationship examined in the current study. Additionally, we did not control for the amount of personal contact that participants might have with people with OUD outside of their professional work, which should be included in future studies as many people who work in the substance use field may have backgrounds with personal experiences that drove them into this field of work. Also, we relied on a cross-sectional survey and a convenience sample to obtain survey data. This approach helped us obtain an adequate sample size but may impact the generalizability of the results outside of Utah. Finally, while a Cronbach's alpha of 0.65 is reasonable (Taber, 2018), it is ideal to achieve a Cronbach's alpha of at least 0.70 to assess the reliability of measures.

Conclusion

Overall, the present study's results add to a limited research base regarding the relationship between amount of contact and health care providers' stigma towards OUD. The

results suggest that increasing the amount of contact health providers have with those with an OUD would improve substance misuse treatment and recovery services, therefore potentially decreasing Utah's OUD-related deaths and injuries. The results of our study may also provide useful information to healthcare providers by suggesting that they increase their amount of contact with those with an OUD and seek education and training opportunities to aid in stigma reduction. However, further research should be done to measure contact/training for SUD/OUD treatment and stigma to account for a possible proxy for training and preparedness.

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Table 1

Stigma scale individual items (Yang et al., 2019)

	Question
1	I believe that a person who is addicted to opioids cannot be trusted.
2	I believe that a person who is addicted to opioids is dangerous.
3	I think that a person who is addicted to opioids is to blame for his or her problems.
4	I believe that a person who is addicted to opioids is lazy.

Table 2

Descriptive statistics for the sample of study participants (N = 88)

Variables	%	
Health Role		
Health care provider	36.1	
Mental health care provider	19.8	
Behavioral health care provider	19.8	
Public health worker	19.8	
Dietician	3.5	
Pharmacist	2.3	
Frequency of interaction		
Never	26.7	
Rarely	23.3	
Often	39.5	
Daily	10.5	
Age		
18 - 24 years old	3.3	
25 – 44 years old	42.1	
45 years or older	54.6	
Race & Ethnicity		
White	66.7	
Non-white	33.3	
Gender		
Male	20.5	
Female	79.6	
	μ (SD)	Range
Years in role	10.5 (8.5)	0.5 – 35
Stigma	2.3 (0.6)	1 – 3.75

Table 3

OLS regression model predicting internalized stigma among professionals working in the health sector (N = 86)

Variables	Coef (*SE*)
Health Role (ref: health care provider)	
Mental health care provider	-0.32 (0.17)
Behavioral health care provider	-0.35 (0.17)*
Public health worker	-0.14 (0.19)
Dietician	0.27 (0.36)
Pharmacist	-0.48 (0.43)
Frequency of interaction (ref: never)	
Rarely	-0.25 (0.18)
Often	-0.31 (0.17)
Daily	-0.69 (0.24)**
18 - 44 years old (ref: 45 years or older)	-0.06 (0.13)
White (ref: non-white)	0.10 (0.15)
Female (ref: male)	-0.25 (0.16)
Constant	3.09 (0.35)***

Coef: Coefficient; SE: Standard Error; * $p<0.05$, ** $p<0.01$, *** $p<0.001$