Mental Health Commission of Canada

Commission de la santé mentale du Canada

An Evaluation of the Reducing Stigma and Promoting Recovery for Opioid Use E-Learning Course

Does it Reduce Stigma?

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Introduction

Stigma, health-care 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 2021, there have been more than 24,000 apparent opioid-related deaths, the vast majority of which are believed to be accidental.[1] While previous data suggested a slight decrease in opioid-related deaths from 2018 to 2019, recent data shows increases in such deaths during the COVID-19 pandemic. Hospitalizations due to opioid poisoning have also risen since the pandemic began (currently averaging about 16 per day), as have stimulant-related hospitalizations (currently averaging about seven per day).[2] Among the likely contributing factors to this worsening crisis are an increasingly toxic drug supply; increased feelings of isolation, stress, and anxiety; and the limited availability of or accessibility to services for people who use drugs.[3]

These numbers represent only a fraction of the day-to-day interactions (whether for treatment or other reasons) that people who use opioids have with health-care providers (HCPs) and first responders (FRs). The public's stigmatizing views toward individuals who use substances are well established,[4] as is the stigma toward medication maintenance therapy, despite its recognition as a best practice in opioid addiction treatment. An acknowledgment that many individuals who live with problematic opioid use developed their condition due to overprescribing by physicians is also lacking.[5] While such negative attitudes and beliefs toward opioid use are found in the public and in HCPs and FRs, the latter stigma is what increases barriers to care and reduces the quality of services received by those who use opioids.[6,7] People seeking or accessing treatment for an opioid use disorder have described feeling degraded, dismissed, and devalued when interacting with HCPs and FRs.[8]

In 2017, the Mental Health Commission of Canada (MHCC) investigated the effects of HCP and FR stigma on service delivery and care received by those who use opioids.[i] One of the study's main findings was the need to have more stigma-informed education and training for HCPs and FRs, using a social-contact (or contact-based) approach.[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 facilitation. In many studies around the world, contact-based approaches were shown to be effective.[10–13] They are widely considered a best practice for stigma reduction and have been used in several of the MHCC's successful initiatives to reduce mental illness-related stigma.[14–17]

In 2019, a second MHCC study set out 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, replicate, and support the scaling up of effective programs and practices. The current report describes the results of one of five programs evaluated as part of this study: a six-module e-learning course developed and delivered by Centre for Addiction and Mental Health.

[i] Funding for this initiative was provided by Health Canada.

Program Description

Reducing Stigma and Promoting Recovery for Opioid Use is a six-module self-directed e-learning course developed and delivered by the Centre for Addiction and Mental Health (CAMH). Several subject matter experts, including people with lived and living experience of opioid use, provided input during its creation. The modules were adapted from a previous CAMH course called Opioid Problems, Treatments, and Solutions, which was designed as facilitated training for health-care providers (HCPs) over several weeks.

Reducing Stigma and Promoting Recovery for Opioid Use is a free, self-directed course for HCPs and other direct service providers who work with people who use opioids (available through the CAMH PSSP Knowledge Exchange portal). The course has two overarching goals:

- to reduce stigma toward opioid use and individuals who use opioids
- to reinforce recovery-oriented care and the notion that recovery is highly individualized

The course includes quizzes, case studies and videos, and the opportunity to reflect on various themes and issues through discussion forums. Its six modules are divided into the following areas:

- the opioid crisis in Canada (includes an overview of the problem of stigma)
- risk factors, priority populations, and harm reduction
- opioid agonist therapy (OAT)
- psychological interventions
- supporting recovery and ongoing care
- reducing stigma

The training also includes access to a "resource vault" with reports, guides, information sheets, and other materials on a range of topics that participants can use and share with clients: the opioid crisis, opioid-related harms, social determinants of health, trauma, harm reduction, naloxone, treatment, recovery-oriented care, reducing stigma, and self-care. Including all supplementary materials, the course takes about nine hours to complete.

CAMH launched Reducing Stigma and Promoting Recovery for Opioid Use in February 2021. This MHCC evaluation to assess key program outcomes took place between late February 2021 and early January 2022.

Evaluation Approach

The program was evaluated using a pre-post design and two mean (M) outcome measures for assessing its impact. The first measure employed the Opening Minds Provider Attitudes Toward Opioid Use Scale (OM-PATOS)[18,19] — developed specifically to assess (1) attitudes and (2) behaviours/motivation to help — among HCP and FR populations interacting with people living with opioid use problems.[2] For each item, participants were asked to indicate their level of agreement on a five-point scale: strongly agree (5), agree (4), neither agree nor disagree (3), disagree (2), or strongly disagree (1). Average OM-PATOS mean scores can range from one to five, with lower scores indicating more positive attitudes (i.e., less stigma).

The second outcome measure asked a series of questions about participants' knowledge and skill levels across the main course components, including stigma and stigma reduction, individual- and system-level harms related to opioid use, best evidence approaches for harm reduction and treatment, and recovery-oriented strategies. Items were scored on a five-point scale where "1" indicated no knowledge or skills and "5" a very high level of knowledge or skills.

For both measures, participants were invited to complete online surveys immediately before (pre) and after (post) completing the course, so that changes over time could be captured. 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-training at the 95 per cent confidence level. Effect sizes (Cohen's *d*) were also calculated to estimate the magnitude of change. Typically, 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. Put in context, Coe describes these effect-size differences as follows (based on descriptions provided by Cohen):

> the difference between the heights of 15 year old and 16 year old girls in the US corresponds to an effect of [small] size. An effect size of 0.5 is . . . "large enough to be visible to the naked eye" [and] corresponds to the difference between the heights of 14 year old and 18 year old girls. . . . An effect size of 0.8 is "grossly perceptible and therefore large" and . . . equates to the difference between the heights of 13 year old and 18 year old girls. (p. 4)[20]

After completing the course, participants were also given a series of questions asking them to reflect on the value and usefulness of the course and what they learned.[3] Two qualitative reflection questions were also included at post-test: What aspects of the course worked well? and What suggestions do you have for improving the course?

Demographic information was not collected for this evaluation.

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[2] While the original OM-PATOS scale contained 19 items, results from recent psychometric analyses (see endnote 20) suggest a possible preference for a 15-item scale that captures two main content areas: attitudes (6 items) and behaviours/motivation to help (9 items).

[3] Descriptive results are provided for these questions.

Results

Between February 25, 2021, and January 9, 2022, 164 participants enrolled in the course. Of these, 67 completed it and were issued a certificate, with 66 providing pre- and post-test data. Of these pre- and post-tests, 20 were excluded from the analysis, as they had been submitted within a very short time frame (less than 2 hours from pre- to post-test).[4] Analyses were completed on the remaining 46 pre- and post-test surveys.

Course completion time

Estimates of course completion time were made using data that tracked when participants submitted their pre- and post-tests. As Table 1 highlights, these times varied, although most participants competed the course within five days of starting. The median completion time was three days; the most frequent completion time (mode) was one day.

Table 1. Estimates of the Time Taken to Complete the Program (*N* = 46)

Time between pre- and post-test	*n*	%
Less than 1 day	9	19.5%
1-5 days	19	41.3%
6-10 days	8	17.4%
11-15 days	5	10.9%
16-20 days	1	2.2%
More than 20 days	4	8.7%

Mean score changes pre- to post-intervention: OM-PATOS

In all, the 46 matched pre- and post-surveys from participants who completed the program were used for analysis. An assessment of scale reliability (Cronbach's alpha) for the OM-PATOS at pre- and post-test showed high levels of internal consistency at both time points (OM-PATOS: Cronbach's alpha = .95 at pre-test and .94 at post-test).

Table 2 highlights score changes for the OM-PATOS. As it shows, the average mean score on the OM-PATOS was 1.48 (SD[5] = .41) at the beginning of the program and 1.38 (SD = .77) at the end, showing a small, non-statistically significant improvement in scores from pre- to post-training, with already very low average levels of stigma at baseline.

An examination of the distribution of baseline (pre-test) scores showed that about half the participants (*n* = 25; 54.3%) had a mean baseline scale score of 1.50 or less, suggesting the possibility

[4] This cut-off was estimated to be the absolute minimum amount of time in which a participant could complete the core elements of the course. Those who completed the pre- and post-tests in less than two hours may have not engaged adequately with the course content or may have completed the post-test out of turn (e.g., at the end of the first module instead of at the completion of the full program).

[5] Standard deviation.

of a ceiling effect.[6] A secondary analysis was therefore undertaken with the participant sample divided into two groups: (1) those who had very low stigma scores at baseline (pre-test score of 1.50 or less) and (2) those with baseline scores above 1.50.

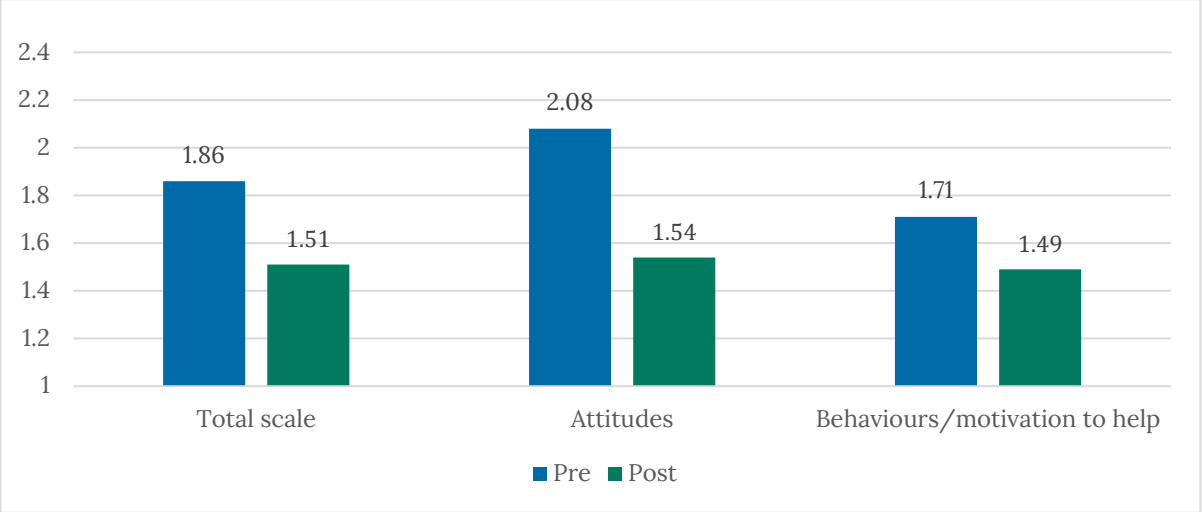
As Table 2 illustrates, this sub-analysis revealed that participants with higher baseline scores (i.e., above 1.50) had a statistically significant improvement in scores from pre- to post-program, with a magnitude of effect solidly in the medium-effect range (Cohen's *d* = .59).

Table 2. Participant Scores at Pre- and Post-Program: OM-PATOS

	N/n	Pre-test *M* (SD)	Post-test *M* (SD)	*t*-test	Effect size (Cohen's *d*)
All participants	46	1.48 (.41)	1.38 (.77)	t(45) = .888, *p*[7] = .379	.16
Baseline score: 1.50 or less	25	1.17 (.18)	1.27 (.82)	t(24) = -.613, *p* = .552	-.17
Baseline score: above 1.50	21	1.86 (.25)	1.51 (.70)	t(20) = 2.42, *p* = .025	.59

As Figure 1 further illustrates, participants in this group (*n* = 21) showed improvements for both of the main components of the OM-PATOS scale — attitudes and behaviours/motivation to help — with particularly strong improvement scores being observed for the attitudes dimension of the scale.

Figure 1. Pre- and Post-Test Scores for the Stigma Dimensions of Attitudes and Behaviours/Motivation to Help



[6] A *ceiling effect* occurs when test items are not challenging enough to a particular group and, as a result, scores accumulate at the high end.

[7] A *p* (probability) value shows the likelihood that a result is due to random occurrences. A lower *p* value indicates less chance that a result is random.

An additional analysis of completion time on score changes from pre- to post-program suggested that these factors were not correlated. In general, however, participants with very low baseline scores tended to complete the course more quickly (median days = 2.0) than those whose baseline scores were higher (median completion time = 4.0 days). This difference was statistically significant ($p = .016$) and showed a medium-level effect (Cohen's d =.40).

Mean score changes pre- to post-intervention: Knowledge and skills

Participants were also asked a series of statements about their knowledge and skill levels in the following areas:

- individual- and system-level harms related to opioid use
- harm reduction strategies
- available OAT programs
- multidisciplinary approaches to the treatment of opioid use disorder (OUD)
- recovery-oriented strategies for clients
- the impacts of stigma
- strategies for reducing stigma

Responses were rated on a five-point scale from none (1) to very high (5). As shown in the pre- and post-changes in mean scores highlighted in Table 3, statistically significant improvements in knowledge and skill levels were observed on all measures, with the magnitude of change solidly in the large-effect range (Cohen's d = -1.12 to -1.70, depending on the domain).

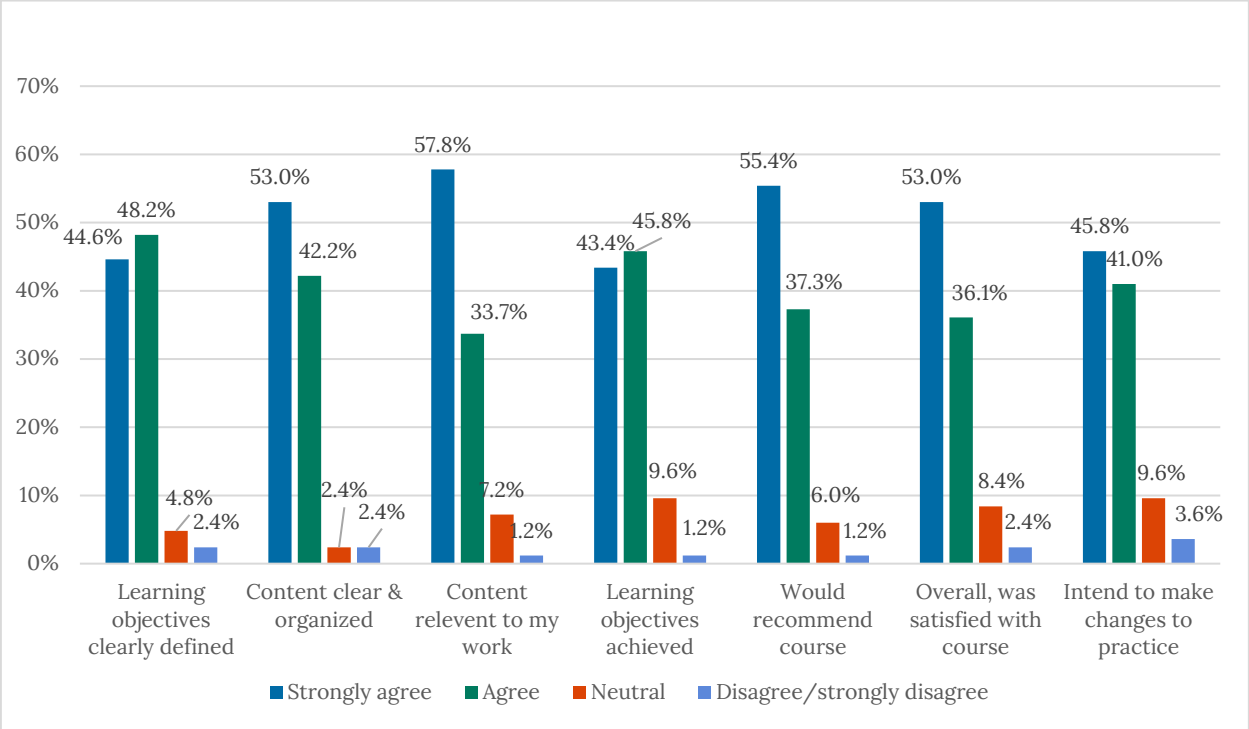
Table 3. Knowledge and Skills: Mean Scores at Pre- and Post-Program

	Pre-test *M* (*SD*)	Post-test *M* (*SD*)	*t*-test	Effect size (Cohen's *d*)
Knowledge of individual- and system-level harms related to opioid use and OUD	2.96 (.99)	4.00 (.92)	$t(65) = -7.16$, $p<.001$	-1.09
Skills in identifying individual- and system-level harms related to opioid use and OUD	2.85 (1.05)	3.96 (.89)	$t(65) = -8.13$, $p<.001$	-1.12
Knowledge of harm reduction strategies for opioid use	2.98 (1.27)	4.24 (.67)	$t(65) = -8.42$, $p<.001$	-1.16
Skills in identifying harm reduction strategies for opioid use	2.00 (1.10)	3.93 (.88)	$t(65) = -8.27$, $p<.001$	-1.22
Knowledge of the available OAT programs in Canada	1.89 (1.08)	3.76 (.87)	$t(65) = -11.89$, $p<.001$	-1.93
Skills in explaining the differences between the available OAT programs in Canada	2.28 (1.15)	4.02 (.83)	$t(65) = -11.66$, $p<.001$	-1.89
Knowledge of multidisciplinary approaches to the treatment of OUD	2.28 (1.17)	3.98 (.80)	$t(65) = -10.68$, $p<.001$	-1.71
Skills in adopting a multidisciplinary approach to the treatment of OUD	2.65 (1.30)	4.20 (.72)	$t(65) = -10.15$, $p<.001$	-1.66
Knowledge of recovery-oriented strategies for clients that use opioids.	2.52 (1.33)	4.04 (.76)	$t(65) = -8.55$, $p<.001$	-1.40
Skills in utilizing recovery-oriented strategies for clients that use opioids	2.67 (1.21)	4.20 (.78)	$t(65) = -8.69$, $p<.001$	-1.33
Knowledge of the impact of stigma on people who use opioids and their support networks	3.48 (1.03)	4.46 (.66)	$t(65) = -6.12$, $p<.001$	-1.12
Skills in explaining the impact of stigma on people who use opioids and their support networks	3.07 (1.08)	4.37 (.68)	$t(65) = -8.25$, $p<.001$	-1.41
Knowledge of stigma-reducing strategies around opioid use/OUD	2.67 (1.21)	4.20 (.78)	$t(65) = -8.69$, $p<.001$	-1.46
Skills in implementing strategies to reduce stigma around opioid use/OUD	2.52 (1.23)	4.22 (.81)	$t(65) = -9.98$, $p<.001$	-1.59

Participant feedback

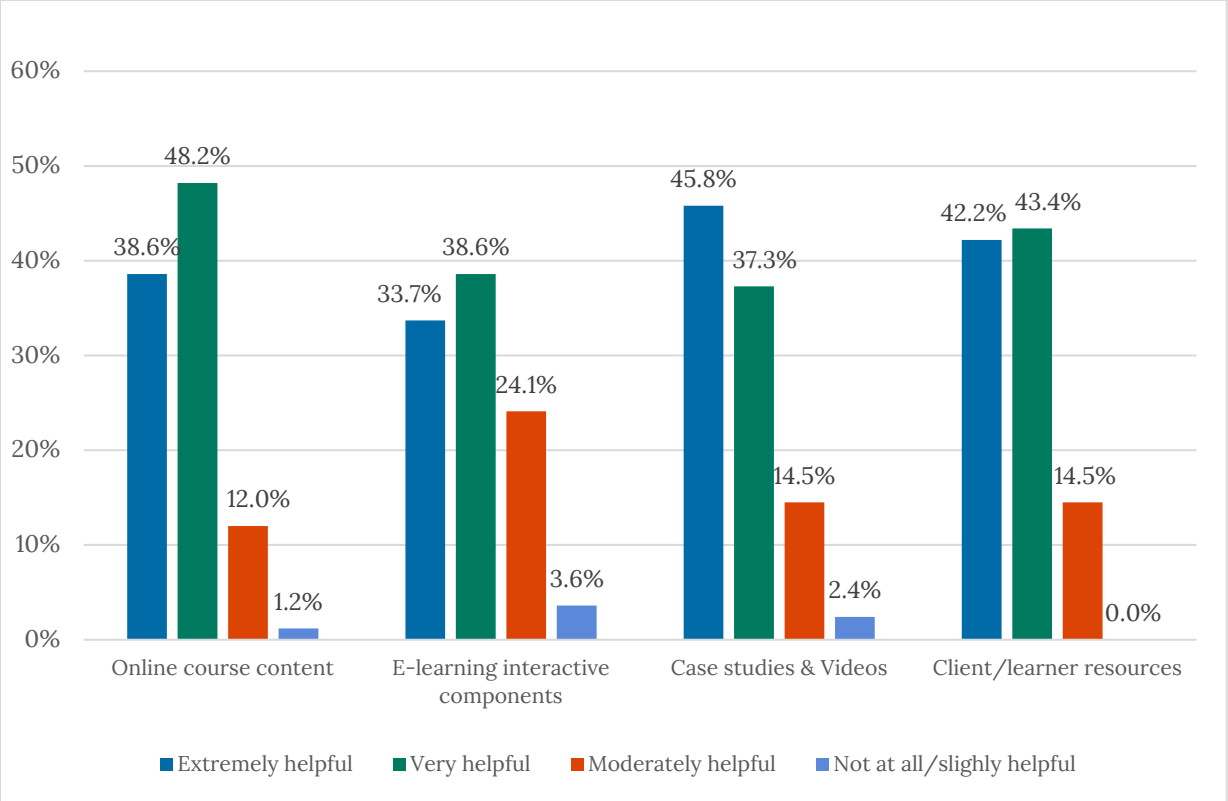
After completing the course, participants were asked several questions about the value and usefulness of the training. As Figure 2 highlights, they were strongly positive about the course. For example, more than nine in 10 indicated that the content was relevant to their work (57.8% strongly agreed; 33.7% agreed). A similar proportion said they were satisfied with the course (53.0% strongly agreed; 36.1% agreed) and would recommend it to others (55.4% strongly agreed; 37.3% agreed). As well, just under nine in 10 felt that the course's learning objectives had been achieved (43.4% strongly agreed; 45.8% agreed), and that they intended to make changes to their practices as a result of what they learned (45.8% strongly agreed; 41.0% agreed).

Figure 2. Participant Agreement with Statements about Program Value and Satisfaction



Participants were also asked to indicate how helpful various components of the program were. As Figure 3 shows, more than eight in 10 (range, 83.1%-86.8%) found the online course content, case studies and videos, and resources to be very or extremely helpful. A slightly smaller majority (72.3%) gave the same ratings for the interactive e-learning components.

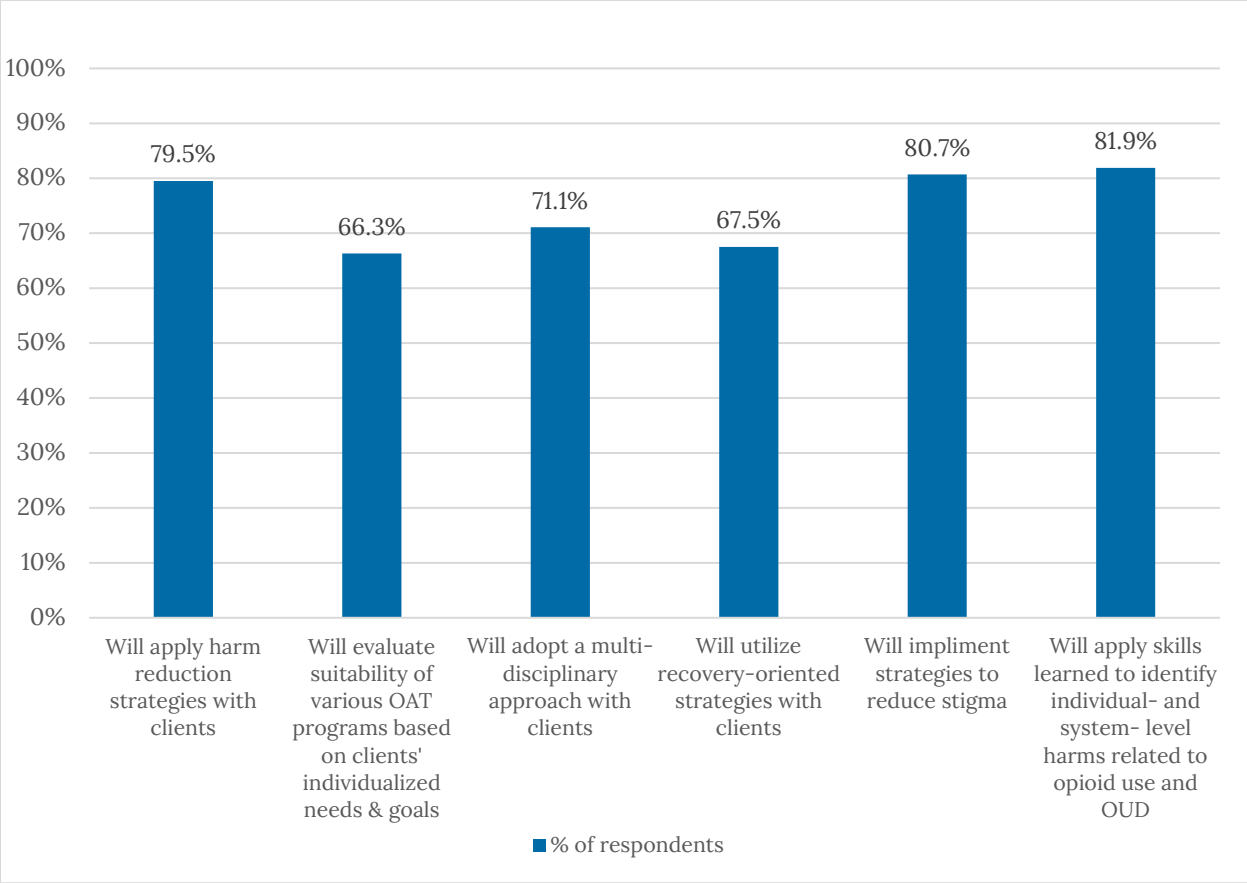
Figure 3. Participant Helpfulness Rating for Course Components



In addition, participants were asked to indicate what they planned to do differently in their practice based on what they learned. In a multiple response format, they were asked to select all of the provided options that applied. As Figure 4 highlights, about eight in 10 said they would implement strategies to reduce stigma in their work (80.7%), would apply the skills they learned to identify individual- and system-level harms related to opioid use and OUD (81.9%), and would use harm reduction strategies with clients (79.5%).

Slightly smaller majorities indicated that they would adopt a multidisciplinary approach with clients (71.5%), utilize more recovery-oriented strategies (67.5%), and evaluate the suitability of various OAT programs based on clients' individualized needs and goals (66.3%).

Figure 4. What Will You do Differently in Your Practice as a Result of This Course? (multiple response)



Finally, participants were asked two open-ended questions: (1) What aspects of the course worked well? and (2) What suggestions do you have for improving the course?

Responses to question one centred on a few main themes. First, that many participants appreciated the overall flow and layout of the course, noting that the organization of the modules and the blend of different interactive elements facilitated the learning process. The following comments illustrate this general theme:

- *I enjoyed the mixture of information combined with videos. [They] provided a good break as opposed to constant reading [and] even helped reduce eye strain.*
- *Excellent blend of multimedia content — very engaging and informative. Easy to identify with the community members sharing their stories.*
- *The information was easy to follow and used different teaching styles (videos, activities, text).*
- *I really liked how the course was laid out, it was very organized.*
- *I appreciated that the content was clear, current, and interactive with the forum. I especially appreciated the sequencing of all of the resources; it really helped bring all the pieces together.*
- *Good flow.*

Second, many participants felt that the case studies and personal videos worked particularly well, and that this element also helped to enhance and integrate their learning. Examples include the following comments:

- *The course was terrific. The videos were a very important aspect to my learning.*
- *I really liked the case studies and the videos that helped share other people's experiences and stories.*
- *The videos of real clients' stories helped illustrate the points made and encouraged empathy.*
- *I enjoyed hearing the personal stories. As mentioned, it is important to put names to these statistics, as it helps it feel more real rather than just a number.*
- *The testimonials were very helpful to point out [the] need for helpers to be empathetic.*
- *The videos and real stories worked really well and made it seem more real.*
- *Third, some participants highlighted specific content elements in the course that they appreciated, as is shown by the following comments:*
- *I loved the bits on recovery. I will be using some of that data and language in my joint session with clients and their families. Also, I might include some bits about stigma in there, too — I usually use the "non-judgmental stance" alone, but I think this would dovetail nicely with stigma material — stigma is essentially judgments, no?*
- *I liked how I was able to learn different methods of treatment of these individuals. As well as learning that peer support is a good way to support these individuals.*
- *Identifying individual- and system-level harms.*
- *Looking at the different ways to reduce stigmatization.*
- *Learning about various OAT programs was very beneficial.*
- *Last, some participants mentioned specific delivery elements that worked well, as the following comments illustrate:*
- *I like that it's work at your own pace, and you can go back and do it whenever.*
- *24-7 accessibility.*
- *The big lettering made it easier for me to understand.*
- *I liked that it's self-directed and that it included a lot of input directly from individuals.*
- *Easy to navigate.*

Regarding responses to question two, most participants had no suggestions for improvement. Among those who did, a few key areas for improvement were noted.

First, several of the participants with suggestions thought there could be enhancements to the course's knowledge-checking elements. Specifically, they felt that including short quizzes instead of (or provided alongside) the discussion/activity posts would sometimes be useful. Examples include the following comments:

- *Include short quizzes instead of having all discussion posts.*
- *Have quizzes rather than [have to] type your own work.*
- *With the course potentially being completed in one elongated sitting, the benefits of posting in discussion forums and options to view replies are mostly unused, and I would even say for myself, avoided.*
- *Knowledge quiz.*

- *Maybe having a small quiz checkpoint after each module.*
- *Remove the activities and add mini-quizzes.*
- *More quizzes and knowledge checks.*
- *More questions related to the topic discussed should be asked during the discussion sessions.*
- *Maybe online multiple-choice questions as well, and use a combination of discussion forums and online quizzes in the course.*
- *Having questions along with discussions.*
- *Questions instead of writing assignments.*

Other content enhancements were less frequent, although several participants suggested the inclusion of more personal stories and testimonies. Examples of such suggestions include:

- *More input regarding fighting stigma; for example, how to address those that are displaying stigmatizing behaviours.*
- *Everything was great. Maybe include in the burnout/self-care recommendations [so] that organizations can also share responsibility in reducing their employees' burnout. Burnout isn't just the individual's issue. But once you've worked long enough in health care, the inefficiency of [the] system just sometimes gets to you. [Also] making the health-care system better for folks trying to change their relationship with substances.*
- *More research on street names for drugs.*
- *Possibly showing successful stories [about people] who are able to live day to day [in spite of] their addictions or trauma.*
- *More videos about physician testimonials on what works to reduce stigma.*
- *More videos of individuals' stories and experiences.*
- *More testimonials.*

Suggestions were also made for logistical and navigational improvements — usually with respect to challenges encountered with the discussion posts. Example comments include:

- *Discussion posts should not be hidden.*
- *Making the wait shorter to view others' comments.*
- *The lockout time limits for the discussion forums ended up serving as a barrier to me, as I was unmotivated to return to them to check other people's answers.*
- *It was difficult to post at times, needing to refresh several times sometimes.*
- *Discussion posts didn't show up after I replied.*
- *When logging out and logging back in — it would be nice to automatically return to the last point of study.*
- *Have separate links for the video, so they can be accessed in a different capacity.*
- *It was a bit difficult to find the reply buttons.*

Lastly, a couple of participants suggested that audio options be included in the course. For example:

- *A text-to-speech option for those with vision problems would be helpful.*
- *Using audio to read it out loud. I found it difficult to retain the knowledge by just reading.*

Summary and Conclusions

Overall, the evaluation of the Reducing Stigma and Promoting Recovery for Opioid Use self-directed online course conveyed encouraging and promising results. This was illustrated by several findings:

- For participants who did not have very low levels of stigma scores at baseline on the OM-PATOS, results indicated a statistically significant improvement across the scale's two key content dimensions (attitudes and behaviours/motivation to help), with an effect size in the medium range.
- Results showed strong and statistically significant improvements in knowledge and skills across all of the program's main content areas, including stigma awareness and the implementation of stigma reduction strategies.
- The evaluation demonstrated high levels of agreement about perceived program impacts and program satisfaction. Well over eight in 10 participants indicated that they were satisfied with the course (53.0% strongly agreed; 36.1% agreed) and would recommend it to others (55.4% strongly agreed; 37.3% agreed). Similar proportions also indicated that, because of the course, they intended to make changes to their practice (45.8% strongly agreed; 41.0% agreed), including 80.7 per cent indicating that they planned to implement strategies to reduce stigma into their practices.
- Qualitative open-ended feedback from participants was strongly positive overall, with positive comments on the flow and sequencing of the modules, program content, the use of various interactive elements, and personal story videos. Similarly, suggestions for improvements were minimal; for instance, including quizzes, improving the functionality of discussion posts, and adding additional personal videos.

A few limitations are important to note. First, the observed ceiling effects (very low baseline scores) for some participants on the OM-PATOS meant that their stigma reduction could only be partially assessed; that is, through the pre-post assessment of increased knowledge and skill levels pertaining to stigma, stigma reduction, and participant feedback, not the OM-PATOS.

It should also be noted that stigma outcomes were only assessed for those who completed the program in two hours or more, which was determined as the minimum time participants would need to get through all the core course content. The fact that several participants received completion certificates after finishing their pre- and post-test in less than two hours may indicate a navigation issue with the course (i.e., that some participants are able to complete the post-test prior to completing the actual course) or another issue related to determining program completion. Future program deliveries should make sure that pre- and post-tests can only be taken before starting and after completing the full course, respectively.

With these limitations in mind, the evaluation results suggest that the Reducing Stigma and Promoting Recovery for Opioid Use e-learning course is promising. Not only is it effective as a stigma reduction intervention tool for those who work with and provide services to people who use opioids, it also shows stronger improvements than other stigma reduction programs evaluated using the OM-PATOS.[21-23] Consequently, it is recommended that the program continue to be delivered in its current form, while giving possible consideration to adding quizzes and personal story videos, as participants have suggested.

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Appendix

Pre-post course assessment

We would like to assess your knowledge surrounding the various content areas we will cover during this course.

Note that all responses are confidential. The responses will be anonymized and used in aggregate (i.e., grouped with others') to support future improvement of this training.

On a scale of 1 to 5, with **5 being the highest rating**, please rate and answer the following questions:

1 = No knowledge/skills/confidence
5 = Very knowledgeable/skilled/confident

* = Response required

Identify individual- and system-level harms related to opioid use/opioid use disorder.*

	1	2	3	4	5
Rate your knowledge of individual- and system-level harms related to opioid use and opioid use disorder.					
Rate your skills in identifying individual- and system-level harms related to opioid use and opioid use disorder.					

Explain the impact of stigma on people who use opioids and their support networks.*

	1	2	3	4	5
Rate your knowledge of the impact of stigma on people who use opioids and their support networks.					
Rate your skills in explaining the impact of stigma on people who use opioids and their support networks.					

Identify harm reduction strategies for opioid use.*

	1	2	3	4	5
Rate your knowledge of harm reduction strategies for opioid use.					
Rate your skills in identifying harm reduction strategies for opioid use.					

Compare and contrast the opioid agonist therapy (OAT) programs for opioid use disorder.*

	1	2	3	4	5
Rate your knowledge of the available OAT programs in Canada.					
Rate your skills in explaining the differences between available OAT programs in Canada.					

Describe a multidisciplinary approach to the treatment of opioid use disorder.*

	1	2	3	4	5
Rate your knowledge of multidisciplinary approaches to the treatment of opioid use disorder.					
Rate your skills in adopting a multidisciplinary approach to the treatment of opioid use disorder.					

Identify strategies that can support the recovery of clients.*

	1	2	3	4	5
Rate your knowledge of recovery-oriented strategies for clients that use opioids.					
Rate your skills in utilizing recovery-oriented strategies for clients that use opioids.					

Identify strategies for reducing stigma around opioid use/opioid use disorder.*

	1	2	3	4	5
Rate your knowledge of stigma-reducing strategies around opioid use/opioid use disorder.					
Rate your skills in implementing strategies to reduce stigma around opioid use/opioid use disorder.					

The Opening Minds Provider Attitudes Toward Opioid Use Scale (OM-PATOS)

This survey asks for your opinions on a series of statements about people with opioid use problems. Opioids include medications such as Percocet, Vicodin, morphine, and oxycodone as well as heroin, fentanyl, and carfentanil. "Opioid use problem" means a pattern of use that leads to serious harms, impairment, or distress. Please answer according to your own beliefs, feelings, and experiences.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I have little hope that people with opioid use problems will recover.					
People with opioid use problems are weak-willed.					
People with opioid use problems are to blame for their situation.					
I tend to use negative terms when talking about people with opioid use problems.					
People with opioid use problems cost the system too much money.					
I would see myself as weak if I had an opioid use problem.					
I tend to act more negatively toward people with opioid use problems than other people I help.					
People with opioid use problems can't be trusted.					
People with opioid use problems who take drug therapies like methadone are replacing one addiction with another.					
I tend to be less patient toward people with opioid use problems than other people I help.					
People with opioid use problems only care about getting their next dose of drugs.					
When people with opioid use problems ask for help with something, I have a hard time believing they are sincere.					
People with opioid use problems should be cut off from services if they don't try to help themselves.					
I tend to negatively judge people with opioid use problems.					
People with opioid use problems who relapse while trying to recover aren't trying hard enough to get better.					
I tend to speak down to people with opioid use problems.					
Most people with opioid use problems engage in crime to support their addiction.					

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
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.					
I tend to think poorly of people with opioid use problems.					

Course Evaluation (Post-Test Only)

Please **rate the various components** of the training related to the course content.

* = Response required

Course content —
Please rate your agreement with the following statements:*

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Learning objectives for this course were clearly defined.					
Course content was clear and well organized.					
Course content was relevant to my work.					
Course content enhanced my knowledge of the impact of stigma on opioid use/opioid use disorder.					
Course content enhanced my skills in implementing strategies to reduce stigma around opioid use/opioid use disorder.					
Course content enhanced my knowledge of recovery-oriented strategies for clients that use opioids.					
Course content enhanced my skills in utilizing recovery-oriented strategies for clients that use opioids.					
Learning objectives for this course were achieved.					
I intend to make changes to my practice based on what I learned in this course.					
I would recommend this course to others.					
Overall, I was satisfied with this course.					

Course components —
Please rate how helpful you found the following activities to your learning:*

	Not at all	Slightly	Moderately	Very	Extremely
Online course content					
E-learning interactive components (e.g., knowledge checks, discussion forums)					
Case studies (e.g., videos of personal stories)					
Client/learner resources					

What will you do differently in your practice as a result of this course?* (select all that apply)

- ☐ I will apply the skills learned to identify individual- and system-level harms related to opioid use and opioid use disorder.
- ☐ I will utilize harm reduction strategies when working with clients who use opioids.
- ☐ I will evaluate the suitability of various OAT programs based on my clients' individualized needs and goals.
- ☐ I will adopt a multidisciplinary approach when treating clients with opioid use disorder.
- ☐ I will utilize recovery-oriented strategies when working with clients who use opioids.
- ☐ I will implement strategies to reduce stigma around opioid use/opioid use disorder.
- ☐ Other, please specify:

What aspects of the course worked well?

What suggestions do you have for improving the course?

Any additional comments?

Mental Health Commission of Canada

Commission de la santé mentale du Canada

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