

Shatterproof Addiction Stigma Index

in collaboration with The Hartford

October 2021



Executive Summary

Eliminating the stigma and discrimination faced by those with substance use disorders (SUD) has never been more important. Despite decades of action from nonprofits, healthcare providers, those with lived experience, and government agencies, stigma remains one of the largest and most persistent drivers of negative outcomes for those struggling with addiction.

During 2020 alone, more than 93,000 people died from overdoses¹– the highest number in history. At the same time, more than 20 million American adults continued to suffer from the disease of addiction.

The COVID-19 pandemic has exacerbated this crisis by increasing economic instability, imposing social isolation, and reducing access to harm reduction, treatment, and recovery services. Structural racism and health inequities have worsened the impacts of the pandemic for marginalized communities, leading to increased rates of substance use² and overdose.³ These effects will be felt for years to come, highlighting the urgent need to act.

Addiction stigma and discrimination experienced by those with a substance use disorder independently leads to tens of thousands of preventable deaths every single year:⁴

- It prevents many with a SUD from ever seeking treatment;
- It makes the public less willing to have someone with a SUD as a close personal friend, a co-worker, a neighbor, and as a family member;
- It limits the ability of institutions and providers to offer help when someone does seek assistance by limiting resources and perpetuating harmful policies;
- And it fuels an ongoing feeling of shame that serves as an obstacle to long-term health for those with a SUD, regardless of whether they have received treatment – entrenching addiction as a relentless and devastating public health crisis.

Three Statistics to Know

- **75.2% of the public do not believe that a person with a SUD is experiencing a chronic medical illness such as diabetes, arthritis, or heart disease.**
- **65.4% of respondents indicated that they would not want someone with a SUD marrying into their family.**
- **46.1% of respondents with an opioid use disorder expressed feeling ashamed of themselves.**

With the American public displaying discriminatory views against this community, which can vary by race and other demographic characteristics, people with a SUD are forced to endure prejudice, social exclusion, and ongoing harm. These views erode self-worth, create social isolation, and reduce access to care, which exacerbates the problem, in addition to clouding the nation's ability to coalesce around meaningful solutions, including treatment, harm reduction, and recovery supports and services.

1 <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>

2 <https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7005a3-H.pdf>

3 <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775360>

4 <https://www.shatterproof.org/sites/default/files/2020-07/A-Movement-to-End-Addiction-Stigma.pdf>

These attitudes are detailed by the first publication of the Shatterproof Addiction Stigma Index (SASI), in collaboration with The Hartford.

Supported by Ipsos alongside Dr. Brea Perry and Dr. Anne Krendl from Indiana University, Shatterproof developed the SASI – a first-of-its-kind measurement tool designed to set a baseline measure of addiction stigma and attitudes from the public about substance use. It also measures the perceptions of those with a SUD, including the degree to which they have internalized societal exclusion. With a comprehensive set of more than 50 validated stigma measures issued to a representative sample of 7,889⁵ U.S. residents, this is both the largest and most expansive survey on addiction stigma ever fielded.

The SASI will be used to measure progress and hold our nation accountable in eliminating one of the major drivers of the addiction crisis. The levels of stigma measured in the SASI are striking. Despite decades of public education, 75.2% of the public do not believe that a person with a SUD is experiencing a chronic medical illness like diabetes, arthritis, or heart disease. Additionally, 53.2% of respondents hold the beliefs that SUD is caused by a person's bad character. Stigmatizing attitudes from the public are connected to broad levels of discrimination felt by those with SUD.

Even worse, 45.4% and 45.9% of the public is unwilling to live next to or be close friends with someone with a SUD, respectively. Stigmatizing attitudes such as these can lead to structural discrimination and can also be found in the discriminatory attitudes displayed by both employers and healthcare professionals who staff and lead institutions meant to support those with a SUD. 44.5% of healthcare professionals surveyed expressed the harmful belief that medications for opioid use disorder were substituting one drug addiction for another. Stigma and discrimination from the public and institutions is often internalized; for example, those who had received treatment for a SUD expressed more self-stigma related to their SUD than people with a SUD who had not received treatment at all.

What's at stake is real. For millions of people across the country – for their loved ones, and for the ones who love them – this is a matter of survival. What has been done to date has not been enough to effect true, impactful change. If we do not address stigma and the resulting individual and structural discrimination toward those with a SUD, we cannot make true progress in ending the addiction and overdose crisis.

Individuals with a substance use disorder face stigma and discrimination

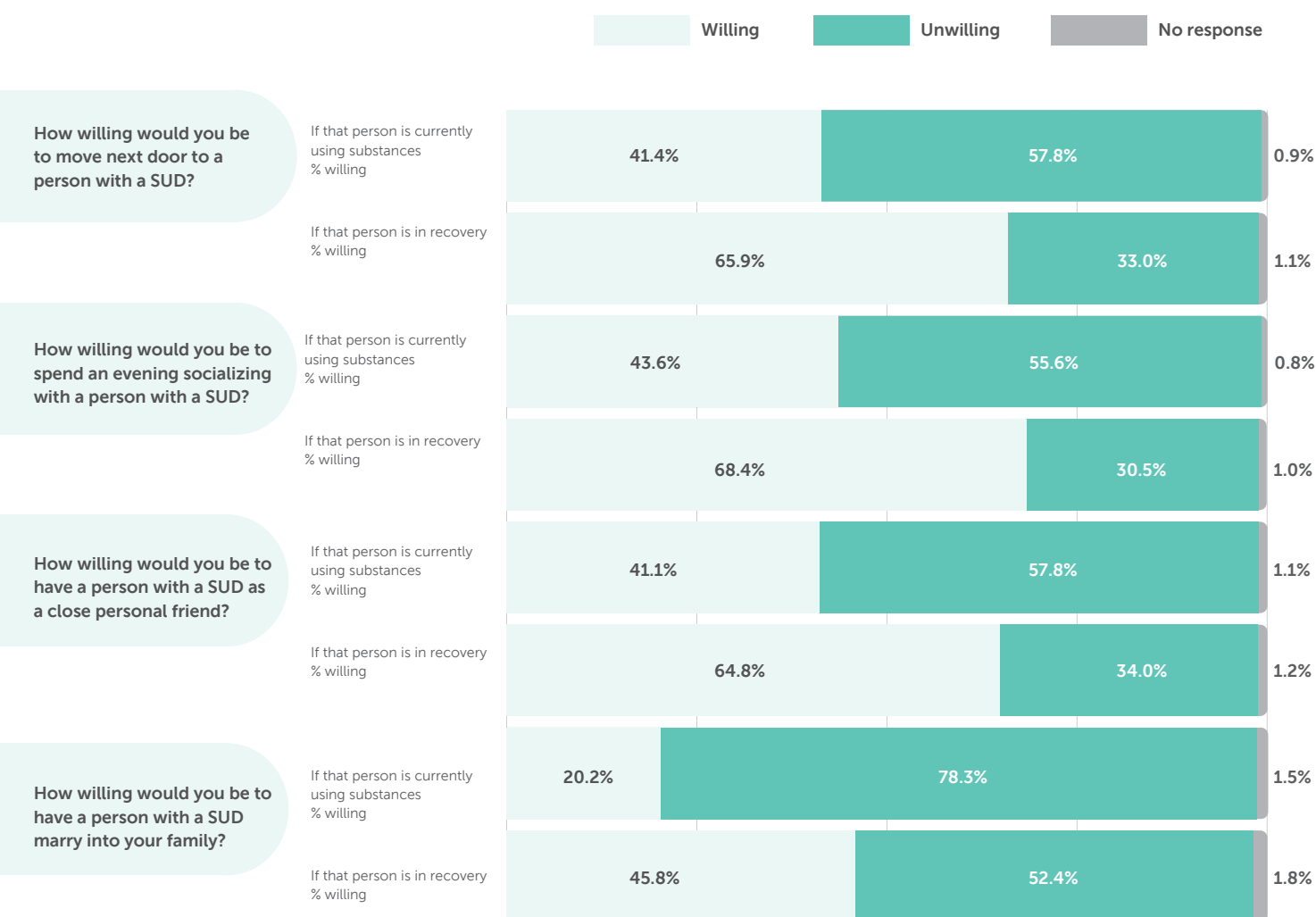
The stigma of addiction and associated discriminatory beliefs and practices have entrenched addiction as a public health issue. This stigma manifests in many places, including in discrimination on individual and systems levels. Public stigma reflects the negative beliefs in society that can isolate those who are struggling with a SUD, while structural stigma limits resources and perpetuates insufficient or harmful policy responses. Those with a SUD often internalize negative stereotypes – fueling self-stigma that serves as an obstacle to recovery and success. Collectively, these three types of stigmas – which also, critically, vary by race and other demographic characteristics – perpetuate the disease and serve as major barriers to treatment, harm reduction, and recovery supports and services.

5 7,805 responses were used to build the Public Stigma Index; 7,798 to build the Structural Discrimination Index; 7,917 responses were recorded overall.

At the core, despite decades of public education campaigns and the hard work of individuals who have shared their addiction stories, few Americans accept addiction as the treatable disease that it is. In fact, the SASI found that less than one quarter of respondents view addiction as a chronic disease.

The widespread incidence of this view was particularly alarming among healthcare workers, only one in four of whom receive training and education throughout school to address this falsehood.⁶ Only 34% of medical schools require didactic training on opioid addiction.⁷ This misconception amongst both the public and healthcare professionals must be addressed – and the false notion that addiction is not a disease must be labeled as outdated and discriminatory.

The public is wary of close contact with individuals who are currently using substances, contributing to a growing sense of isolation among those individuals. Only a quarter of respondents find someone currently using substances to be trustworthy. Only 41% of respondents reported that they would be willing to have someone currently using substances as a neighbor or close friend. The public continues to be wary even of those in recovery, with over a third unwilling to move next door to them or have them as a personal friend. Over half of respondents are unwilling to have someone in recovery marry into their family.



⁶ <https://rizema.org/wp-content/uploads/2019/07/GE-Rize-Shatterproof-White-Paper-Final.pdf>

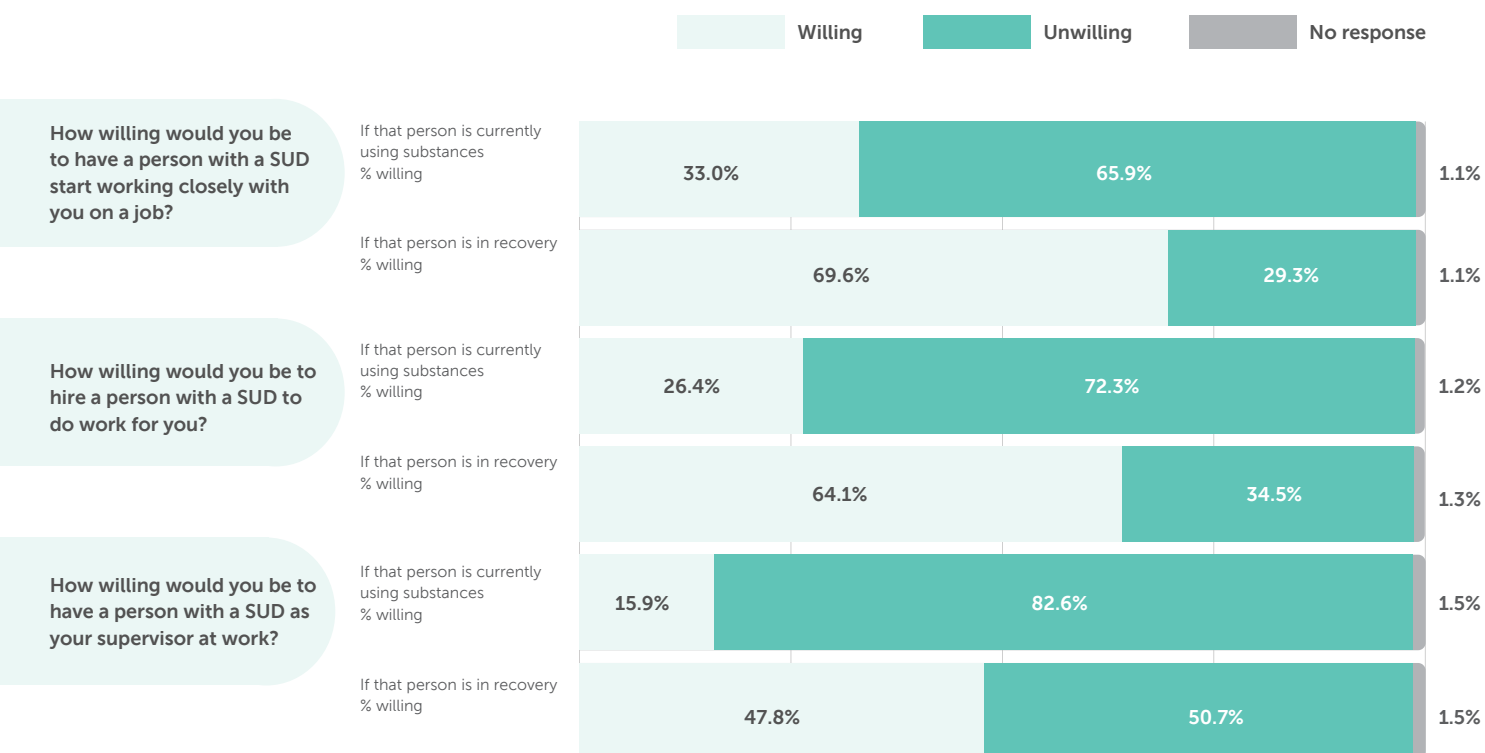
⁷ <https://www.aamc.org/data-reports/curriculum-reports/interactive-data/opioid-addiction-prevention-and-treatment-during-required-experiences>

Again, responses among healthcare professionals were especially discouraging. Healthcare professionals had similar levels of public and structural stigma toward those with a SUD compared to the general population.⁸ Given their ability to directly impact the care of people with a SUD, their similar levels of limited knowledge and stigmatizing views toward medications for opioid use disorder (MOUD) compared to the public is unexpected. Of healthcare professionals surveyed, 44.5% endorsed the harmful belief that MOUD is substituting one drug for another. In comparison, 41.2% of the public expressed the same belief. Moreover, one in four healthcare professionals do not agree that more providers should offer MOUD to increase accessibility.

Addiction stigma not only causes people with SUD to be cut off from those around them and impacts their treatment opportunities. It also affects their ability to find employment. Prejudicial viewpoints heavily influenced the way Americans viewed the employability of those with a SUD in the survey.

When a respondent expressed prejudicial views against someone with a SUD in earlier measures, they were three times less likely to want that person as a coworker, 5.5 times less likely to have that person as a supervisor, and six times less likely to hire that person to do work for them in comparison to those respondents who did not hold prejudicial views.

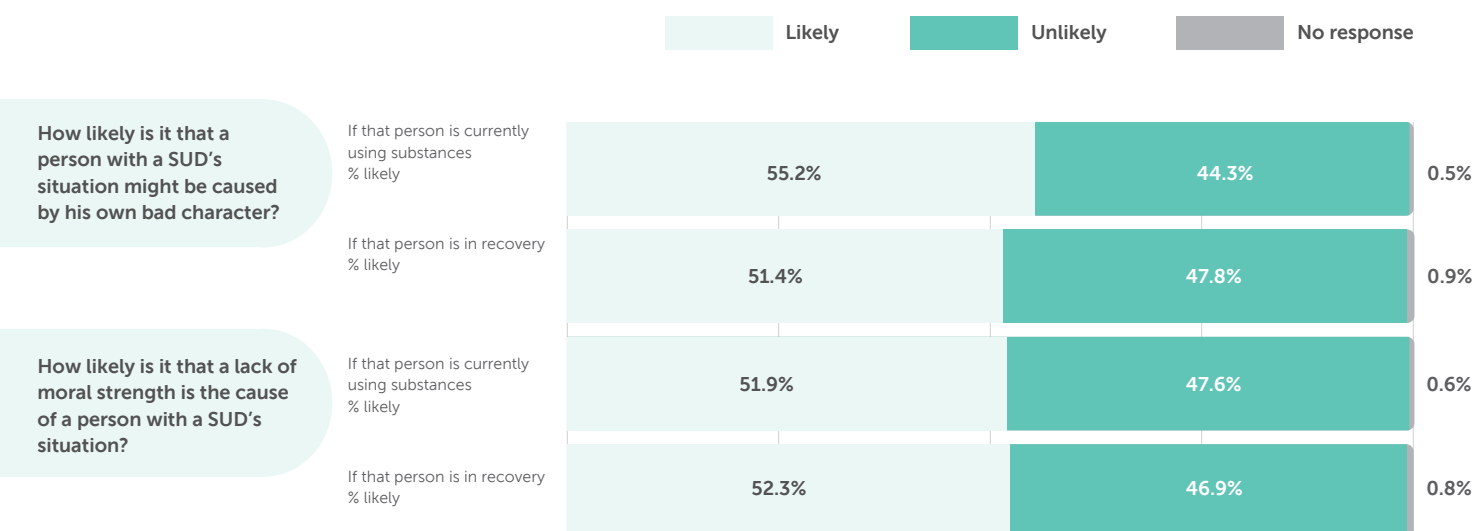
Even if a person is in recovery, fewer than half of respondents indicated that they would be willing to have that person as a supervisor in the workplace, suggesting only moderate levels of support toward those in recovery and showing that any association with substance use can impact long-term perceptions of competency.



⁸ Public stigma: general population at 2.54; healthcare professionals at 2.53; structural stigma: general population at 1.80; healthcare professionals at 1.79; there were no significant differences.

Stigma perpetuates addiction

“Moral failing,”⁹ the belief that addiction is a result of an individual’s irresponsibility, contributes to public stigma. Unfortunately, despite decades of anti-stigma efforts, over half of respondents indicated that a person’s SUD is caused by their own bad character and that lack of moral strength is likely a causal factor. These stigmatizing attitudes create an environment where individuals feel unwelcome and rejected. Social isolation can have significant consequences for a person’s physical, emotional, and cognitive health, and has been identified as a clear risk factor for increased likelihood of substance use and overdose.^{10,11} There were also minimal differences in the perception of those currently using substances and those in recovery in this area, suggesting that people with a SUD face similar levels of judgement regardless of their current or past use, enabling ongoing isolation even years after someone has stopped misusing drugs.



Furthermore, respondents who had personally experienced a SUD reported high levels of stigma toward them from other people and institutions (e.g., job interviewers). Of note, people who had received treatment for a SUD expressed more self-stigma than people with a SUD who had not received treatment at all. Although this last finding could be due to a number of factors (e.g., differences in addiction severity), it suggests that treatment might be associated with increased levels of stigma, and more work should be done to determine if this is true. Anticipated stigma may pose an ongoing potential barrier to accessing treatment and support for an individual’s SUD. It may be possible to reduce anticipated stigma through reductions in both public and structural stigma – but according to the survey, these reforms would take time to be felt by those with a SUD, even with the benefit of clear, compassionate, and targeted communication strategies.

⁹ <https://doi.org/10.1371/journal.pmed.1002969>

¹⁰ <https://academic.oup.com/scan/article/16/7/645/6157894#267286449>

¹¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7838520/>

Stigmatizing attitudes toward evidence-based, effective interventions prevent those with a SUD from accessing the resources and care they need to keep themselves safe. They may also be associated with generating limited funding and public support, further reducing access to these services. Encouragingly, the survey did find widespread support for broadening access to treatment through increased insurer and employer coverage of treatment, as well as a strong belief that healthcare providers should care for someone with a SUD just as they would treat anyone else with a chronic illness.

Agree Disagree No response

Employers should provide opportunities for a person with a SUD to seek treatment and stay employed.

87.8%

11.0%

1.2%

If a person with a SUD wanted to go to treatment, their health insurance should be required to cover it in the same way they would cover any other chronic illness.

87.7%

10.9%

1.4%

Healthcare providers should care for someone with a SUD just as they would treat anyone else with a chronic illness.

90.7%

8.0%

1.2%

People who are addicted to drugs should receive treatment instead of being sentenced to prison for drug-related, non-violent crimes.

81.5%

16.9%

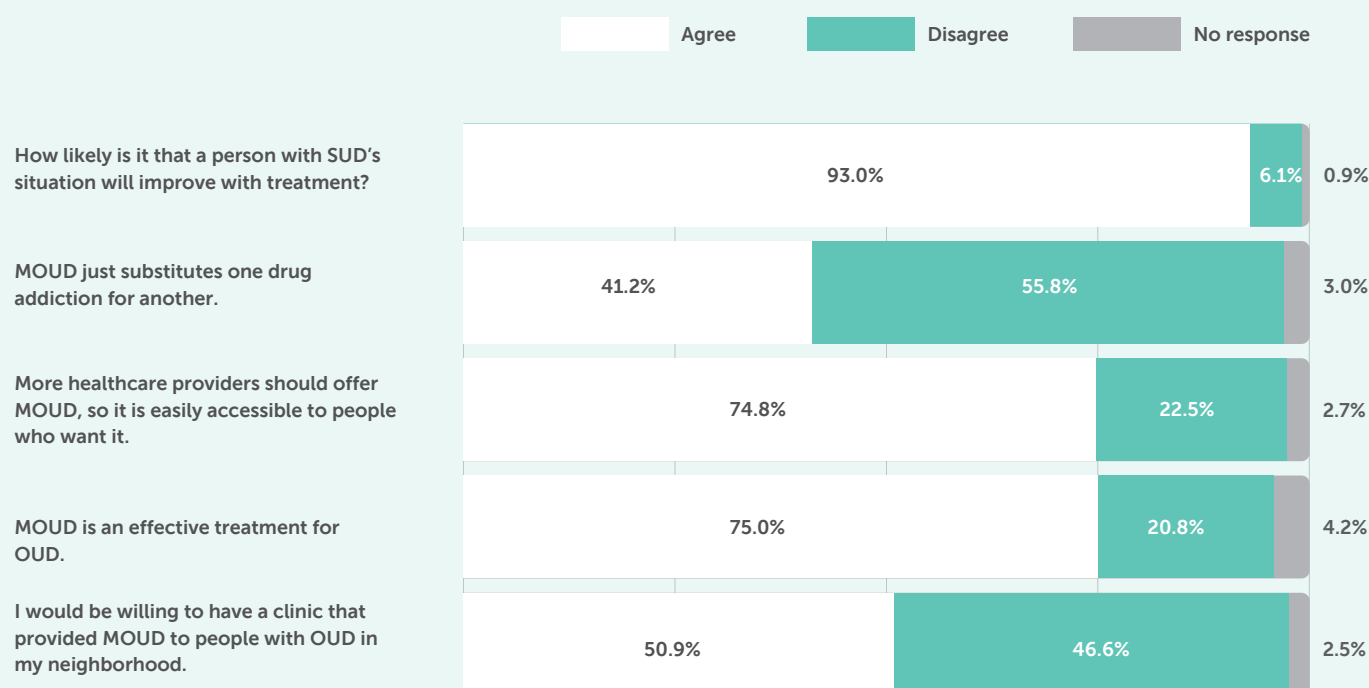
1.5%

Even though structural policy reform is generally supported by the public, this support has not translated into lower levels of either public or self-stigma. This finding highlights the need to continue implementing evidence-based stigma reduction efforts and interventions, to evaluate their impact, and to recognize that structural shifts made to reduce stigma may take time to change attitudes among the larger population. Most importantly, decision makers must recognize that the public supports efforts that reduce structural discrimination and stigma and ensure that support is translated and codified.



Attitudes on medications for opioid use disorder

Methadone, buprenorphine, and extended-release naltrexone are effective FDA-approved medications for OUD (MOUD), and it has been shown that people receiving these medications are significantly less likely to die from an overdose.¹² The survey shows favorable perceptions of MOUD in theory, with 93% of respondents believing someone's situation will improve with treatment and 90.7% agreeing that providers should care for someone with SUD as they would for someone with a different chronic illness. Despite this support, however, the National Survey on Drug Use and Health found that less than 20% of people who had an OUD received MOUD in 2019.¹³



Our survey found that attitudes toward MOUD contained significant contradictions. Over 90% of respondents broadly indicated that treatment works, but at the same time, close to half of the respondents agreed with the statement that MOUD is substituting one drug for another. Meanwhile, despite general support for treatment, almost half of respondents reported not wanting a clinic in their neighborhood, although Black, non-Hispanic respondents were more likely to express support for clinics than white, non-Hispanic respondents. One bright spot in these results is that respondents who had received treatment from a doctor or medical professional for opioid use indicated generally positive outcomes from their treatment, with over 80% saying treatment helped them recover from opioid use disorder.

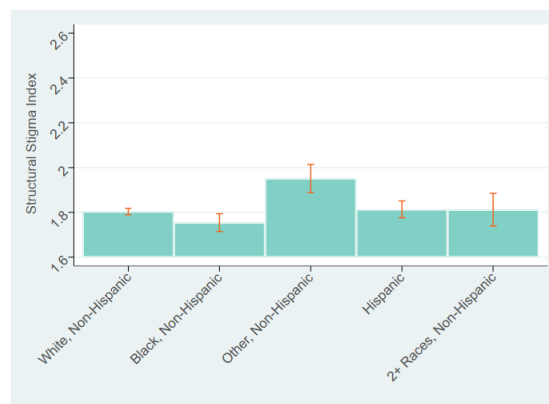
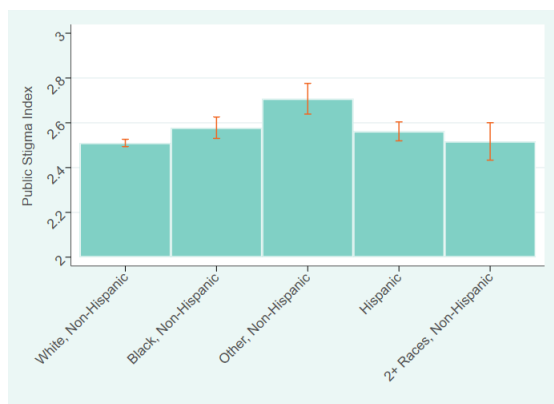
¹² <https://doi.org/10.1136/bmj.j1550>

¹³ <https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFRPDFWHTML/2019NSDUHFR1PDFW090120.pdf>

Attitudes toward addiction manifest differently across populations

The intersection of racism, discrimination, and substance use in the United States is well documented, and stigma further disadvantages populations who have the least access to care and support. For years, Black communities have borne the brunt of discriminatory policies like mandatory sentencing laws, severe discrepancies in sentencing times depending on the type of substance used, and the categorization of nonviolent drug offenses as federal violations. Today, [nearly 80%](#) of people in federal prison and almost 60% of people in state prison for drug offenses are Black or Latino/a. Approximately half of federal drug cases are brought against Latino/a people, even though this group makes up just 17% of the U.S. population.

While the SASI did not assess individual cases of experienced stigma (except by assessing for self-stigma in respondents who reported personally having a SUD), it did capture some racial and ethnic differences in approaches to stigma and support for reform. White, non-Hispanic respondents held less public stigma against people with a SUD than their peers of other racial categories; and Black, non-Hispanic respondents supported greater amounts of structural reform for those with a SUD than their peers of other racial categories.



It's clear that significant work remains to be done to address stigma and racial inequities, and that this topic demands further research, evaluation, and targeted intervention. Similarly, more data is required to understand the intersection of stigma and other vulnerable populations. More resources – including improved data collection – are needed to assess and address the intersection of addiction stigma, the social determinants of health, and health inequities. While there is more information to be gathered, the SASI's data will serve as a foundation and a starting point for future efforts.

Index sets a baseline for tracking future progress

This survey confirms the destructive nature of stigma in the United States, with particularly negative views from both the public and healthcare professionals. Even though structural policy reform receives generally high levels of support from the public, this support in the abstract stands in contrast to relatively high levels of public and self-stigma, highlighting the need to continue stigma reduction efforts and interventions to end addiction stigma. A national movement to eliminate this stigma is already underway, being led by organizations like Shatterproof, as well as nonprofits, companies and businesses, advocates, those with lived experience, and local, state, and federal government – but data is needed to gauge advancement and demonstrate success.

This is where the SASI lends vital support. Built to include a set of validated measures to capture the wide range of attitudes and beliefs that underlie addiction stigma in a comprehensive and rigorous way – a measure of changes in representative groups of individual data points – the SASI consists of three stigma indices that quantify public stigma, structural stigma, and self-stigma where “one” is the lowest amount of stigma possible, and “four” is the highest amount of stigma possible. The full survey instrument used to compose each index can be found in Appendix B. In its inaugural year, the SASI establishes a benchmark for future measurement (see Appendix C). In future years, using the SASI to measure changes in stigma will enable Shatterproof and the United States to track progress and hold ourselves accountable.

Ultimately, the Shatterproof Addiction Stigma Index is the most robust tool developed to date to inform efforts to eliminate stigma, and to enable each actor to measure their progress over time.

Moving forward together

The SASI highlights the overwhelming nature of addiction stigma. It’s clear that negative perceptions of those with a SUD are extensive and deep-rooted – not only among the public, but among employers, healthcare professionals, and even those with a SUD themselves. These perceptions affect and often dictate how policies are created, how healthcare is provided, and how people perceive treatment. Most importantly, these beliefs entrench deep feelings of exclusion and shame for individuals with a SUD throughout their lives, regardless of their recovery status – powering a vicious cycle that makes SUD much more difficult to address and fueling negative outcomes.

The results of this index may feel disheartening because they show the enormity of the challenge still ahead of us. The road ahead is certainly long, and progress can seem out of reach. Yet our results also provide a path forward. Previously, much of the response to the addiction epidemic by physicians, policy experts, advocates, and other public health professionals had not recognized or prioritized the need to eliminate stigma, despite stigma’s overwhelming role in this ongoing crisis. Even when groups and organizations have sought to take aim at the issue, there has been no standard to measure changes in addiction stigma, leaving significant gaps in knowledge.

The SASI provides a critical tool to begin that work, demonstrating the scope of the necessary effort and laying bare the steps we must take to make our goals a reality. By measuring selected indicators related to Shatterproof's [National Stigma Strategy](#), derived from decades of leading stigma research, this survey offers a baseline for determining progress. This research will be distributed to public health officials, community advocates, individuals in recovery, and others to inform communication strategies, public health interventions, and other efforts to reduce addiction stigma. Over time, similar research using the same methods can be conducted repeatedly and consistently to ensure our nation is accountable to its results.

Of course, the survey is only one part of the battle. Shatterproof's National Movement to End Addiction Stigma, launched in 2020, seeks to centralize evidence-based best practices while also scaling behavior-change campaigns targeted at eliminating stigma across the United States. The movement's work has already begun with the delivery of a National Strategy to End Stigma, an [Addiction Language Guide](#), groundbreaking stigma reduction state campaigns, and the [Stigma of Addiction Summit](#). We hope to continue our work alongside national organizations, universities, nonprofits, advocates, and the federal government as they begin to prioritize stigma reduction, which is included in both the National Institute on Drug Abuse and the Office of National Drug Control Policy strategies.

It's clear that we have a great deal of work to do. We need to continue elevating the efforts, stories, and expertise of advocates with lived experience who are leading the charge at the national and local level. We need to couple our dedication to ending addiction stigma with antidiscrimination and pro-acceptance initiatives to ensure widespread adoption, understanding, and efficacy of interventions for all people. We need to redouble our commitment to these initiatives and provide ironclad assurances that they will continue into the future, so that our progress can be measurable, effective, and durable over the long term.

These are real and challenging considerations, and it's clear that there is more work to do – but the SASI represents a monumental step. We have an extraordinary chance to learn from our results, to take steps toward destigmatizing people with a SUD, and to create a national movement to treat addiction like the chronic disease it is. By offering evidence-based resources for prevention, treatment, and recovery free of the stigma that has stood in the way of progress, we have an opportunity to dismantle discrimination, to meet our moment, and to build a more tolerant, more compassionate, and healthier future.



ACKNOWLEDGEMENTS

We would like to thank The Hartford for their generous contribution to the development and publishing of the inaugural Shatterproof Addiction Stigma Index. We appreciate their ongoing commitment to addiction stigma reduction as a founding partner of Shatterproof's National Movement to End Addiction Stigma, their continued leadership as an employer addressing the addiction crisis in the workplace, and their invaluable willingness to share critical knowledge and information.

We would also like to thank Ipsos for their partnership in developing and implementing the survey. Their expertise and proficiency in survey design enabled us to establish a benchmark for future measurement of changes in addiction stigma. The scope of this survey – with a total of 7,889 completed interviews – offers a significantly larger sample than any other addiction stigma-related survey and lends these findings notable weight and significance.

We would also like to extend our gratitude to Drs. Perry and Krendl at Indiana University for their extraordinary work in stigma research, survey development, and data analysis. Their continued dedication to understanding, researching, and reducing stigma is an inspiration to all of us, and their efforts were instrumental in creating a final product that will set the stage for measuring stigma reduction in years to come.

Lastly, we would like to acknowledge the support and guidance offered by our reviewers, which included people with lived experience, other experts in the stigma reduction field, and other partners. Their thoughtful feedback was integral to this publication and will continue to be critical as we work together to end addiction stigma.

APPENDIX A

The survey was conducted using the web-enabled KnowledgePanel®, a probability-based panel designed to be representative of the U.S. population. Initially, participants are chosen scientifically by a random selection of telephone numbers and residential addresses. Persons in selected households are then invited by telephone or by mail to participate in the web-enabled KnowledgePanel. For those who agree to participate, but do not already have Internet access, Ipsos provides a laptop/netbook and ISP connection at no cost. People who already have computers and Internet service are permitted to participate using their own equipment. Panelists then receive unique login information for accessing surveys online and are sent emails each month inviting them to participate in research.

Demographic details follow:

Age	Percent
18-34	28.94
35-44	16.67
45-54	16.24
55-64	16.91
65+	21.24

Gender	Percent
Male	48.27
Female	51.73

Metropolitan Status	Percent
Non-Metro	13.4
Metro	86.6

Race/ Ethnicity	Percent
White, Non-Hispanic	62.99
Black, Non-Hispanic	11.81
Other, Non-Hispanic	6.91
Hispanic	16.48
2+ Race, Non-Hispanic	1.81

APPENDIX B

The 14 validated stigma measures included in the Public Stigma Index are as follows:

- "How willing would you be to move next door to John?"
- "How willing would you be to spend an evening socializing with John?"
- "How willing would you be to have John start working closely with you on a job?"
- "How willing would you be to have a group home for people like John opening in your neighborhood?"
- "How willing would you be to have John marry into your family?"
- "How willing would you be to have John as a close personal friend?"
- "In your opinion, how able is John to make his own decisions about managing his own money?"
- "How willing would you be to hire John to do work for you?"
- "How willing would you be to have John as your supervisor at work?"
- "How willing would you be to have John as your co-worker?"
- "People like John are unpredictable."
- "In your opinion, how likely is it John would do something violent toward other people?"
- "In your opinion, how likely is John to be trustworthy?"
- "In your opinion, how likely is John to be competent?"

The five validated stigma measures included in the Institutional Discrimination Index are as follows:

- "Employers should provide opportunities for John to seek treatment and stay employed."
- "If John wanted to go to treatment, his health insurance should be required to cover it in the same way it would cover any other chronic illness."
- "Healthcare providers should care for someone like John just as they would treat anyone else with a chronic illness."
- "Schools should be allowed to expel someone like John if they found out about his problems."
- "People who are addicted to drugs should receive treatment instead of being sentenced to prison for drug-related, nonviolent crimes."

The 15 validated stigma measures included in the Self-Stigma Index, measured using the Luoma scale,¹⁴ are as follows:

- "I feel inferior to people who have never had a problem with substances."
- "I deserve the bad things that have happened to me."
- "I feel out of place in the world because of my problems with substances."
- "I feel ashamed of myself."
- "I feel that a major reason for my problems with substances is my own poor character."
- "I feel I cannot be trusted."
- "I have the thought that I have permanently screwed up my life by using substances."
- "People think I'm worthless if they know about my substance use history."

¹⁴ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3680138/>

- “People around me will always suspect I have returned to using substances.”
- “If someone were to find out about my history of substance use, they would expect me to be weak-willed.”
- “If someone were to find out about my history of substance use, they would doubt my character.”
- “A job interviewer wouldn’t hire me if I mentioned my substance use history.”
- “People would be scared of me if they knew my substance use history.”
- “People will think I have little talent or skill if they know about my substance use history.”
- “People think the bad things that have happened to me are my fault.”

APPENDIX C

A primary challenge in reducing stigma is the lack of existing tools to consistently measure changes associated with reduction efforts. Shatterproof, in collaboration with its founding partner The Hartford and supported by Drs. Perry and Krendl from Indiana University and Ipsos, developed the SASI, a first-of-its-kind annual measurement tool specifically designed to evaluate addiction stigma in our country. In its inaugural year, the SASI has established a benchmark for future measurement of changes in addiction stigma. The survey responses provide a view on the country’s current levels of addiction stigma, reaffirming that stigma exists and is impacting millions of people across the country. In future years, measuring changes in this composite manner will enable us to track progress comprehensively. This is a vital component of stigma reduction, as progressing on one data point will not eradicate addiction stigma. Instead, continued progress on all fronts will be necessary for long-lasting and impactful change.

The target population consisted of noninstitutionalized¹⁵ adults aged 18 and older residing in the United States, with a total of 7,889 completed interviews¹⁵ – a significantly larger sample than any other addiction stigma-related survey. Further demographic details are shared in Appendix A. This sample included healthcare professionals and individuals who reported current or past substance use (alcohol, opioids, stimulants, or some combination of these substances).

The SASI utilized a vignette strategy, wherein respondents were randomly assigned one of 10 vignettes describing a person (named John) using a substance (alcohol, prescribed prescription opioids, illicit prescription opioids, heroin, or stimulants), or a person who previously used those substances and is now in recovery. Respondents answered a series of widely used, well-established validated measures that assessed attitudes related to public stigma, including attributions, prejudice, desire for social distance, and novel questions related to approval of structural stigma and support for harm reduction policies and MOUD. Additionally, respondents reporting substance use problems were asked about self-stigma and treatment experiences.

An index is a set of items that scale well together – a measure of changes in a representative group of individual data points. The SASI consists of three stigma indices that measure public stigma, structural stigma, and self-stigma, wherein one is the lowest amount of stigma possible, and four is the highest amount of stigma possible. The full list of measures used to compose each index can be found in Appendix B. Put another way, any respondent who scored above a two on any of the scales holds stigmatizing attitudes about people who use substances and people with a SUD.

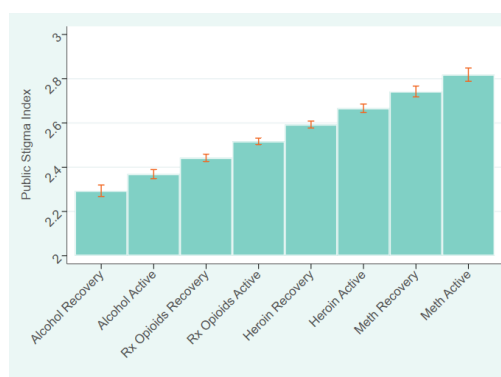
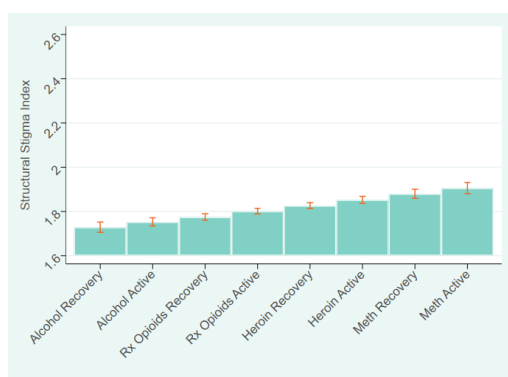
¹⁵ Civilian noninstitutional population is defined as persons 16 years of age and older residing in the 50 states and the District of Columbia, who are not inmates of institutions (e.g., penal and mental facilities, homes for the aged), and who are not on active duty in the armed forces.

¹⁶ The vignette strategy has been used in other well-known national measures of stigma, including the National Stigma Study – Replication II in the 2018 General Social Survey (GSS). Many of the questions used to assess public stigma came from the GSS.

APPENDIX C cont'd

- The SASI measured high levels of stigma on the Public Stigma Index (PSI). Using 14 validated stigma measures from the survey to measure traditional prejudice and social distance (also called social exclusionary sentiments), respondents measured at 2.54.
- The Self-Stigma Index (SSI), measured using the Luoma scale,¹⁷ comprises 15 validated stigma measures that measure internalized stigma and enacted stigma against people with addiction. Only respondents who reported either current or past problems with substance use answered the self-stigma section of the survey, measuring at 2.08.
- Using five validated stigma measures from the survey to measure support for discrimination against people with addiction in laws and institutions using the Structural Discrimination Index (SDI), respondents measured, on a scale of 1-4, at 1.81.

The survey demonstrated that alcohol or prescription opioid use (both for licit and illicit prescription opioids use, and regardless of recovery status) had lower levels of both public and structural stigma relative to heroin and methamphetamine use. This may reflect implicit positive biases toward drugs that are legal, including alcohol and prescription opioids – even if taken illicitly, and even though illicit prescription opioid use is conceptually and chemically similar to heroin use. Legality, and the perceived divide between “soft” or “hard” drugs, may be important elements to consider when addressing stigmatizing viewpoints, and these viewpoints often intersect with problematic and inaccurate historical associations between race, class, and drug use.



When aggregated by race, the survey found white, non-Hispanic respondents reporting lower levels of public stigma on the Public Stigma Index than non-white monoracial individuals, and that Black, non-Hispanic respondents had a lower level of stigma on the Structural Discrimination Index than white, non-Hispanic respondents. In other words, white, non-Hispanic respondents held less public stigma against people with an SUD than their peers of other racial categories, and Black, non-Hispanic respondents felt less structural stigma against people with an SUD than their peers of other racial categories. It is important to note that the SASI measures how the respondents actively stigmatize people with a SUD. Aside from the self-stigma, validated stigma measures those respondents who reported either current or past problems with substance use answered, the SASI did not assess how individuals experienced stigma – an area for further research, evaluation, and targeted intervention.

¹⁷ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3680138/>