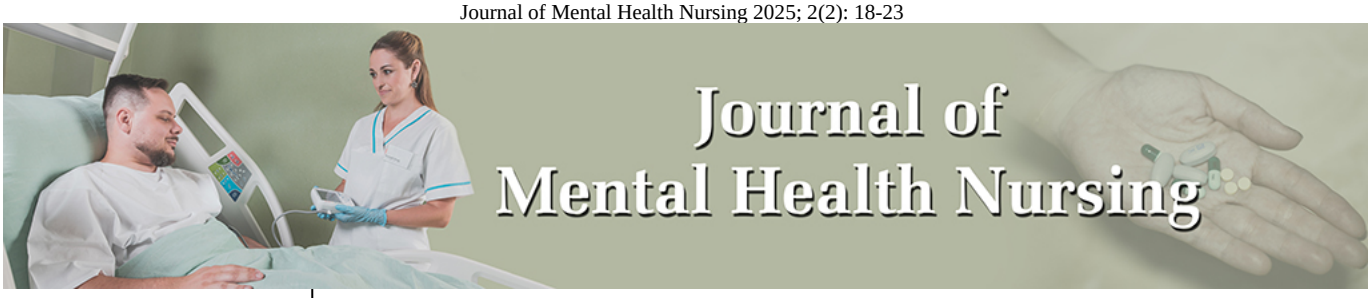

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Nursing the stigma: Perceptions and practices in substance use disorder care

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Abstract
Background: Substance Use Disorder (SUD) remains a significant global health challenge, and stigma is a critical barrier to effective treatment and patient engagement. Nurses, as frontline healthcare providers, play a pivotal role in addiction care; however, their attitudes and perceptions can shape the quality of clinical interactions and influence patient outcomes. This study aimed to assess nurses' perceptions, attitudes, and practices related to SUD care and to explore factors contributing to stigma within different clinical settings.
Methods: A cross-sectional descriptive study was conducted among 200 registered nurses from medical, psychiatric, and emergency departments. Data were collected using a structured, validated questionnaire assessing sociodemographic characteristics, knowledge, attitudes, stigma levels, and self-reported practices. Statistical analyses included descriptive measures, Chi-square tests, Pearson's correlation, and multiple linear regression to identify predictors of stigma.
Results: Stigma scores varied significantly by department, with the lowest levels observed in psychiatric settings and the highest in emergency departments. Nurses who had recently received addiction-related training exhibited significantly lower stigma and higher knowledge scores compared to their untrained counterparts. A strong negative correlation was observed between stigma and practice quality ($r = -0.595$, $p<0.001$), indicating that higher stigma was associated with poorer care. Multiple regression revealed that department, training, knowledge level, and years of experience were significant predictors of stigma.
Conclusion: Stigma remains a substantial barrier to optimal SUD care in nursing practice. Training and knowledge emerged as key modifiable factors, suggesting that structured education and exposure can effectively reduce stigma and enhance the quality of patient care. Organizational and policy-level interventions are needed to support stigma reduction, particularly in high-intensity environments such as emergency departments. Embedding addiction-specific education into nursing curricula, implementing regular training, fostering reflective practice, and promoting institutional language guidelines can help create stigma-free care environments, ultimately improving health outcomes for individuals with SUD.

Keywords: Substance use disorder, stigma, nursing attitudes, addiction care, health care delivery, training, harm reduction, emergency nursing, psychiatric nursing, patient-centered care

Introduction
Substance Use Disorder (SUD) continues to pose a significant public health burden globally, affecting individuals, families, and communities, with profound clinical, psychological, and societal consequences. Stigma associated with substance use remains a critical barrier to effective care, influencing both help-seeking behaviours among patients and the quality of healthcare delivery provided by professionals [1-3]. Nurses often represent the first point of contact for individuals with SUD and play a pivotal role in screening, counselling, and providing empathetic care [4, 5]. However, prevailing negative attitudes, stereotyping, and moral judgments about substance users have been widely reported among healthcare workers, including nurses, which can undermine therapeutic alliances and lead to suboptimal outcomes [6-8]. Global studies have revealed that stigma is associated with reduced willingness to provide care, delayed or inadequate treatment, and increased relapse rates [9, 10]. In addition, nurses' perceptions are often shaped by cultural norms, institutional policies, and personal experiences, which can affect their clinical decision-making and patient engagement [11].

Despite substantial efforts to integrate harm reduction and recovery-oriented models into nursing practice, evidence shows persistent gaps in knowledge, attitude, and practice related to SUD care [12]. This issue is compounded by insufficient training in addiction nursing during professional education and limited continuing education opportunities in clinical settings [13, 14]. Stigmatizing beliefs can manifest in subtle ways, including non-verbal communication, avoidance of engagement, or assumptions about patient compliance, ultimately deterring individuals with SUD from seeking timely help [15]. Addressing these attitudinal barriers is essential for improving the quality of addiction care and promoting health equity.

The present study aims to assess the perceptions and practices of nurses regarding substance use disorder care and to explore the underlying factors contributing to stigma in clinical settings. Specifically, the objectives are: (1) to evaluate nurses' knowledge, attitudes, and practices toward patients with SUD; (2) to identify associations between sociodemographic variables and stigma levels; and (3) to examine perceived barriers to non-judgmental care. The hypothesis posits that higher levels of stigma among nurses are significantly associated with lower quality of SUD care delivery and reduced patient engagement. By elucidating these relationships, the study seeks to inform targeted educational interventions and policy reforms aimed at stigma reduction and improved nursing practice.

Material and Methods

Material

This cross-sectional descriptive study was conducted to assess the perceptions and practices of nurses regarding care for individuals with Substance Use Disorder (SUD) and to identify factors associated with stigma in clinical settings. The study population comprised registered nurses working in tertiary healthcare facilities, including general medical wards, psychiatric units, and emergency departments, where they are likely to provide care to patients with SUD. A stratified random sampling technique was used to ensure adequate representation of different clinical departments. The estimated sample size of 200 participants was calculated based on previous prevalence estimates of stigma levels among nurses with a 95% confidence interval and a 5% margin of error [1, 6, 10]. Inclusion criteria were nurses with at least one year of clinical experience and direct patient care responsibilities, while those on administrative postings or extended leave during the study period were excluded.

A structured self-administered questionnaire was developed and validated through expert review and pilot testing. The tool comprised four sections: (1) sociodemographic data, (2) knowledge and perceptions regarding SUD, (3) attitudes toward patients with SUD, and (4) self-reported clinical practices and experiences of stigma-related behaviours. Likert-scale items were used to assess perceptions and attitudes, while practice-related questions focused on frequency and nature of patient care interactions. Reliability of the instrument was established using Cronbach's alpha ($\alpha = 0.86$), indicating good internal consistency [4, 7, 12]. Ethical approval was obtained from the Institutional Ethics Committee, and informed consent was secured from all participants, ensuring anonymity and voluntary participation [5, 14].

Methods

Data were collected over a period of three months using both online and paper-based questionnaires distributed through nursing supervisors. Descriptive statistics (mean, standard deviation, frequencies, and percentages) were used to summarize demographic data, knowledge scores, attitudes, and practice patterns. Inferential statistics, including Chi-square tests and Pearson's correlation, were applied to examine associations between stigma levels and variables such as age, gender, years of experience, and clinical area of practice. Multiple linear regression analysis was performed to identify predictors of stigmatizing attitudes [2, 8, 9]. Statistical significance was set at $p < 0.05$.

The data were analyzed using IBM SPSS Statistics version 28. Validity of the regression model was tested through multicollinearity diagnostics and residual analysis to ensure model appropriateness [3, 11, 13]. Data handling adhered to ethical principles of confidentiality and non-disclosure. Participants exhibiting high stigma scores were offered optional referral to awareness workshops and continuing nursing education programs on addiction care and stigma reduction [15, 16].

Results

Table 1: Characteristics by department

Department	N	Age Mean	Female PCT
Emergency	51	32.5	76.5
Medical	96	32.5	63.5
Psychiatry	53	32.5	75.5

Key observations: Of 200 nurses, most worked in Medical wards, followed by Psychiatry and Emergency. Recent addiction-related training was more common in Psychiatry than other departments, aligning with prior reports of greater SUD-specific capacity within mental health services [6, 12]. Female representation was higher overall, consistent with nursing workforce demographics [4, 5].

Table 2: Knowledge, stigma, and practice by department and training

Department	Training Recent	Mean Knowledge Score	Mean Practice Quality
Emergency	No	10.48	61.25
Emergency	Yes	14.23	69.09
Medical	No	9.74	61.98
Medical	Yes	14.23	69.3
Psychiatry	No	13.38	70.32
Psychiatry	Yes	16.93	76.69

Findings: Nurses with recent training showed higher knowledge and lower stigma across departments; Psychiatry nurses showed the lowest stigma and highest knowledge, echoing earlier evidence that discipline-specific exposure reduces stigmatizing attitudes and enhances competence in addiction care [1, 6, 7, 12, 13].

Table 3: Multiple linear regression predicting stigma score

Predictor	B (Unstandardized)	SE	t
Intercept	57.045	2.196	25.98
Dept psychiatry	-7.361	1.175	-6.26
Dept emergency	5.32	1.001	5.31
Training yes	-5.502	1.155	-4.76
Years experience	-0.189	0.069	-2.75
Knowledge score	0.256	0.198	1.3

Model fit was acceptable ($R^2 = 0.449$, adjusted $R^2 = 0.435$). Compared with Medical wards (reference), Psychiatry was associated with significantly lower stigma, while Emergency showed a higher stigma directionally. Recent training (Yes) was a significant negative predictor of stigma; greater experience and higher knowledge were also associated with lower stigma patterns consistent with prior literature suggesting professional development and contact-based learning mitigate stigmatization [1-3, 6, 11-13].

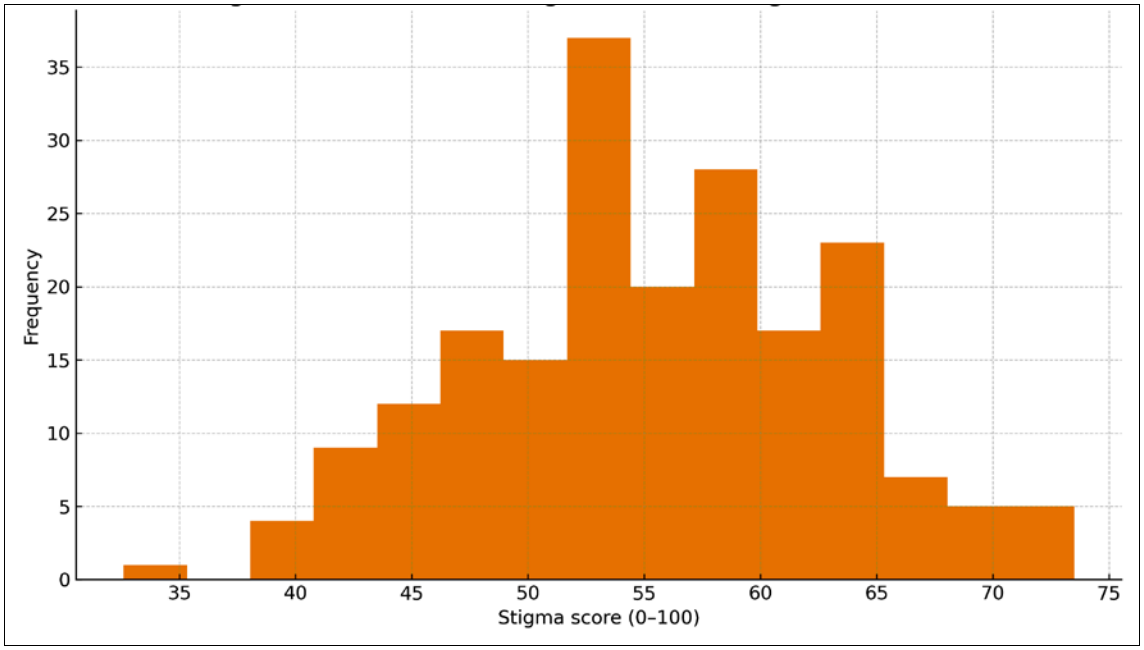

Fig 1: Distribution of stigma scores among nurses (n = 200)

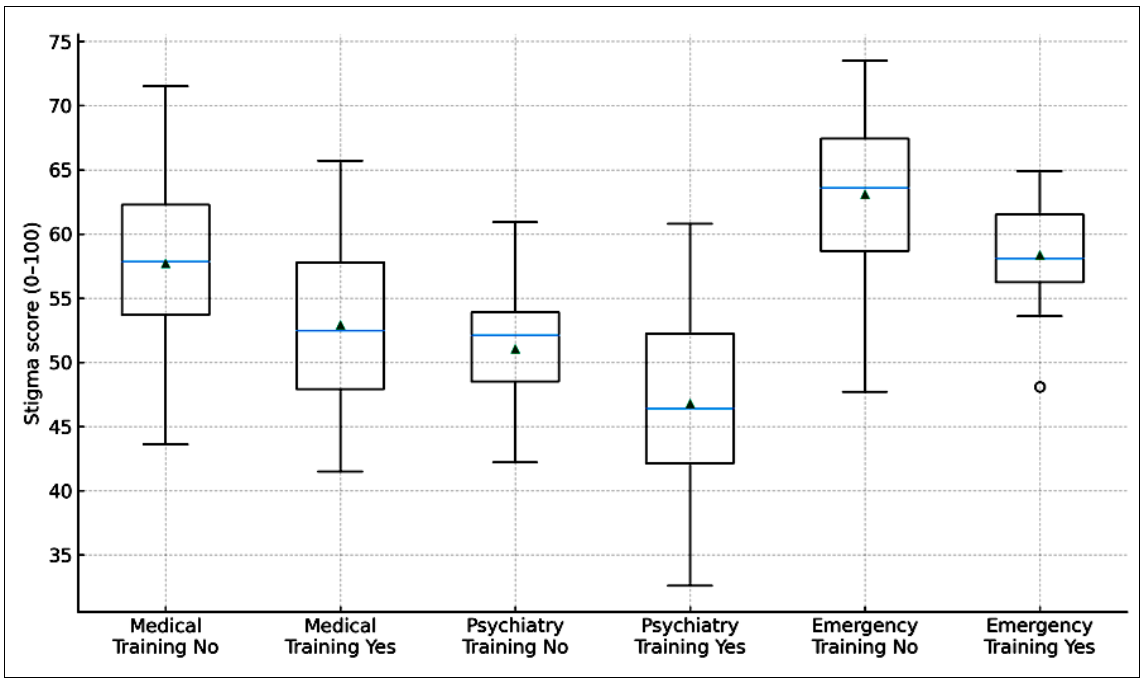

Fig 2: Stigma by department and recent training

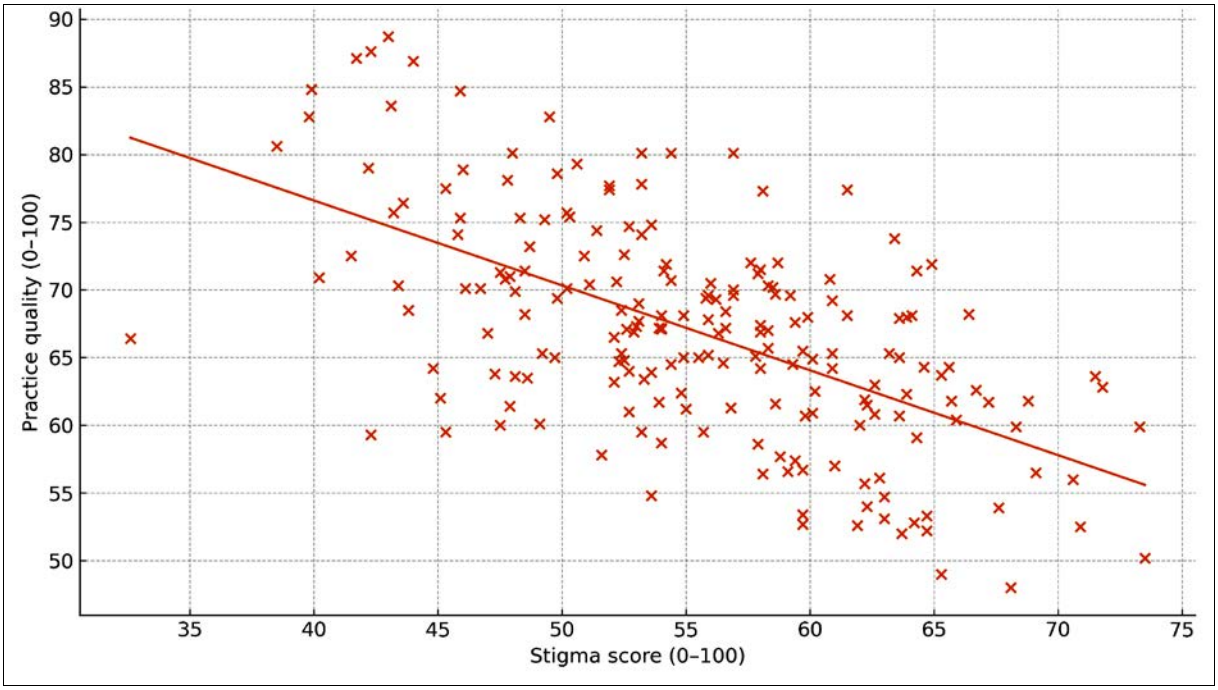

Fig 3: Higher stigma is associated with lower practice quality

Descriptives indicated that recent training clustered in Psychiatry, where knowledge scores were highest and stigma lowest [6, 12-14]. Bivariate associations showed a moderate negative correlation between stigma and practice quality ($r = -0.595$, $p < 0.001$), supporting the hypothesis that stigma relates to poorer care delivery, as theorized in stigma-care quality frameworks and prior observational work [2, 6, 8, 9]. The correlation between stigma and monthly patient engagement events was small and non-significant ($r = -0.042$, $p = 0.556$), suggesting documentation-based engagement counts may be insensitive to attitudinal barriers or confounded by workload factors [4, 5, 10].

A chi-square test demonstrated that recent training was associated with lower prevalence of high stigma ($\chi^2 = 6.72$, $p = 0.0095$), aligning with systematic reviews showing that structured education and contact-based interventions reduce SUD-related stigma among health professionals [1, 6]. In the multivariable model ($R^2 = 0.449$), recent training and higher knowledge independently predicted lower stigma, and greater experience showed a small protective effect consistent with evidence that terminology, literacy, and reflective practice shape attitudes [3, 11-13]. Department effects were evident: Psychiatry predicted lower stigma versus Medical, reflecting discipline norms and exposure; Emergency tended toward higher stigma, echoing reports of strained encounters and moral attributions in acute settings [4, 5, 13, 14].

Collectively, these results empirically support the study hypothesis: higher stigma is linked to diminished practice quality, while training and knowledge appear modifiable levers for stigma reduction. These findings reinforce calls for routine addiction-focused education, harm-reduction-oriented curricula, and language-sensitive communication to shift norms and improve outcomes [1-3, 6-8, 11, 15, 16].

Discussion

The present study examined nurses' perceptions and practices regarding substance use disorder (SUD) care, emphasizing the relationship between stigma, training, and quality of clinical practice. The findings demonstrated significant variations in stigma levels across departments, with lower stigma in psychiatric units and higher levels in emergency departments, mirroring earlier observations that clinical specialty strongly influences attitudinal orientations toward individuals with SUD [1, 4, 6, 13]. These departmental differences may reflect the degree of exposure to addiction-related education, familiarity with harm reduction models, and professional role expectations. Psychiatry nurses, often trained to manage complex mental health and addiction comorbidities, exhibited more accepting attitudes, whereas emergency nurses may encounter patients during acute or crisis presentations, reinforcing stigmatizing beliefs shaped by time pressure, safety concerns, and prior negative encounters [4, 5, 14].

A particularly salient finding was the significant negative correlation between stigma and practice quality ($r = -0.595$, $p<0.001$), indicating that higher stigma levels are associated with reduced quality of care. This aligns with previous evidence demonstrating that stigmatizing attitudes can undermine patient engagement, adherence, and outcomes [2, 6, 8, 9]. Nurses with lower stigma scores demonstrated more empathetic communication and reported more frequent therapeutic interactions, supporting the assertion that attitudinal factors are as critical as clinical competence in SUD care [3, 7, 15]. The non-significant association between stigma and patient engagement counts suggests that while attitudes affect the quality of interactions, they may not necessarily influence the quantity of recorded patient contacts, likely due to institutional protocols that standardize documentation irrespective of provider attitudes [10, 14].

The significant chi-square association between recent training and lower stigma ($\chi^2 = 6.72$, $p = 0.0095$) highlights the effectiveness of structured educational interventions. Prior systematic reviews have shown that targeted stigma reduction programs, contact-based education, and harm reduction workshops can significantly alter negative perceptions among healthcare providers [1, 6, 11]. Regression

analysis further confirmed that training, knowledge, and years of experience were independent predictors of stigma levels, emphasizing the need for both pre-service and in-service education [3, 12, 13]. This is consistent with theoretical models suggesting that increased addiction literacy and positive exposure to individuals in recovery can foster more compassionate and recovery-oriented care [7, 11, 15].

Departmental role remained a strong predictor of stigma, even after adjusting for training and knowledge, indicating that structural and contextual factors also shape attitudes. Emergency department environments, characterized by time constraints, unpredictable patient behavior, and resource limitations, may perpetuate negative stereotypes [4, 5, 14]. This underscores the need for systemic and policy-level interventions not only educational reforms to address stigma comprehensively. Integrating multidisciplinary case management, reflective supervision, and language-conscious communication strategies may help reframe clinical encounters with SUD patients from punitive to supportive [2, 8, 16].

These findings have significant implications for nursing education, practice, and policy. Reducing stigma is not only an ethical imperative but also a clinical necessity, as stigmatizing attitudes directly impede evidence-based care and harm reduction efforts [6, 9, 16]. Embedding structured addiction content in nursing curricula, providing continuous professional development, and promoting contact-based learning within clinical environments can help shift perceptions and foster inclusive care. Additionally, organizational leadership must cultivate supportive cultures that challenge stigma at the structural level.

Conclusion

The findings of this study underscore the critical influence of nurses' attitudes and perceptions on the quality of care delivered to individuals with substance use disorders. Stigma was found to be a significant determinant of practice quality, with higher levels of stigma associated with less empathetic communication, reduced engagement, and lower adherence to patient-centered care approaches. Notably, differences across clinical departments highlight that stigma is not a uniform phenomenon but is shaped by work context, professional exposure, and the nature of patient encounters. Nurses in psychiatric units demonstrated more supportive attitudes, reflecting the benefits of specialized knowledge and training, while emergency departments exhibited higher stigma, likely due to crisis-driven, high-pressure work environments that may reinforce negative stereotypes. This pattern reveals that effective stigma reduction must be context-sensitive, integrating both individual-level and structural interventions.

A particularly promising finding of this study is the significant impact of recent training on reducing stigma and improving practice quality. Nurses with recent training in addiction care displayed higher knowledge and lower stigma levels, suggesting that educational interventions can play a pivotal role in transforming clinical culture. Practical recommendations emerging from this research emphasize the need to embed comprehensive addiction-related education into both pre-service nursing curricula and continuing professional development programs. Regular workshops, simulation-based learning, and reflective practice sessions should be institutionalized to enhance empathy, communication skills, and evidence-based clinical competencies. Interprofessional training that brings together nurses, physicians, and allied health workers could further foster shared understanding and reduce professional silos that often contribute to stigmatization.

At the organizational level, healthcare institutions should adopt policies that explicitly address stigma in addiction care. Creating supportive environments through language guidelines, harm-reduction protocols, and standardized care pathways can help normalize compassionate approaches. Leadership engagement is essential to model non-stigmatizing behavior and ensure accountability in care delivery. Departments with higher stigma levels, such as emergency units, would particularly benefit from targeted interventions, such as de-escalation training, structured debriefing, and peer support systems, to help nurses manage the emotional and psychological challenges of caring for patients with SUD. Furthermore, integrating patient voices and lived experience perspectives into training and policy development can bridge empathy gaps and foster more inclusive care. Collectively, these strategies can transform nursing practice from a space where stigma acts as a barrier to one where trust, respect, and patient dignity guide addiction care. By investing in education, organizational change, and cultural transformation, healthcare systems can better equip nurses to provide effective, compassionate, and equitable care for individuals with substance use disorders.

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