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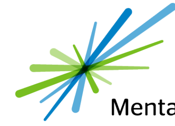

Mental Health Commission of Canada
Commission de la santé mentale du Canada

Evaluating a Contact-Based Substance Use Stigma Reduction Intervention

Can a general contact-based substance use stigma reduction intervention reduce opioid-related stigma?

Mental Health Commission of Canada
mentalhealthcommission.ca

Ce document est disponible en français

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Introduction: Stigma, Health Providers, First Responders, and the Opioid Crisis

The opioid crisis continues to affect thousands of people in Canada each year. Between January 2016 and June 2020, there were more than 17,000 apparent opioid-related deaths, with the highest number in one period being 1,628 deaths recorded between April and June 2020.[1] While previous data suggested a decrease in opioid-related deaths from 2018 to 2019, recent data shows that deaths are increasing once again in the context of the COVID-19 pandemic. In addition to opioid-related deaths, there were over 21,000 opioid poisoning-related hospitalizations in Canada between January 2016 and June 2020.[2] This number illustrates just a fraction of the interactions that people who use opioids have had with health-care providers (HCPs) and first responders (FRs). What we don't see from this number is the many day-to-day interactions that happen, whether for treatment or other reasons.

It has been well established that the public holds stigmatizing views toward individuals who use substances.[3] However, people who use opioids must also contend with the additional stigma of medication maintenance therapy, despite it being recognized as a best practice in opioid addiction treatment.[4] There is also a lack of acknowledgment that many individuals with opioid use problems developed their conditions due to overprescribing by physicians.[5] The negative attitudes and beliefs associated with the use of opioids manifest themselves both in interactions with the public and with HCPs and FRs. HCP and FR stigma increases barriers to care and reduces the quality of services received by those who use opioids.[6] People seeking or accessing treatment for an opioid use disorder have described feeling degraded, dismissed, and devalued when interacting with HCPs and FRs.[7]

In 2017, the Mental Health Commission of Canada (MHCC) set out to investigate the effects of HCP and FR stigma on service delivery and care received by those who use opioids.[*] One of the study's main findings was to identify the need for more stigma-informed education and training for HCPs and FRs, using a social-contact (or contact-based) approach.[8,9] Social contact includes the direct and meaningful involvement of people with lived and living experience of substance and/or opioid use. Involvement can range from personal testimonies to program design and/or facilitation.[10,11] Many studies around the world have shown contact-based approaches to be effective. They are widely considered a best practice for stigma reduction[12] and have been leveraged in many of the MHCC's successful stigma reduction initiatives around mental illness.[13]

In 2019, the MHCC embarked on a second study to identify and evaluate specific anti-stigma programs for HCPs and FRs. It sought to learn what works and why in order to share, promote, and replicate those findings and support the scaling up of effective programs and practices.

This report describes the results of one of four programs the MHCC evaluated as part of this study: a workshop-based stigma reduction and education program developed and delivered by a national non-profit organization. This organization works to end stigma around substance use and operates in partnership with a non-governmental organization that provides national leadership on this issue.

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[*] Funding for this MHCC Opening Minds initiative was provided by Health Canada.

Program Description

This program is an in-person workshop that aims to reduce substance use-related stigma through education on addiction, the effects of stigmatizing behaviours and language, and the importance of compassion. Over 500 people across Canada — from health-care, research, support, and first responder communities, as well as other professions and the general public — have attended half- or full-day workshops. Social contact or contact-based education is a central component.

During the workshops, experts review evidence and experiences of stigma. Participants are encouraged to recognize stigma in their own lives and are challenged to change how they think about substance use and addiction. Core elements of the workshop include

- education on the neuroscience of addiction
- education about stigma and the use of stigmatizing language
- messages and personal stories from people with lived experience of substance use, delivered in-person and through videos
- messaging around the importance of compassion, the use of person-first language and approaches, and a focus on *wellness* as a paradigm for recovery (e.g., as opposed to abstinence-only approaches and understanding)
- action planning and group activities on what participants can do to help reduce stigma in their organizations and personally.

In February 2020, the MHCC was invited to partner with the two organizations on an evaluation of a half-day workshop in Lethbridge, Alberta. This workshop was delivered to a mixed audience, where many participants worked directly with people living with substance use problems and addiction.[*] The evaluation approach and methodology are outlined in the following section.

Evaluation Approach

The workshop was evaluated using a pre-post design and employed a standardized measure for assessing program impact: the Opening Minds Provider Attitudes Toward Opioid Use Scale (OM-PATOS).[14] This 19-item OM-PATOS was designed specifically to measure attitudes and behaviours among HCP and FR populations toward people with opioid use problems.[†]

Since the workshop was not opioid-specific, participants also completed a nine-item ad hoc adaptation of the OM-PATOS to assess attitudes and behavioural intentions toward people with substance use problems more generally. This adaptation was created in partnership with the organization that designed and delivered the workshop.

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[*] Three workshop sessions (morning, afternoon, and evening) were delivered in Lethbridge. Evaluation results are based on data collected from the afternoon session only. This session adhered closely to survey administration protocols, whereas the morning and evening sessions did not include pretests.

[†] While the original OM-opioid scale contained 24 items, results from recent psychometric analyses suggest the adoption of a 19-item single factor solution (unpublished data). Contact Stephanie Knaak at sknaak@mentalhealthcommission.ca for more information.

To assess the change in participants' attitudes and behavioural intentions, they were invited to complete online versions of the OM-PATOS immediately before (pre) and after (post) completing the course. For each item, participants were asked to indicate their level of agreement on a 5-point scale: *strongly agree*, *agree*, *neither agree nor disagree*, *disagree*, or *strongly disagree*. Average mean scores on the OM-PATOS can range from 1 to 5, with lower scores indicating more positive attitudes (i.e., less stigma).

Unique ID numbers were created so that pre- and post-surveys could be matched for analysis. Paired *t*-tests were used to analyze the statistical significance of average mean score changes from pre- to post-intervention at the 95% confidence level. Effect sizes (Cohen's *d*) were also calculated to estimate the magnitude of change. Conventionally, a benchmarking criterion is used to interpret effect sizes. Values around .20 are considered small in impact, effect sizes around .50 are considered medium, and those of .80 and greater are considered large.[*]

Outcomes on the OM-PATOS were also assessed using a "threshold of success" measure. This analysis was based on an examination of how many participants reached a minimum 80% threshold of success on the scale at pre- and post-intervention. In other words, it looked at how many participants responded to at least 16 of the 19 items on the scale in a non-stigmatizing way. The threshold of success measure was derived by recoding each participant's response so that it represented either a stigmatizing or a non-stigmatizing response. For example, the statement "People with opioid use problems are to blame for their situation" is recoded as non-stigmatizing if the respondent selects *strongly disagree* or *disagree* or as stigmatizing if the respondent choses *neither agree or disagree*, *agree*, or *strongly agree*. This recoding was done for both pre- and post-survey scores. Though somewhat arbitrary, we have used this cut-off in other evaluations to show the number of participants who achieve an A grade or higher before and after an educational session.[15]

Reflection and program impact questions were also included at post-test to capture respondents' own perceptions of what they learned, how the program influenced their behaviours and attitudes, and any aspects (program or delivery) they found particularly helpful or unhelpful.

Basic demographic information was also collected.

Results

Participant characteristics

Participant characteristics are highlighted in Table 1. As is shown, most workshop participants were female (75.0%) between the ages of 21 and 40 (21-30 = 34.1%, 31-40 = 31.7%). Participants were from a range of occupations, many of which related to supporting people with opioid use problems. Several indicated that they worked as nurses or in other health-care-specific roles (10.5%), as harm education specialists or addiction counsellors (12.5%), as support workers (17.5%), or in office, administrative, or research capacities (20.0%).

[*] These analyses were undertaken for both the OM-PATOS and the adapted version of measuring attitudes toward substance use more generally.

Table 1. Workshop Participant Characteristics

	n	Valid %*
Gender		
Female	33	75.0%
Male	10	21.7%
Non-binary	1	2.3%
No response	2	
Age		
20 and under	1	2.4%
21-30	14	34.1%
31-40	13	31.7%
41-50	5	12.2%
51-60	5	12.2%
Over 60	3	7.3%
No response	5	
Profession		
Nurse/Alberta Health Services/health care	4	10.0%
Addiction counsellor/harm reduction specialist	5	12.5%
Support worker	7	17.5%
Librarian/assistant librarian	2	5.0%
Probation officer	3	7.5%
Indigenous-specific/Truth and Reconciliation Commission	2	5.0%
Crisis intervention	2	5.0%
Administration/office/research	8	20.0%
Social work	1	2.5%
Youth services	2	5.0%
Other	4	10.0%
No response	6	

n = 46 *Valid per cent means missing data have been excluded from the percentage calculation.

Mean score changes pre- to post-intervention

In all, 46 participants completed one or both evaluation surveys. A total of 28 surveys could be matched from pre-to post-test. Score changes from these 28 matched cases were used to assess program impact.

A comparison of participant characteristics for those who completed both surveys versus those who completed only one showed no major differences, with one exception: participants who completed both tended to be younger, on average, than those completing only one survey (mean age completing both = 33.8 yrs.; mean age completing one = 43.3 yrs.; $t(42) = 1.18$, $p = .021$)

An assessment of scale reliability (Cronbach's alpha) for both scales at pre- and post-test showed acceptable levels of internal consistency at both time points (OM-PATOS: Cronbach's alpha = .95 at pre-test and .97 at post-test; adapted scale: Cronbach's alpha = .85 at pre-test and .89 at post-test).

Score changes for both the OM-PATOS and the adapted measure are highlighted in Table 2. As is shown, total average mean scores on the OM-PATOS improved from 1.87 ($SD = .66$) pre-workshop to 1.69 ($SD = .64$) post-workshop, for an average relative score improvement of 9.6%. This change was found to be statistically significant at the 95% confidence level ($t[27] = 3.09$; $p = .005$) with an effect size (Cohen's *d*) of .27, which is considered small.

As Table 2 highlights, change for the adapted version of the scale (which measured attitudes toward people with substance use problems more generally) also showed a statistically significant improvement ($t[27] = 4.76$; $p < .001$). The positive change observed represented an average relative score improvement of 12.8% and an effect size (Cohen's *d*) of .43, which is considered medium.

Table 2. Score Change Pre-to-Post Program: OM-PATOS and Adapted Scale

	Pre-test mean (*SD*)	**Post-test mean (*SD*)***	***t*-test**	***p* value**	**Effect size (Cohen's *d*)**
OM-PATOS (19 items)	1.87 (.66)	1.69 (.64)	$t(27) = 3.09$	.005	.27
Scale adaptation — Substance use (9 items)	1.96 (.58)	1.71 (.59)	$t(27) = 4.76$	<.001	.43

* Lower scores indicate less stigma.

Changes in score for individual items on both scales were also assessed. This analysis showed statistically significant improvements (at the 95% confidence level) from pre- to post-intervention for the following eight items on the OM-PATOS, with effect sizes still considered small but ranging from .28 to .36:

- "I have little hope that people with opioid use problems will recover" (Cohen's $d = .28$).
- "People with opioid use problems cost the system too much money" (Cohen's $d = .34$).
- "People with opioid use problems who take drug therapies like methadone are replacing one addiction with another" (Cohen's $d = .35$).
- "People with opioid use problems only care about getting their next dose of drugs" (Cohen's $d = .30$).
- "When people with opioid use problems ask for help with something, I have a hard time believing they are sincere" (Cohen's $d = .34$).
- "If a co-worker says something negative about people with opioid use problems, I would be more likely to speak negatively when discussing them myself" (Cohen's $d = .36$).
- "I tend to think poorly about people with opioid use problems" (Cohen's $d = .29$).

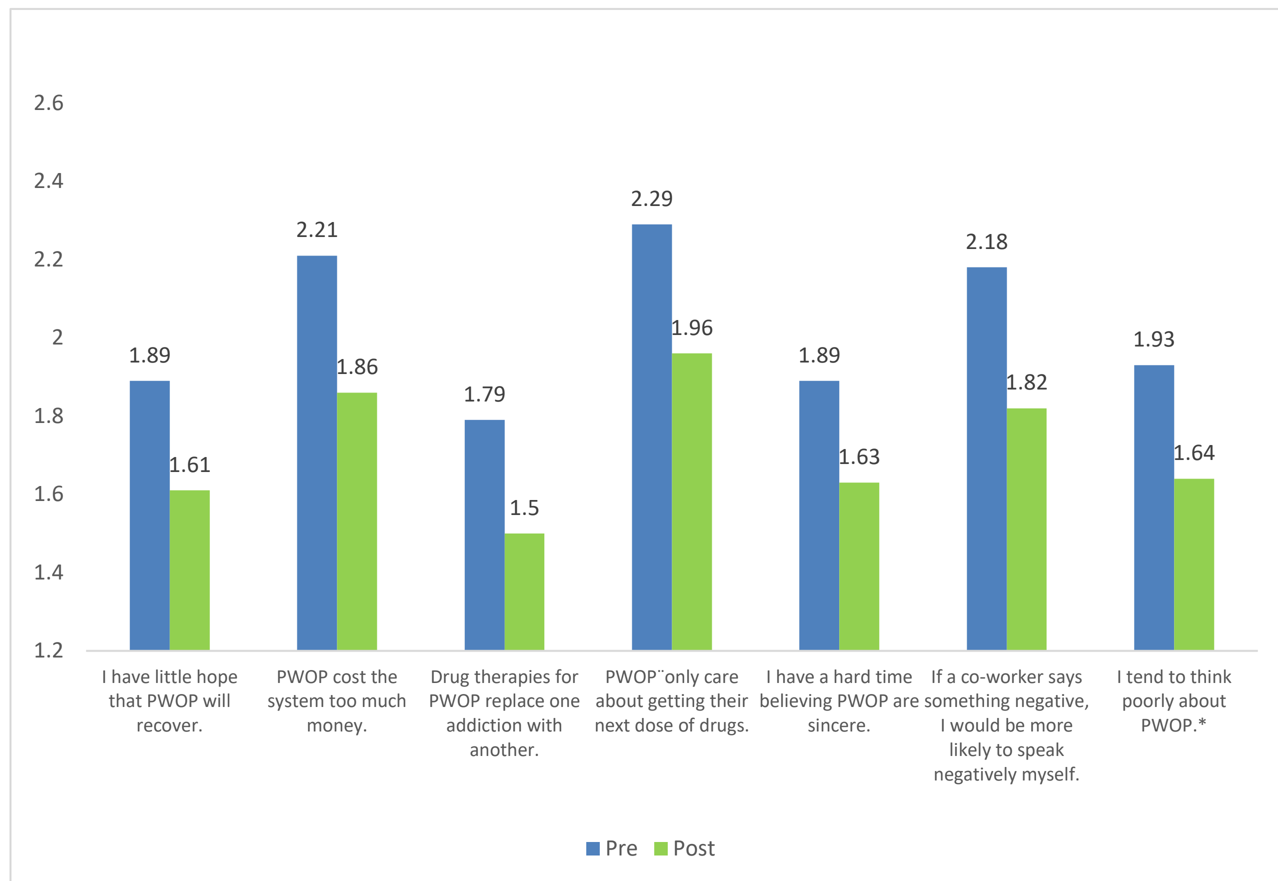
Score changes for these items are highlighted in Figure 1.

No items showed significant negative change from pre- to post-intervention. Items that showed the least amount of change were the following two statements:

- “People with opioid use problems are weak-willed” (pre-test mean = 1.36, *SD* = .56; post-test mean = 1.36, *SD* = .49).
- “I tend to use negative terms when talking about people with opioid use problems” (pre-test mean = 1.82, *SD* = .86; post-test mean = 1.79, *SD* = .92).

Note: the first sentence had a relatively low average mean score at baseline, indicating the possibility that there may be less room for change on this item.

Figure 1. Items Showing the Most Change From Pre- to Post-Intervention on the OM-PATOS



* PWOP = people with opioid-use problems. On a 5-point scale, *strongly agree* is coded as 1, and *agree* is coded as 2; lower scores indicate less stigma.

For the adapted version of the scale, the analysis showed statistically significant improvements (at the 95% confidence level) from pre- to post-workshop on the following three items, with effect sizes ranging from .37 to .64:

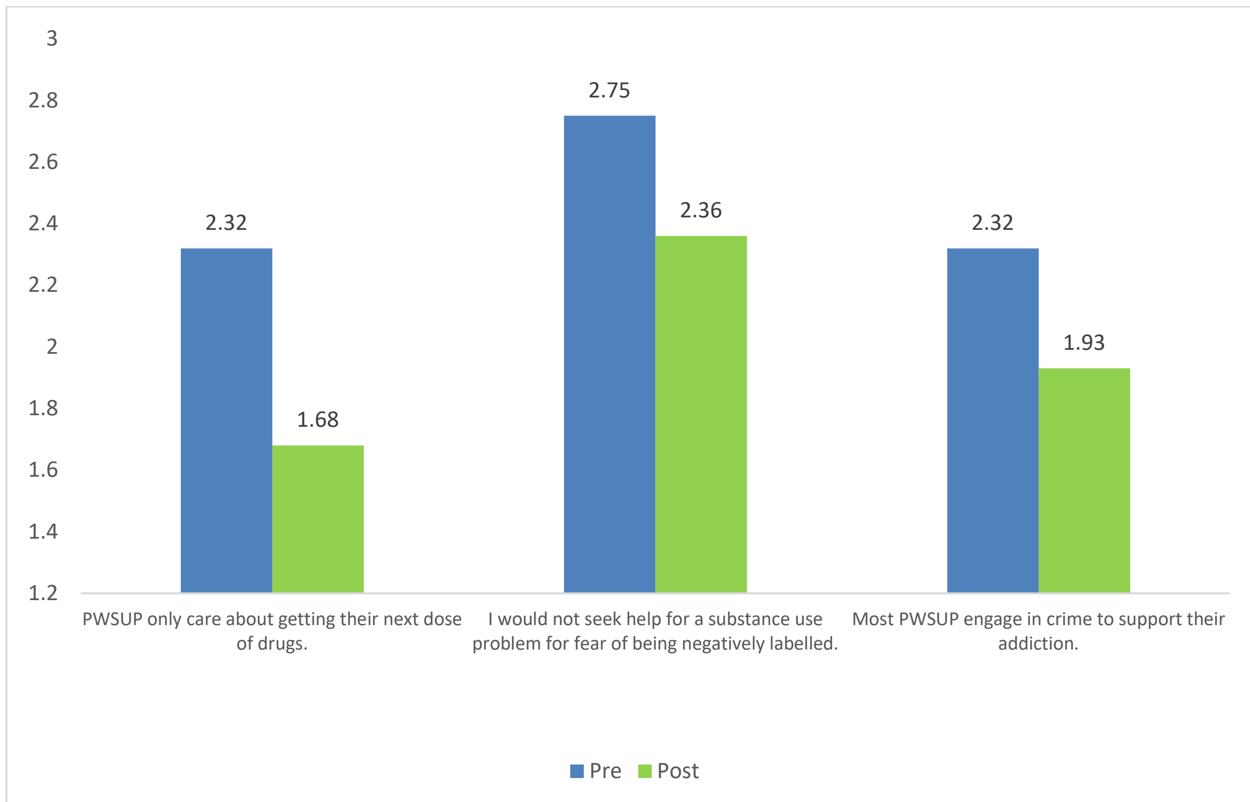
- “People with substance use problems only care about getting their next dose of drugs” (Cohen’s *d* = .64).
- “I would not seek help for a substance use problem for fear of being negatively labelled” (Cohen’s *d* = .37)
- “Most people with substance use problems engage in crime to support their addiction” (Cohen’s *d* = .45).

Score changes for these items are highlighted in Figure 2.

No items on the adapted scale showed significant negative change from pre- to post-intervention. The following item saw the least amount of change from pre- to post-test:

- "I would have a hard time trusting someone who used to have a substance use problem" (pre-test mean = 1.86, *SD* = .76; post-test mean = 1.89, *SD* = .88).

Figure 2. Items Showing the Most Change From Pre- to Post-Intervention on the Adapted Scale



PWSUP = people with substance use problems. On a 5-point scale, *strongly agree* is coded as 1, and *agree* is coded as 2; lower scores indicate less stigma.

Threshold of success change pre- to post-intervention

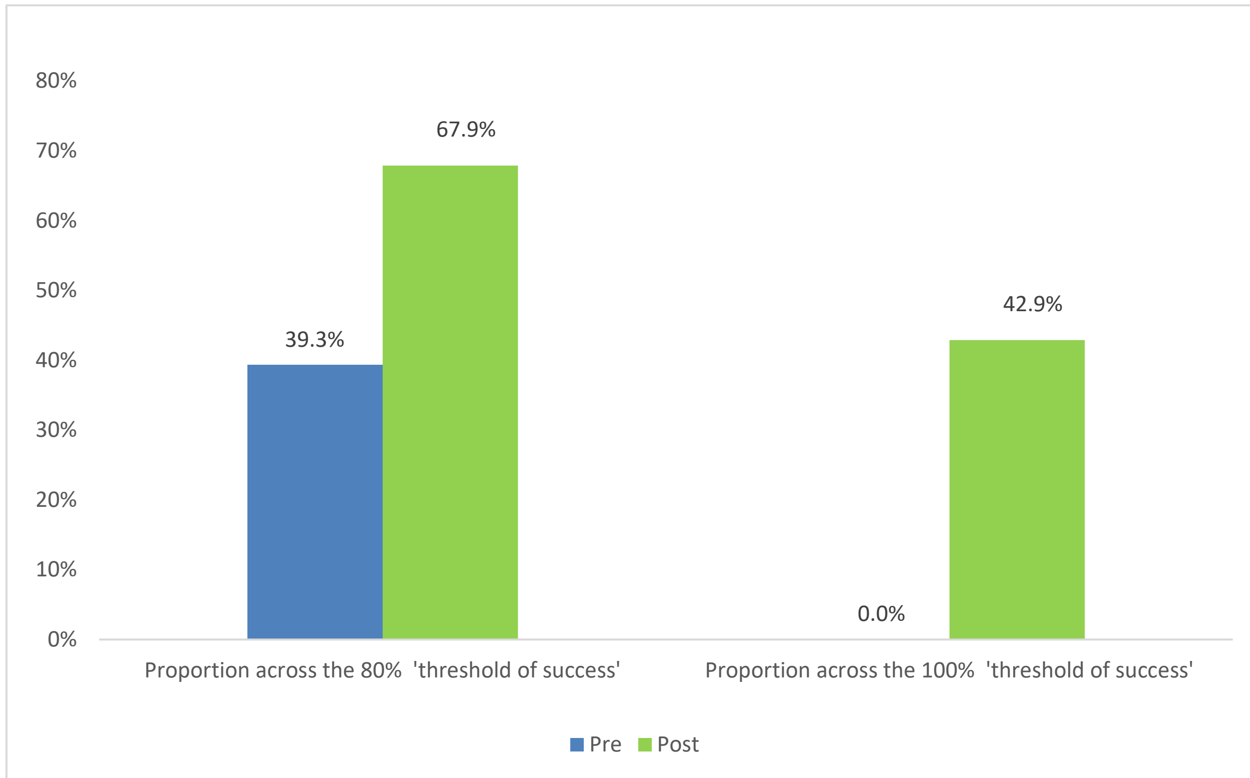
Pre-to-post changes in score on the OM-PATOS were also analyzed according to the threshold of success criteria. These results are highlighted in Figure 3. As is shown, the proportion of participants across the threshold (i.e. the proportion who responded to at least 80% of the items in a non-stigmatizing way) increased notably from 39.3% at pre-test to just under two-thirds at post-test (64.3%).

Equally encouraging was that the proportion of participants who responded to all 19 scale items in a non-stigmatizing way (i.e., the 100% threshold of success) increased from 0% of participants at pre-test to over four in 10 at post-test (42.9%).

In all, 14.3% of the participants showed no change in score from pre- to post-workshop. An analysis showed that these participants had very low stigma scores at baseline (pre-test average mean score = 1.11, *SD* = .22), indicating little possible room for improvement. As well, five participants' scores

worsened slightly from pre- to post-workshop (pre-test mean score = 1.83, *SD* = .41; post-test mean score = 2.04, *SD* = .59), although the change was non-significant and did not affect their threshold of success scores.

Figure 3. Pre-to-Post "Threshold of Success": OM-PATOS



n = 28 Threshold of success = the number of participants who responded to at least 80% of the statements (16 of 19) or 100% of the items (19 of 19) in a non-stigmatizing way.

Perceived program impact and participant feedback

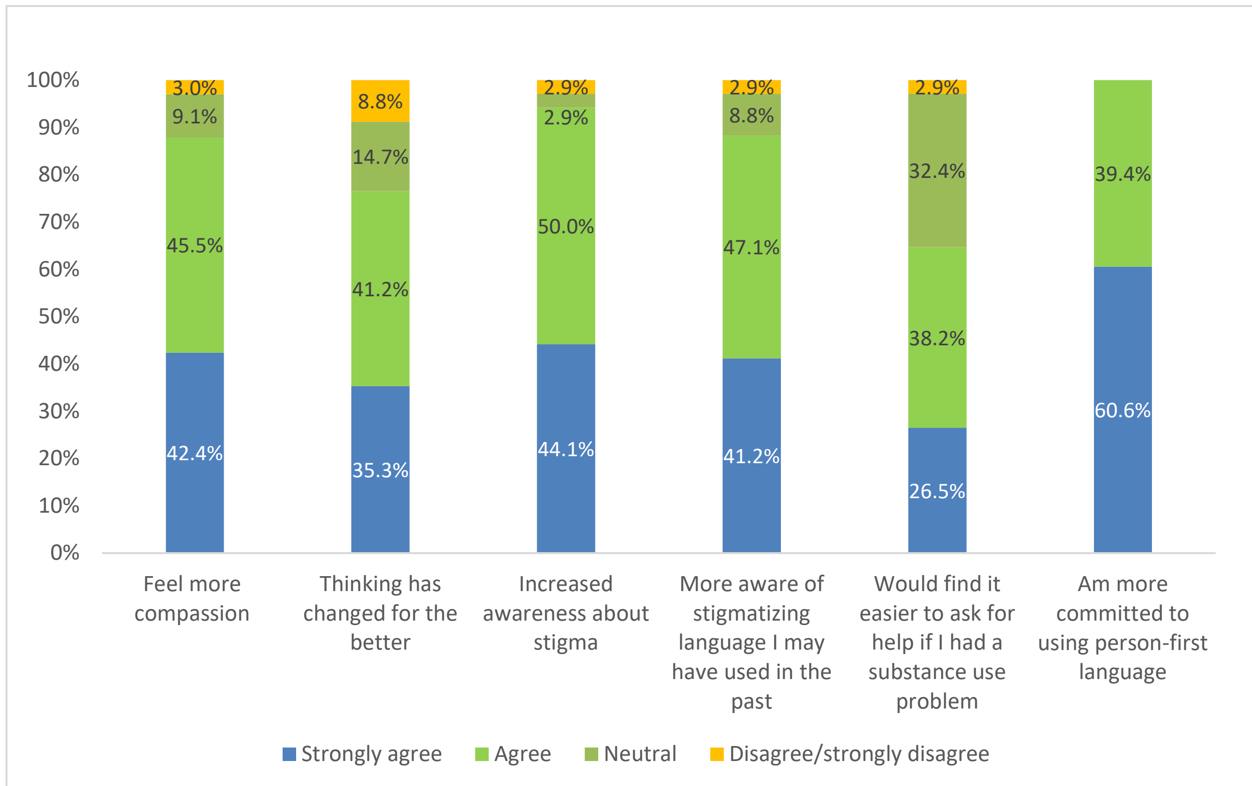
Respondents were asked a series of questions at the end of the workshop (i.e., at post-test) pertaining to what they learned.

First was the extent to which they agreed or disagreed with a series of statements about the program's impact on their attitudes, awareness, and behaviours (see Figure 4).

As is shown, 100% of participants agreed or strongly agreed that since attending the workshop, they were more committed to using person-first language when speaking about people with substance use problems (*agree* = 39.4%; *strongly agree* = 60.6%). Results further suggest that, for many participants, the workshop re-affirmed and deepened their commitment to be compassionate and supportive when interacting with people with substance use problems. Additionally, most (64.7%) agreed or strongly agreed that they would find it easier to reach out for help if they had a substance use problem (*strongly agree* = 26.5%; *agree* = 38.2%). As well, just over three-quarters of participants (76.5%) agreed or strongly agreed that their thinking about people with substance use problems had changed for the better (*strongly agree* = 35.3%; *agree* = 41.2%).

Over eight in 10 (87.9%) reported feeling more compassion toward people with substance use problems (*strongly agree* = 42.4%; *agree* = 45.5%).

Figure 4. Perceived Program Impacts



n = 33-34

In three open-ended questions, participants were also asked to (1) describe which elements or parts of the workshop most affected their understanding of people with substance use problems, (2) whether they felt their behaviour would be different than before the intervention, and (3) which parts of the workshop they found most valuable. Responses include the following:

Which parts most affected your perception or understanding of people with substance use problems?

- “Explaining that it is a disorder — we know it hurts us, but we can’t stop doing it anyway.”
- “[The facilitator’s] stories and the firsthand, lived experiences that he shared.”
- “Hearing stories of people with substance use problems caring for and helping others.”
- “That it’s a brain malfunction that causes people to use substances to fill a void.”
- “Realizing that professionally I have not used first-person language.”
- “It served as a good reminder why language is so impactful and important.”
- “More thinking around the concept of compassion and it being a large component of this issue.”
- “The personal stories that create hope and make the impossible possible — recovery.”
- “Understanding language to reduce stigma in my community as a whole. Also about prioritizing humanizing people instead of focussing so much on why/how they got there.”
- “The information shared by [the facilitator]. The group discussion and insight of the group.”

- “Getting challenged on why in Canada we treat our neighbours the way we have.”

Will your behaviour change? If so how; if not, why not?

- “I feel re-centered and have a bit more awareness, I am sure I will have the opportunity to grow from and work on.”
- “I hope I will continue to be patient and compassionate.”
- “It was a good reminder to be mindful while at work and while not at work.”
- “No. I think I treat people with compassion.”
- “Yes, to be more compassionate.”
- “Try to be more patient and open to hearing people’s personal experiences.”
- “Unsure — I feel I was already aware of stigma and tried not to let it affect how I treat people, but increased understanding will hopefully help me to do even better.”
- “Yes, how I speak, use of language.”
- “Yes, I am more aware of who people with substance issues are. They are people too.”
- “Yes, I am more aware of enabling others’ stigmatizing language.”
- “Yes, kinder words, not labeling. Keeping my practice compassionate to all.”
- “Yes, stronger than before.”
- “Yes, positive language and stopping negative self-talk when I hear it from those suffering from a substance use disorder.”
- “Yes, more compassion.”
- “Sure, in that I am committed to always being better in how I treat people compassionately.”
- “Yes, I am re-committed to helping and supporting people who are changing.”

Which parts of the workshop were most valuable to you?

- “All of it was great.”
- “Approaching stigmatizing individuals with compassion instead of anger.”
- “Break-out session.”
- “[The facilitator’s] presentation.”
- “Great to hear from personal experiences. Nice discussion with my table at the end.”
- “Hearing from people with substance use problems, and group discussion.”
- “Language — moving away from ‘recovery’ to ‘living well.’”
- “Learning the different ways of speaking to individuals with substance issues.”
- “The combination of speakers and videos to hear other stories, also [local lived experience speaker] coming in.”
- “We must help facilitate change. It starts with us to show we want and can help.”
- “Stories (personal), videos.”
- “Time for discussion with other people.”
- “The power of language.”

Summary and Conclusions

Overall, the evaluation of the workshop showed encouraging and promising results. This was evidenced by a number of findings:

- Statistically significant improvements were observed on the OM-PATOS as well as the adapted measure examining attitudes and behavioural intentions toward people substance use problems more generally, with effect sizes in the small (OM-PATOS) to medium (adapted measure) range.
- A notable increase in the proportion of participants across the 80% threshold of success was observed, from under half to nearly two-thirds of participants. Equally encouraging was that the proportion of participants across the 100% threshold of success (i.e., the number of participants who answered all scale items in a non-stigmatizing way) increased from 0% at pre-test to 42.9% at post-test.
- All (100%) of the program participants at post-test agreed or strongly agreed that since taking the workshop they were committed to using person-first language when speaking about people with substance use problems, indicating that participants left the program with a strong action-oriented stigma reduction commitment.
- High levels of agreement from participants about perceived program impacts were observed. A strong majority of participants indicated that (1) they were feeling more compassion toward people with substance use problems as a result of taking the workshop, (2) their thinking about people with substance use problems had changed for the better, and (3) they would find it easier to reach out for help if they had a substance use problem.
- Qualitative open-ended feedback from participants was strongly positive. This feedback highlighted (1) the learning value of various key elements of the content, (2) the positive impact of hearing live and video-based personal stories from people with lived experience of a substance use problem, (3) the helpfulness of the group discussion component, and (4) the strength of the facilitator (who also spoke about personal lived experiences of a substance use problem).

The fact that certain scale items and participant scores worsened slightly from pre- to post-test is an area for further investigation. Some potential factors to consider may include the potential readiness to change among some participants, normal random scale error, and/or program elements.

That greater changes were observed for the adapted measure is perhaps unsurprising, as the workshop is tailored to reduce substance use stigma more generally, rather than to opioid-related stigma. Given the more general thrust of the program, the significant improvements observed on the opioid-specific scale (OM-PATOS) is positive and encouraging.

This evaluation is not without limitations. For one, study results are based on only one session of the workshop. Additional evaluations should be undertaken on future workshops to replicate program outcome findings. As well, attrition was observed in the total number of survey completions and matched data. Because all participants did not complete both surveys — and because a difference in average age was observed for participants who completed both surveys as compared to those who did not — results should be interpreted with some caution.

With these limitations in mind, the current evaluation supports the conclusion that the workshop is promising in its effectiveness as a stigma reduction intervention program, both for stigma related to

opioid use and substance use more generally. The results further suggest that if this intervention were specifically adapted so as to target opioid-related stigma (e.g., by providing more stories from people with lived experience of an opioid use problem and tailoring some aspects of its content), greater impacts in stigma reduction specific to attitudes and behaviours toward people with opioid problems would likely be observed.

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Appendix

Workshop Evaluation Survey

The Mental Health Commission of Canada is undertaking an evaluation of this workshop in order to better understand people's opinions and perspectives with respect to substance use and substance use problems. As part of this evaluation, we are asking all participants to complete a survey just prior to the beginning the workshop, and once again at the completion of the workshop.

Your participation is completely voluntary, and you can choose to answer or not answer any question on the survey. The survey is completely anonymous and confidential. Only aggregated data is used for analysis. If you choose to participate, please answer the questions according to your own beliefs, feelings, and experiences. Your honest opinions are very important, as the aggregated information will be used to help guide the development, improvement, and adoption of education and training tools and programs.

Unique ID Code

In order to be able to match surveys across time points while still ensuring all your responses remain anonymous, we are asking participants to use a unique ID code. Please answer the following questions to create this code:

- What is the last digit of your birth year? ______ (e.g., if you were born in 1977, you would write down "7")
- What is the last digit of the day of the month you were born? ______ (e.g., if you were born on the 25th of the month, you would write down "5")
- What are the last two digits of your home phone number? _____
- What is the last letter of your last name? _____

Section A

The first set of questions asks for your opinions on a series of statements about people with substance use problems. Please answer the questions according to your own beliefs, feelings, and experiences. Please mark the box that best reflects your personal opinion.

Please indicate the extent to which you agree or disagree with each of the following statements.	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
A1. People with substance use problems are weak-willed.	☐	☐	☐	☐	☐
A2. People with substance use problems can't be trusted	☐	☐	☐	☐	☐
A3. People with substance use problems only care about getting their next dose of drugs.	☐	☐	☐	☐	☐
A4. People with substance use problems should be cut off from services if they don't try to help themselves.	☐	☐	☐	☐	☐
A5. People with substance use problems who relapse while trying to recover aren't trying hard enough to get better.	☐	☐	☐	☐	☐

Please indicate the extent to which you agree or disagree with each of the following statements.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
A6. I would not seek help for a substance use problem for fear of being negatively labelled.	☐	☐	☐	☐	☐
A7. I tend to speak down to people with substance use problems.	☐	☐	☐	☐	☐
A8. Most people with substance use problems engage in crime to support their addiction.	☐	☐	☐	☐	☐
A9. I would have a hard time trusting someone who used to have a substance use problem.	☐	☐	☐	☐	☐

Section B*

This section asks for your opinions on a series of statements about people with opioid use problems. Examples of opioids include medications such as Percocet, Vicodin, morphine, and oxycodone. It also includes heroin, fentanyl and carfentanil. By "opioid use problem" we mean a problematic pattern of use that leads to serious harms, impairment, or distress. Please mark the box that best reflects your personal opinion.

Please indicate the extent to which you agree or disagree with each of the following statements.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
B1. I have little hope that people with opioid use problems will recover.	☐	☐	☐	☐	☐
B2. People with opioid use problems are weak-willed.	☐	☐	☐	☐	☐
B3. People with opioid use problems are to blame for their situation.	☐	☐	☐	☐	☐
B4. I tend to use negative terms when talking about people with opioid use problems.	☐	☐	☐	☐	☐
B5. People with opioid use problems cost the system too much money.	☐	☐	☐	☐	☐
B6. I would see myself as weak if I had an opioid use problem.	☐	☐	☐	☐	☐
B8. People with opioid use problems can't be trusted.	☐	☐	☐	☐	☐
B9. People with opioid use problems who take drug therapies like methadone are replacing one addiction with another.	☐	☐	☐	☐	☐
B11. People with opioid use problems only care about getting their next dose of drugs.	☐	☐	☐	☐	☐
B13. People with opioid use problems should be cut off from services if they don't try to help themselves.	☐	☐	☐	☐	☐
B14. I tend to use negative terms when talking about people with opioid use problems.	☐	☐	☐	☐	☐

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Please indicate the extent to which you agree or disagree with each of the following statements.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
B15. People with opioid use problems who relapse while trying to recover aren't trying hard enough to get better.	☐	☐	☐	☐	☐
B16. I tend to speak down to people with opioid use problems.	☐	☐	☐	☐	☐
B17. Most people with opioid use problems engage in crime to support their addiction.	☐	☐	☐	☐	☐
B18. If a co-worker says something negative about people with opioid use problems, I would be more likely to speak negatively when discussing them myself.	☐	☐	☐	☐	☐
B19. I tend to think poorly of people with opioid use problems.	☐	☐	☐	☐	☐

Please answer the following questions ONLY if you are in a helping profession	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
B7. I tend to act more negatively toward people with opioid use problems than other people I help.	☐	☐	☐	☐	☐
B10. I tend to be less patient toward people with opioid use problems than other people I help.	☐	☐	☐	☐	☐
B12. When people with opioid use problems ask for help with something I have a hard time believing they are sincere.	☐	☐	☐	☐	☐

SECTION C

These questions are being asked to provide information on program participation that may assist with analyses.

1. Age: ________
2. Gender: ☐ Male ☐ Female ☐ Non-binary
3. Occupation:____
4. Do you know someone who has a substance or opioid use problem, either currently or in the past? (select all that apply)

   ☐ Yes, a friend ☐ Yes, a family member ☐ Yes, an acquaintance

   ☐ Yes, other ___________________________ (please specify)

   ☐ No ☐ Don't know ☐ Prefer not to answer

SECTION D (for post-test only)

The final questions ask you to reflect on the workshop and how it impacted you. Please mark the box that best reflects your personal opinion.

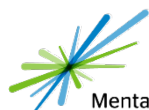
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
D1. I feel more compassionate toward people with substance use problems since taking this workshop.	☐	☐	☐	☐	☐
D2. This workshop has changed my thinking about people with substance use problems for the better.	☐	☐	☐	☐	☐
D3. The workshop increased my awareness about stigma experienced by people with substance use problems.	☐	☐	☐	☐	☐
D4. Because of this workshop, I have become more aware of stigmatizing language I may have used in the past.	☐	☐	☐	☐	☐
D5. If I had a substance use problem, I would find it easier to ask for help since taking this workshop.	☐	☐	☐	☐	☐
D6. Since taking this workshop, I am more committed to using person-first language when speaking about people with substance use problems.	☐	☐	☐	☐	☐

D7. Thinking back on today's workshop, which elements/parts most affected your perception or understanding of people with substance use problems? Please explain.

D8. Do you feel your behaviour toward people with substance use problems will be different than before this workshop? If yes, in what way? If no, why?.

D9. What were the most valuable parts of this workshop for you?

THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS SURVEY.



Mental Health Commission of Canada

Suite 1210, 350 Albert Street
Ottawa, ON K1R 1A4

Tel: 613.683.3755
Fax: 613.798.2989

mhccinfo@mentalhealthcommission.ca
www.mentalhealthcommission.ca

@MHCC_ /theMHCC /1MHCC @theMHCC
/Mental Health Commission of Canada