OPPORTUNITIES FOR CHANGE

An analysis of drug use and recovery stigma in the U.S. healthcare system

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Elevyst riwi

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Elevyst is a comprehensive public health consulting group specializing in helping organizations further their initiatives through research, education, and advocacy.

PRO-A (Pennsylvania Recovery Organizations Alliance) is a statewide nonprofit grassroots advocacy organization dedicated to supporting individuals in recovery and educating the public on addiction and recovery.

RIWI is a leading provider of real-time global citizen sentiment data. RIWI's patented Random Domain Intercept Technology (RDIT) made the collection of mass anonymized opinion data possible.

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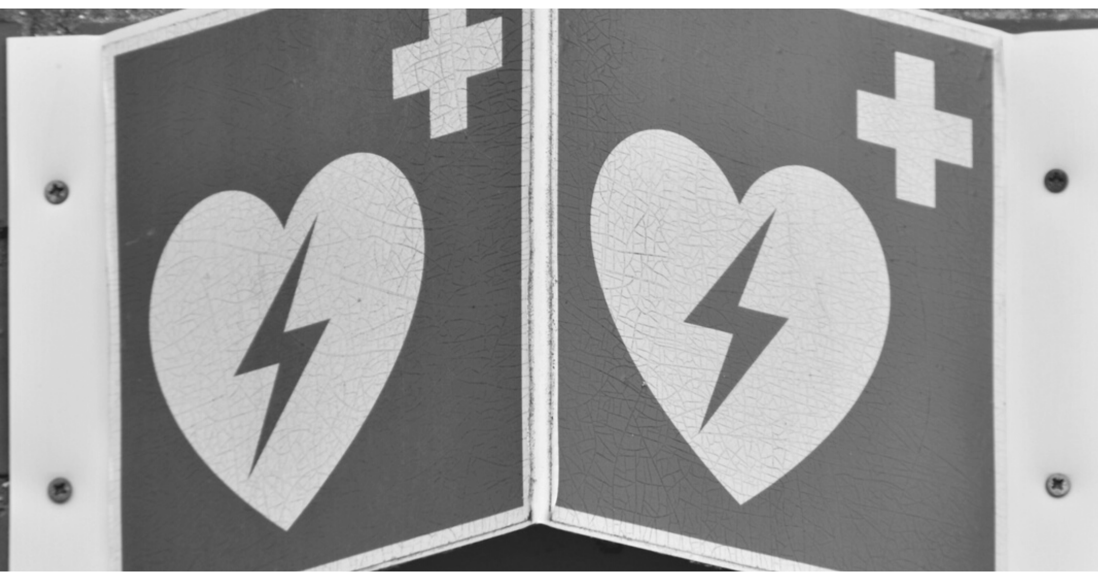
INTRODUCTION

In April 2022, Eleyvst and PRO-A released a report highlighting the results of their large-scale survey[1] of Americans' opinions regarding perceived social stigma against **People Who Use Drugs or are In Recovery (PWUD/IR)**. The survey examined differences in perceived societal stigma across a vast range of demographic factors, including age, race, and socioeconomic status. The key learning from that research endeavor was that, despite major efforts by governmental bodies and the nonprofit sector to combat stigma against PWUD/IR, perceived societal stigma remains highly prevalent, and, consequently, is a significant obstacle to improving the policies and practices that can reduce stigma, save lives, and help people thrive in recovery.

In this new report, we present our key findings from the largest research study to date assessing endorsed and perceived substance use and recovery stigma expressed by U.S. healthcare workers, as compared to non-healthcare workers. Healthcare workers in this study include: doctors, nurses, pharmacists, social workers, paramedics, and healthcare systems support staff. Healthcare workers are important to study in this context because they frequently encounter PWUD/IR in a professional setting. There is also an inherent power dynamic between healthcare workers and their patients.[2]

Altogether, the totality of negativity surrounding drug use and recovery in the healthcare setting is vast, impacting attitudes that circumscribe the professional practice of many healthcare workers who care for PWUD/IR— such as the desire for social distancing from these patients, or the view that PWUD/IR in their care suffer from an unchangeable affliction.[3] Discriminatory treatment is still commonplace. Improvements in the law include the Hughes Act of 1970, which brought public funding to addiction treatment,[4] and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA),[5] but such laws suffer from a poor history of enforcement.[6]



Even today, the majority of healthcare practitioners hold negative perceptions about PWUD/IR, making them "agents of structural stigma."[7] As stigma in the clinical environment is anathema to quality clinical care, this should be a primary concern for healthcare providers.[8] Because of poor patient-provider relationships, many PWUD/IR simply opt out of going to the doctor for regular care, leaving a variety of illnesses untreated until they require hospitalization.[9] When PWUD/IR become pregnant, the typical patient-provider relationship is further strained on account of hyper-surveillance and providers expressing disapproval of their patients' actions, which, in turn, intensifies mutual distrust.[10]

However, it is the healthcare sector, not the criminal justice sector, that has the greatest potential to support people in this population as they attempt to balance substance use with the pursuit of healthy, happy lives. Even law enforcement leaders agree: they have recognized that society is not going to arrest and incarcerate itself out of high rates of unsafe drug use. But our survey shows that the two places people who use drugs are least willing to seek help from are law enforcement agencies and healthcare facilities.

"Our survey shows that the two places people who use drugs are **least willing to seek help** from are **law enforcement agencies** and **healthcare facilities.**"

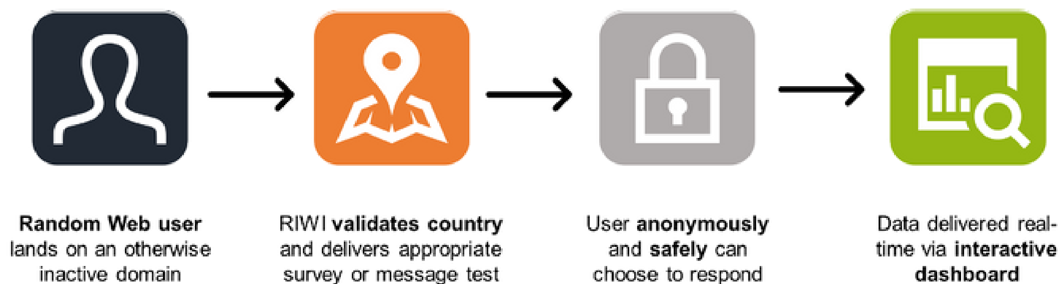
As long as healthcare workers are not willing to embrace cultural change and take responsibility for intervention,[11] diverting unsafe drug use away from the criminal justice system to the healthcare sector will remain an untenable policy solution.

METHODOLOGY

This report represents the largest study looking at perceived substance use disorder (SUD) stigma expressed by US healthcare workers as compared to non-healthcare workers. Multiple measures of stigma were assessed, including both perceived and endorsed stigma.

Procedure

This research harnessed global data collection company RIWI's patented Random Domain Intercept Technology (RDIT) to hear from a demographically diverse and regionally broad audience across the U.S. RDIT is a form of online intercept sampling.[12] Individuals surfing the Web have a chance of landing on or being redirected to a dormant domain. If that domain is temporarily being managed by RIWI, the Web user is then "intercepted" and exposed to a RIWI survey. Upon exposure, RIWI uses RDIT to validate the country of the Web user and deliver an appropriate survey. Web users may choose to safely and anonymously participate in the survey. No identifiable information such as a name or email address is collected. To further ensure the anonymity of respondents, there are no incentives provided for participation and respondents may end their participation at any time. These privacy measures encourage individuals to respond honestly, reducing social desirability bias and eliminating incentive bias.[13]

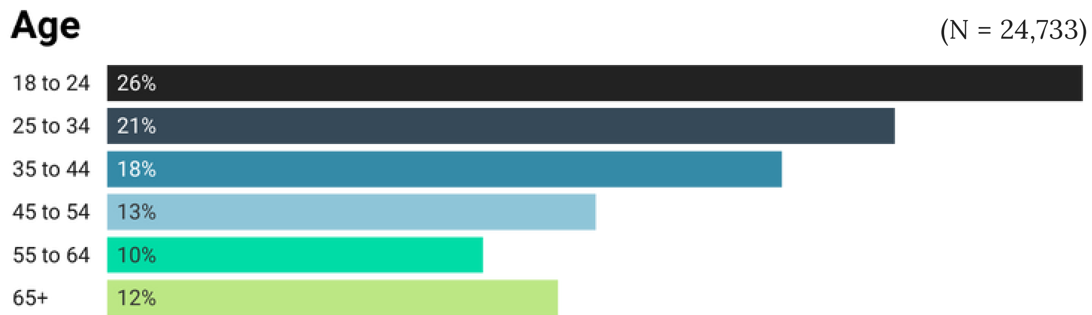


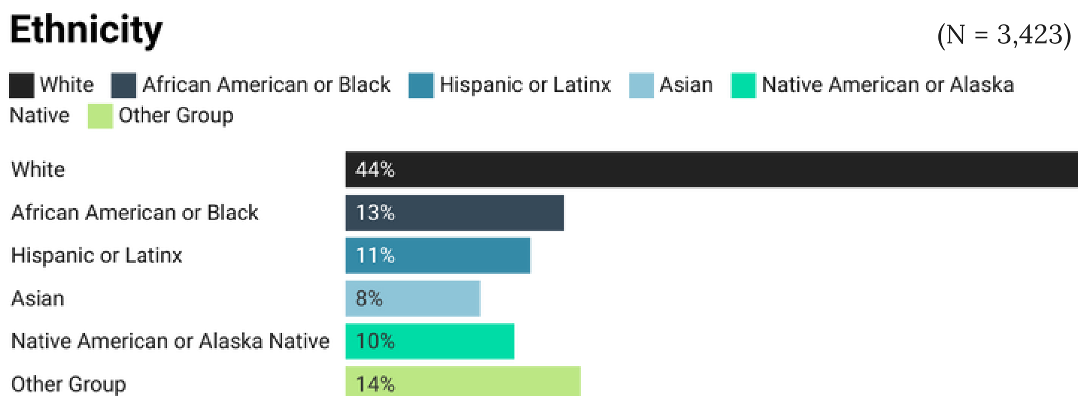
Note. Visualization of how RIWI's patented Random Domain Intercept Technology works.

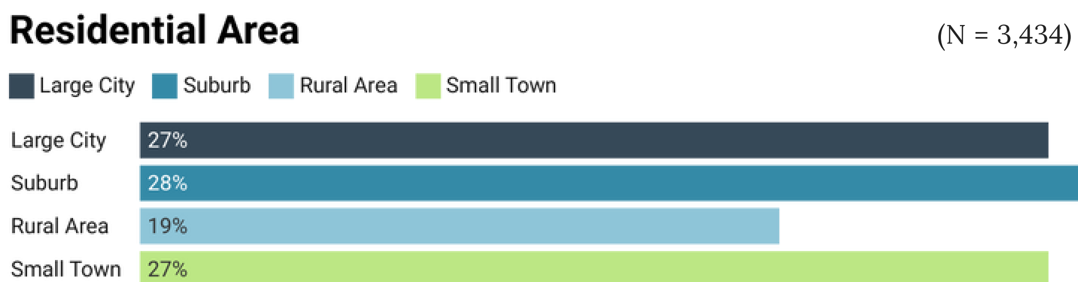
Respondents

Between June 9, 2022 to June 24, 2022, 24,733 respondents in the United States opted in to the survey, providing their age and gender, and answering the first subsequent question on healthcare provider status (i.e.,, Are you one of the following: Medical Doctor, Nurse, Pharmacist, Social Worker, Emergency Medical Services/Paramedic, or other health professional). As previously noted, respondents were not incentivized to remain through the end of the survey. Of the 24,733 who opted in, 3,340 (13.5 percent) completed the entire 22-item questionnaire, an expected retention rate for this methodology and survey length. Of the 5,708 healthcare professionals who opted in, 838 (14.7 percent) completed the survey.

The survey was provided in English to U.S. residents over 18 years of age. To make the most of all respondent data, we utilized the full respondent set available on each question and did not limit our analyses to only those who completed the entire survey. The number of respondents per question varies from 2,729 to 24,734. For healthcare professionals, the range varies from 863 to 5,708.







***Note**. Results are based on the available cases for each item. Percentages may not total to 100% due to rounding.*

We first asked respondents about whether they fell into one of several healthcare provider/SUD demographic categories:

IDENTIFICATION	OVERALL N (%)	COMPLETE N (%)
Healthcare worker status		
Healthcare worker	5,708 (23%)	838 (25%)
Not a healthcare worker	19,025 (77%)	2,502 (75%)
Family with SUD		
Person with at least one family member with a drug or alcohol addiction or who is in recovery	3,286 (18%)	926 (28%)
No family connection to SUD	14,916 (82%)	2,414 (72%)
SUD Identification		
Person who uses drugs	1,776 (9%)	390 (12%)
Person with an addiction	786 (4%)	200 (6%)
Person in recovery	832 (4%)	238 (7%)
None of the above	16,990 (83%)	2,512 (75%)

Overall, individuals who are healthcare workers and those who have a connection to substance use, either through themselves or family, are more likely to remain throughout the entirety of the survey. Out of the 5,708 healthcare professionals who opted in to participate, 4,826 answered the substance use identification question. According to this survey, 40 percent of healthcare professionals use drugs, have a substance use disorder, or are in recovery.

> "40 percent of healthcare professionals use drugs, have a substance use disorder, or are in recovery."

SUD IDENTIFICATION	AMONG HEALTHCARE WORKERS	AMONG NON-HEALTHCARE WORKERS
Person who uses drugs	839 (17%)	937 (6%)
Person with an addiction	597 (12%)	189 (1%)
Person in recovery	508 (11%)	324 (2%)
None of the above	2,882 (60%)	14,108 (91%)

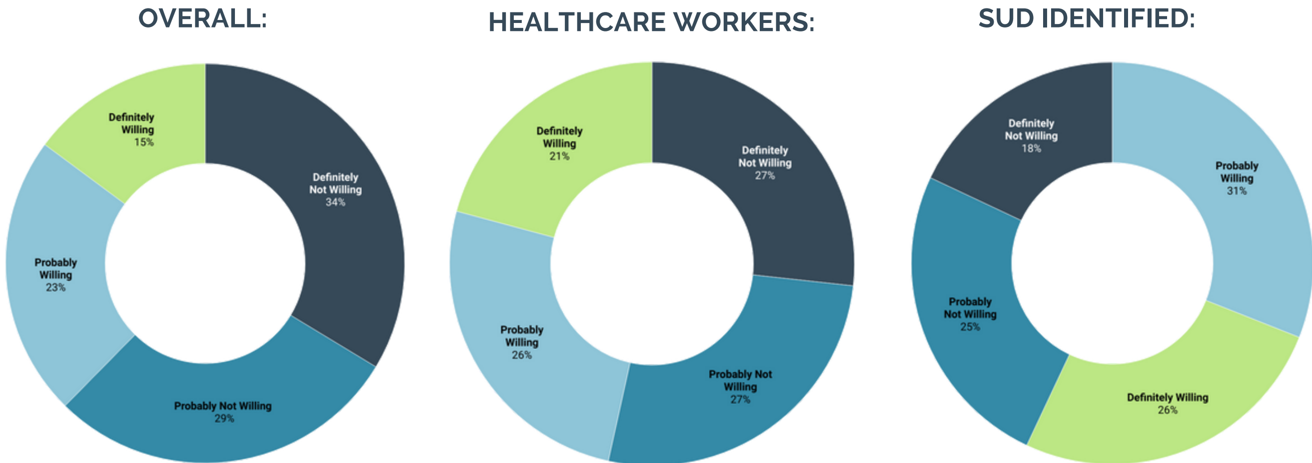
RESULTS

In the following pages, we share a number of important insights derived from our data. These insights highlight the complex nature of stigma directed toward PWUD/IR, and how that stigma works to create barriers, fracture the relationship between healthcare practitioner and patient, and disconnect this patient population from our systems of care and the human connection that makes their self-defined healthcare goals and/or recovery possible.

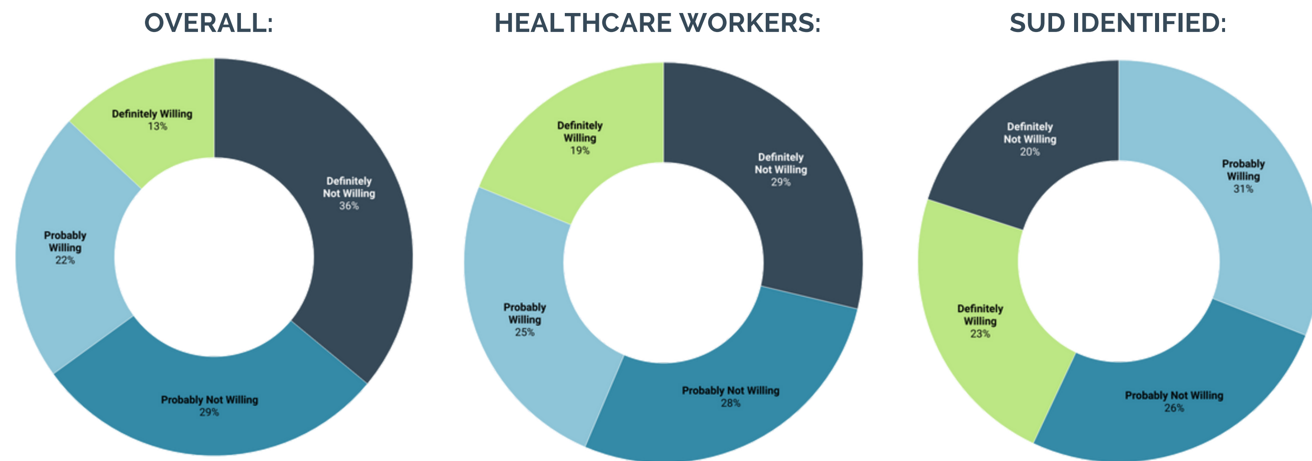
Healthcare workers are less willing to have people who use drugs or alcohol problematically as coworkers or neighbors than people with SUD, but are more willing than the general population.

Question: *Imagine a person uses drugs or alcohol problematically, how would you feel about having that person as a neighbor?*

Definitely Not Willing | Probably Not Willing | Probably Willing | Definitely Willing



Question: *Imagine a person uses drugs or alcohol problematically, how would you feel about working on the same job as that person?*

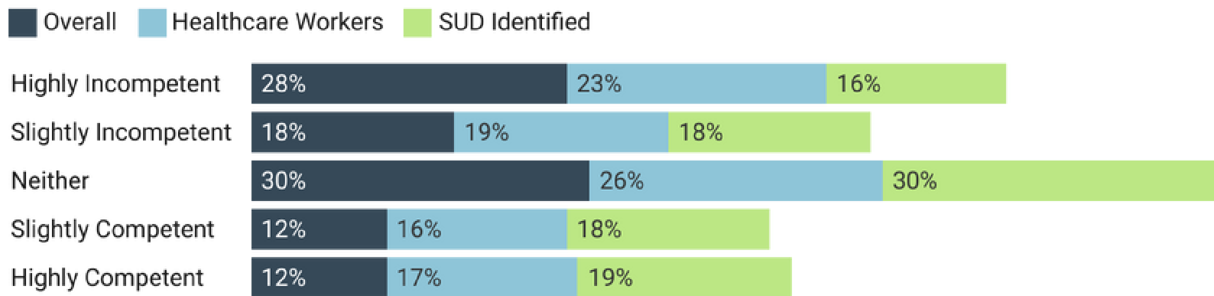


Note. Results are based on the available cases for each item. Percentages may not total to 100% due to rounding.
Neighbor item: Overall available N = 12,031. Healthcare worker available N = 2,748. SUD identified available N = 2,351
Coworker item: Overall available N = 10,466. Healthcare worker available N = 2,421. SUD identified available N = 2,135

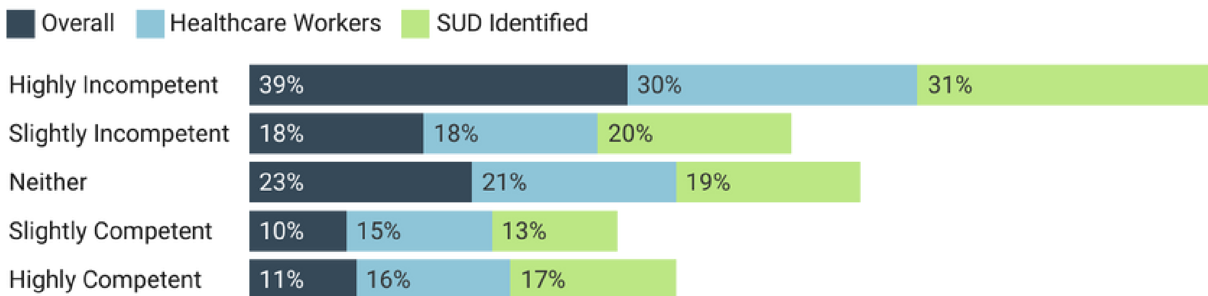
Despite acceptance among healthcare professionals that chronic drug and alcohol misuse is a treatable disease, our data suggest that the desire for social distance remains high.[14] These findings also demonstrate a significant improvement relative to previous research, which found that "less than 30 percent of primary care physicians were willing to have a person taking medication for opioid use disorder (OUD) as a neighbor or marry into their family."[15] This may be due to our question asking generally about problematic drug or alcohol use, rather than specifically asking about OUD, which is more highly stigmatized than a number of other substance use disorders.[16] Nonetheless, this is indicative of an encouraging shift.

Healthcare workers report less "perceived" and "endorsed" stigma than the general population, but higher "perceived" stigma than "endorsed" stigma.

Question: Imagine a person uses drugs or alcohol problematically, how competent would you say this person is?

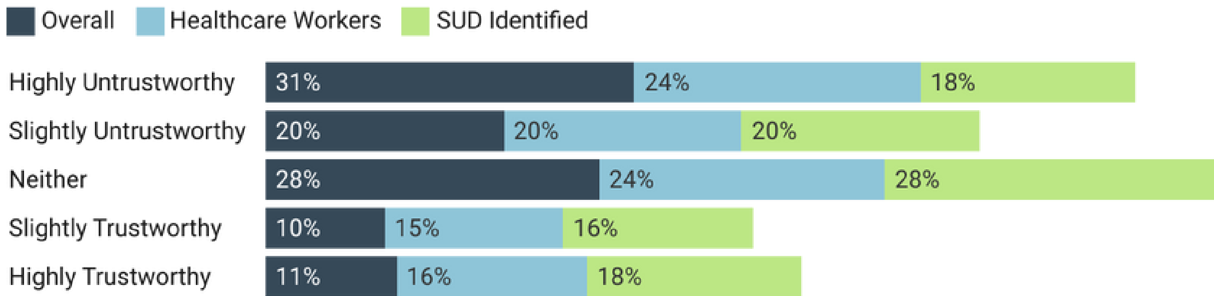


Question: Imagine a person uses drugs or alcohol problematically, how competent would you say society judges this person to be?

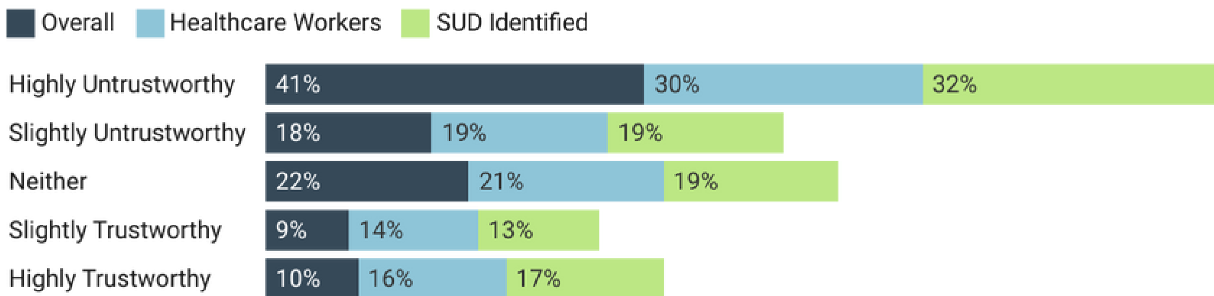


Note. Results are based on the available cases for each item. Percentages may not total to 100% due to rounding.
Self item: Overall available N = 8,950. Healthcare worker available N = 2,151. SUD identified available N = 1,940.
Society item: Overall available N = 7,481. Healthcare worker available N = 1,812. SUD identified available N = 1,676.

Question: Imagine a person uses drugs or alcohol problematically, how trustworthy would you say this person is?

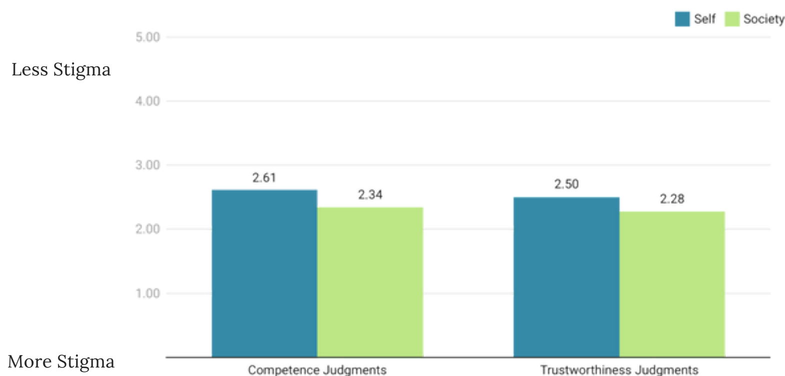


Question: Imagine a person uses drugs or alcohol problematically, how trustworthy would you say society judges this person to be?



Note. Results are based on the available cases for each item. Percentages may not total to 100% due to rounding.
Self item: Overall available N = 8,179. Healthcare worker available N = 1,979. SUD identified available N = 1,804.
Society item: Overall available N = 6,989. Healthcare worker available N = 1,681. SUD identified available N = 1,557

Our study explored competence and trustworthiness as they relate to personally endorsed and perceived societal stigma, highlighting the complexities of stereotypes toward PWUD/IR.[17] For both, stigma was generally high, though perceived societal stigma was consistently higher when compared to endorsed stigma in healthcare professionals. This has far-reaching implications for how we see and treat PWUD/IR, as false consensus bias[18] surrounding PWUD/IR may help providers justify a lower standard of care.



Note. Lower response options indicate greater endorsed/perceived stigma. Results are based on the complete cases for questions 7-10. Available N = 6,989. Error bars represent standard deviations.

Healthcare worker respondents are less positive overall about macro-level recovery prospects than the non-healthcare worker respondents, but have more polarized views amongst themselves on recovery prospects.

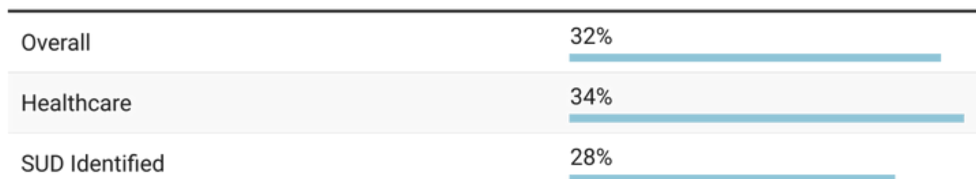
In response to the question, "In general, can someone who currently uses drugs or alcohol problematically maintain recovery?," the following population samples believe that someone with problematic substance use has a high chance or can definitely maintain recovery.

Note. Results are based on the available cases for each item. Recovery item: Overall available N = 5,794. Healthcare worker available N = 1,436. SUD identified available N = 1,347.

Healthcare workers are slightly more positive than the general public about the possibility that a person can maintain recovery from a substance use disorder. A significant number (38%) also believe this person has a low or no chance of maintaining recovery as compared to (31%) of the general public. However, studies show that recovery is the probable outcome for most people.[19] This tension exists despite the attention placed on evidence-based practices in the healthcare sector.

Healthcare professionals are more inclined than the general population to believe problematic drug and alcohol use is predominantly caused by internal factors.

In response to the question, "To what extent do you believe that problematic drug and alcohol use is caused by internal and external factors?," the following population samples believe that problematic drug and alcohol use is more or entirely caused by internal factors.



Note. Results are based on the available cases for each item. Internal vs. external factors item: Overall available N = 5,220. Healthcare worker available N = 1,304. SUD identified available N = 1,236.

Healthcare professionals are split on whether addiction is caused predominantly by internal factors (34 percent) versus predominantly external factors (35 percent). A large portion (30 percent) believe that these factors are equally important, but not as much as the general population (43 percent). While 64 percent of healthcare professionals report a belief that external or both external and internal factors are significant causes of addiction, roughly a third believe that PWUD/IR are afflicted with a condition that can never be changed.

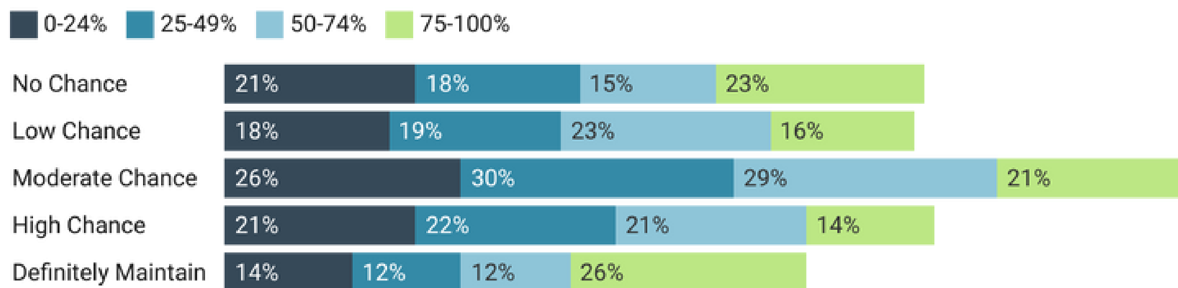
Healthcare workers who see PWUD/IR patients the most have much higher rates of belief in prospects of recovery and the importance of external factors.

Overall, when we examined the time healthcare professionals spend caring for the PWUD/IR population and the practitioners' beliefs in the ability to maintain recovery and internal versus external causes of problematic drug or alcohol use, the beliefs were quite similar. But one standout finding was that practitioners who spent the most time caring for the PWUD/IR population had a much greater belief that a person who uses drugs or alcohol problematically can definitely maintain recovery, and a much greater belief that problematic drug or alcohol use was caused by external factors.

"Practitioners who spent the most time caring for the PWUD/IR population had a much greater belief that a person who uses drugs or alcohol problematically can definitely maintain recovery, and a much greater belief that problematic drug or alcohol use was caused by external factors."

Recovery and Medical Beliefs by Healthcare Contact:

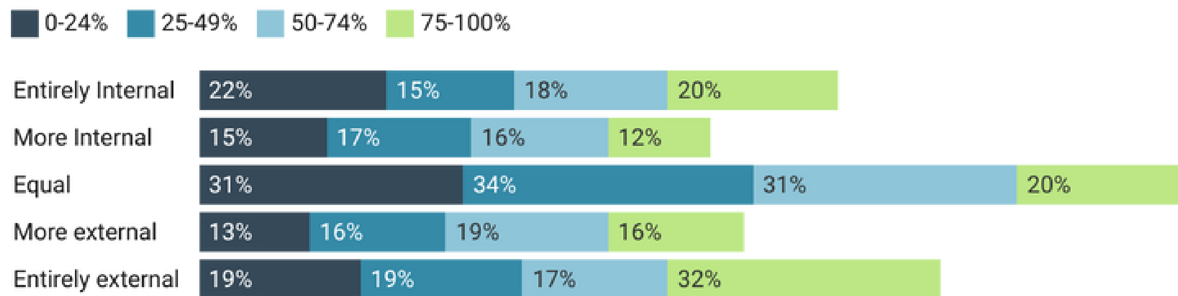
Question: In general, can someone who currently uses drugs or alcohol problematically maintain recovery?



Note. Results are based on the available cases for each item among the healthcare worker sample. Percentages may not total to 100% due to rounding. Recovery item available N = 1,436.

Recovery and Medical Beliefs by Healthcare Contact:

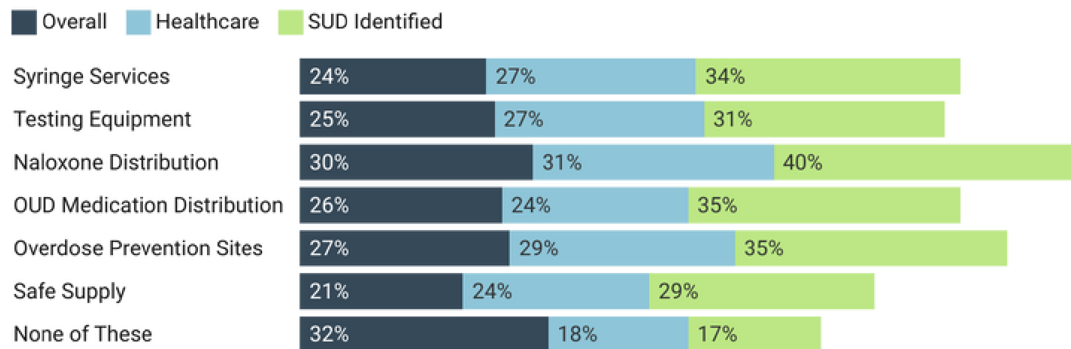
Question: To what extent do you believe that problematic drug and alcohol use is caused by internal and external factors? (Internal factors: genetics and personality. External factors: social/family dynamics, traumatic life experiences.)



Note. Results are based on the available cases for each item among the healthcare worker sample. Percentages may not total to 100% due to rounding. Internal vs. external factors item available N = 1,304.

Healthcare worker support for harm reduction services is often higher than the general population but lower than people who self-identify with having a SUD. A surprising lack of support for OUD medication persists.

Selected Cases for: "Which of the following harm reduction practices and policies should be made available in the places you receive healthcare?"



Note. Results are based on the available cases for each item. Overall available N = 4,131. Healthcare worker available N = 1,062. SUD identified available N = 1,015. Error bars represent percentage values.

Circa 2022, harm reduction services range from the "radical" to the borderline mainstream. Our data reflects this: more participants overall support Naloxone distribution than syringe exchange programs, and more participants support syringe exchanges than safe supply. More than 80 percent of healthcare providers support some form of harm reduction in the places where healthcare is delivered. The PWUD/IR cohort reported the most favorability toward harm reduction, followed by the healthcare provider cohort, followed by all participants.

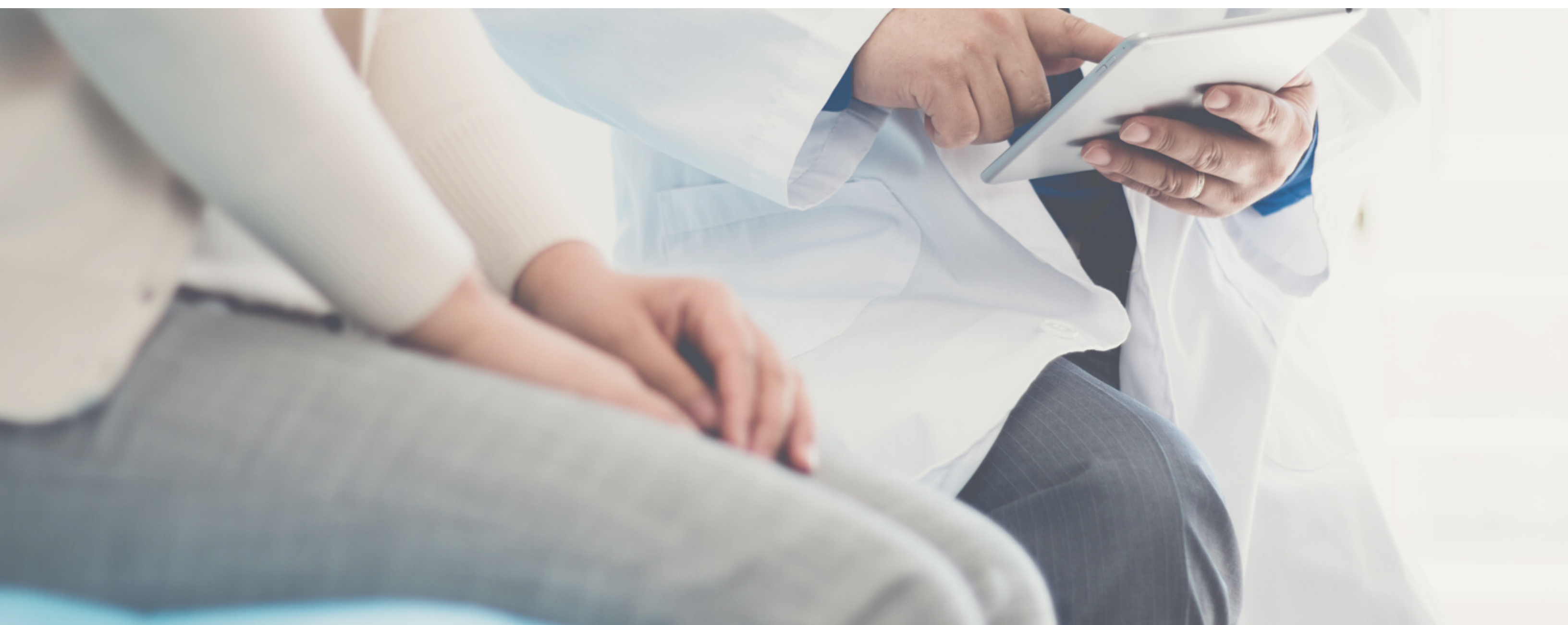
"More than 80 percent of healthcare providers support some form of harm reduction in the places where healthcare is delivered."

Healthcare worker opinions often diverge from the current state of the law as it applies to harm reduction measures. Despite news reports amplifying claims that overdose prevention sites (OPS) are far outside the American public's comfort zone, nearly 30 percent of healthcare workers surveyed support OPS. Significantly, fewer healthcare workers support opioid use disorder (OUD) medications: approximately 24 percent, and nearly the same number that support safe supply. This aligns with our previous research that showed only 28 percent of Americans believe a person who takes medications for their addiction are always in recovery.[20]

Other indications of public sentiment, namely US law, cut the opposite way. OUD medications such as buprenorphine are generally legal, so long as the possessor has a prescription.[21] This highlights the fact that the recent removal of the waiver requirement to prescribe buprenorphine is only a small step in expanding access, improving care, and delivering better outcomes for patients with OUD within the current healthcare system.[22] OPS are generally thought to be illegal in the US,[23] and only two legal OPS sites currently exist. Both are in New York City. That said, research evidence continues to support the expansion of OPS elsewhere.[24]

Relationships between indicators reveal that healthcare workers may internalize perceptions of societal stigma and let stigmatizing views influence the quality of care.

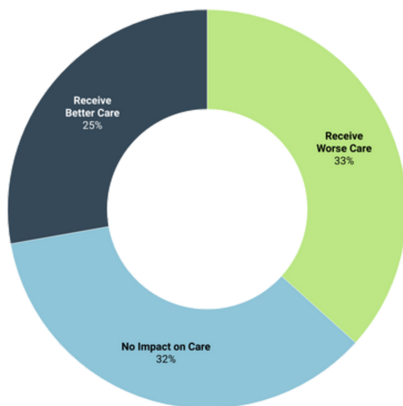
While not indicative of a causal relationship, certain negative perceptions of PWUD/IR are commonly interrelated. For example, healthcare providers who report a general belief that PWUD/IR are untrustworthy and incompetent often also believe that PWUD/IR have a low willpower to change and desire greater social distance from them. Fear over the odds of encountering providers such as these contributes to these members of our community avoiding medical treatment unless absolutely necessary.[25]

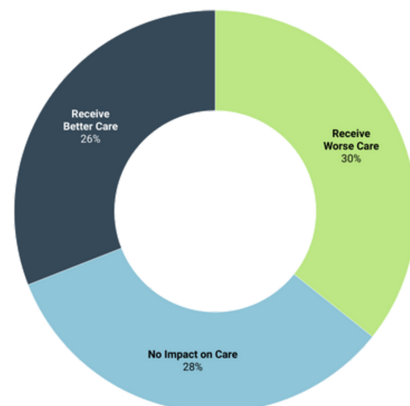


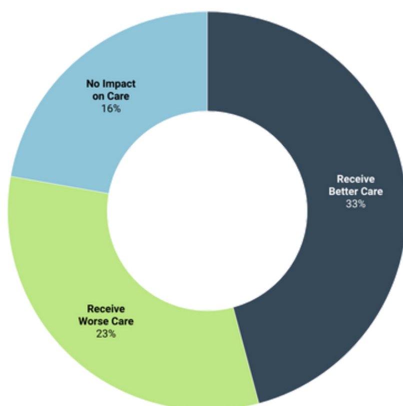
Healthcare providers who hold higher levels of stigma (defined by social distance: neighbor and coworker) are more likely to believe that negative views about PWUD negatively influence quality of care.

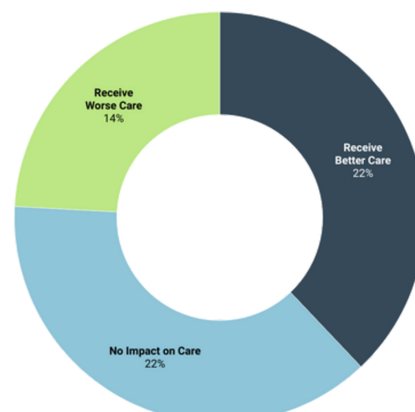
Survey participants who self-identified as healthcare workers were asked an additional question: "In general, how does a history of problematic drug and alcohol use impact the quality of medical care that a person receives?"

COWORKER:

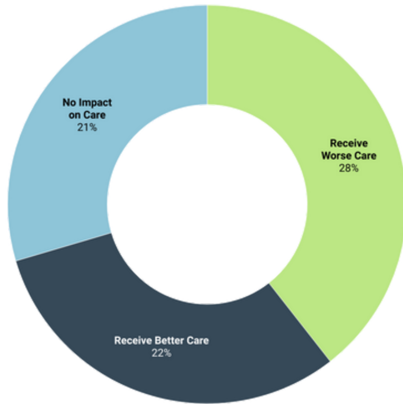


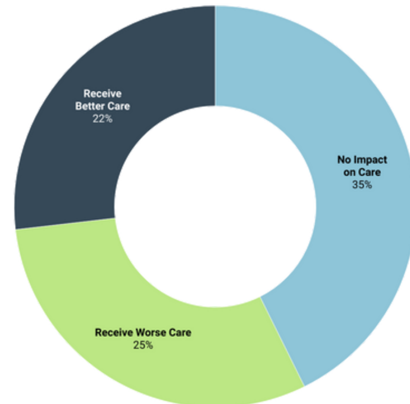


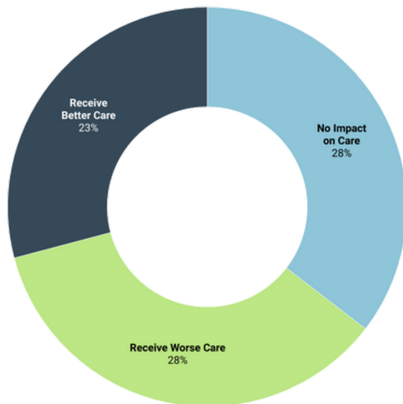


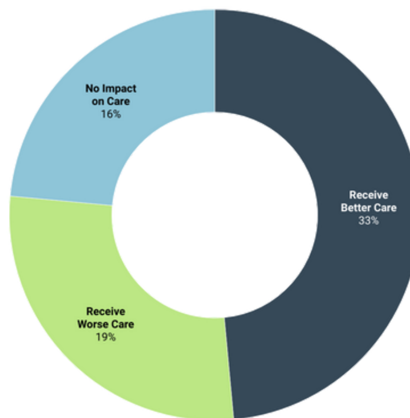


NEIGHBOR:







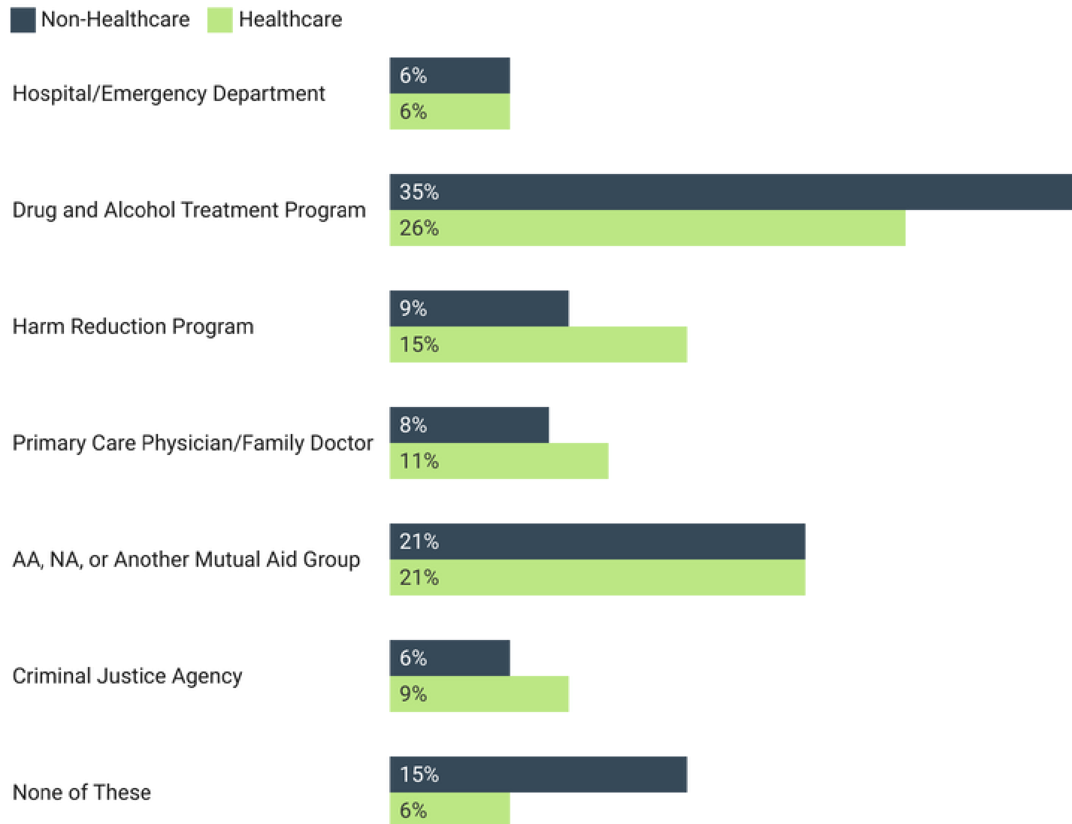


Note. Results on pages 17-18 are based on the available cases for each item on pages among the healthcare worker sample. Available N = 1,228. Percentages may not total to 100% due to rounding

For healthcare participants who answered they would be “definitely willing” to be a PWUD/IR’s neighbor, (33 percent) of this cohort answered that PWUD/IR receive better care than others. Similarly, more healthcare participants who answered that they are “definitely not willing” to have a PWUD/IR neighbor also answered that PWUD/IR receive worse care (28 percent), rather than the same care (21 percent) or better care (22 percent). The same trend was found regarding the coworker question.

When participants strongly preferring social distance from PWUD/IR treat patients with substance use disorders poorly, that course of action is likely deliberate, rather than unintended or accidental.

Healthcare workers, just like the general population, believe that the healthcare system is not where PWUD/IR should seek help.



1,153 of healthcare professionals and 3,393 of general respondents answered the question "Where do you think is the best place to take a person with problematic drug or alcohol use?" While some proportions were different, the ranking of options between the two groups was the same. Both places that respondents were least comfortable sending PWUD/IR to get help were the healthcare system and the criminal justice system.

DISCUSSION THEMES

1. The attitudes of healthcare professionals toward people who use drugs or are in recovery are very negative and not markedly different from the average American.

Healthcare workers are obliged by the ethics codes of their professions to care for all people, including the marginalized. But healthcare workers also operate within a society. In the United States, residents are constantly bombarded with messages that imply that people who use drugs or are in recovery (PWUD/IR) are morally bankrupt and prone to serious criminality.[26]

Because there is historic lack of recognition of addiction medicine's importance[27] and a lack of training in school and residency,[28] there should be little surprise that the healthcare sector is performing poorly in helping the PWUD/IR patient population.

Despite all the evidence that substance use exists on a continuum of use, that most people who use drugs do not develop an addiction, and that most people with less severe forms of addiction heal naturally from misuse, American culture shares an entrenched belief that substance misuse signifies deep moral failings. We internalize these messages as they are passed down within families, religious institutions, and schools. Addressing these internalized messages in ways that allow people to consider these deeply internalized biases requires examination and focus across all of our medical education institutions.[29]

Further complicating the issue, healthcare providers are also afraid of being labeled criminals over their prescribing patterns, especially in a regulatory environment that constantly hovers over the prescription of medications designed to treat, not exacerbate, substance use disorder.

2. There is a strong need for more (and more robust) educational initiatives to teach future healthcare professionals about the importance of empathetic, evidence-informed care for people who use drugs or are in recovery in reaching positive treatment outcomes.

PWUD/IR often avoid going to the doctor, which is understandable. When they do go, they are often discouraged from talking about pressing concerns, such as use reduction, clean needle access, and access to treatment and recovery support.[30] Other patients may feel silenced by healthcare workers lecturing about the evils of drugs when they are present for urgent treatment needs, such as wound care or a bacterial illness. These behaviors on the part of healthcare professionals are linked to discriminatory views that can be unlearned.[31]

Our survey found that 27 percent of healthcare workers surveyed spend at least 50 percent of their typical days working with PWUD/IR. This is quite high, considering the lack of training and education that most healthcare workers receive in addiction medicine. It also highlights the importance of integrating substance use and addictions training into school and training curricula, especially since the attitudes of trainees generally become more negative toward PWUD/IR over time.[32] However, this overall aligns with previous research that has demonstrated increased contact with highly stigmatized individuals lowers stigma.[33]

Institutions that provide training and education to future healthcare professionals should find more opportunities to instruct students on the specific health needs of PWUD/IR, as well as the different theories of drug misuse.[34] Having curricula challenge overly moralistic beliefs about substance misuse is vital, as is bringing people with lived experience into the educational sphere, including healthcare professionals who have used drugs or are in recovery from SUD. Educational modules should require students to examine their own biases and how these biases have been reinforced through various socialization experiences. If society is serious about improving healthcare outcomes for PWUD/IR, future healthcare providers should be periodically reminded in school and training that the dehumanization of any patient cohort, including PWUD/IR, is unacceptable and subject to potential discipline. Supervisors and instructors should model appropriate behavior in the clinical setting and this behavior needs to continuously be practiced, evaluated, and supported.

3. More interaction with patients who use drugs or are in recovery tends to encourage less stigmatizing views from healthcare providers, but the issue is complicated.

Healthcare professionals surveyed were asked what percentage of their patients belong to the PWUD/IR cohort, then were asked, “In general, can someone who currently uses drugs or alcohol problematically maintain recovery?” The major finding was that practitioners who spent the most time caring for the PWUD/IR population had a much greater belief that a person who uses drugs or alcohol problematically can definitely maintain recovery, and a much greater belief that problematic drug or alcohol use was caused by external factors.

However, the full picture is more complicated. Healthcare workers who predominantly treat PWUD/IR have a greater share of opinions on both extreme ends. It is the case that some share of these healthcare workers would answer that some PWUD/IR can definitely maintain recovery, while others will definitely not. The truth is that such practitioners tend to see a wide spectrum of substance use issues, from the most benign to the most challenging cases.

Since healthcare professionals rarely advertise their level of comfort with PWUD/IR, this population will often be forced to obtain care from healthcare workers who are uncomfortable with them. This can lead to undertreatment, denial of care, and increased morbidity and mortality.[35] However, the amount of contact and familiarity a healthcare professional has with PWUD/IR seems to have a positive attitudinal impact. 41 percent of clinicians with minimal contact are willing to have a person who uses drugs or alcohol problematically as a neighbor, compared to 54 percent for clinicians with high contact. When it comes to having this same individual as a co-worker, 37 percent of clinicians with low contact are willing, compared to 53 percent of clinicians with high contact. These numbers suggest improvement over prior studies, but this could also be because of the wording of the questions (for example, including all substance use disorders, rather than just opioid use disorders).

4. Regulatory boards should focus on ways to rehabilitate, rather than ostracize, healthcare professionals with a substance misuse history.

The fact that more medical professionals believe that these issues should not be handled within the healthcare sector as a first-line option is reflective of the need for greater cultural change from within the healthcare community. Such change should start from the top, beginning with the regulatory boards that govern the healthcare professions.

Currently, many healthcare professionals experience even low-level criminal contacts related to substance use disorder as the "death penalty" in licensing matters.[36] There are healthcare providers who get their licenses back for conduct that society considers vastly more morally opprobrious, such as sex crimes.[37] This happens while mainline healthcare organizations purportedly believe that drug misuse is a health issue, rather than a moral issue. Regulatory boards in charge of licensing healthcare professionals can learn from attorney licensing, which better recognizes the human capacity for change.[38]

5. Answers to the survey questions varied significantly, based on healthcare contact.

Healthcare professionals with limited exposure to PWUD/IR patients had the highest rates of believing that problematic drug use is driven by factors that are “entirely internal.” A close second were professionals who see the highest volume of PWUD/IR patients. However, this group of clinicians sees the broadest spectrum of PWUD/IR patients. Such clinicians see many patients who put forth herculean efforts to recover yet quickly return to use in community settings. They also see many patients who recognize their own substance use disorders, work to overcome them, and maintain recovery.

For healthcare providers who never or rarely encounter the PWUD population, these responses can be explained by lack of exposure and experience coupled with limited time for patient encounters. For those who often encounter this population, these responses cannot be attributed to ignorance alone. Burnout and compassion fatigue are likely culprits, as are deeply-rooted biases that may be informed by lived negative experiences relating to persons experiencing problematic drug use.[39]

Healthcare providers also get frustrated when patients demand more opioid medications than they deem necessary to treat pain, even as we know that the use of these medications long-term can sensitize patients to experience more pain.[40] Such frustration is multiplied when providers suspect this to be “drug-seeking” behavior resulting from an underlying addiction or dependency. Healthcare providers also have to deal with various regulatory landmines when prescribing controlled substances, including a renewed interest by the government to criminally prosecute providers who are deemed to be overprescribing and inappropriately prescribing certain medications. For many physicians, including those specializing in pain management, the answer is to simply avoid treating PWUD/IR, even when their drug use had iatrogenic origins. For others, those who treat predominantly PWUD/IR patients, negative experiences on the job without training to examine and address underlying biases may cause them to harden their views toward the very population they treat.

CONCLUSION

Drug use and recovery stigma is deeply entrenched in the U.S. healthcare system and the professionals tasked with delivering care. Cultural change to improve outcomes will take a unified effort that explores and addresses the beliefs, perceptions, and behaviors that reinforce the current system. Advocacy and education can be helpful when trying to ameliorate social inequities, but without measuring what works, organizations attempting to make lives better for PWUD/IR are mostly operating in the dark. Evidence is needed, both to understand what views are contributing to the status quo and how to effectively shape new views and drive the actions that improve the care experience and outcomes for PWUD/IR.

This report and the data presented can guide a public health strategy, inclusive of prevention, treatment, harm reduction, and advocacy to address drug use, addiction, and overdose in the U.S. healthcare system. It also reveals the need for more research in several areas, including assessments of how often healthcare providers signal their comfort with patients who belong to the PWUD/IR demographic.

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