Session E:

Research on Stigma Interventions and Impacts

Moderator:

Ashli Sheidow

Chestnut Health Systems Hub

Presentations by:

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2. *Martha Tillson – University of Kentucky Hub*
3. *Valerie Hardcastle – J-RIG Grantee/Northern Kentucky University*
4. *Trey Dellucci – Indiana University Hub*
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Understanding experienced, anticipated, and internalized stigma through the voluntary and involuntary disclosure of addiction, MOUD, and criminal legal system histories

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FRI FRIENDS RESEARCH INSTITUTE
Advancing research to promote health and well-being

HEAL JCOIN Steering Committee Meeting 2024

Bethesda, MD - June 11-13, 2024

UNIVERSITY of MARYLAND SCHOOL OF MEDICINE
Department of Psychiatry

Disclosures

In-kind study drug from Braeburn for parent trial.

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Multiple overlapping life challenges that are widely stigmatized

Our focus:

Criminal Justice Involvement

Opioid Use Disorder

Use of Medications Treatment

in the context of social identities, life situations, and other health conditions that may also be stigmatized

1. Societal Stigmatization

= messages, animosity, disrespect, discrimination commonly known to come from (some) society members

2. Experienced Stigmatization

= what you yourself have experienced

3. Anticipated Stigmatization

= expecting to be un-welcome, disrespected, treated badly

4. Accepted Stigmatization

= what you yourself agree are accurate, legitimate judgements (stereotypes) of an identity group you belong to.

5. Internalized Stigmatization (aka “self stigma”)

= when you absorb societal stigmatization into your own self concept, believe the messages to be true of yourself.

5 Ways Stigmatization Manifests

Ending Self Stigma → Medications for Justice-Involved People (ESS-MJP) → SASS

1. **Started with ESS manual + knowledge of stigma re justice-involvement, MOUD, OUD**
   Through systematic literature review, review of related interventions, and team expertise
   → Developed draft of ESS-MJP version 1.0

2. **Then semi-structured stakeholder interviews and focus groups**
   Individual interviews with 13 diverse justice-involved MOUD clients + 6 MOUD program counselors
   Two staff focus groups.
   Qualitative thematic analysis → Revise 1.0 to create ESS-MJP version 2.0 manual

3. **Rapid iterative pilot delivery with OTP clients**
   Pilot round 1 using version 2.0 + team observations & detailed participant feedback → version 2.5
   Pilot round 2 using version 2.5 + team observations & detailed participant feedback → version 3.0
   Participants suggested the name Stay Strong Against Stigma

4. **Finalize manual and materials for future efficacy trial**

STAY STRONG
SSAS
AGAINST STIGMA

Methods

MOUD Client Participants (N = 13)

- Active OTP patients referred by staff
- Range of time in recovery at methadone program (i.e., weeks to years)
- All justice system involvement history; not currently on parole or probation
- 7 male; 6 female
- 62% non-Hispanic White; 38% African American
- 62% high school diploma or less; 23% some college; 15% Associate's degree

Procedures

- 11 interviews done via Zoom; 2 interviews done in-person
- 2 experienced qual interviewers conducted interviews independently
- Audio recorded and professionally transcribed
- Content analysis conducted in Atlas.ti 9.0

Sources of Stigma and Intersectional Experiences

- Internalized, experienced, and anticipated stigma all reported by participants.
- Internalized sigma largely associated with substance use.
- Experienced stigmatization from family members is especially emotionally painful.
- Cyclical impact: Stigmatization of addiction driving MOUD stigma and intensifying carceral stigma. Carceral stigma compounding addiction stigma.
- Vulnerabilities press people to endure discrimination & disrespect without complaint; housing, services, employment, relationships, etc. all feel fragile.
- Experienced and anticipated stigmas impinge on recovery and other health behaviors.

General Qualitative Results

Voluntary vs. Involuntary Disclosure (Anticipated Stigma)

Concealable… or Not?

Addiction: ***YES (employer)***

R: Yeah, I think like if I were to have to reveal that information to a potential employer that they would view it negatively and I probably wouldn't get hired.

I: Which identity, which part of your history would you be most worried about disclosing?

R: Well probably the drug.

MOUD: ***NO (healthcare provider)***

R: It's hard to say. If it's in a setting where it's a dentist or something no, I'm not going to do [disclose] it. I'm not going to write it because I know it's not going to help one way or the other… And for the most part now a days I don't really think you have much of a choice anyway. I think once you're into the system I think it's pretty much in the system. So just because I know from experience when I go, I usually stay under the same umbrella of hospitals and outpatient stuff, so I think it's all in the system anyway.

Criminal Legal: ***NO (judge and employer)***

I: Can you think of other experiences where you're like oh I don't want to have to disclose that?...

R: Just even going to court or something and then pulling my record up I feel will be very bad for me. Or if like anybody does a background check on me just out of curiosity and they see that it would not be good.

I: What do you think would happen like with the court you specifically mentioned that…?

R: They'd probably just feel like I was a person that didn't care, that I needed probably like the harshest penalty…

Voluntary vs. Involuntary Disclosure

Downsides of Not Disclosing

- Avoidance of encounters

not getting possible support/services

not getting necessary treatment

penalties (e.g., "failure to show")

not finding gainful employment

- Lying

reinforces negative stereotypes

possible treatment complications

penalties (e.g., rejection of housing or employment applications)

Conclusions

- Disclosure of multiple stigmatized identities can create short- and long-term difficulties.
- Helping people identify their anticipated stigma and effectively navigate voluntary and involuntary disclosure is an essential element to address in an individual-focused stigma reduction intervention.

Thank you!

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Substance Use-related Stigma and Social Supports Among Incarcerated Women with Opioid Use Disorder

Martha Tillson, Carrie B. Oser, J. Matthew Webster, Mary Levi, Megan F. Dickson, & Michele Staton

University of Kentucky JCOIN hub (PI: Staton)

JCOIN Steering Committee Meeting – June 12, 2024

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NIH HEAL INITIATIVE

JUSTICE COMMUNITY OPIOID INNOVATION NETWORK (JCOIN)

Introduction

- Stigma related to substance use can be a significant barrier to recovery.[1-3]
  - Compounded by other stigmatizing statuses (e.g., criminal legal system involvement)[4]
  - Intersectional with other aspects of identity (e.g., gender)[5]
- Past experiences of stigmatization (enacted stigma) may contribute to expectation of future stigma (anticipated stigma).[6]
  - Need to understand what can impact this connection
- Stigma is a social construct – what is the role of social support?

In this presentation, we aim to examine:

1. Relationship between enacted and anticipated substance use (SU) stigma
2. Relationship between social support and anticipated SU stigma
3. How social support might affect the potential relationship between enacted-anticipated SU stigma

Methods

- Women (*N*=900) recruited from nine Kentucky jails through random selection
- Screened for OUD, consented, and interviewed while incarcerated
- **Substance Use Stigma Mechanisms Scale (SU-SMS)**[7]
  - Subscales for *enacted* (α=.89) and *anticipated* stigma (α=.92; 6 items each)
- **Multidimensional Scale of Perceived Social Support (MSPSS)**[8]
  - Subscales for support from *significant others* (α=.96), *family* (α=.97), and *friends* (α=.97; 4 items each)
- Analyses included correlations and linear regressions with moderation

Participant Profile (*N*=900)

	M (SD) or %
Age (range 18-62)	37.3 (8.6)
Race – non-Hispanic White	92.6%
Sexual orientation – heterosexual	72.7%
Residence – living in rural county before jail (vs. urban)	65.5%
Education – achieved HS diploma or GED	73.5%
Days incarcerated at enrollment (range 2-1,950)	253.7 (309.3)

Participant Profile – Substance Use Stigma and Support (*N*=900)

	M (SD)
Substance Use Stigma Mechanisms Scale (range 1-5)	
Enacted stigma	3.35 (1.13)
Anticipated stigma	2.78 (1.15)
Multidimensional Scale of Perceived Social Support (range 1-7)	
Significant other	5.78 (1.43)
Family	5.16 (1.85)
Friends	4.81 (1.93)

Note: "Significant other" MSPSS items were framed to participants as about "a special person in my [participant's] life."

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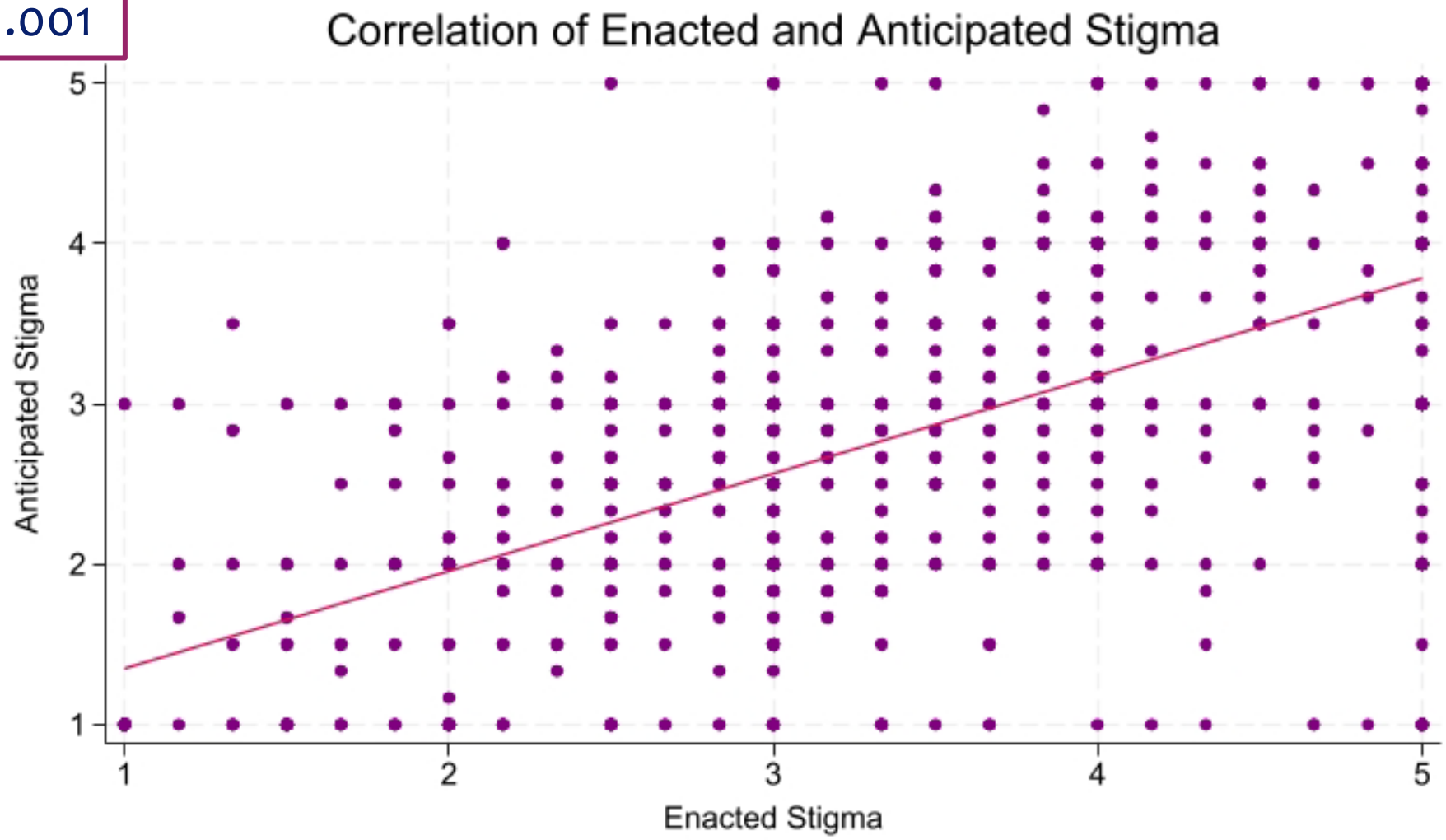
JUSTICE COMMUNITY OPIOID INNOVATION NETWORK (JCOIN)

Enacted SU Stigma Relates to Higher Anticipated SU Stigma

$r = .60, p < .001$



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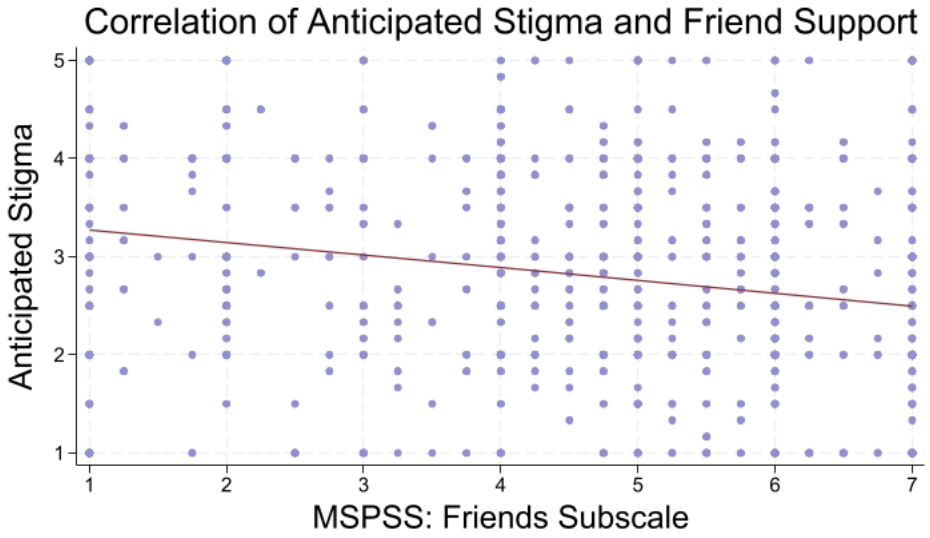
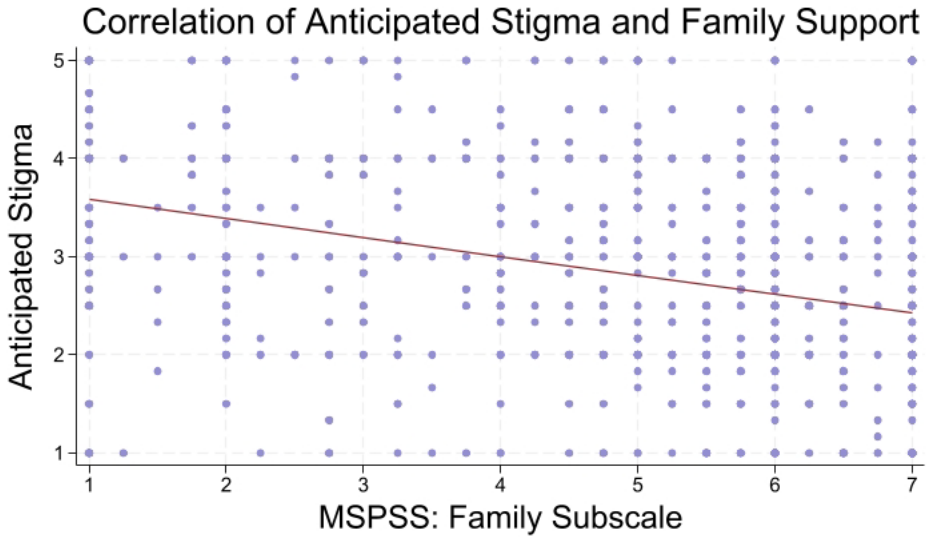
JUSTICE COMMUNITY OPIOID INNOVATION NETWORK (JCOIN)

Social Support Relates to Lower Anticipated Substance Use Stigma



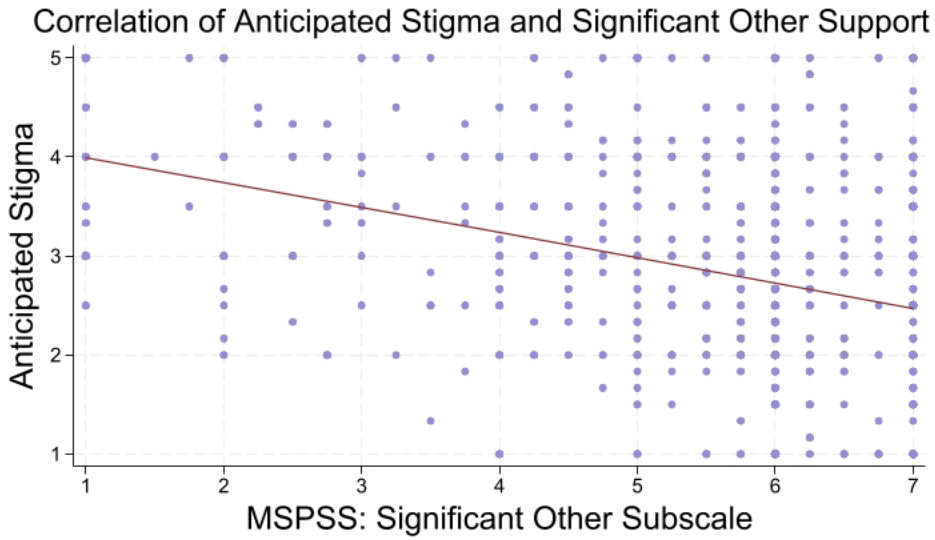
Friends

$r = -.22$, $p < .001$



Family

$r = -.31$, $p < .001$



Significant Other

$r = -.31$, $p < .001$

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JUSTICE COMMUNITY OPIOID INNOVATION NETWORK (JCOIN)

Does Social Support Moderate the Relationship Between Enacted and Anticipated Substance Use Stigma?

Significant Other Support

DV: Anticipated stigma	B [95% CI]	*p*-value
Enacted stigma	0.76 [0.53, 0.98]	<.001
Significant other support	-0.07 [-0.20, 0.07]	.327
Interaction term	-0.03 [-0.07, 0.01]	.120

Family Support

DV: Anticipated stigma	B [95% CI]	*p*-value
Enacted stigma	0.72 [0.54, 0.89]	<.001
Family support	-0.04 [-0.14, 0.07]	.478
Interaction term	-0.03 [-0.06, 0.01]	.094

Friend Support

DV: Anticipated stigma	B [95% CI]	*p*-value
Enacted stigma	0.82 [0.69, 0.96]	<.001
Friend support	0.07 [-0.01, 0.16]	.327
Interaction term	**-0.05 [-0.07, -0.02]**	**.001**

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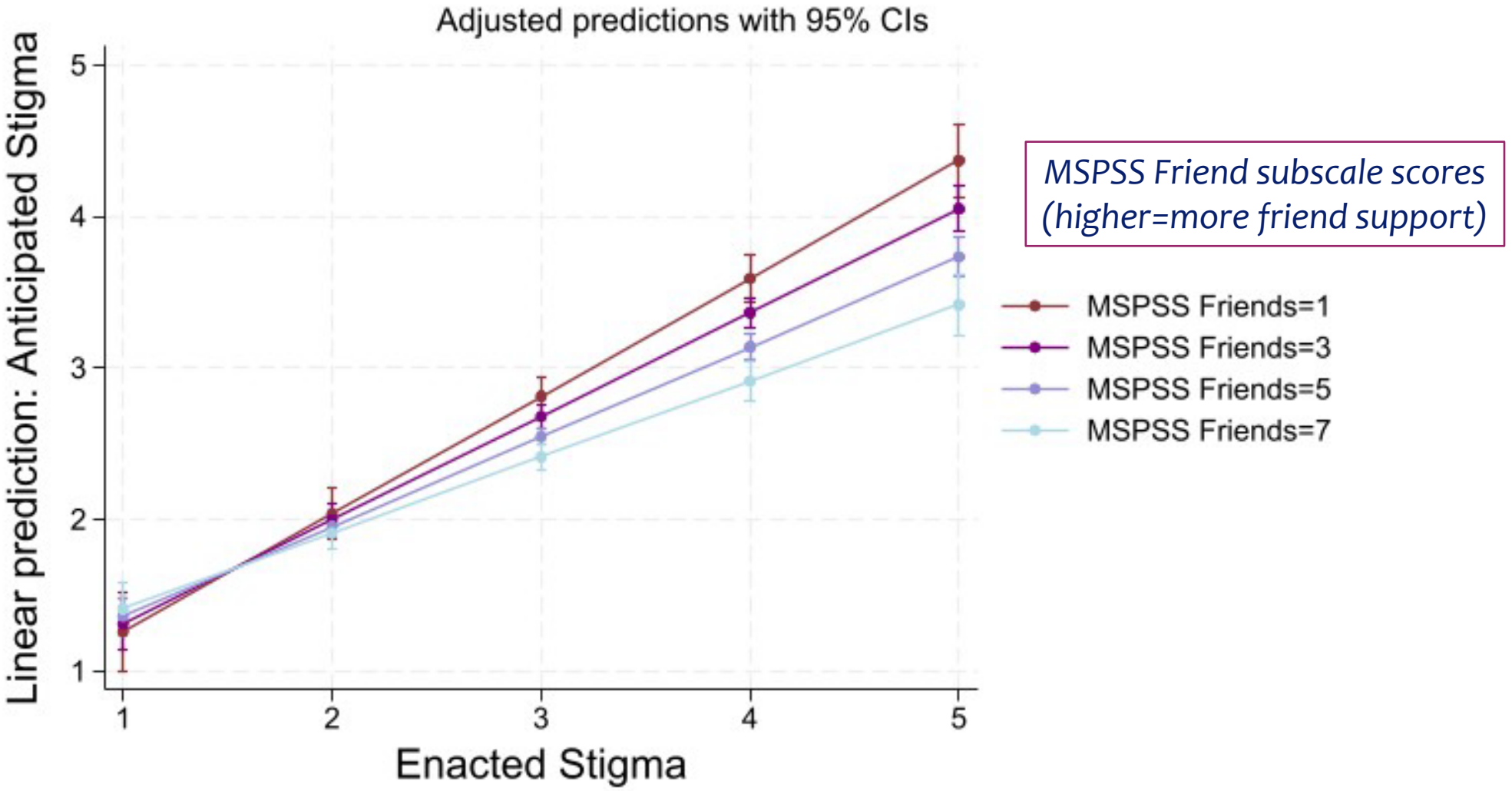
Friend Support Moderates Enacted-Anticipated Substance Use Stigma Relationship



MSPSS Friend subscale scores (higher=more friend support)

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Limitations

- Self-report, cross-sectional data, collected in jail setting in a single state
- SU-SMS is limited in sources of stigma it asks about (family, healthcare workers)
- MSPSS only asks about three types of support (significant others, family, and friends)
- Scale measures do not provide context (e.g., who were “friends”? How many friends provided support?)

Summary

- Substance use-related stigma that women have experienced in the *past* strongly relates to stigma they expect in the *future.*
- Women with higher social support anticipate *less* stigma, in general.
- BUT – in this study, only support from **friends** mitigated this association, among women who felt highly stigmatized in the past.
  - For women who have not experienced much stigma, anticipated stigma is already low, friend support matters less.
  - Women reporting higher enacted stigma had a higher expectation of future stigma – but among those who also have strong support from friends, anticipated stigma is relatively lower.

Future Directions

- Future research should examine what might be unique about *friend* support compared to that from significant others and family members.
- For women with low friend support – can peers fill this gap?
- Is the enacted/anticipated stigma relationship impacted by friends' substance use or recovery status?
- Examine longitudinal changes in substance use stigma, social supports after release.

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Thank You!

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In-Detention SUD Treatment and Its Impact on Sense of Self

Presenter:

Valerie Gray Hardcastle

Co-Authors:

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University of Cincinnati – Stacie Furst-Holloway, Carlos Munoz Serna, Katherine Baltrusch

NKU NORTHERN KENTUCKY UNIVERSITY

The Problem:
Incarceration, SUD & Recidivism

People with SUD are at high risk for recidivism and relapse (Edwards et al., 2022)

72% of incarcerated women (compared to 60% of men) met diagnostic criteria for substance use disorder (Bronson et al., 2017)

The number of incarcerated women in the United States grew by about 525% between 1980 and 2021, twice the rate of growth for men (Monazzam & Budd, 2023)

Study Purpose

To examine how detainees' sense of self evolves as a result of their participation in an in-detention treatment program for SUD.

SUD Program Description

Program Strategies

- 6-month residential program + minimum of two years outpatient/ community supervision
- In-detention components include group and 1-on-1 meetings
- Post-detention components include group therapy + wrap around services

Program Characteristics

- Detainees seek or are mandated to complete in-detention treatment
- Provide wrap-around services
- Increase support network through program staff and other participants
- Increase participant Independence (license, job, education)
- Decreased relapse and recidivism rates

Study Procedure

Data Collected

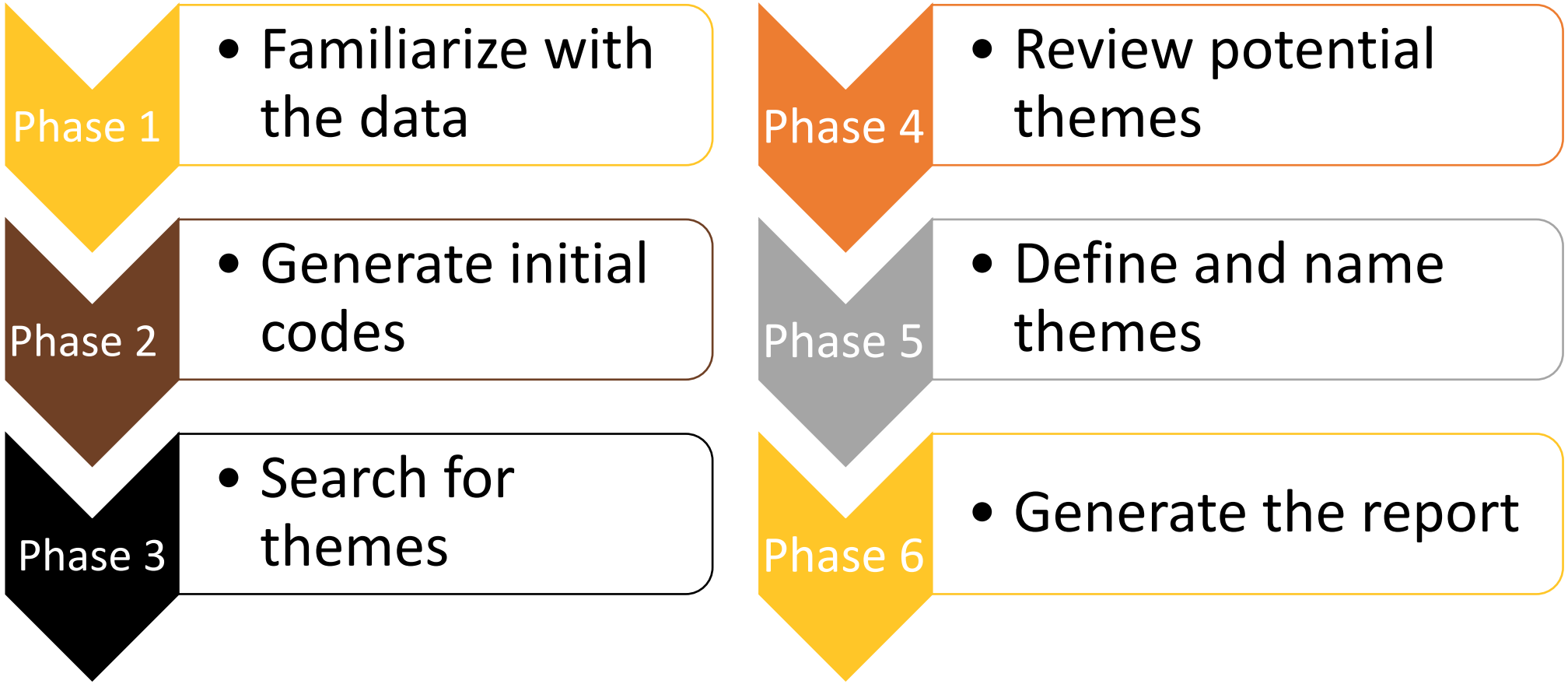
- "How I Feel" letters written pre- (n=42) and post- (n=30) treatment
- De-identified so unable to examine within person changes or to examine themes as a function of personal characteristics or substance and judicial history

Profile of Study Participants

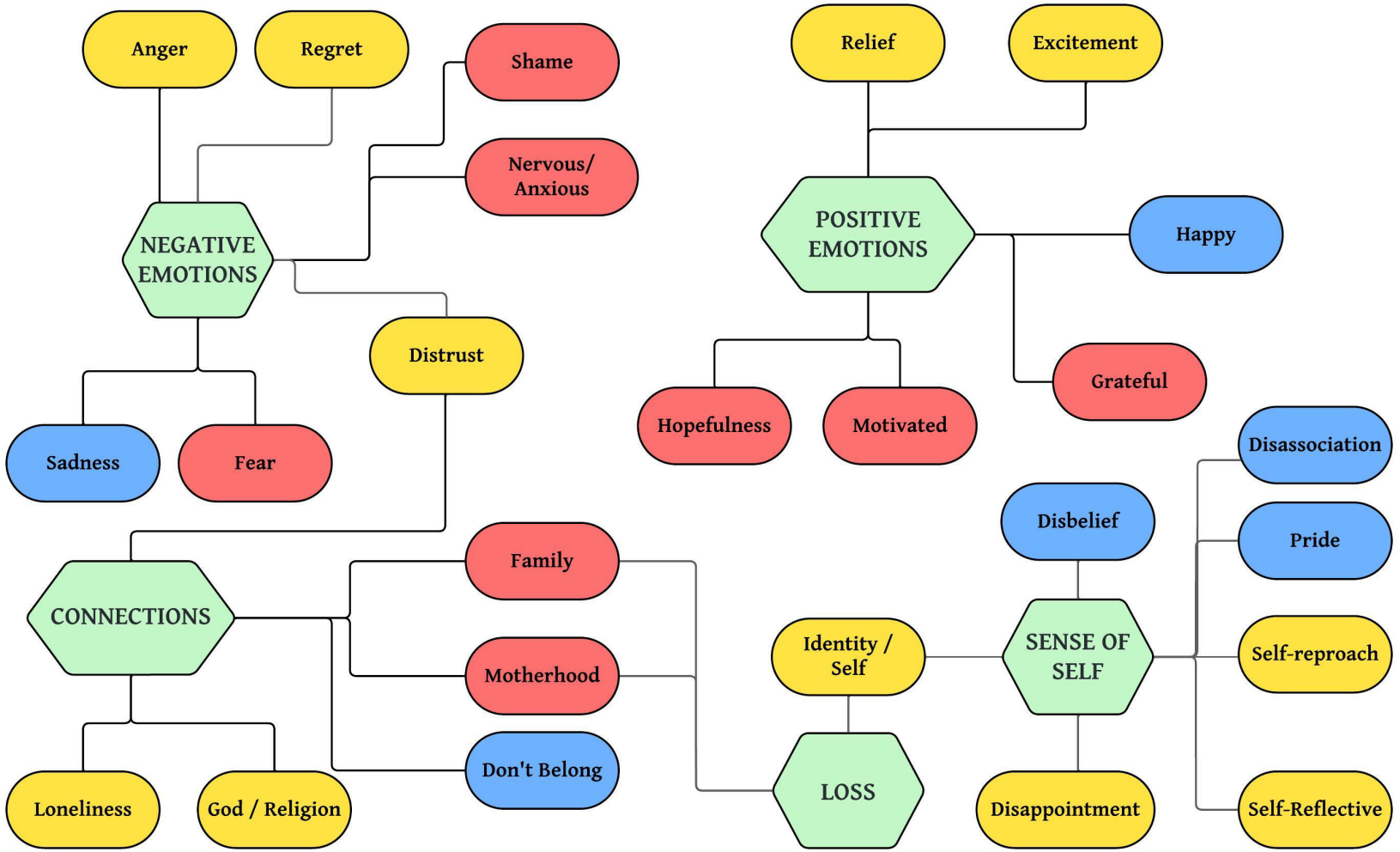
- Race (32 White (86%), 1 Native American, 3 Bi-Racial, 1 Hispanic)
- Time in Detention (M = 8.5 months, Range = 3 days to 41 months)
- Age: M = 35 years old, STDEV = 9.5 months
- Education: 5 BA/BS, 3 Associates, 12 Some College, 11 HS or GED, 5 < HS (2 with tech training)

Thematic Analysis Procedures

(Braun & Clarke, 2006)

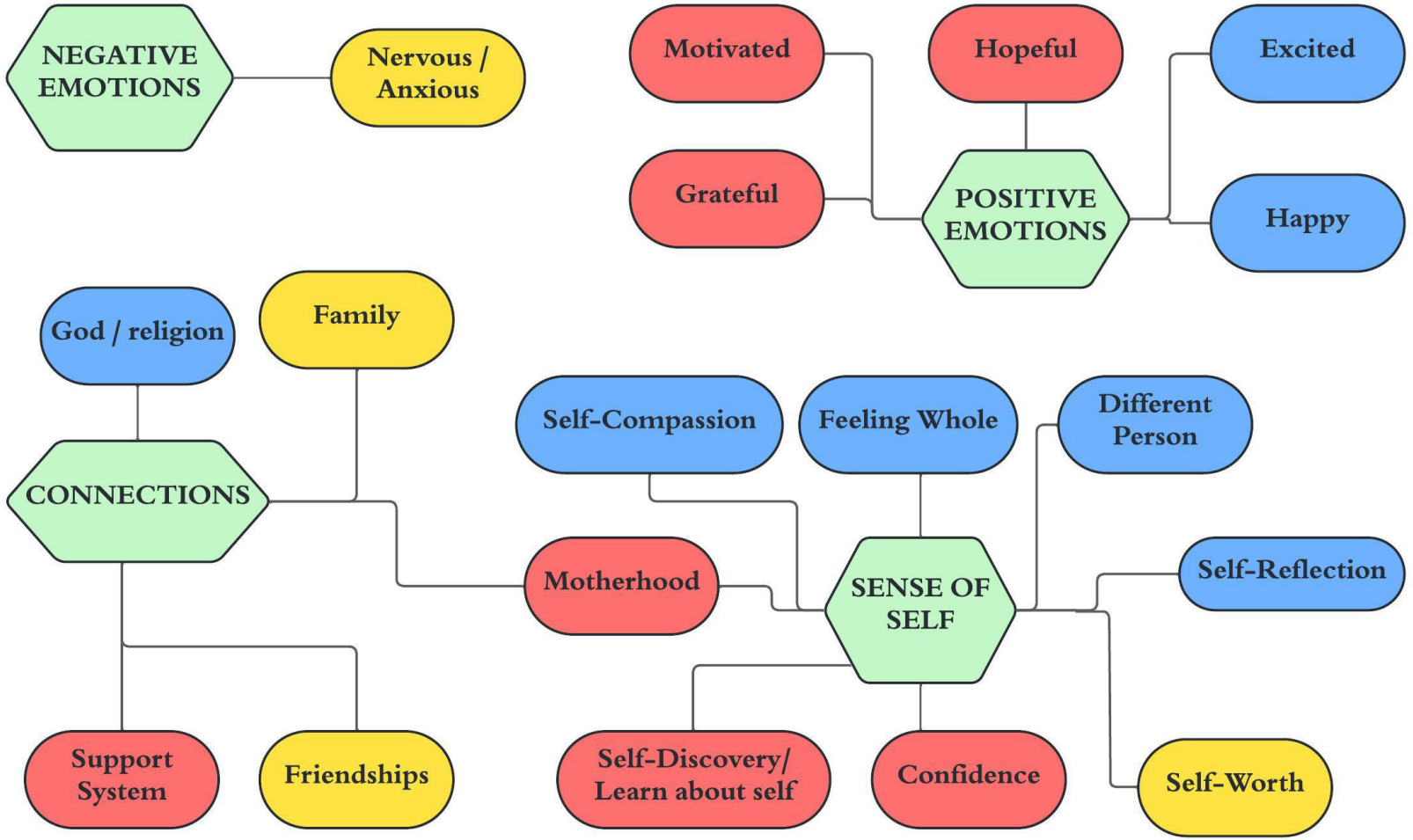


Pre-Treatment Themes



GREEN: THEME
RED: 10+
YELLOW: 6-10
BLUE: 2-5

Post-Treatment Themes



GREEN: THEME
RED: 10+
YELLOW: 6-10
BLUE: 2-5

Negative Self-Concept

- Self-reproach, guilt, shame
- Role of being a mother

Sense of Self: *Pre-Treatment*

"I feel ashamed, lost, guilty, and my thoughts just go on and on…. I keep beating myself up over and over. I feel so bad for being in jail again."

"I feel like I have failed my children and my family because I haven't been the best mother or daughter I could have been."

More Positive Self-Concept

- Worthiness to receive good things
- Increased personal strength and confidence
- Self-discovery and reflection

Sense of Self: *Post-Treatment*

"I can look at myself in the mirror and I can honestly say that I am happy with the person that I am. I've gained self-acceptance and so much gratitude that I don't think any words could really do it justice."

Gratitude, Hope, and Motivation

- Accompanied by doubt and nervousness

Gratitude: *Pre-Treatment*

"I am beyond grateful for this opportunity to better myself and to learn new tools to overcome this addiction and to fight my demons that I have yet to be able to face in here. I am so happy to be out of the general population and in this program because I feel this will be my saving grace."

"I'm ready to move on with my life and get this bullshit past me. Because I'm feeling really shitty. I never want to feel like this again."

"The day I got locked up this time I was some sort of relieved. Was happy to be off the streets."

Gratitude, Hope, and Motivation

- Increased self-efficacy and self-confidence
- Grateful for the opportunity

Gratitude: *Post-Treatment*

"I'm grateful for the love of my family. I'm grateful for the Treatment Team for not giving up on me and pushing me to do better. I'm grateful for the support I have in here and the friends that I've made. I'm grateful for change, patience, and willingness."

"I feel blessed to have been able to be a part of this program; I'm grateful to have been able to grow a trust worthy relationship with the treatment team....I feel excited to be coming out and optimistic about being able to succeed...I feel like I have a good plan and now I can succeed."

Loss, Anger, and Sadness

- Broken relationships due to addiction
- Lack of trust with other participants
- Lack of belonging in program to be in the program
- Hope and motivation for their futures because of program

Connections and Relations:

Pre-Treatment

"The past weeks that I've been in jail, have been the lowest and darkest time of my life....My whole world feels like it has come to a complete stop and with everyday that passes being kept between these walls, my heart aches and breaks as time ticks away."

"I know I'm here for a "reason" but I don't belong here by any means. I'm terrified I won't be the same woman when I leave here."

Community and Sense of Belonging

- Increased self-efficacy and self-confidence
- Grateful for the opportunity

Connections and Relations:
Post-Treatment

"I have built some amazing and very healthy relationships while being in this program. That is why I am so excited about the aftercare portion of this program. It is going to be a place where I can stay connected with all of the amazing women that I have connected with through this process. I have also made some very important therapeutic relationships as well, with [program staff]. I know that I can go to them about anything, and I trust that they have my best interest at heart."

Behavior as Mothers

- Shame and guilt due to addiction

Motherhood: *Pre-Treatment*

"There I was again letting myself and my kids down….The self-hatred I had for myself was so much I felt like the worst type of person since I let down my daughter AGAIN... I couldn't even stay sober long enough to be a mother for my kids. I'm everything I hated about my own mother and instead of being different and being better than her for my kids I instead keep showing my kids that I would choose a man or a drug over them everytime... I just don't feel like I'm good enough for them. "

Role as Mothers

- Connections
- Hopefulness
- Best mother they can be

Motherhood: *Post-Treatment*

"They gave my husband back his wife, my kids back their mom, and my grandkids will finally have their grandma."

"I'm excited for my family to see the change in me. They want this just as much as I do. I'm looking forward to strengthening our relationships and becoming closer. Allowing them to love me because I deserve to be loved. I want to show them I love them and prove who I can and want to be. It's my turn to show them what they've shown me my whole life."

Anxiety about:

- The program
- Doubt or worry if they would be able to stay sober and

Anxiety: *Pre-Treatment*

"Coming into the program I feel unsure and a little timid. Not sure what this program can do for me."

"I'm terrified as hell. This is the 1st time I've been sober for as long as I have in over 20+ years. I don't have a home of my own. I'm afraid if I go back to my hometown I'll be back in active addiction in no time."

"While I'm extremely grateful for the opportunity to work on myself, I am afraid that I'll get shipped before I complete it. Or worse that I'll get kicked out because I'm not sentenced to it and they'll need the bed for someone who is."

Role as Mothers

- Leaving the stability of their detention and the community they've built
- Ability to stay sober and on a positive path in their everyday lives
- Not being surrounded by the same levels of support shown in their treatment program

Anxiety: *Post-Treatment*

"I'm nervous and scared to deal with life on life's terms; Of course I'm nervous to leave because I've been shut off from the world for 7 months but I will adjust and learn new things again."

"Upon my release I am a little anxious yet excited to get back to my life and be with my family and to start my journey outside of these walls. I would be lying if I said I wasn't a little scared to jump right back into motherhood and life"

CONCLUSIONS AND IMPLICATIONS

Findings demonstrate how in-detention treatment programs can be used to help shift detainees' sense of self

- Connection with program staff
- Connection with program participants
- Educational materials about addiction
- Self-understanding is a key factor to change sense of self

STUDY LIMITATIONS

De-Identified Nature of the Data

- Unable to measure within participant changes
- Unable to connect letter responses to recidivism rates

Self-Report and Social Desirability Bias

Timing of Letters

- Both written during time in detention
- Isolated in detention, shielded from stigma associated with their status as being incarcerated

FUTURE RESEARCH

Conduct a longitudinal study to examine within person changes, including the post-release period

Utilize a diary study methodology post-release to assess daily experiences and how those shape self-perceptions in the near and long-term

Explore how changes in social-network-ties impact perceptions of self

THANK YOU

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Understanding the association between medical mistrust, opioid knowledge, and stigma towards adults with a history of an opioid use disorder

Trey V. Dellucci, PhD (he/him/his)
Indiana University School of Medicine

Identities and How I Navigate the World

Personal Identities
Gender: Cisgender* Male
Pronouns: he/him/his
Sexual Identity: Queer/Gay
Race/Ethnicity: Italian-American White
Region: Southern – dash of Chicagoan

Professional Identities
Pediatric Psychologist
Health Disparity & Relationship Scientist

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Abbreviations & Terminology

1. Opioid use disorder (OUD)

2. Medications for opioid use disorder (MOUD)

3. Sexual Identity
   - Sexual majority, a person who identifies as heterosexual
   - Sexual minority, a person who identifies as gay, lesbian, bisexual, or another non-heterosexual identity

4. Racial Identity
   - Racial majority, a person who identifies as non-Hispanic White
   - Racial majority, a person who identifies as black, Hispanic, Asian, or another non-White identity

Background

Background

- Drug overdose is the leading cause of accidental death in the United States[1]
  - 8.9 million people have a history of opioid misuse[2]
  - 6.1 million people are living with an opioid use disorder[2]
- Treatment options for OUDs exists
  - ~20% of people with OUD receive MOUD[3]

Stigma is a Barrier to MOUD

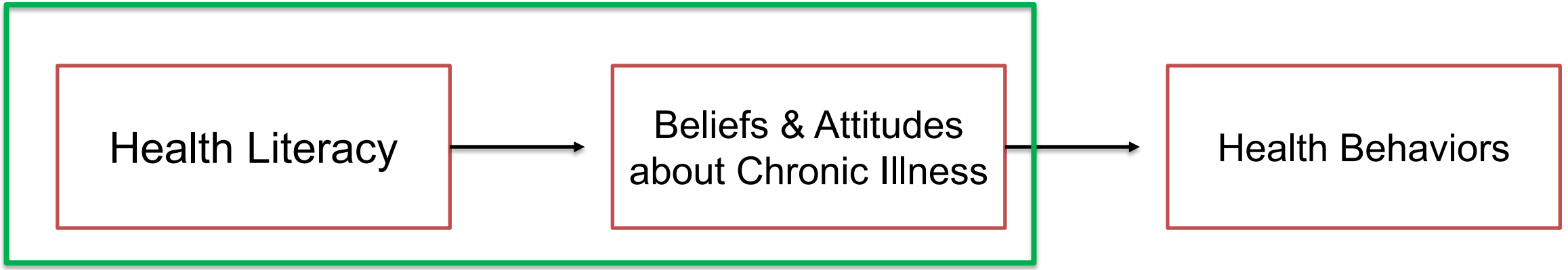
- Stigma is a robust predictor of accessing OUD treatment
  - Strict rules related to MOUD reduces access to medication treatment[5]
  - Perceptions that MOUD is equivalent to opioid misuse reduces patients' engagement in MOUD[6]
- Opioid-related stigma encompasses negative attitudes, discrimination, social distancing, and support for punitive punishments rather than treatment for OUD about people with OUD based on stereotypes[4]

What predicts opioid-related stigma?

Predictors of Opioid-Related Stigma

- Most of the literature focused on predicting negative believes about opioid use has focused on individual characteristics (e.g., age, race, gender)
- Sexual identity has been overlooked in the literature on opioid stigma
- These studies do not offer modifiable targets for stigma reduction programs

Knowledge Attitude Behavior Framework[7]



- Poor health knowledge is associated with more negative attitudes towards chronic health conditions such as obesity, tuberculosis, and HIV

Opioid Health Knowledge

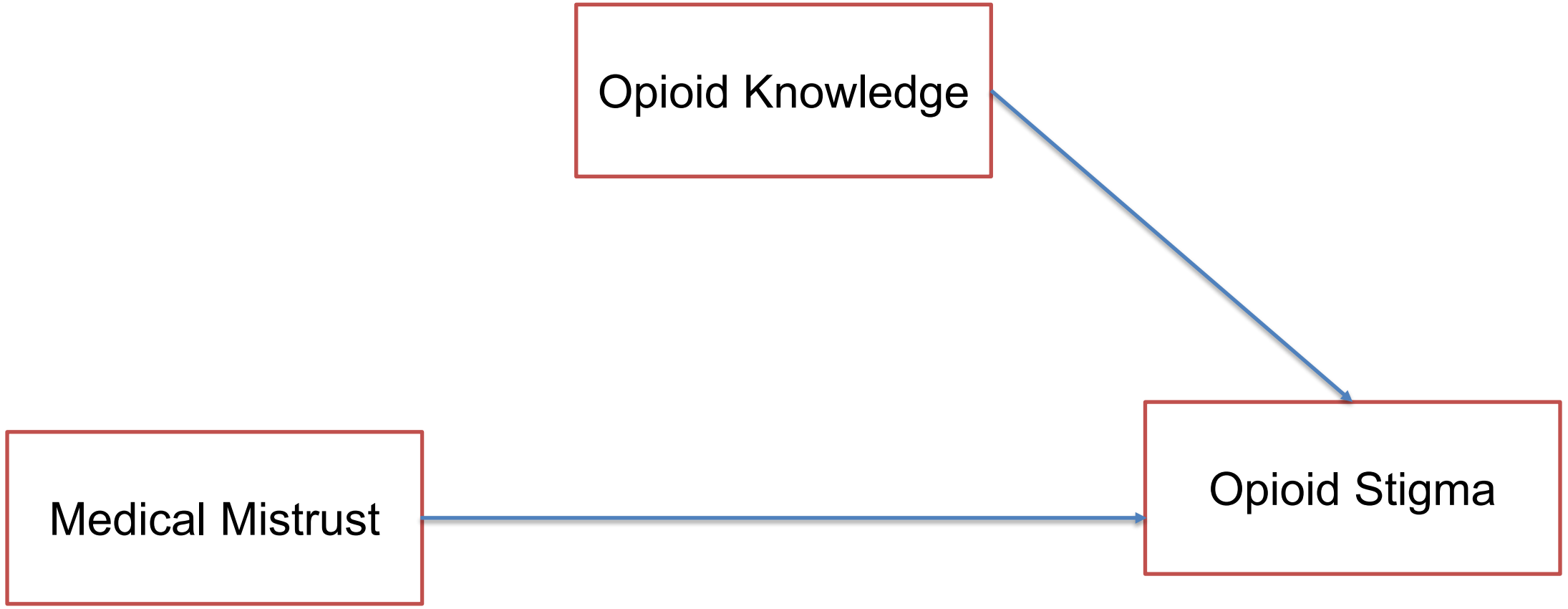
- Opioid health knowledge has only begun gaining attention over the past decade
- Unaware of studies examining the association between opioid knowledge and opioid stigma
- We suspect that poor opioid health knowledge will maintain or facilitate misinformation about opioids, which in turn will lead to negative attitudes or increased stigma towards people living with an OUD

Medical Mistrust and Health Knowledge

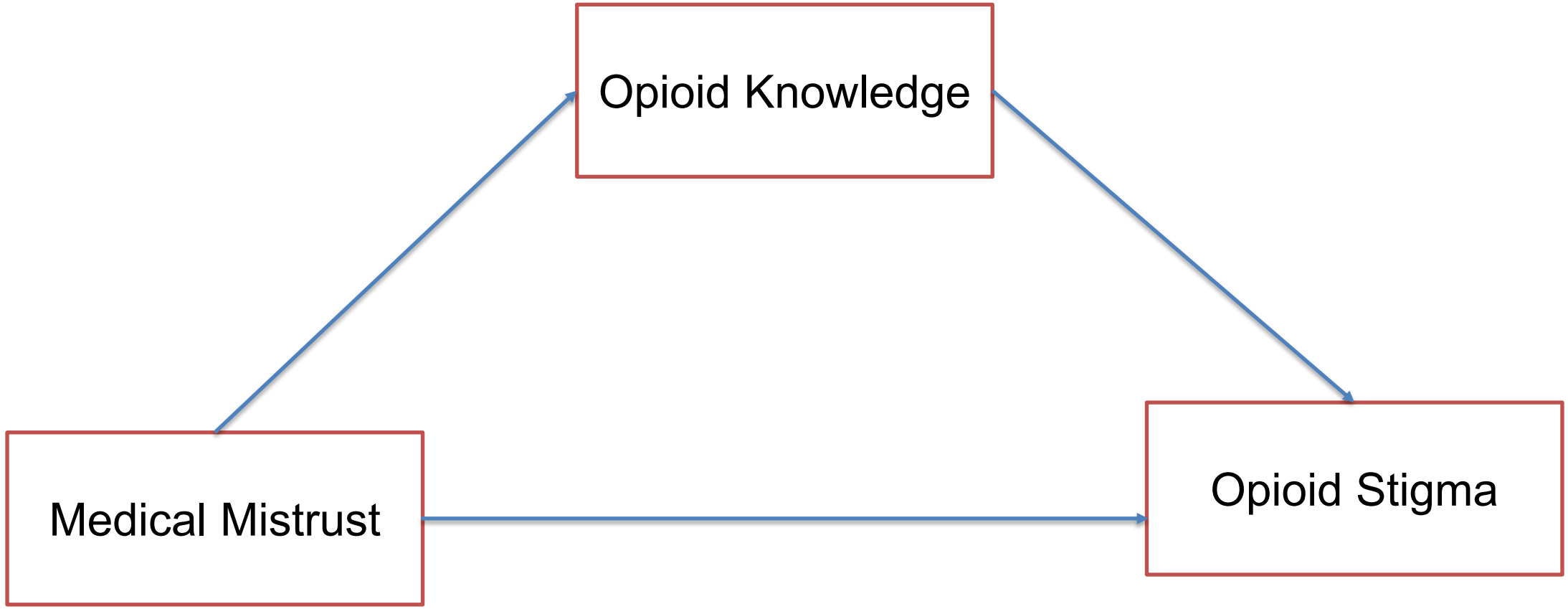
- Health care providers are an important source for obtaining accurate health information
- Mistrust in the medical system is barrier in the patient-provider relationship that can negatively impact health knowledge
- We suspect that individuals who are mistrusting of the medical field will seek out information from unreliable sources that may perpetuate negative attitudes or beliefs towards people living with an OUD

The Current Study

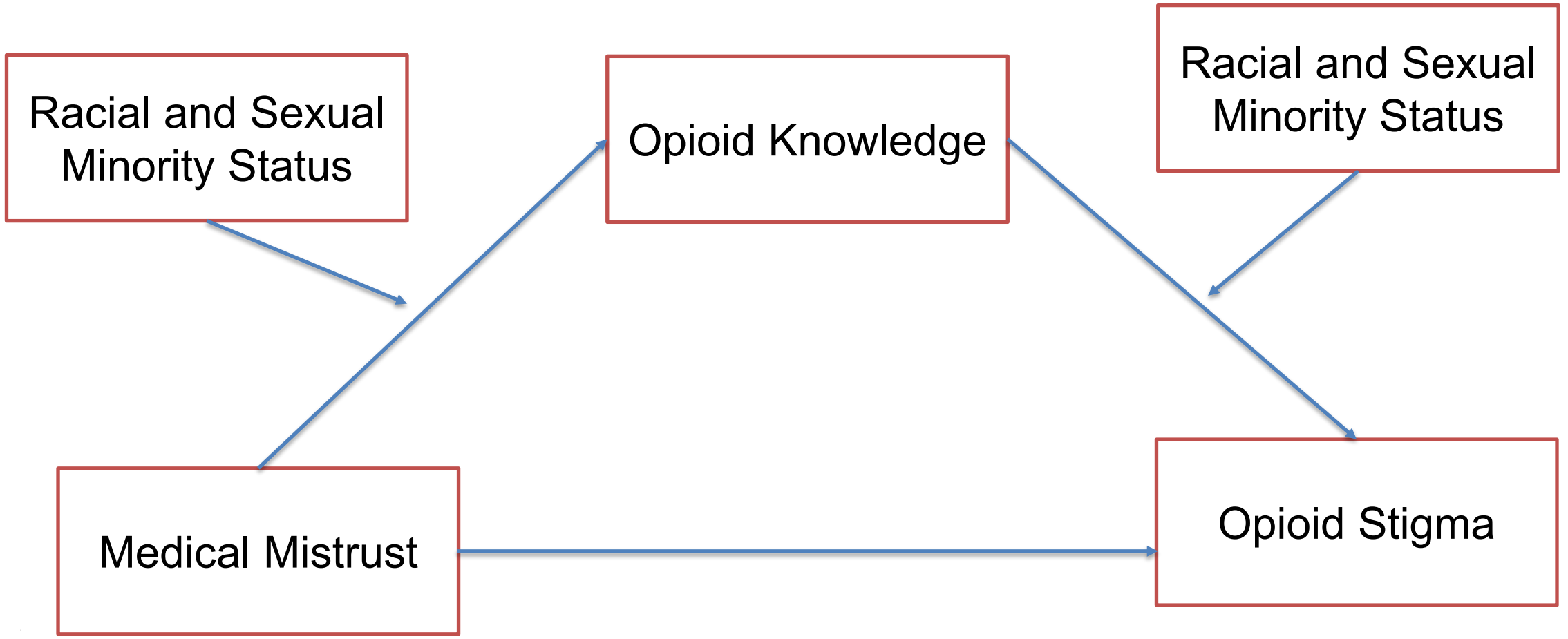
Is Opioid Stigma associated with Knowledge and Medical Mistrust?

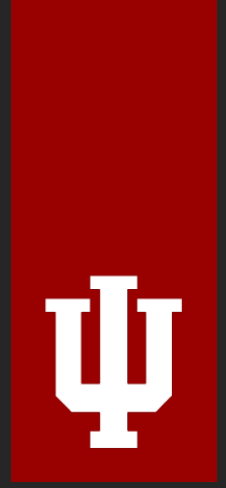


Is medical mistrust associated with opioid stigma indirectly through opioid knowledge?



Are these associations moderated by identity?





Methods

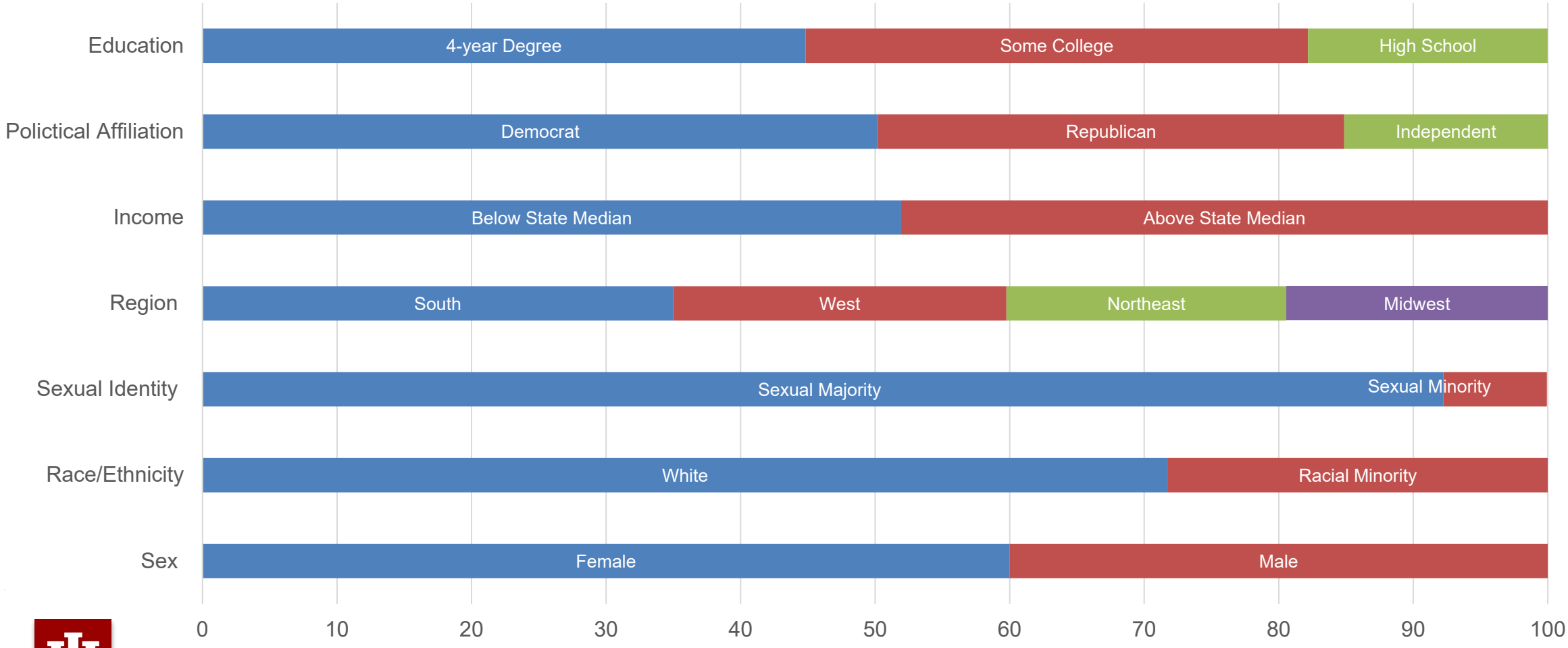
Methods

- Analyzed data from AmeriSpeak®

Measures of Interest:

- Social stigma toward OUD[9] (10-items, α = .84)
- Corbie-Smith Distrust in Clinical Research Index[10] (7-items, α = 0.86)
- Opioid Knowledge Scale[11] (4-items, α = 0.63)
- Sexual minority identity
- Racial minority identity

Participant Characteristics (*n* = 6,310)



Analytic Plan

- A series of linear regression models:
  - The Baron & Kenney (1986) method for detecting indirect effects is used to examine if medical mistrust is associated with opioid stigma indirectly through opioid knowledge.
  - Interaction effects are entered into the final step in the hierarchical regression model to examine if racial and sexual minority status moderate the possible pathways.

Predicting Opioid Knowledge

	B	95%CI	p
Racial Minority	-0.07	-0.17, 0.03	.160
Sexual Minority	0.24	0.10, 0.38	.001
Medical Mistrust (MM)	-0.16	-0.19, -0.13	<.001
MM x Racial Minority	-0.03	-0.08, 0.02	.215
MM x Sexual Minority	-0.04	-0.11, 0.04	.295

Predicting Opioid Stigma (Step 1)

	B	95%CI	p
Racial Minority	0.14	0.04, 0.25	.009
Sexual Minority	-0.31	-0.47, -0.16	<.001
Medical Mistrust (MM)	0.03	0.001, 0.06	.048
Opioid Knowledge (OK)			

Notes. Covariates included age, sex, region, education, political affiliation, and income

Predicting Opioid Stigma (Step 2)

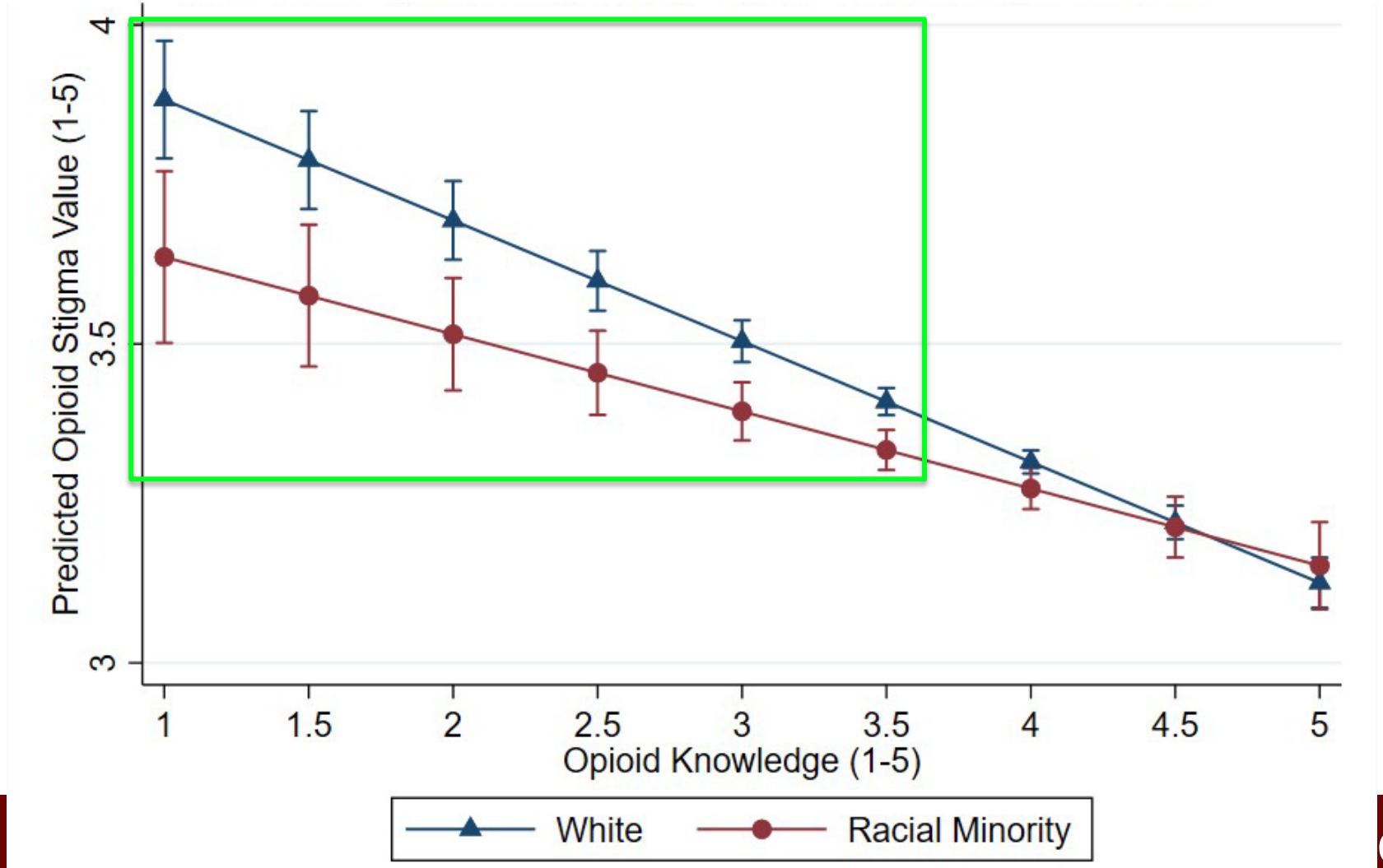
	B	95%CI	p
Racial Minority	0.13	0.03, 0.23	.02
Sexual Minority	-0.27	-0.43, -0.12	<.001
Medical Mistrust (MM)	0.003	-0.03, 0.03	.843
Opioid Knowledge (OK)	-0.17	-0.19, -0.14	<.001

Notes. Covariates included age, sex, region, education, political affiliation, and income

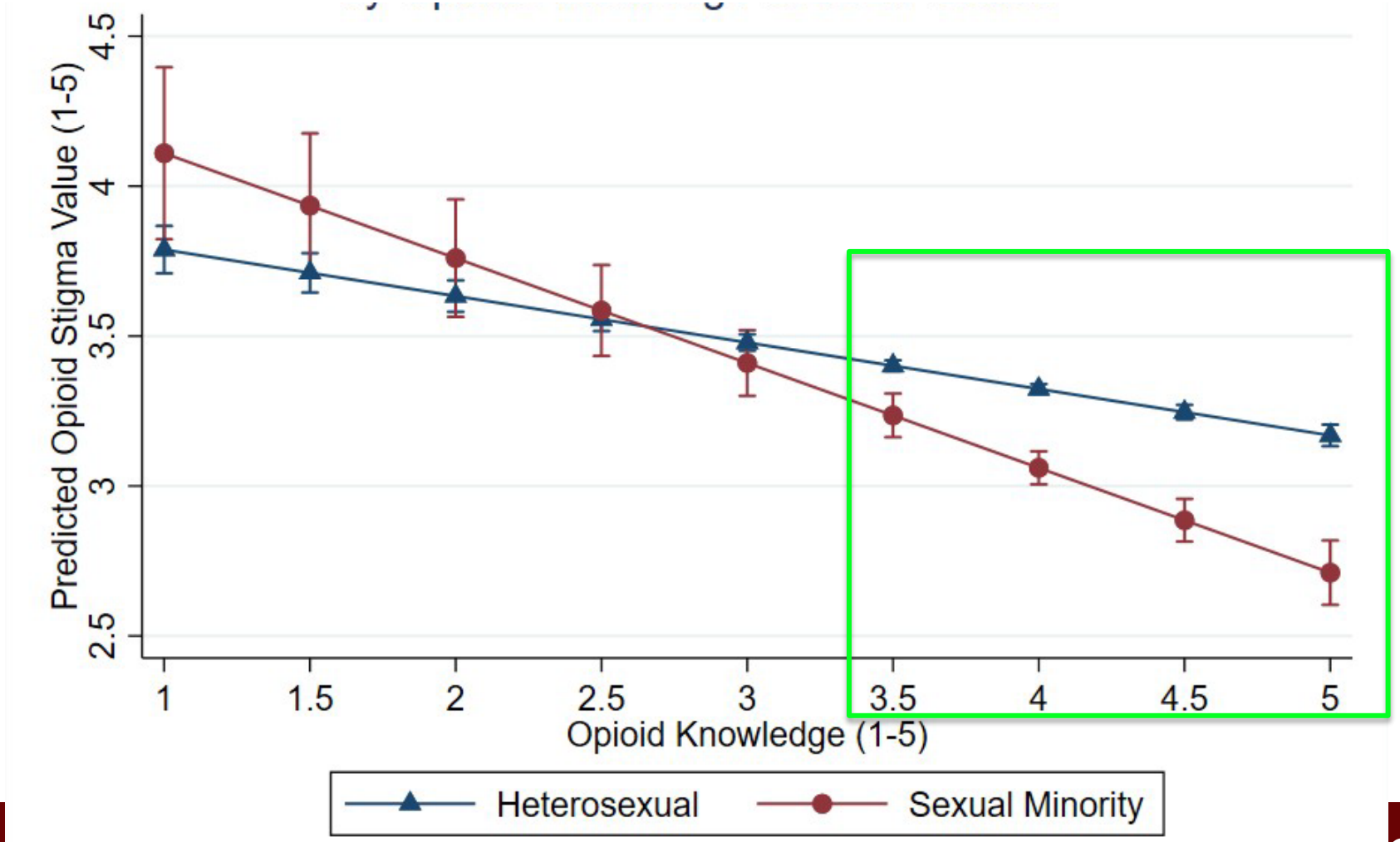
Predicting Opioid Stigma (Step 3)

	B	95%CI	p
Racial Minority	-0.16	-0.43, 0.11	.243
Sexual Minority	0.63	0.12, 1.13	.014
Medical Mistrust (MM)	0.001	-0.28, 0.03	.903
Opioid Knowledge (OK)	-0.18	-0.21, -0.14	<.001
MM x Racial Minority	-0.02	-0.07, 0.03	.463
MM x Sexual			

Opioid Knowledge by Race



Opioid Knowledge by Sexual Identity



Discussion

Preliminary Evidence of an Indirect Pathway

- Supported an indirect pathway where medical mistrust is associated with stigma towards people with a history of an OUD through opioid knowledge.
- Distrust in the medical system may lead to health seeking information from unreliable sources, increasing vulnerability to negative messages about opioid misuse
- Health literacy may increase one's ability to navigate, understand, and utilize health information, which in turn reduces negative internalized attitudes or beliefs about people living with OUDs

Minority Status Moderates the Pathways

- The association between opioid knowledge and opioid stigma varied across identity status.
  - Stronger for sexual minorities at higher levels of opioid knowledge
  - Weaker for racial minorities at lower levels of opioid knowledge
- May reflect cultural intervention efforts that are unique to minority groups
  - Faith-based community initiatives[13-15]
  - Broader health education efforts that include stigma prevention[16-17]

Thank You!

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EAST TENNESSEE STATE UNIVERSITY

Stigma Reduction Among Criminal Legal Staff: Evidence from a Multilevel Stigma Reduction Intervention

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Disclosures

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- I or my immediate family have no conflicts of interest to disclose.

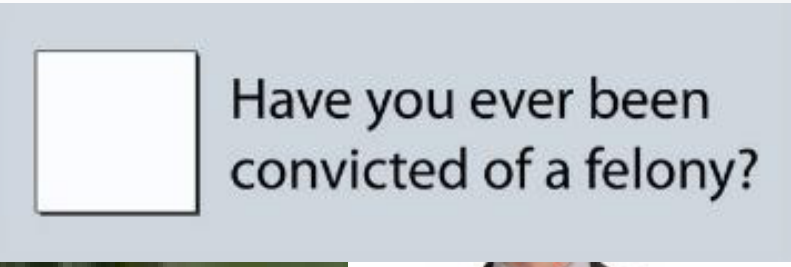
Social Stigma

Social
(attitudes and behaviors)

Structural
(laws and policies)

Self
(individual responses)

Behavior



Stereotypes about criminal involvement

- Untrustworthy, dishonest, manipulative
- Dangerous, violent, unpredictable
- Unlikely to change, unmotivated, lazy
- To blame, problems are due to personality rather than circumstance
- Can’t benefit from treatment
- Different from other people
- Immoral, bad people
- Weak-willed, lacking in self-control
- Unintelligent, lacking skills

- More negative for racial minorities, people convicted of sex offenses

Rade et al., 2016; Hirschfield & Piquero, 2010

Stereotypes about substance use disorder

- Same attitudes about people with criminal involvement as well as:
  - Addiction is a choice; people choose to be addicted
  - Addiction is a moral failing
  - Addiction is not the same as other mental health problems
  - People with addiction don't respond to treatment
  - People with addiction will never recover
  - Skepticism about treatment approaches (e.g., medication)

- More negative for people who are pregnant, parents, or who inject drugs

Nieweglowski et al., 2019; Wakeman & Rich, 2018

Why target both types of stigma?

- Criminal involvement stigma is pervasive, severe, and problematic
- Substance use and criminal involvement are intersectional
- Stigma about “criminals” may be more predictive of attitudes toward substance use treatment

Rade et al., 2016; Moore et al., 2022

Criminal legal culture and stigma

- Staff often endorse stereotypes about substance use disorder and criminal involvement

- Criminal legal contexts can be challenging, stressful, and high-risk workplaces
  - https://www.youtube.com/watch?v=SXlZLppZ7L8

- Aspects of workplace culture may influence stigmatizing attitudes
  - Burnout and compassion fatigue linked to less support for rehabilitation

Schaefer and Williams 2018; Frost and Scott 2020

Research questions

1. How much stigma do criminal legal staff hold toward substance use and criminal involvement?

2. Is workplace stress related to stigmatizing attitudes and behaviors?

3. Do staff's attitudes change after participating in a social stigma intervention?

Multilevel stigma reduction

Social stigma

-All criminal justice sectors

-Intersection of stigma toward substance use, criminal involvement, and medications for addiction

-Didactic, co-led by peer recovery specialist

-Attitude and behavior change

-Interactive examples specific to criminal legal system

Self-stigma

-Adapted from evidence-based acceptance and commitment therapy for addiction self-stigma

-Intersection of stigma toward substance use, criminal involvement, and medications for addiction

-Behavioral strategies for increasing coping skills, accepting stigma-related barriers and persevering

-Encourages treatment retention

Moore et al., 2023

Procedures

-Target population: Tennessee Recovery-Oriented Compliance Strategy (TN-ROCS) in 6 rural counties

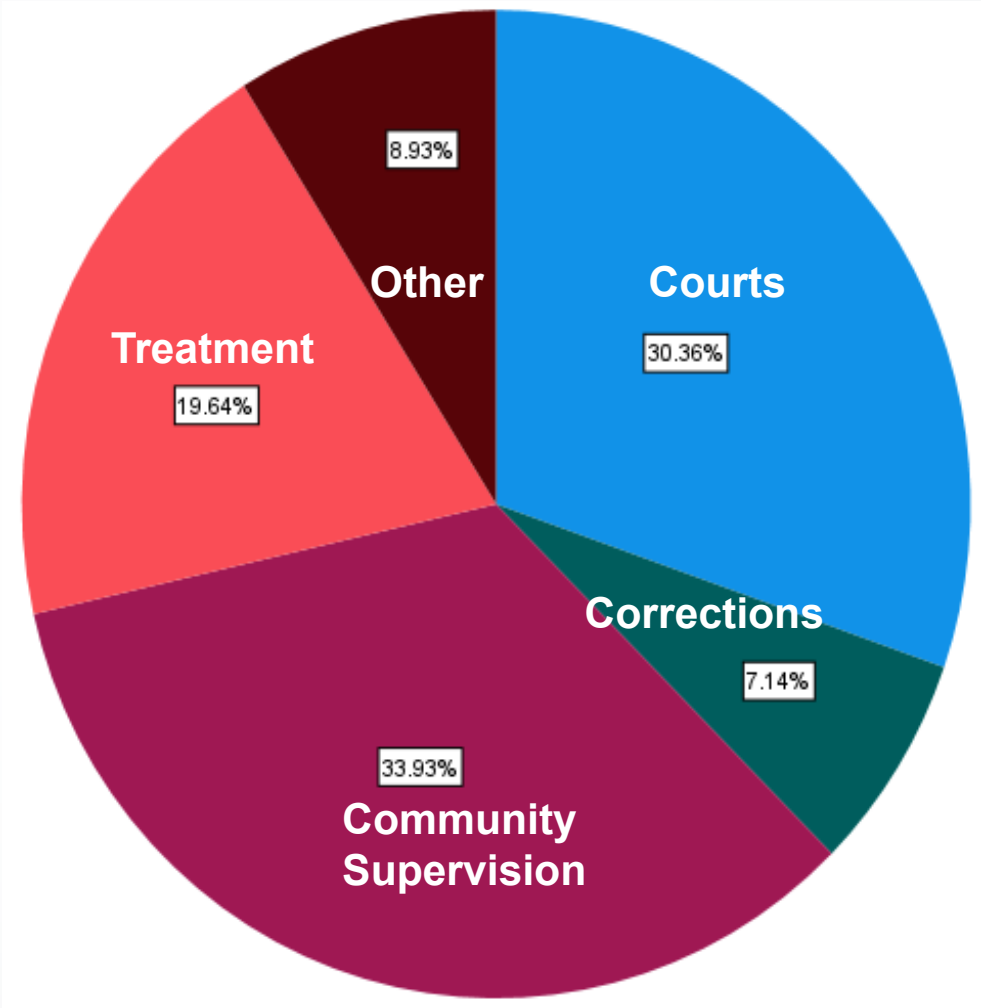
-Engaged treatment staff and judges in each county to facilitate recruitment

-Staff registered via zoom and attended a virtual synchronous intervention session delivered by Moore and peer recovery specialist

-Completed redcap surveys at baseline, post-intervention, 3 month follow-up

Participants

- Criminal legal staff
  - TN-ROCS staff in the 6 counties, n = 46
  - 94% white, 6% Black, 72% female, 42 years old on average
  - 34% had a doctoral degree, 22% had a master's degree, 30% had a bachelors degree, 14% had a high school diploma or some college
  - 78% had daily contact with TN-ROCS clients

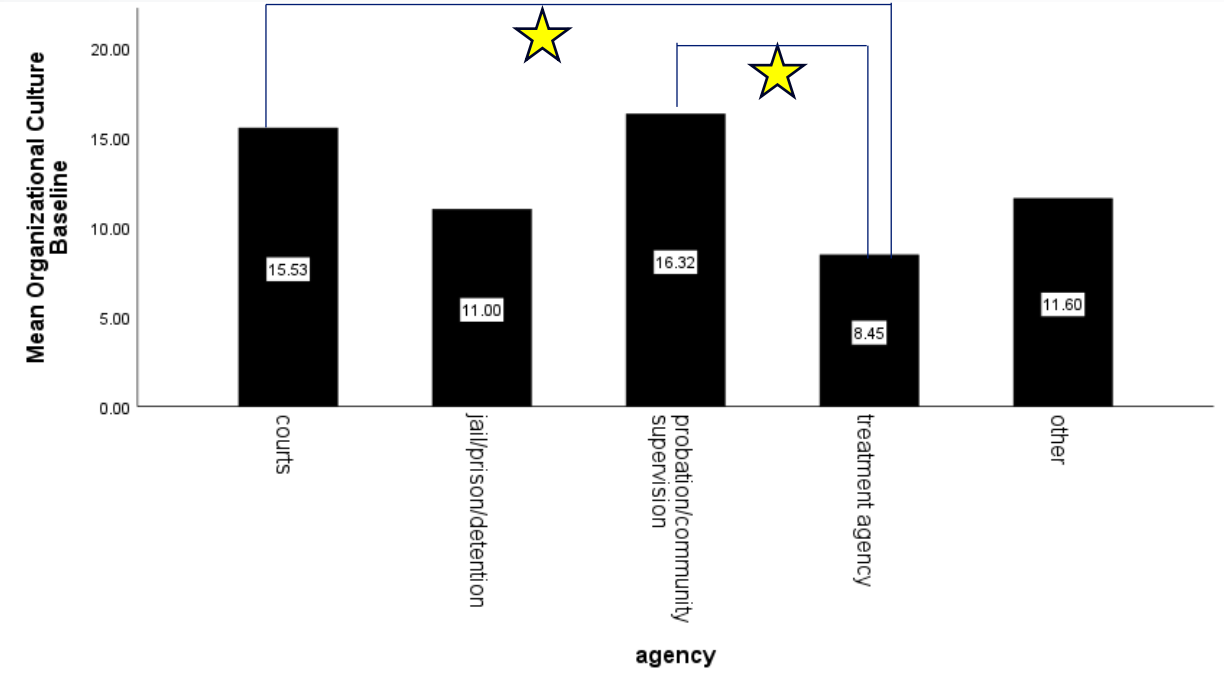


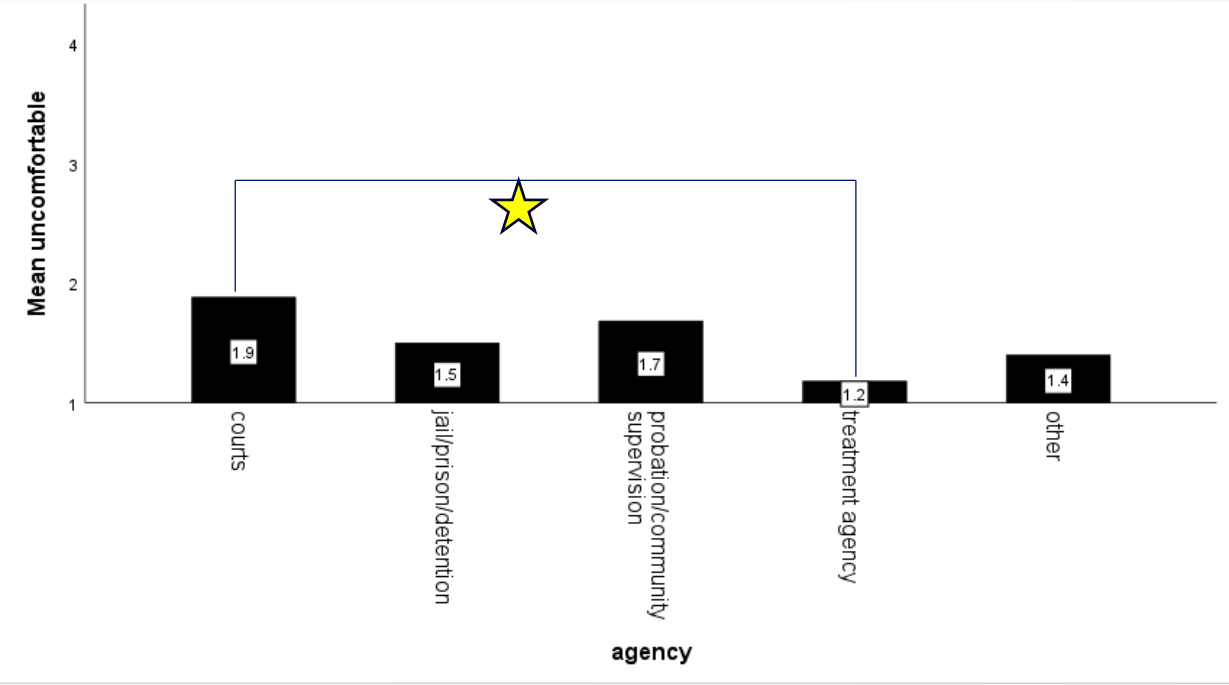
Measures

- Workplace variables
  - Agency type (courts, jail/prison, probation, treatment, other)
  - Organization culture (JCOIN measure, ex., “Staff frustration is common here” “Staff are under too much pressure to do their jobs effectively”)
  - Discomfort interacting with clients (internally developed, ex., “To what extent have justice-involved people made you feel uncomfortable at your job?”)

- Stigmatizing attitudes
  - Difference and Disdain scale, substance use and criminal involvement (Corrigan et al., 2015)
  - Stereotype Agreement subscale, substance use and criminal involvement (Corrigan et al., 2016)
  - 22-item Perspectives on Stigma Reduction scale (internally developed)

Results: Workplace stress by agency

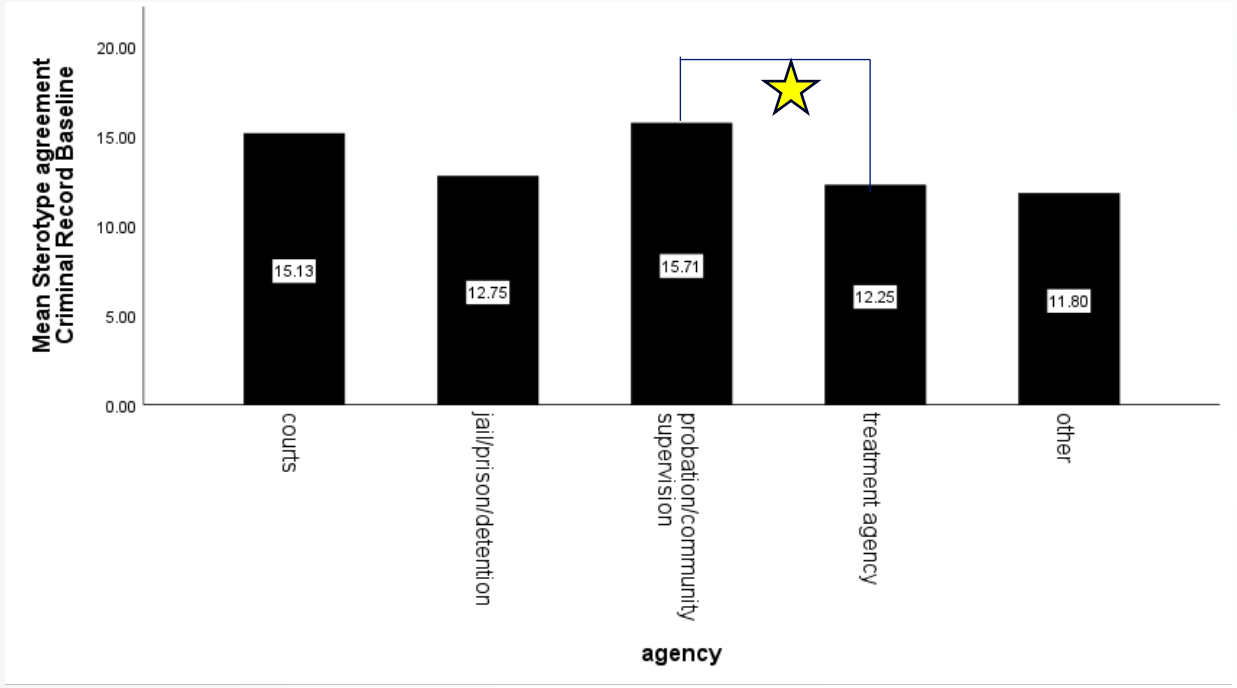


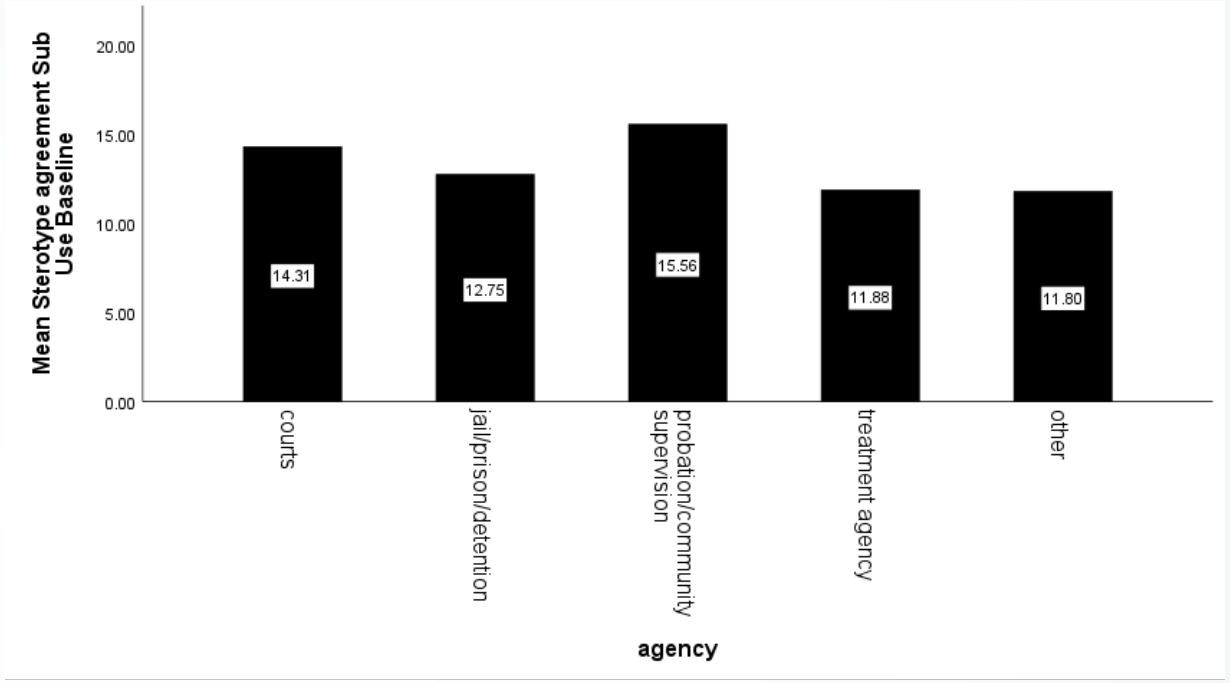


- Courts and probation offices reported significantly more workplace stress than treatment agencies

- Courts reported significantly more discomfort interacting with justice-involved clients than treatment agencies

Results: Stigmatizing attitudes by agency

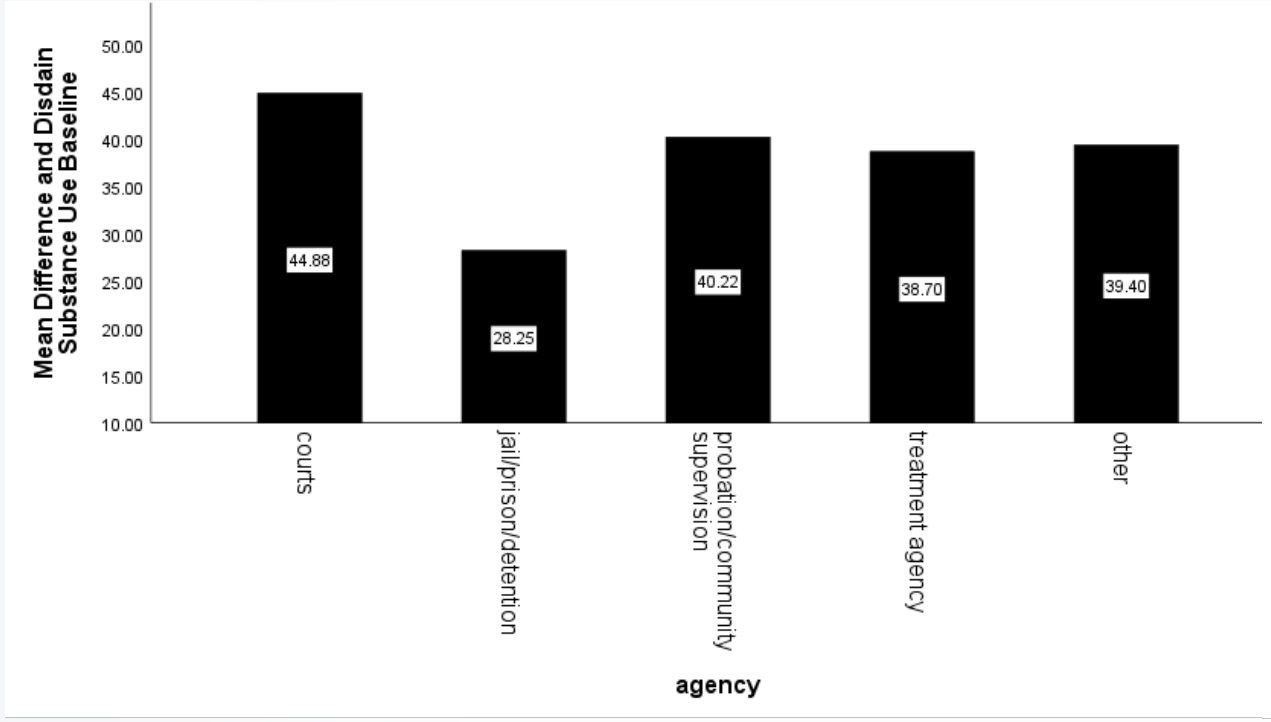


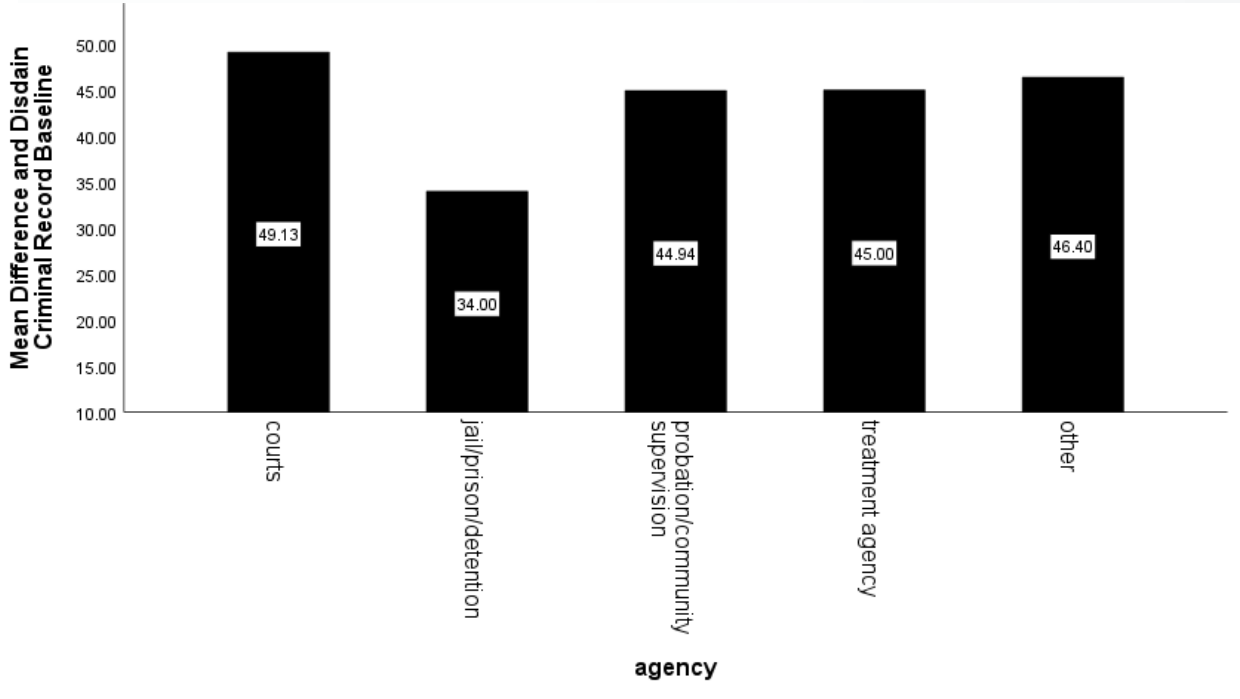


- Probation staff reported significantly more stigma toward criminal involvement than treatment agencies

- Probation staff reported more stigma toward substance use (differences not significant)

Results: Difference and disdain by agency





- Court staff (e.g., attorneys, judges) reported the most difference and disdain (differences not significant)

Results: Correlations between workplace stress and stigma

- Higher workplace stress associated with:
  - More stereotypes about criminal involvement (r = .32, p = .024)
  - More stereotypes about substance use disorder (r = .31, p = .038)
  - Less agreement that stigma is a barrier to recovery (r = -.33, p =.025), treatment success (r = -.31, p = .039)
  - Higher expectation clients will relapse (r = .30, p = .044)
  - Greater self-reported use of labels like criminal, addict, rapist, etc. (r = .46, p = .002)
  - Greater self-reported unfair treatment toward justice-involved clients (r = .32, p = .034)
  - Less self-reported enjoyment interacting with justice-involved people (r = -.51, p < .001)
  - Less self-reported openness to and interest in learning about stigma reduction (r = .39, p = .009)

Results: Changes in stigma after intervention

Stigmatizing Attitudes Scales	Baseline Mean (SD)	Post-test Mean (SD)	p	d
Difference and Disdain-Substance Use	40.6 (12.9)	31.6 (12.2)	<.001	9.8
Difference and Disdain-Criminal Involvement	46.0 (12.0)	36.3 (12.3)	<.001	9.9
Stereotype Agreement-Substance Use	14.3 (3.6)	14.1 (4.7)	.748	3.0
Stereotype Agreement-Criminal Involvement	14.6 (3.7)	14.1 (4.6)	.372	2.9

Results: Changes in stigma after intervention

Select items: Perspectives on Stigma Reduction	Baseline Mean (SD)	Post-test Mean (SD)	p	d
Stigma is a barrier to recovery	7.1 (1.9)	7.2 (1.9)	.600	1.1
Stigma is a barrier to treatment	6.6 (1.9)	6.9 (2.0)	.142	1.2
How similar are you to justice-involved people?	5.3 (1.2)	5.9 (1.5)	.019	1.2
When justice-involved individuals relapse or re-offend, are you open to giving them additional chances to succeed?	7.0 (1.6)	7.2 (1.7)	.664	1.8
Are you open to changing how you interact with justice-involved individuals if you knew it would make them more comfortable or feel less judged?	8.0 (1.7)	10.2 (1.9)	<.001	1.4
How confident are you in your ability to reduce stigma?	7.0 (2.1)	7.6 (1.9)	.049	1.4
How much have you enjoyed interacting with clients in the past month?*	7.0 (2.0)	8.0 (1.3)	.040	1.9
How much have tried to help justice-involved individuals feel comfortable, respected, and accepted when they interact with you?*	7.7 (1.4)	8.5 (0.8)	.006	1.1

Conclusions

- Criminal legal staff stigmatizing attitudes do not vary much between agency types, but workplace stress does
- Workplace stress is related to stigmatizing attitudes among staff
- Some stigmatizing attitudes and behavioral intentions change after participating in a social stigma intervention
- Stigma reduction efforts should be tailored to different agency types within the criminal legal system and incorporate elements to reduce workplace stress

Questions?

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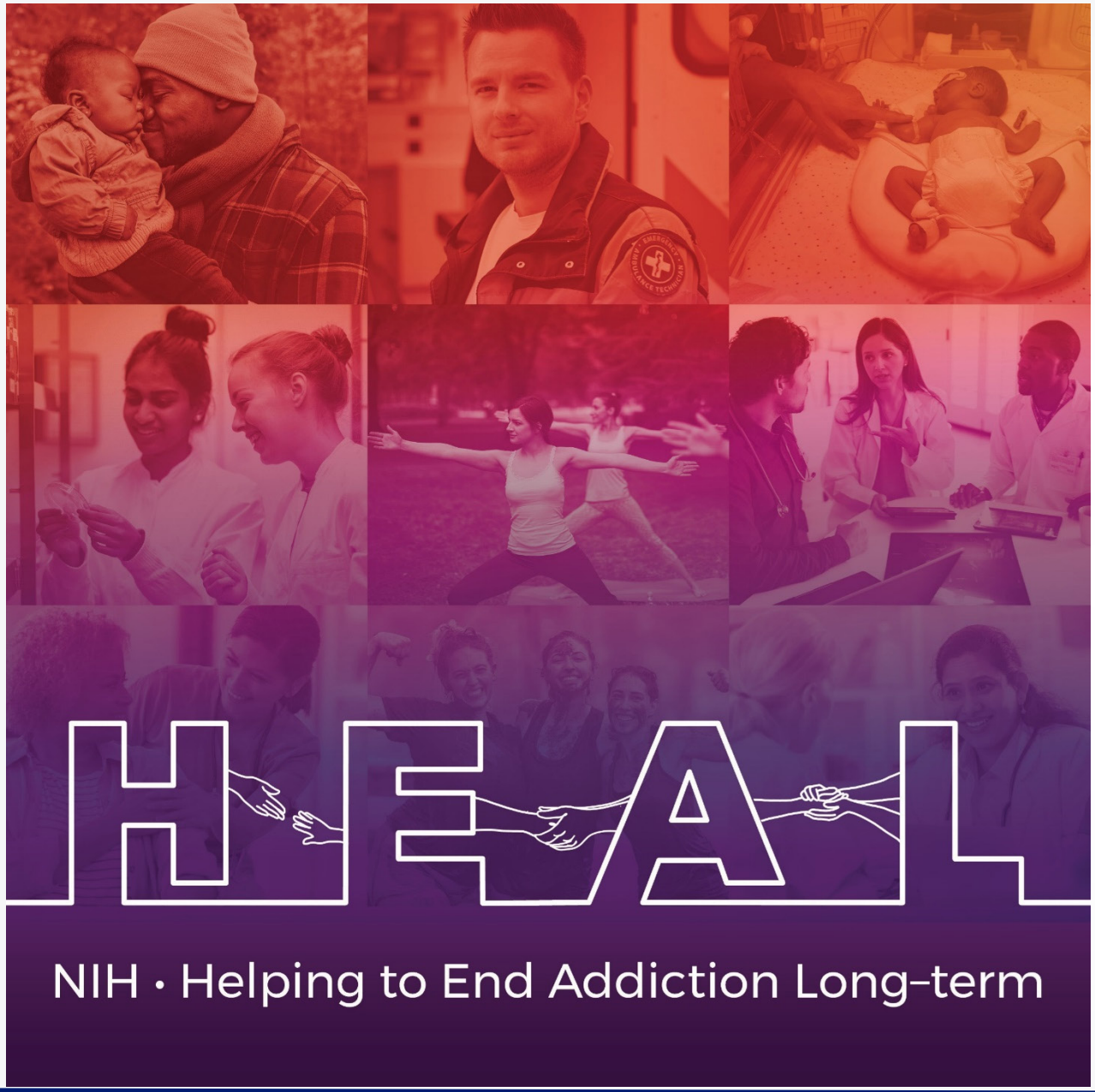

Thank you!

The next session will begin at 12pm.