



Stigma of people with addiction by health professionals: current knowledge. A scoping review

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**La stigmatisation des personnes avec addiction par les professionnels de santé
est-elle toujours d'actualité ?
Une revue focalisée (scoping review) des connaissances**

Directeur de thèse
Monsieur le Professeur Marc AURIACOMBE

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Madame le Professeur Mélina FATSÉAS	Présidente
Monsieur le Professeur Cédric GALÉRA	Juge
Monsieur le Professeur Nematollah JAAFARI	Juge et Rapporteur
Madame le Docteur Elisabeth MONTHIOUX	Juge
Monsieur le Docteur Jacques DUBERNET	Juge

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ABRÉVIATIONS

AMSTAR : Assessment of Multiple Systematic Reviews

AUD : Alcohol Use Disorder

AUDIT : Alcohol Use Disorders Identification Test

ISUD : Illegal Substance Use Disorder

PWA : People With Addiction

SUD : Substance Use Disorder

TUD : Tobacco Use Disorder

SYNOPSIS

La stigmatisation est un phénomène ancien, dont les fondements remontent à l'Antiquité, période à laquelle le stigma correspondait à une marque physique des esclaves. Depuis, le concept de stigmatisation a évolué mais conduit toujours à l'exclusion des personnes qui en sont victimes (1-3). Dans le domaine médical, la stigmatisation, et la discrimination qui lui est associée, apparaissent comme des obstacles majeurs au repérage diagnostique et à l'accès aux soins en santé mentale (4, 5). Parmi les troubles psychiatriques, l'addiction représente la pathologie la plus fréquente, touchant environ un milliard de personnes dans le monde (6, 7).

La société partage des représentations négatives de l'addiction et des personnes avec addiction (8-10) qui développent un phénomène d'auto-stigmatisation (11, 12). Ces deux processus contribuent à réduire la recherche, l'accès et l'adhésion au soin des personnes avec addiction (13-17). Enfin, la stigmatisation structurelle, relative au système sanitaire, judiciaire ou politique, peut également engendrer une discrimination en santé mentale (18). Malgré l'existence de thérapeutiques efficaces de l'addiction (19, 20), une minorité de personnes avec addiction bénéficieraient d'une prise en charge de leur addiction (21, 22). Il a été suggéré que l'attitude des professionnels de santé pourrait être un obstacle à l'accès au soin des personnes avec addiction. Dans les années 60, les professionnels de santé rapportaient des représentations et des attitudes négatives à leur égard (23-25). Depuis, le modèle de l'addiction a évolué vers celui d'une pathologie chronique, caractérisée par des critères diagnostiques explicites, comme pour les maladies en général (26). Qu'en est-il des attitudes des professionnels de santé ?

L'objectif de ce travail était d'évaluer la stigmatisation des personnes avec addiction par les professionnels de santé. Nous voulions explorer les caractéristiques des professionnels de santé qui stigmatisent et celles des patients stigmatisés. La prévalence de ce phénomène est-elle stable ? A-t-elle diminué du fait de l'émergence de l'addiction comme maladie chronique et de l'addictologie comme discipline à part entière ? Pour cela nous avons fait le choix d'une revue focalisée des revues de la littérature (27).

À partir des 19 revues sélectionnées (Tableau 5 à 8), il apparaît qu'environ 20% à 60% des professionnels de santé avaient des attitudes ou des représentations négatives de l'addiction, contribuant à une discrimination plus importante des personnes avec addiction par rapport à d'autres pathologies chroniques, y compris psychiatriques. Une formation en addictologie et une pratique clinique au contact de personnes avec addiction étaient associées à une attitude moins négative. À

l'inverse, les représentations négatives des professionnels, le manque de temps et de soutien dans la pratique étaient associés à une moindre implication dans le soin de l'addiction. Une addiction au tabac ou à des substances illégales, une rechute, une comorbidité ou un antécédent judiciaire étaient associés à une attitude plus négative. L'influence de plusieurs variables était inconstante (expérience personnelle, catégorie professionnelle, âge, sexe, niveau d'études). L'évaluation de l'évolution de la stigmatisation semblait montrer une diminution des attitudes négatives entre les années 1960 et les années 2000.

La coexistence d'un modèle moral où la personne est responsable et doit agir sur son comportement, et d'un modèle de maladie chronique de l'addiction où la personne est prise en charge (28) pourrait expliquer le maintien de la stigmatisation par les professionnels de santé (29). La persistance du modèle moral (30), y compris dans les structures d'addictologie (31), pourrait être liée à la crainte que le modèle médical de maladie chronique rende la personne impuissante face à un trouble incurable (28). Ainsi, paradoxalement, la résistance au changement de modèle pourrait contribuer à maintenir la stigmatisation (32, 33) alors que la diffusion du modèle médical de l'addiction et de l'existence de moyens thérapeutiques efficaces permettrait de la réduire (34-39).

La dégradation des attitudes des soignants pendant leurs études pourrait s'expliquer par le manque de formation, d'avantage d'interaction avec des patients ayant un trouble sévère plutôt qu'en rémission, et les attitudes stigmatisantes des médecins séniors formés sur le modèle moral (40, 41).

La meilleure attitude des professionnels d'addictologie (35, 42, 43) pourrait être liée au fait que ces soignants ont déjà une attitude moins stigmatisante, avant leur formation en addictologie. Ces formations peuvent manquer d'impact sur les attitudes stigmatisantes des professionnels (36, 44-47). Des soignants évitant de se former par crainte d'attirer trop de personnes avec addiction (48).

Faire de la stigmatisation un objet de formation spécifique pourrait donc permettre d'améliorer l'attitude des professionnels de santé (49). Il serait également intéressant de modifier le vocabulaire utilisé par les professionnels pour décrire l'addiction, car des termes confondant la personne avec son trouble participeraient au maintien de la stigmatisation (50-53).

L'adhésion à des modèles différents selon les objets d'addiction (28) pourrait aussi entretenir des stéréotypes et des préjugés qui limitent l'implication des professionnels dans le diagnostic ou le traitement d'une addiction (54).

Un antécédent personnel d'addiction pourrait favoriser (55) ou restreindre l'implication des professionnels (56-58). La nécessité de faire face à son propre trouble pourrait empêcher l'implication des professionnels dans le traitement (40).

Au moment où émergent la médecine digitale et les technologies d'intelligence artificielle, les agents conversationnels animés pourraient offrir une alternative dans le diagnostic de l'addiction (59, 60). Aussi bien, voire mieux acceptés par les patients que les professionnels « humains », et libres de tout préjugé, les agents conversationnels animés pourraient faciliter l'accès au soin des personnes avec addiction.

La stigmatisation persiste et peut s'expliquer par différentes variables, sur lesquelles il serait possible d'agir : modèle moral de l'addiction, représentations négatives des professionnels, manque de formation, de temps, et de soutien dans la pratique. Enseigner l'addictologie selon un modèle médical de maladie chronique, et faire de la stigmatisation un objet spécifique de formation, pourraient permettre aux soignants d'améliorer leur attitude et de rester fidèles aux principes fondamentaux de la déontologie médicale.

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ARTICLE

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Stigma of people with addiction by health professionals: current knowledge.

A scoping review

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Abstract

Background: Stigma of people with addiction (PWA) is a long-known phenomenon, shared by general population, health professionals and patients themselves. Our aim was to assess the stigma of PWA by health professionals, its characteristics and its evolution.

Methods: We chose to conduct a scoping review of the literature. A systematic search of PubMed, Scopus and PsycINFO databases targeted only literature reviews.

Results: From the 19 selected reviews, it appears that 20% to 60% health professionals had negative attitudes/beliefs about addiction. Addiction training and clinical experience with PWA were associated with a less negative attitude. Health professionals' negative beliefs, lack of time or support were associated with less involvement in addiction care. A tobacco use disorder (TUD), illegal substance use disorder (ISUD), a relapse, a comorbidity or a criminal record were associated with a more negative attitude. The influence of several variables was inconsistent (personal experience, professional category, age, gender, education level). Evaluation of stigma changes overtime seemed to show a decrease in health professionals' attitudes between the 1960s and the 2000s.

Conclusions: Stigmatization of PWA by health professionals persists, and some variables that contribute to this trend could be changed: moral model of addiction, health professionals' negative beliefs, lack of training, time, and role support. Teaching addiction specialty according to a medical model of chronic disease, and developing stigma-focused training, could enable caregivers to improve their attitude and remain faithful to the fundamental principles of medical deontology.

Keywords: stigma, beliefs, attitude of health personnel, health professionals, substance use disorder, addiction

1. Introduction

The concept of stigmatization dates back to antiquity, from the term « stigma », which corresponded to « bodily signs designed to expose something unusual and bad about the moral status of the signifier ». Over time, the meaning of stigma has shifted from the physical symbol, to refer to a characteristic or behaviour that can alter social interactions. Stigma, defined as « an undesirable attribute that is deeply discrediting », has therefore been associated with a negative stereotype (Goffman 1963). According to social theories, individuals carrying such an attribute would then be « labelled » as « deviants » from the social norms (Becker 1963). As a result, those experienced statut loss and discrimination (Link and Phelan 2001).

Stigmatization, and the associated discrimination, emerge as major barriers to access to mental health care (Clement et al. 2015; World Health Organization 2001). Among mental disorders, addiction is the most prevalent. Worldwide, 933 million people smoke daily and are likely for the majority to have a tobacco use disorder (TUD) (G. B. D. Tobacco Collaborators 2017), 100.4 million people have an alcohol use disorder (AUD), 59.7 million have an illegal substance use disorder (ISUD) (G. B. D. Alcohol and Drug Use Collaborators 2018). Health consequences of a substance use disorder (SUD) are major because addiction induces excess use without self-regulation. AUD and ISUD's mortality is estimated 0.6% worldwide and 12% for smoking (G. B. D. Risk Factor Collaborators 2018).

Society holds a negative view of addiction (Schomerus et al. 2011; Yang et al. 2017), more negative than other mental disorders (Barry et al. 2014). People with addiction (PWA) are viewed by the general population as more dangerous, more unpredictable, less able to make decisions, and noteworthy, more responsible for their disorder (Schomerus et al. 2011; Yang et al. 2017). These stereotypes can be internalized by people who are victims, leading to self-stigma (Corrigan 2002), which weakens self-esteem and feelings of self-efficacy: the « why try » effect (Corrigan et al. 2009). Social stigma or self-stigma reduces seeking, accessing and adhering to care for PWA (Crapanzano et al. 2019; Cunningham et al. 1993; Luoma et al. 2007; Mojtabai et al. 2014; Probst et al. 2015). Structural stigma, relating to the health, justice or political system, can lead to discrimination, particularly in mental health (Corrigan et al. 2004). Despite the existence of effective addiction treatments (Reus et al. 2018; World Health Organization and United Nations Office on Drugs and Crime 2020), a study on 26 countries revealed that only 7.1% of all PWA received minimally adequate treatment during the last year (Degenhardt et al. 2017). Another study

showed that AUD is the disorder, in mental health care, with the widest treatment gap (Kohn et al. 2004).

If accessing to care is difficult for PWA, what is the attitude of health professionals who receive them? In the 1960-1970s, health professionals perceived « alcoholism » as a disorder occurring primarily among « derelicts », prioritized « medical » problems and considered people with AUD as weaker, more aimless and hopeless than average (Fisher, Keeley, et al. 1975; Wolf et al. 1965). Most patients experienced negative attitude of professionals in the emergency room and avoided addiction treatment. A more compassionate attitude made it possible to create a therapeutic alliance and engage the patient in care (Chafetz et al. 1962). Since, the addiction model has evolved into a complex chronic disease medical model, defined by explicit diagnostic criteria, as for diseases in general (Auriacombe, Serre, et al. 2018).

Our aim was to assess, through a scoping review of the literature, the current state of knowledge about stigmatization by health professionals towards PWA. We wanted to explore the characteristics of health professionals that stigmatize and that of PWA that are stigmatized. Is the prevalence of this phenomenon stable or has it decreased due to the emergence of the chronic disease model of addiction and that of addiction as a medical specialty?

2. Methods

To explore the complex topic of stigma, extract key concepts and assess its determinants, we chose to conduct a scoping review of the literature (Arksey and O'Malley 2005; Levac et al. 2010). Unlike a systematic review, which seeks to test a hypothesis or evaluate the effectiveness of an intervention, a scoping review provides a guide to achieve a state of knowledge on a complex phenomenon, with a rigorous and transparent method inspired by systematic reviews (Fusar-Poli and Radua 2018; Munn et al. 2018; Pham et al. 2014; Schultz et al. 2018; Tricco et al. 2018).

2.1. Search strategy

A systematic search of PubMed, Scopus and PsycINFO databases was conducted in April 2020. We targeted literature reviews whose explicit aim included the following terms: *stigma by healthcare professionals on people with addiction or addiction treatment*. For our study, stigma was defined as negative attitudes or negative beliefs of healthcare professionals towards PWA, addiction, addiction treatment, or a lesser involvement in the treatment. The publication dates and language of reviews

were not limited. The search strategy was the same for the three databases. Keywords were adapted to the specific thesaurus of each database (Table 1). To be considered a literature review, the publication had to have an explicit strategy of collecting the literature present in title, abstract or full article. Clinical studies, protocols and case studies were excluded.

2.2. Study Selection

After extracting from the databases and removing duplicates, the first selection was based on the title. The words « people with addiction » or « addiction treatment » (or equivalent), « health professionals » (or equivalent) and « stigma » (or equivalent) had to appear (Table 2). The following selections, from the abstract and then the full text, checked the aim of the review and that they were literature reviews. Literature references for each included study were systematically checked for additional publications.

2.3.Quality assessment

We assessed the quality of publications using the AMSTAR checklist (Shea et al. 2009). This tool assessed in particular the process of literature search, study selection, data extraction, evaluation of the quality of studies, the method for combining results and publication bias. Each item was answered with « yes », « no », « cannot answer » or « not applicable ». This scoring system was worth 1 point for « yes » and 0 point for the other response options. Categories were determined as follows : low (score 0 to 3), medium (score 4 to 7), and high (score 8 to 11)(Canadian Agency for Drugs and Technologies in Health 2011).

2.4.Data extraction

Useful data were extracted and collected in a table for thematic analysis. First, we collected the raw data, then we constituted a closed checklist using discrete homogeneous categories. Each publication was then re-analyzed using this checklist. Data collected were synthesized to answer the study's aims. Based on the data collected, the synthesis focused on (1) stigma characteristics and prevalence (2) health professionals' characteristics (3) stigmatized patients' characteristics and (4) the evolution of stigma prevalence over time.

3. Results

The flow chart of the selection process is presented Figure 1. Of the 266 publications initially selected, 17 met the inclusion criteria. Exclusion criteria were an objective not focused on stigmatization by professionals or a type of study outside the literature review. Analysis of the

references of the included reviews identified two additional reviews. The general characteristics of the included reviews are detailed in Table 3. Of the 17 included reviews, 11 were systematic, 4 of which with meta-analysis or meta-synthesis, and 8 were narrative. They were each based on 8 to 56 publications. A total of 415 publications were cited at least once, of which 16 (3.85%) were cited by two reviews. The studies cited were published between 1963 and 2016. The quality of the publications ranged from 0 to 8, with a mean score of 4.9/11. Health professionals' characteristics, stigmatized persons' characteristics, and the association of both characteristics with the attitude of health professionals are available Table 4. Six reviews reported negative attitudes, 13 reviews reported negative beliefs and 14 reviews reported barriers to involvement in addiction management.

3.1. Stigma's characteristics and prevalence (Table 5)

Eleven reviews reported quantitative and/or qualitative prevalence. Of these, three reported on the general attitudes of professionals (Ducray and Pilch 2017; Howard and Chung 2000a; Van Boekel et al. 2013). Ten reviews reported professionals' beliefs, including five on PWA (Guydish et al. 2007; Howard and Chung 2000a, b; Sheals et al. 2016; Van Boekel et al. 2013), five on addiction (Guydish et al. 2007; Howard and Chung 2000a, b, c; Sheals et al. 2016), and seven on its treatment (Flemming et al. 2016; Guydish et al. 2007; Howard and Chung 2000b; Rush et al. 1994; Sheals et al. 2016; Stead et al. 2009; Vogt et al. 2005).

3.1.1. General attitude

Whatever the addiction type, health professionals « generally » had negative attitudes towards PWA (Van Boekel et al. 2013). Up to a third of nurses had « morally condemnatory » attitudes (Howard and Chung 2000a). PWA were « consistently » held with very low regard, lower than patients with other chronic conditions such as diabetes or depression (Ducray and Pilch 2017; Van Boekel et al. 2013). A review reported that « many » nurses had negative attitudes towards people with AUD (Howard and Chung 2000a). 23.2% of HIV and ISUD patients had physicians with negative attitudes (Van Boekel et al. 2013). However, two reviews reported « generally » positive attitudes of professionals (Van Boekel et al. 2013). Up to 80% of them described themselves as tolerant and understanding towards people with AUD (Howard and Chung 2000a).

3.1.2. Health professionals' beliefs towards PWA

More than a quarter of professionals considered PWA to be antisocial (Howard and Chung 2000b). Up to 59% of professionals perceived a lack of motivation in people with TUD (Guydish et al. 2007; Sheals et al. 2016) or AUD (Howard and Chung 2000a). Up to 55% considered patients with

AUD to be difficult, dishonest about their use (Howard and Chung 2000b), and « many nurses » thought they were violent (Howard and Chung 2000a). People with ISUD were « often » perceived as manipulative, aggressive and unmotivated (Van Boekel et al. 2013). Up to 46% of professionals considered people with intravenous ISUD as a threat to society because of possible HIV infection (Howard and Chung 2000a).

3.1.3. Health professional's beliefs towards addiction

Five reviews explored this issue. Up to one-third of professionals considered addiction as a moral or spiritual condition (Howard and Chung 2000a, b). 26% perceived addiction as a character weakness (Howard and Chung 2000b, c) and 20% held patients responsible for their disorder (Howard and Chung 2000b). More than two-thirds viewed addiction as a chronic disease (Howard and Chung 2000a). Up to 17% of professionals perceived smoking as helpful to patients recover from other SUD (Guydish et al. 2007) and up to 33.5% as helping to establish therapeutic relationship (Guydish et al. 2007; Sheals et al. 2016).

3.1.4. Health professional's beliefs towards addiction treatment

Four reviews were explored TUD treatment. 40.5% of professionals had a negative attitude toward treatment of TUD, 38% considered quitting smoking to be excessive and 26.5% considered TUD care not to be a priority (Sheals et al. 2016). Up to 38% perceived TUD treatment as ineffective (Sheals et al. 2016; Vogt et al. 2005), difficult (Stead et al. 2009), 42% too time-consuming, 18% as unpleasant (Vogt et al. 2005). Between 18% and 47% feared a negative impact of TUD treatment on other addictions (Guydish et al. 2007) and about 25% on an associated psychiatric disorder (Sheals et al. 2016). Although 71% of professionals thought that TUD should be treated like any other addiction, about 25% of directors of addiction departments suggested to delay TUD care (Guydish et al. 2007). Up to 18% of psychiatric professionals did not perceive that they should be involved in the management of TUD treatment (Sheals et al. 2016). Many health professionals feared TUD treatment could negatively affect relationship with the patients (Flemming et al. 2016).

Three reviews explored AUD or ISUD care. Up to 79% of nurses were optimistic about the outcome of treatment, but about 50% described the management of AUD as discouraging, hopeless unsatisfactory, and requiring patient motivation to be successful (Howard and Chung 2000a). Treatment was rewarding for only 20% of professionals (Howard and Chung 2000a) and only 18% to 39% of general practitioners were motivated to manage AUD (Howard and Chung 2000b; Rush et al. 1994).

3.2. Health professionals' characteristics (Table 6)

3.2.1. Addiction training

Training in addiction was explored by 14 reviews. Nine associated training in addiction medicine with a positive attitude of health professionals towards PWA and a better involvement in addiction care (Bakhshi and While 2013; Ducray and Pilch 2017; Guydish et al. 2007; Howard and Chung 2000a, b; Okoli et al. 2010; Rush et al. 1994; Stead et al. 2009; Van Boekel et al. 2013). One review noted that there was no difference between trained and untrained health professionals (Stead et al. 2009). Seven reviews identified lack of training of professionals and lack of confidence in their care abilities as the main barriers to caring for PWA (Chandrakumar and Adams 2015; Conlon et al. 2017; Flemming et al. 2016; Guydish et al. 2007; Malone et al. 2018; Okoli et al. 2010; Sheals et al. 2016).

3.2.2. Personal experience of addiction or psychiatric disorder

The influence of health professionals' personal experience of addiction or of psychiatric disorder was explored by 11 reviews. Five associated the professionals' personal experience of addiction with a positive attitude toward PWA. Regardless of the substance, a history of addiction was associated with a positive attitude toward patients, optimism about the effectiveness of treatment and adherence to a disease model of addiction (Howard and Chung 2000b; Van Boekel et al. 2013). Professionals with TUD had high skill in advising to counsel (Chandrakumar and Adams 2015) people with TUD toward smoking cessation, and referred more to an addiction specialist (Duaso et al. 2014). Students with a family history of psychiatric disorder had a more positive attitude for people with ISUD (Ducray and Pilch 2017).

Nine reviews suggested the reverse association. Six reported a personal history of TUD as a barrier to managing the patient's TUD (Conlon et al. 2017; Duaso et al. 2017; Duaso et al. 2014; Guydish et al. 2007; Sheals et al. 2016; Stead et al. 2009). Professionals with TUD perceived more barriers to patients' care (Guydish et al. 2007) and provided a bad example for patients (Sheals et al. 2016). A personal history of depression increased the risk of negative attitudes toward patients with TUD (Ducray and Pilch 2017).

One review revealed that doctors who were at greater risk of AUD, on the basis of AUDIT, were more tolerant of their patients' alcohol use and started AUD treatment later (Bakhshi and While 2013). Health professionals whose alcohol use was extreme (very heavy use or abstinence) developed more punitive attitudes (Howard and Chung 2000b).

Four reviews collected studies showing no association, or non-significant differences between personal experience and health professionals' attitudes (Bakhshi and While 2013; Ducray and Pilch 2017; Guydish et al. 2007; Stead et al. 2009).

3.2.3. Work experience with PWA

Four reviews assessed the association between work experience and professionals' attitudes. Three of them associated professional's work experience with PWA and positive attitudes (Howard and Chung 2000b; Rush et al. 1994; Van Boekel et al. 2013). One review showed that professionals with fewer experience, but more education, had more positive attitudes (Howard and Chung 2000a).

3.2.4. Health professional's belief

Twelve reviews assessed the impact of health professionals' beliefs about addiction on their attitudes and their management of PWA. Violence, manipulation or lack of motivation perceived by health professionals towards PWA were barriers to addiction treatment management (Conlon et al. 2017; Guydish et al. 2007; Okoli et al. 2010; Van Boekel et al. 2013), while a positive attitude towards PWA was associated with greater involvement in care (Rush et al. 1994).

The health professionals' view of SUD was associated with the degree of professional involvement in addiction management. Adherence to a moral model of addiction, in which the user was seen as responsible for his use and able to control it, was associated to negative attitudes (Van Boekel et al. 2013), avoidance of addiction care (Howard and Chung 2000c) or social rejection of PWA (Howard and Chung 2000a). Conversely, adherence to the chronic medical disease model of addiction was associated with positive attitudes and optimism about the effectiveness of treatment (Howard and Chung 2000a). In addition, some health professionals perceived tobacco use as a reward for appropriate psychiatric behavior, which encouraged smoking as a reward. Patients in psychiatric care reported that professionals had advised them to smoke to regulate their mental illness symptoms (Malone et al. 2018).

Professionals' beliefs of treatment could facilitate or hinder management of SUD. A first obstacle to care was the lack of perception of the caregiver's role in treatment (Conlon et al. 2017; Okoli et al. 2010). Although they recognized their role in care, health professionals could be pessimistic about the prognosis for treatment (Howard and Chung 2000b), which they perceived as not rewarding (Stead et al. 2009). Fear of ineffectiveness (Okoli et al. 2010; Rush et al. 1994), inducing stress or guilt in the patient (Conlon et al. 2017; Okoli et al. 2010; Stead et al. 2009), or weakening the caregiver-patient relationship (Flemming et al. 2016; Malone et al. 2018; Okoli et al. 2010; Stead et

al. 2009) were other barriers to addiction treatment. Due to previous negative experiences of aggression or agitated behaviour, some professionals of psychiatric units reported that quitting smoking was not appropriate (Malone et al. 2018). Conversely, optimism about treatment (Bakhshi and While 2013; Howard and Chung 2000a) and perceptions of the usefulness and effectiveness of treatment were associated with positive attitudes (Bakhshi and While 2013; Conlon et al. 2017; Rush et al. 1994).

3.2.5. Professional category, specialty work setting and education level

Four reviews examined the association between health professionals' attitudes and professional category. Nurses and nurse-assistants (NA) had more negative attitudes and beliefs than physicians, psychologists or social workers (Howard and Chung 2000a, b), adhered more to the disease model of addiction than NA (Howard and Chung 2000b), and reported fewer stereotypical beliefs than ward managers (Van Boekel et al. 2013). When PWA were nurses, their managers were more likely to take disciplinary measures, while their nursing colleagues reported that treatment would be beneficial (Howard and Chung 2000c).

Six reviews assessed the impact of the professionals' specialty work setting. Three of them showed a positive association between specialized addiction services and the attitude of professionals or their management of SUD (Guydish et al. 2007; Howard and Chung 2000b; Van Boekel et al. 2013), except for the TUD, where there was the same reluctance to treat, regardless of professionals' smoking status (Guydish et al. 2007; Sheals et al. 2016). One review associated medical doctors not working in addiction services with the most negative attitudes, compared to all professionals working in an addiction service (Van Boekel et al. 2013). Non-addiction specialist doctors were more likely to arrange a follow-up for a patient with TUD than none specialist doctors (Duaso et al. 2014). Psychiatric services were described as accepting and supportive of tobacco use (Malone et al. 2018; Sheals et al. 2016).

Five reviews assessed educational level. Three associated higher levels of education with negative attitudes (Howard and Chung 2000a, b; Van Boekel et al. 2013), two with positive attitudes (Howard and Chung 2000a, c). One review reported inconsistent results (Ducray and Pilch 2017).

3.2.6. Structural factors

Eight reviews identified lack of time as a barrier to addiction treatment (Chandrakumar and Adams 2015; Conlon et al. 2017; Guydish et al. 2007; Okoli et al. 2010; Rush et al. 1994; Sheals et al. 2016; Stead et al. 2009; Van Boekel et al. 2013). Professionals treating fewer patients per week

developed a more positive attitude (Van Boekel et al. 2013). Those with a larger caseload assessed smoking less frequently (Guydish et al. 2007), but one review showed that positive attitudes toward AUD were correlated with the number of patient consultations for AUD (Rush et al. 1994).

Lack of staff (Flemming et al. 2016), particularly addiction specialists (Guydish et al. 2007), and the absence of a protocol for the care of pregnant women (Flemming et al. 2016; Okoli et al. 2010) limited treatment. Lack of role support in the workplace reduced the positive influence of training on the attitude of professionals (Van Boekel et al. 2013). According to professionals, the accessibility of TUD treatment facilities would facilitate TUD screening and management (Stead et al. 2009).

3.2.7. Age and gender

Six reviews explored the influence of the age of health professionals. Four linked a young age to a more positive view of addiction (Howard and Chung 2000a, b, c; Rush et al. 1994), but one review identified an improvement in attitude with age (Ducray and Pilch 2017), and two found no association (Ducray and Pilch 2017; Stead et al. 2009).

With respect to gender, two reviews showed significantly more positive attitudes in women (Ducray and Pilch 2017; Howard and Chung 2000a), two reported the opposite (Howard and Chung 2000a; Rush et al. 1994), and three reported no association (Ducray and Pilch 2017; Okoli et al. 2010; Stead et al. 2009).

3.3. Stigmatized patient's characteristics (Table 7)

3.3.1. Addiction vs. other diseases

The six reviews assessing this variable reported a significantly more negative attitude of professionals towards PWA, compared to people with other diseases, physical or psychiatric (Diniz and Caron Ruffino 1996; Ducray and Pilch 2017; Howard and Chung 2000b, c; Rush et al. 1994; Van Boekel et al. 2013). Working with PWA was perceived as less rewarding (Howard and Chung 2000c; Van Boekel et al. 2013). PWA were judged more negatively (Diniz and Caron Ruffino 1996; Howard and Chung 2000b) and more responsible for their disorder (Howard and Chung 2000c; Van Boekel et al. 2013).

3.3.2. Addiction type

Four reviews considered the type of addiction. Up to 60% of professionals considered TUD to be less important to treat than other addictions (Guydish et al. 2007; Sheals et al. 2016), but tobacco

use was reported as an easier issue to raise in consultation than alcohol use (Rush et al. 1994). Professionals had a more negative attitude about AUD/ISUD compared with TUD (Howard and Chung 2000b). Two reviews showed a more negative perception of people with ISUD compared to AUD (Howard and Chung 2000b, c).

3.3.3. Addiction intensity

One review noted a more positive attitude towards PWA in recovery compared to PWA in relapse (Van Boekel et al. 2013). In contrast, for TUD, professionals were more likely to manage « heavy smokers » compared to « light smokers », and patients with smoking related symptoms (Stead et al. 2009).

3.3.4. Comorbidity

The same barriers to care were found in TUD when isolated or combined with cancer or pregnancy (Conlon et al. 2017; Flemming et al. 2016; Okoli et al. 2010; Stead et al. 2009). For example, although health professionals perceived TUD treatment as worthwhile, pregnancy was seen as a difficult time to modify tobacco use, because tobacco use was seen as a source of support (Flemming et al. 2016; Okoli et al. 2010). Health professionals reported frustration and helplessness with people whose addiction was associated with a psychiatric disorder (Van Boekel et al. 2013).

3.3.5. Criminal record

Only one review suggested that a history of detention reinforced negative views of PWA (Van Boekel et al. 2013).

3.4. Evolution of stigma prevalence over time (Table 8)

Four reviews assessed changes in attitudes over time. Studies between 1970 and 1992 showed the persistence of negative stereotypes applied to people with AUD during this period (Diniz and Caron Ruffino 1996). Conversely, a review from the same period reported an improvement in attitudes among more recently trained professionals (Rush et al. 1994). In another review, the majority of studies from the 1990s reported fewer stigmatizing attitudes than those from the 1960s (Howard and Chung 2000a). According to a 2009 review, the proportion of general practitioners who felt that discussing smoking with patients was not their role had decreased from 29% to 9% in three years, and the proportion reporting that it was embarrassing to talk about it had halved in two years (Stead et al. 2009).

4. Discussion

The aim of this scoping review was to examine the stigmatization by health professionals of PWA, its characteristics and development. We did not find any recent literature reviews attempting to synthesize in the same work both the prevalence of stigma towards several SUDs including tobacco, the influence of health professionals' characteristics including students, those of PWA, and the evolution of this stigma. From the 19 selected reviews, it appears that health professionals had negative attitudes and negative beliefs about addiction, contributing to a greater discrimination of PWA compared to other chronic diseases, including psychiatric disorders. Addiction training and clinical experience with PWA were associated with a less negative attitude. Conversely, health professionals' beliefs, lack of time or support were associated with less involvement in addiction care. An AUD or ISUD, a relapse, a co-morbidity or a criminal record were associated with a more negative attitude. The influence of several variables was inconsistent (personal experience, work experience, professional category, age, gender, education level). Evaluation of stigma changes over time seemed to show a decrease in health professionals' negative attitudes between the 1960s and the 2000s.

Reviews described that approximately 20% to 60% of professionals may have negative attitudes or beliefs. Publications outside our review reported similar data. Forty-six percent and sixty percent of emergency room professionals considered people with AUD and ISUD as « dangerous » (Giandinoto et al. 2018), respectively, and 98% of residents considered PWA as « difficult » (Renner et al. 2009). A « significant proportion » of professionals commonly exhibited « punitive » attitudes (Skinner et al. 2009). Other sources confirmed the greater stigmatization of PWA compared to people with physical or psychological disorders (Avery et al. 2017; Dupouy et al. 2018; Giandinoto et al. 2018; McCann et al. 2018; Ronzani et al. 2009; Skinner et al. 2009). Professionals considered them more difficult to treat and more responsible for their disorder than people with obesity, depression or schizophrenia (Ronzani et al. 2009). Interestingly, studies reported more positive attitudes among young professionals who had recently graduated (Gilchrist et al. 2011; Kennedy-Hendricks et al. 2020; Skinner et al. 2009). However, negative attitudes increased over time during student's training (Avery et al. 2017; Fisher, Mason, et al. 1975; Lindberg et al. 2006).

The coexistence of a longtime moral model of addiction and the more recent development of the medical chronic disease model of addiction (Barnett et al. 2018), could explain the persistence of stigma for addiction (Avery and Avery 2019). According to the moral model, the individual is

responsible for his disorder and its solution. According to the medical model, the individual is a victim of a disease requiring protection from society and access to treatment with proactive involvement of health professionals (Auriacombe et al. 2017; Brickman P 1982). This attribution of responsibility, historically associated to people with « mental » illnesses rather than to people with « physical » illnesses, resulted in less compassionate attitudes of caregivers (Weiner 1988). Our review showed an association between the moral model and negative professional attitudes towards addiction and PWA (Howard and Chung 2000a, c; Van Boekel et al. 2013). A recent study (Avery et al. 2020) reported this association and noted that the majority of professionals endorsed the concept of addiction as a chronic disease. However, more than half of caregivers still believed that patients were in control and therefore had the choice to use or not. The persistence of the moral model, including among professionals of specialized addiction services (Simmat-Durand and Toutain 2012), may be related to the fear of potential negative impact of the disease mode. It could increase helplessness in relation to an incurable disorder (Barnett et al. 2018). Hence, resistance to disengage from the moral model, although based on fear of harm for PWA, may nonetheless contribute to maintain stigmatization (Schmidt 2018; Volkow 2020) while the spread of the medical model of addiction and the existence of effective treatments, including medications, would reduce stigmatization. Training in addiction medicine and psychiatry, based on this chronic disease model may contribute to improve the attitudes of health professionals (Ayu et al. 2020; Dupouy et al. 2018; Livingston et al. 2012). The seemingly contradictory influence of age, gender, education, work experience and professional category on stigmatization could therefore be related to the education received. Professionals trained with the chronic disease model of addiction were more likely to engage in treating people with addiction using available addiction treatments (Kennedy-Hendricks et al. 2020), and had more positive attitudes, despite less work experience (Gilchrist et al. 2011; Skinner et al. 2009). Deterioration in professionals' attitudes during their studies could be explained by lack of training, more interaction with patients with severe addiction rather than patients in recovery, and stigmatizing attitudes of senior physician supervisors trained in the moral model (Avery and Zerbo 2015; Miller et al. 2001). Generally, physicians perceived more legitimacy and role adequacy to treat addiction than nurses (Geirsson et al. 2005; Iqbal et al. 2015). Nevertheless, addiction professionals, both physicians and non-physicians, developed a better attitude than their non-specialist colleagues (Gilchrist et al. 2011; Iqbal et al. 2015; Van Boekel et al. 2014). However, it is possible that professionals who chose to train and work in addiction services had a less stigmatizing attitude toward addiction and PWA prior to their training. According to one study training improved attitudes of those with more positive attitudes prior training (Ayu et

al. 2020) and addiction training may have little impact on the pre-existing negative attitudes of professionals (Crapanzano et al. 2014; D'Onofrio et al. 2002; Howard and Chung 2000c; Lindberg et al. 2006; Livingston et al. 2012). Some caregivers avoid addiction training by fear of being involved with too many PWA (McLaughlin et al. 2006).

It has therefore been proposed to develop training centered on stigmatization (Livingston 2020). One study assessed the impact of specific teaching on the stigmatization of PWA on the attitudes of professionals (Avery et al. 2019). Residents in psychiatry and internal medicine were questioned before and six months after training on their attitude towards people with alcohol or opiate addiction. Six months later, the attitudes of the residents were better than before the training. It would therefore be interesting to develop such teaching. In addition, the wording used by professionals to describe addiction or PWA may also contribute to stigma. Terms confusing the person with their disorder would also contribute to maintain stigmatization (Bertholet et al. 2019; Scholten et al. 2017). Patients themselves, when questioned, avoided stigmatizing terms (Pivovarova and Stein 2019), which would maintain the negative attitude of professionals and limit access to care (Kelly et al. 2010; Kelly and Westerhoff 2010).

Our review showed different attitudes according to the addiction type, or the presence of comorbidity. Adherence to different models depending on the type of addiction could limit care, by associating, for example AUD with a more medical model than ISUD (Barnett et al. 2018), or cannabis with less danger during pregnancy (Oni et al. 2019). If the patient did not integrate the stereotype of the « drug addict », as is the case with TUD, discrimination could be expressed by trivialization of the disorder or greater tolerance in patients with cancer or psychiatric comorbidities. During pregnancy, screening may be limited by the stereotype that pregnant women do not use substances (Oni et al. 2019).

The influence of health professionals' personal experience was variable both in our review and in the literature data. Professionals with heavy alcohol use reported a better ability to treat people with AUD (Geirsson et al. 2005). However, regular alcohol and tobacco users were less likely to screen and counsel for reduced alcohol or tobacco use (Underner et al. 2006), including pregnant women (Andler et al. 2018). Nevertheless, health professionals with personal exposure to SUD adhered more to the medical model (Barnett et al. 2018). Professionals who smoke, once in recovery, observed that their own addiction could prevent patients from talking about their tobacco use (Underner et al. 2006). A personal history of SUD could therefore help or hinder addiction management (Ketterer et al. 2014), but require to confront their own disorder could prevent professionals involvement in treatment (Miller et al. 2001).

With the development of digital medicine and artificial intelligence technologies, Embodied Conversational Agent (ECA) designed to screen tobacco and alcohol use disorder, in individuals who did not seek medical help for these disorders are being developed. The ECA's screening capabilities were similar to that of real human professionals and it was as well or better accepted by the patients (Auriacombe, Moriceau, et al. 2018; Philip et al. 2020). Unlike "human" professionals, this ECA, free of any prejudice, could make access to care for PWA easier.

Some limitations must be considered in this study. We chose to conduct a scoping review focused on literature reviews. This choice implied not to re-examine the quality or results of the studies included in the reviews, but to focus on the synthesis carried out by the authors. We also chose to consider all the reviews about stigma according to our definition (negative attitudes, negative beliefs, care involvement) without making any restriction on the evaluation methods used. The methodological diversity of the reviews could impact the evidence's level of our results. We weighted our results according to the quality of the eligible reviews, using the AMSTAR checklist. The quality score did not seem to influence the results.

5. Conclusions

Stigma of PWA is a long-known phenomenon, shared by general population, health professionals and patients themselves. This review shows that stigma by health professionals persists, despite an improvement in attitudes over the past sixty years. Some variables that contribute to this trend could be changed: moral model of addiction, negative beliefs, lack of training, time, and role support. Teaching addiction specialty according to a medical model of chronic disease, and developing stigma-focused training, could enable caregivers to reduce their negative attitudes and thus remain faithful to the fundamental principles of medical deontology.

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Contributors

A. Cazalis performed the searches, selected the papers, extracted data, and constructed the tables. M. Auriacombe was involved in the process of selection and resolving selection issues, data extraction, tables construction, production and revision of manuscript. L. Lambert contributed to selection methods and process and the revision of the manuscript.

Conflict of interest

No conflict declared.

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Figures and Tables

Figure 1
Flowchart of the literature selection process

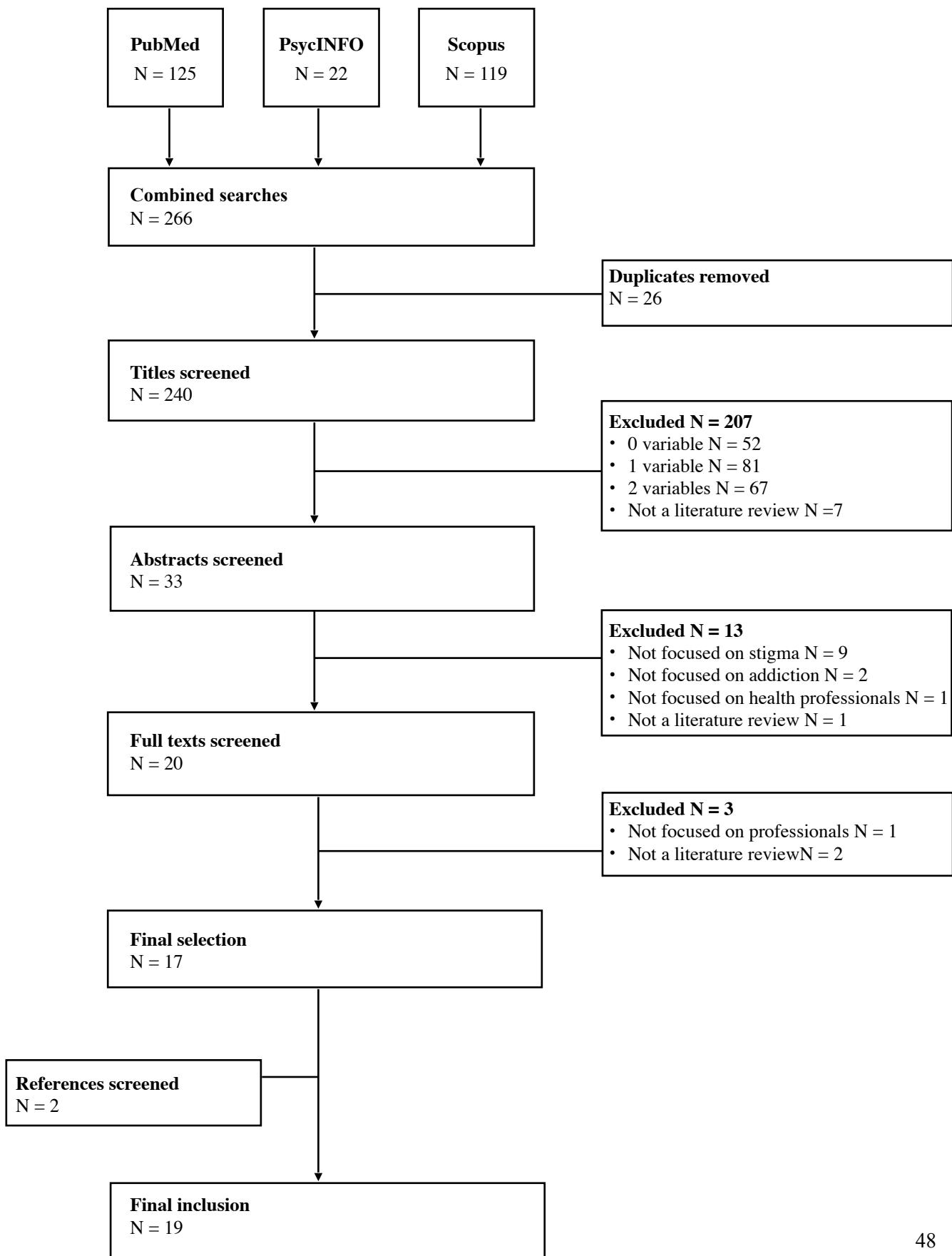


Table 1
Systematic search strategy according to PubMed, PsycINFO, Scopus databases

<i>PubMED</i>	<i>PsycINFO</i>	<i>Scopus</i>
#1 « health personnel »	#1 DE « Health Personnel »	#1 « health personnel »
#2 « psychiatrist »	#15 DE « Counseling Psychologists »	#13 « nursing staff »
#3 « resident »	#2 DE « Allied Health Personnel »	#14 « nurse »
#4 « psychologist »	#16 DE « Social Workers »	#15 « nursing aide »
#5 « counselor »	#17 DE « Psychiatric Social Workers »	#16 « social worker
#6 « social worker »	#3 DE « Caregivers »	#17 « health students »
#7 « students, health occupations »	#4 DE « Medical Personnel »	#18 « medical students »
#8 « psychiatric hospital »	#18 « Health students »	#19 « nursing students »
#9 « general hospital »	#19 DE « Medical Students »	
#10 « primary health care »	#5 DE « Mental Health Personnel »	#20 « psychiatric
#11 « emergency medical services »	#20 DE « Nursing Students »	hospital »
#12 « ambulatory care facilities »	#21 DE « Hospitals »	#21 « general hospital »
	#6 DE « Physicians »	#22 « Psychiatric Hospitals »
	#7 DE « Family Physicians »	#23 DE « Emergency Services »
	#8 DE « General Practitioners »	#24 DE « Crisis Intervention Services »
	#9 DE « Psychiatrists »	#10 « resident »
	#10 « Residents »	#11 « psychologist »
	#11 DE « Nurses »	#12 « counselor »
	#12 DE « Psychiatric Nurses »	#23 « primary health care »
	#13 DE « Psychologists »	#24 « ambulatory care facilities »
	#14 DE « Clinical Psychologists »	
#13 #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26	#27 #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24	#25 #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24

Table 1 (continued)

<i>PubMED</i>	<i>PsyINFO</i>	<i>Scopus</i>
#14 « substance-related disorders »	#28 DE « Substance-related disorders »	#26 « substance related disorder »
#15 « smoking »	#50 « Drug users »	#42 « smoking »
#16 « smokers »	#51 « Smokers »	#43 « cannabis
#17 « alcoholics »	#52 « Alcoholics »	#44 « heroin addiction »
#18 « drug users »	#38 DE « Cannabis Use Disorder »	#45 « amphetamine ad-
#19 « behavior, addictive »	#30 DE « Addiction »	diction »
#20 « pathological gambling »	#31 DE « Drug Abuse »	#39 DE « Opioid Use Disorder »
#21 « gaming disorder »	#32 DE « Drug Dependence »	#40 DE « Heroin Addiction »
#22 « sexual addiction »	#33 DE « Alcohol Use Disorder »	#41 DE « Crack Cocaine »
	#42 DE « Nonsubstance Related Addictions »	#42 DE « Nonsubstance Related Addictions »
	#43 DE « Food Addiction »	#31 « addiction »
	#44 DE « Gambling Disorder »	#32 « drug abuse »
	#45 DE « Internet Addiction »	#33 « drug addiction »
	#46 DE « Sexual Addiction »	#34 « behavior
	#48 DE « Intravenous Drug Usage »	#34 « alcohol related disorder »
	#49 DE « Inhalant Smoking »	#35 « pathological
	#36 DE« Tobacco Use Disorder »	#36 « alcoholism »
	#37 DE « Tobacco Abuse »	#37 « alcohol dependence »
		#38 « alcohol abuse »
		#39 « alcoholic »
		#40 « alcohol addiction »
		#41 « tobacco use disorder »
		#42 « gambling »
		#43 « drug users »
		#44 « smokers »
		#45 « intravenous drug use »
		#46 « inhalants abuse »
		#47 « food addiction »
		#48 « sexual addiction »
		#49 « gamers »
		#50 « pathological disorder »
		#51 « gaming disorder »
		#52 « sexual addiction »
		#53 « food addiction »
		#54 « drug users »
		#55 « smokers »
		#56 « intravenous drug use »
		#57 « inhalants abuse »
#23 #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22	#53 #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45 OR #46 OR #47 OR #48 OR #49 OR #50 OR #51	#58 #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45 OR #46 OR #47 OR #48 OR #49 OR #50 OR #51 OR #52 OR #53 OR #54 OR #55 OR #56 OR #57

Table 1 (continued)

	<i>PubMED</i>	<i>PsycINFO</i>	<i>Scopus</i>
<i>Stigma</i>	#24 « attitude of health personnel »	#54 DE « Health Personnel Attitudes »	#59 « attitude of health personnel »
	#25 « stigma »	#55 DE « Stigma »	#60 « stigma »
	#26 « discrimination »	#56 DE « Social Discrimination »	#61 « discrimination »
	#27 « professional patient relations »	#57 « professional patient relations »	#62 « professional-patient relations »
	#28 #23 OR #24 OR #25 OR #26 OR #27	#58 #54 OR #55 OR #56 OR #57	#63 #58 OR #59 OR #60 OR #61 OR #62
	#29 « literature review »	Literature Review OR Systematic Review OR Meta Analysis	#64 « literature review »
	#30 « systematic review »		#65 « systematic review »
	#31 « meta analysis		#66 « meta analysis »
	#32 #27 OR #28 OR #29 OR #30 OR #31		#67 #63 OR #64 OR #65 OR #66
	<i>Combination</i>	#33 #13 AND #23 AND #28 AND #32	#27 AND #53 AND #58 AND #67

PubMed: all terms are searched in the [MeSH Terms] field. Terms in italics are not MeSH terms.

PsycINFO: DE terms are searched in the « Subject [exact] ». Non-DE terms are search terms « without precision »

Scopus: all terms are searched [Title-Abstract-Keywords] field.

Table 2
Keyword thesaurus for the selection of reviews after extraction from databases

	<i>Health professionals</i>	<i>People with addiction</i>	<i>Stigma</i>	<i>Excluding</i>
Caregiver	Hospital setting	Addiction	Access	Opinion
Clinical services	Medical care	Alcohol	Attitude	Study
Clinician	Medical schools	Alcoholic	Barriers	Case study
Dentist	Medical students	Alcoholism	Beliefs	Protocol
Doctor	Nurses	Cannabis	Deficit	Practices
Emergency department	Nursing	Cocaine	Denial	Quality
Emergency room	Pharmacist	Dependence	Discouragement	Regard
Family physician	Pharmacy	Drug	Discriminating	Professional patient
General practitioner	Physician	Drug use	Discrimination	relation
GP	Primary care	Drug users	Disparition	Representation
Health care	Primary health care	Eating disorder	Engagement	Rights violation
Health facilities	Provider	Ecstasy	Inadequate	Satisfaction
Health personnel	Psychiatrist	Food addiction	Marginalization	Stereotype
Health professionals	Resident	Gambling	Negative beliefs	Stigma
Health service	Staff	Heroin	Nonprescription	Stigmatisation
Health student	Therapist	Illicit drugs	Obstacle	View
Healthcare provider	Treatment providers	Marijuana		
Healthcare practitioner		MDMA		
Healthcare worker	Treatment services	Metamphetamine		
Hospital	Treatment setting	Tobacco		

Table 3
General characteristics of the reviews included (type of literature review, objective(s) declared by the authors, number of studies included in the review, review study period, stigma assessment, stigma prevalence data, changes in stigma prevalence over time, quality score)

<i>Reference</i>	<i>Type of literature review</i>	<i>Declared aim(s)</i>	<i>No of studies included</i>	<i>Study period</i>	<i>Stigma assessment</i>	<i>Stigma prevalence</i>	<i>Change in prevalence over time</i>	<i>Quality score</i>
Examine HPs' alcohol-related health promotion practices								
Bakhshi et al. 2014	Systematic review	Explore the relationship between HPs' personal alcohol attitudes and behaviors, and their professional alcohol-related health promotion practices	32	2007-2012	Attitude Care involvement	NA	NA	7
Chandrakumar et al. 2015	Narrative review	Assess smoking rates among nurses Explore the factors influencing the nurse's role in promoting smoking cessation among patients	9	2001-2013	Care involvement	NA	NA	2
Conlon et al. 2017	Systematic review	Establish common attitudes and beliefs surrounding smoking cessation of HCP working with cancer patients Establish factors which repeatedly facilitate and hinder the delivery of smoking cessation interventions to cancer patients	19	2000-2016	Attitude Beliefs Care involvement	NA	NA	6
Diniz et al. 1996	Narrative review	Relate the obstacles that interfere in the communication between nurses and alcoholics	8	1970-1992	Attitude Beliefs	NA	Yes	0
Duaso et al. 2014	Systematic review and meta-analysis	Establish whether the smoking status of doctors is associated with their engagement in smoking cessation	20	1997-2012	Care involvement	NA	NA	8

Table 3 (continued)

Reference	Type of literature review	Declared aim(s)	No of studies included	Study period	Stigma assessment	Stigma prevalence	Stigma valence over time	Change in prevalence over time	Quality score
Duaso et al. 2017	Systematic review and meta-analysis	Establish whether the smoking status of nurses is associated with their engagement in smoking cessation	15	2000-2014	Care involvement	NA	NA	NA	8
Ducray et al. 2017	Systematic review	Determine how health students regard substance-using patients	16	2002-2015	Attitude	Qualitative	NA	NA	8
Flemming et al. 2016	Systematic review	Explore the barriers and facilitators to supporting smoking cessation in pregnancy and after birth from the perspective of health professionals	9	2003-2013	Beliefs Care involvement	Qualitative	NA	NA	6
Guydish et al. 2007	Systematic review	Assess smoking prevalence among drug abuse treatment staff	22	1983-2007	Attitude Beliefs Care involvement	Quantitative	NA	NA	4
Howard et al. 2000 I	Narrative review	Summarize the range of barriers to provision of nicotine dependence intervention to clients receiving addictions treatment	14	1964-1995	Attitude	Quantitative Qualitative	Yes	NA	3
Howard et al. 2000 II	Narrative review	Assess nurses' attitudes towards substance misusers	24	1964-1994	Attitude Beliefs Care involvement	Quantitative Qualitative	NA	NA	3
Howard et al. 2000 III	Narrative review	Assess nurses' attitudes towards substance misusers	30	1963-1995	Attitude Beliefs Care involvement	Quantitative	NA	NA	3
Malone et al. 2018	Systematic review and meta-synthesis	Explore the facilitators for people with mental illness to continue to smoke and the facilitators to quit smoking	15	2000-2015	Beliefs Care involvement	NA	NA	NA	6

Table 3 (continued)

Reference	Type of literature review	Declared aim(s)	No of studies included	Study period	Stigma assessment	Stigma prevalence	Evolution of stigma prevalence over time	Quality score
Okoli et al. 2010	Narrative review	Summarize research studies that address the current state of practice as well as the barriers and limitations for HCPs engagement in SC interventions among pregnant smokers	29	1990-2008	Care involvement	NA	NA	4
Rush et al. 1994	Narrative review	Review the opinions, attitudes, beliefs, perspectives of general practitioners toward alcohol and patients with alcohol problems.	11	1982-1992	Care involvement	Attitude Beliefs	Quantitative	Yes 3
Sheals et al. 2016	Systematic review and meta-analysis	Synthesize MHPs' attitudes towards smoking and smoking cessation among people with mental illnesses and/or substance abuse disorders	38	2004-2014	Care involvement	Attitude Beliefs	Quantitative	NA 7
Stead et al. 2009	Narrative review	Explore European GPs' engagement in smoking cessation, and the factors and barriers that influence their engagement in smoking cessation	56	1990-2007	Care involvement	Attitude Beliefs	Quantitative Qualitative	Yes 3
Van Boekel et al. 2013	Systematic review	Assess HP' attitudes towards PWA Examine factors causing negative attitudes of HP and their impact on healthcare delivery	28	2000-2011	Care involvement	Attitude Beliefs	Quantitative Qualitative	NA 7
Vogt et al. 2005	Systematic review	Estimate the proportion of GPs and family physicians (FPs) with negative beliefs and attitudes towards discussing smoking cessation with patients.	20	1988-2004	Attitude Beliefs	Quantitative	NA	6

Abbreviations : FPs family physicians, HPs health professionals, MHPs mental health professionals, NA not applicable

Categories of quality were determined as follows : low (score 0 to 3), medium (score 4 to 7), and high (score 8 to 11) (Canadian Agency for Drugs and Technologies in Health 2011)

Table 4

HPs' characteristics (professional category, specialty work setting, PWA's characteristics (addiction type, comorbidity), and HPs' or PWA's characteristics associated with HPs' attitude (addiction training, age, education level, gender, HP's beliefs, personal experience, professional category, specialty work setting, structural factors, work experience with PWA, addiction type and addiction intensity, addiction vs. other diseases, comorbidity of PWA, criminal record)

<i>Reference</i>	<i>Professional category</i>	<i>Specialty work setting</i>	<i>HPs' characteristics associated with their attitude towards PWA</i>	<i>Addiction type</i>	<i>PWA comorbidity</i>	<i>PWA</i>	<i>Associated with attitude of health professionals toward them</i>
Bakhshi et al. 2014	Doctors, nurses, pharmacists, dentists, midwives, nursing assistants, medecine students	Antenatal care center, emergency, gynaecology, paediatric, pharmacy, primary care	Addiction training, personal experience	Alcohol	NR	NA	
Chandramoorthy et al. 2015	Nurses, nursing students	NR	Addiction training, personal experience, structural factors	Tobacco	NR	NA	
Conlon et al. 2017	Cancer center directors, doctors, nurses	Oncology, otolaryngology, radiotherapy	Addiction training, beliefs (towards PWA and addiction treatment), personal experience, structural factors	Tobacco	Cancer	Comorbidity	
Diniz et al. 1996	NR	NR	NR	NR	NR	NR	Addiction vs other disease
Duaso et al. 2014	Doctors	Cardiology, primary care, internal medicine, oncology, surgery	Personal experience, professional category	Tobacco	NR	NA	
Duaso et al. 2017	Nurses	Hospital, oncology, paediatrics, primary care, psychiatry	Personal experience	Tobacco	NR	NA	
Ducray et al. 2017	Dental, medical, midwifery, occupational therapy, paramedic or social work students	NA	Addiction training, age, education gender, level, personal experience	Alcohol Illegal substances Tobacco	NR	NR	Addiction vs other disease

Table 4 (continued)

<i>Reference</i>	<i>Professional category</i>	<i>Specialty work setting</i>	<i>HPs' characteristics associated with their attitude towards PWA</i>	<i>Addiction type</i>	<i>PWA comorbidity</i>	<i>PWA</i>	<i>PWA's characteristics associated with attitude of health professionals toward them</i>
Flemming et al. 2016	Child health support workers, dieticians, doctors, health visitors, midwives, social workers	Obstetric/gynecology	Addiction training, beliefs (towards addiction, addiction treatment), structural factors	Tobacco	Pregnancy Post partum	Addiction vs other disease Comorbidity	
Guydish et al. 2007	Counsellors, doctors, nurses, program directors, psychologists, social workers	Addiction specialized services	Addiction training, beliefs (towards PWA, addiction and addiction treatment), personal experience, structural factors, specialty work setting	Tobacco	NR	Addiction type	
Howard et al. 2000 I	Doctors, nurses, students, social workers	AIDS treatment unit, industrial medicine, public health, infectious disease units, medical-surgical units, tuberculosis sanitarium	Addiction training, age, beliefs (towards PWA, addiction and addiction treatment), education level, gender, personal experience, professional category, work experience in addiction specialty, specialty work setting	Alcohol Illegal substances	NR	Addiction type	
Howard et al. 2000 II	Doctors (psychiatrists, GPs), nurses, nurse assistants, socials workers, various students	Addiction specialized services, General medicine, medical-surgical unit, neurology Psychiatry, sanitarium,	Addiction training, age, beliefs (towards PWA, addiction and addiction treatment), education level, personal experience, professional category, specialty work setting, work experience with PWA	Alcohol Illegal substances	NR	Addiction type	
Howard et al. 2000 III	Doctors, nurses, supervisory nurses	Emergency departments	Age, beliefs (towards PWA and addiction), education level, professional category	Alcohol Illegal substances	NR	Addiction type	

Table 4 (continued)

<i>Reference</i>	<i>Professional category</i>	<i>Specialty work setting</i>	<i>HPs' characteristics associated with their attitude towards PWA</i>	<i>Addiction type</i>	<i>PWA comorbidity</i>	<i>PWA's characteristics associated with attitude of health professionals toward them</i>
Malone et al. 2018	Staff	Psychiatry	Addiction training, beliefs (towards addiction and addiction treatment), specialty work setting	Tobacco	Psychiatric disorder	NA
Okoli et al. 2010	Doctors, nurses, nurse-midwives, nutritionists, nutrition assistant, midwives, physician assistant, social workers, student midwives	Obstetric Pediatric Primary care	Addiction training, beliefs (towards PWA, addiction and addiction treatment), gender structural factors	Tobacco	Pregnancy	Comorbidity
Rush et al. 1994	Doctors	General medicine/primary care	Addiction training, age, beliefs (towards PWA and addiction treatment), gender, personal experience, structural factors, work experience with PWA	Alcohol	NR	Addiction vs other disease Addiction type
Sheals et al. 2016	Clinical directors, clinical psychologists, counselors, doctors, medical directors, nurses, nurse managers	Psychiatry Addiction specialized services	Addiction training, beliefs (towards PWA, addiction and addiction treatment), personal experience, structural factors, specialty work setting	Tobacco	Psychiatric disorder	Addiction type
Stead et al. 2009	Doctors (GPs, cardiologists, lung physicians, oncologists), nurses	Cardiology General medicine Oncology	Addiction training, age, beliefs (towards addiction treatment), gender, personal experience, structural factors	Tobacco	NR	Addiction intensity Comorbidity

Table 4 (continued)

<i>Reference</i>	<i>Professional category</i>	<i>Specialty work setting</i>	<i>HPs' characteristics associated with their attitude towards PWA</i>	<i>Addiction type</i>	<i>PWA comorbidity</i>	<i>PWA's characteristics associated with attitude of health professionals toward them</i>
Van Boekel et al. 2013	Doctors, nurses, residents, social worker practitioners, ward managers	Anesthesiology Primary care Psychiatry Addiction specialized services	Addiction training, beliefs (towards PWA, addiction and addiction treatment), education level, personal experience, professional category, structural factors, specialty work setting, work experience with PWA	Alcohol Illegal substances	HIV HCV Psychiatric disorder	Addiction vs other disease Addiction intensity Criminal record Comorbidity
Vogt et al. 2005	Doctors	General medicine/primary care	Beliefs toward addiction treatment	Tobacco	NR	NA

Abbreviations : GPs general practitioners, HCV hepatitis C virus, HIV human immunodeficiency virus, HPs health professionals, NA not applicable, NR none reported

Table 5

Characteristics and prevalence of stigma of PWA by HPs (general attitude, health professionals' beliefs towards PWA, addiction and addiction treatment)

<i>Expression of stigma</i>	<i>Quantitative and/or qualitative prevalence</i>	<i>References</i>
General attitude		
Negative	A third of nurses Towards 23 % of patients « generally» « consistently » « many nurses » « generally»	(Howard and Chung 2000a; Van Boekel et al. 2013) (Ducray and Pilch 2017; Howard and Chung 2000a; Van Boekel et al. 2013) (Van Boekel et al. 2013)
Positive	Up to 80 % « often » « the most frequently » « many nurses »	(Howard and Chung 2000a) (Howard and Chung 2000a; Van Boekel et al. 2013) (Howard and Chung 2000a)
Manipulative, aggressive		
Violent	From 27% to 59%; « a majority of nurses »	(Guydish et al. 2007; Howard and Chung 2000a; Sheals et al. 2016)
HPs' beliefs toward PWA		
Uncooperative, not honest, very demanding	From 37% to 55%	(Howard and Chung 2000b)
Antisocial	25 %	(Howard and Chung 2000b)
Threat to society	From 43% to 46%	(Howard and Chung 2000a)
Disease model	« most nurses»; from 2/3 to 74%	(Howard and Chung 2000a,b)
Moral or spiritual model	1/5 of physicians, 1/3 of nurses	(Howard and Chung 2000b)
Character weakness	From 20% to 26%	(Howard and Chung 2000b)
HPs' towards addiction	Approximately 20%	(Howard and Chung 2000b)
Themselves to blame	From 14% to 17%	(Guydish et al. 2007)
Helpful to patients		
Helpful to therapeutic relationship	From 13% to 33,5 %	(Guydish et al. 2007; Sheals et al. 2016)

Table 5 (continued)

<i>Expression of stigma</i>	<i>Quantitative and/or qualitative prevalence</i>	<i>References</i>
Negative attitude	40,5 %	(Sheals et al. 2016)
Not a priority	26,5 %	(Sheals et al. 2016)
To delay	25 %	(Guydish et al. 2007)
Quitting smoking is too much	38 %	(Sheals et al. 2016)
To treat like other SUD	71 %	(Guydish et al. 2007)
Negative impact on recovery from other SUD / psychiatric symptoms	From 18% to 47%	(Guydish et al. 2007; Sheals et al. 2016)
Fear of negative impact on professional-patient relationship	« many professionals »	(Flemming et al. 2016)
Ineffective	From 27% to 38%	(Sheals et al. 2016; Vogt et al. 2005)
Difficult	38 %	(Stead et al. 2009)
Enjoying	35 %	(Stead et al. 2009)
Unpleasant	18 %	(Vogt et al. 2005)
Too time-consuming	42 %	(Vogt et al. 2005)
Not professionals' role	From 5% to 18 %	(Sheals et al. 2016; Vogt et al. 2005)
Not psychiatric services' role	17,4 %	(Sheals et al. 2016)

Table 5 (continued)

<i>Expression of stigma</i>	<i>Quantitative and/or qualitative prevalence</i>		<i>Références</i>
Requires patient motivation	50 %		(Howard and Chung 2000a)
Motivating	From 18% to 39%		(Howard and Chung 2000b; Rush et al. 1994)
Discouraging and hopeless	About 50%		(Howard and Chung 2000a)
Dissatisfied	48 %		(Howard and Chung 2000a)
HPs' beliefs towards addiction treatment	Satisfied Effective Ineffective	29 % « generally » « generally »	(Rush et al. 1994) (Howard and Chung 2000a) (Howard and Chung 2000b)
Rewarding	19 %		(Howard and Chung 2000a)
Optimism regarding treatment	79 % « a majority » « larger proportions »		(Howard and Chung 2000b)

Abbreviations : AUD alcohol use disorder, HPs health professionals, PWA people with addiction, SUD substance use disorder TUD tobacco use disorder

Table 6

Association between HPs' characteristics and HPs' attitude towards PWA (age, addiction training, gender, health professionals' beliefs towards PWA-addiction treatment, level of education, personal experience, professional category, specialty work setting, structural factors, work experience with PWA)

HPs' characteristics	HPs' attitude	References
Addiction training	Received	(Bakhshi and While 2013; Ducray and Pilch 2017; Guydish et al. 2007; Howard and Chung 2000a,b; Okoli et al. 1994; Stead et al. 2009; Van Boekel et al. 2013)
	Lacking	(Chandrankumar and Adams 2015; Conlon et al. 2017; Flemming et al. 2016; Guydish et al. 2007; Malone et al. 2018; Okoli et al. 2010; Sheals et al. 2016)
	No association	(Stead et al. 2009)
Personal experience (personal/family history of addiction or psychiatric disorder)	Positive	(Chandrankumar and Adams 2015; ; Ducray and Pilch 2017; Duaso et al. 2014; Howard and Chung 2000b; Van Boekel et al. 2013)
	Negative	(Bakhshi and While 2013; Conlon et al. 2017; Duaso et al. 2014, 2017; Ducray and Pilch 2017; Guydish et al. 2007; Howard and Chung 2000b; Sheals et al. 2016; Stead et al. 2009)
	No association	(Bakhshi and While 2013; Ducray and Pilch 2017; Guydish et al. 2007; Stead et al. 2009)
Work experience with PWA	Strong	(Howard and Chung 2000b; Rush et al. 1994; Van Boekel et al. 2013)
	Positive	(Rush et al. 1994)
	Negative	(Conlon et al. 2017; Guydish et al. 2007; Okoli et al. 2010; Van Boekel et al. 2013)
HPs' beliefs towards PWA		

Table 6 (continued)

<i>HPs' characteristics</i>	<i>HPs' attitude</i>	<i>References</i>
Medical chronic disease model	Positive	(Howard and Chung 2000a)
Moral model	Negative	(Howard and Chung 2000a,c; Van Boekel et al. 2013)
Reward for good behaviour	Negative	(Malone et al. 2018)
Help to regulate mental illness symptoms/stresses	Negative	(Flemming et al. 2016; Malone et al. 2018; Okoli et al. 2010)
Optimism	Positive	(Bakhshi and While 2013; Howard and Chung 2000a)
Perceived effectiveness, reward	Positive	(Rush et al. 1994)
Perceived usefulness	Positive	(Bakhshi and While 2013; Conlon et al. 2017)
HPs' role not perceived	Negative	(Conlon et al. 2017; Okoli et al. 2010)
Unrewarding	Negative	(Stead et al. 2009)
Pessimism regarding problem drinkers' prognoses	Negative	(Howard and Chung 2000b)
Fear of ineffectiveness	Negative	(Okoli et al. 2010; Rush et al. 1994)
Fear of inducing guilt or stress	Negative	(Conlon et al. 2017; Okoli et al. 2010; Stead et al. 2009)
Fear of weakening professional-patient relationship	Negative	(Flemming et al. 2016; Malone et al. 2018; Okoli et al. 2010; Stead et al. 2009)
Negative past experiences	Negative	(Malone et al. 2018)

Table 6 (continued)

	<i>HPs' characteristics</i>	<i>HPs' attitude</i>	<i>References</i>
Professional category	Nurses vs supervisory nurses	Positive	(Howard and Chung 2000c; Van Boekel et al. 2013)
	Nurses vs nurse-assistants	Positive	(Howard and Chung 2000b)
	Nurses vs doctors, psychologists, social workers	Negative	(Howard and Chung 2000a,b)
Specialty work setting	Psychiatry vs primary care	Positive	(Howard and Chung 2000b)
		Positive	(Guydish et al. 2007; Howard and Chung 2000b; Van Boekel et al. 2013)
	Specialized addiction services	Negative	(Guydish et al. 2007; Sheals et al. 2016)
Education level	Specialist doctors (not in addictology) vs not specialist doctors	Positive	(Duaso et al. 2014)
	Psychiatry	Negative	(Malone et al. 2018; Sheals et al. 2016)
	Forensic psychiatry services vs general psychiatry services	Negative	(Van Boekel et al. 2013)
AIDS treatment unit	AIDS treatment unit vs infectious disease unit or medical-surgical unit	Positive	(Howard and Chung 2000b)
	High	Negative	(Howard and Chung 2000a,b; Van Boekel et al. 2013)
	Low	Negative	(Howard and Chung 2000a,c)
	Inconsistent		(Ducray and Pilich 2017)

Table 6 (continued)

<i>HPs' characteristics</i>		<i>HPs' attitude</i>	<i>References</i>
Structural factors	Number of patient consultations for AUD	Positive	(Rush et al. 1994)
	Treating fewer patients per week	Positive	(Van Boekel et al. 2013)
	Existence of local smoking cessation services	Positive	(Stead et al. 2009)
	Lack of time	Negative	(Chandrakumar and Adams 2015; Conlon et al. 2017; Guydish et al. 2007; Okoli et al. 2010; Rush et al. 1994; Sheals et al. 2016; Stead et al. 2009, Van Boekel et al. 2013)
	High caseload	Negative	(Guydish et al. 2007)
	No protocol or procedure	Negative	(Flemming et al. 2016; Okoli et al. 2010)
	Understaffing	Negative	(Flemming et al. 2016; Guydish et al. 2007)
	Low role support	Negative	(Van Boekel et al. 2013)
	Old	Positive	(Ducray and Pilch 2017)
	Young	Positive	(Howard and Chung 2000a,b,c; Rush et al. 1994)
Gender	Women vs men	No association	(Ducray and Pilch 2017; Stead et al. 2009)
	Men vs women	Positive	(Ducray and Pilch 2017; Howard and Chung 2000a)
		Positive	(Howard and Chung 2000a; Rush et al. 1994)
		No association	(Ducray and Pilch 2017; Okoli et al. 2010; Stead et al. 2009)

Abbreviations: AUD alcohol use disorder, HPs health professionals, PWA people with addiction

Table 7
Association between PWA's characteristics and HPs' attitude towards PWA (addiction vs other diseases, addiction type, addiction intensity, comorbidity, criminal record)

	<i>PWA's characteristics</i>	<i>HPs' attitude</i>	<i>References</i>
Addiction vs other diseases			(Diniz and Caron Ruffino 1996; Ducray and Pichl 2017; Howard and Chung 2000b,c; Rush et al. 1994; Van Boekel et al. 2013)
TUD vs AUD		Positive	(Rush et al. 1994)
TUD vs other SUD		Positive	(Howard and Chung 2000b)
		Negative	(Guydish et al. 2007; Howard and Chung 2000b; Sheals et al. 2016)
Addiction type			
ISUD vs AUD		Negative	(Howard and Chung 2000b,c)
High vs low (TUD)		Positive	(Stead et al. 2009)
Recovery vs relapse		Negative	(Van Boekel et al. 2013)
Psychiatric disorder		Negative	(Van Boekel et al. 2013)
Comorbidity	Pregnancy	Negative	(Flemming et al. 2016; Okoli et al. 2010; Stead et al. 2009)
	Cancer	Negative	(Conlon et al. 2017)
Criminal record			
		Negative	(Van Boekel et al. 2013)

Abbreviations: AUD alcohol use disorder, HPs health professionals, ISUD illegal substance use disorder, PWA people with addiction, TUD tobacco use disorder

Table 8
Evolution of stigma of PWA by health professionals prevalence over time

<i>Change in prevalence overtime</i>	<i>References</i>
Persistence of negative attitudes	(Diniz and Caron Ruffino 1996)
Improvement of attitudes	(Howard and Chung 2000a; Rush et al. 1994; Stead et al. 2009)

Abbreviations: PWA people with addiction

SERMENT D'HIPPOCRATE

“Au moment d’être admis à exercer la médecine, je promets et je jure d’être fidèle aux lois de l’honneur et de la probité.

Mon premier souci sera de rétablir, de préserver ou de promouvoir la santé dans tous ses éléments, physiques et mentaux, individuels et sociaux.

Je respecterai toutes les personnes, leur autonomie et leur volonté, sans aucune discrimination selon leur état ou leurs convictions. J’interviendrai pour les protéger si elles sont affaiblies, vulnérables ou menacées dans leur intégrité ou leur dignité. Même sous la contrainte, je ne ferai pas usage de mes connaissances contre les lois de l’humanité.

J’informerai les patients des décisions envisagées, de leurs raisons et de leurs conséquences.

Je ne tromperai jamais leur confiance et n’exploiterai pas le pouvoir hérité des circonstances pour forcer les consciences.

Je donnerai mes soins à l’indigent et à quiconque me les demandera. Je ne me laisserai pas influencer par la soif du gain ou la recherche de la gloire.

Admis dans l’intimité des personnes, je tairai les secrets qui me seront confiés. Reçu à l’intérieur des maisons, je respecterai les secrets des foyers et ma conduite ne servira pas à corrompre les moeurs.

Je ferai tout pour soulager les souffrances. Je ne prolongerai pas abusivement les agonies. Je ne provoquerai jamais la mort délibérément.

Je préserverai l’indépendance nécessaire à l’accomplissement de ma mission. Je n’entreprendrai rien qui dépasse mes compétences. Je les entretiendrai et les perfectionnerai pour assurer au mieux les services qui me seront demandés.

J’apporterai mon aide à mes confrères ainsi qu’à leurs familles dans l’adversité.

Que les hommes et mes confrères m’accordent leur estime si je suis fidèle à mes promesses ; que je sois déshonoré et méprisé si j’y manque.”

RÉSUMÉ

Contexte: La stigmatisation des personnes avec addiction est un phénomène ancien, partagé par la population générale, les professionnels de santé et les patients eux-mêmes. Notre objectif était d'examiner la stigmatisation des personnes avec addiction par les professionnels de santé, sa prévalence, ses caractéristiques, et son évolution.

Méthode: Nous avons réalisé une revue focalisée des connaissances. Une recherche systématique à partir des bases de données PubMed, Scopus et PsycINFO a ciblé exclusivement les revues de la littérature.

Résultats: À partir des 19 revues sélectionnées, il apparaît que 20 à 60% des professionnels avaient des attitudes/représentations négatives de l'addiction. Une formation en addictologie et une pratique clinique au contact des personnes avec addiction étaient associées à une attitude moins négative. À l'inverse, les représentations négatives des soignants, le manque de temps et de soutien dans la pratique étaient associés à une moindre implication dans le soin. Une addiction au tabac, à des substances illégales, une rechute, une comorbidité ou un antécédent judiciaire étaient associés à une attitude plus négative. L'influence de plusieurs variables était inconstante (expérience personnelle, catégorie professionnelle, âge, sexe, niveau d'études). L'évaluation de l'évolution de la stigmatisation semblait montrer une diminution des attitudes négatives entre les années 60 et les années 2000.

Conclusion: La stigmatisation persiste et peut s'expliquer par différentes variables, sur lesquelles il serait possible d'agir: modèle moral de l'addiction, représentations négatives des professionnels, manque de formation, de temps, et de soutien dans la pratique. Enseigner l'addictologie selon un modèle médical de maladie chronique, et faire de la stigmatisation un objet spécifique de formation, pourrait permettre aux soignants d'améliorer leur attitude et rester fidèles aux principes fondamentaux de la déontologie médicale.

Stigma of people with addiction by health professionals: current knowledge. A scoping review

Background: Stigma of people with addiction (PWA) is a long-known phenomenon, shared by general population, health professionals and patients themselves. Our aim was to assess the stigma of PWA by health professionals, its characteristics and its evolution.

Methods: We chose to conduct a scoping review of the literature. A systematic search of PubMed, Scopus and PsycINFO databases targeted only literature reviews.

Results: From the 19 selected reviews, it appears that 20% to 60% health professionals had negative attitudes/beliefs about addiction. Addiction training and clinical experience with PWA were associated with a less negative attitude. Health professionals' negative beliefs, lack of time or support were associated with less involvement in addiction care. A tobacco use disorder (TUD), illegal substance use disorder (ISUD), a relapse, a comorbidity or a criminal record were associated with a more negative attitude. The influence of several variables was inconsistent (personal experience, professional category, age, gender, education level). Evaluation of stigma changes over time seemed to show a decrease in health professionals' attitudes between the 1960s and the 2000s

Conclusions: Stigmatization of PWA by health professionals persists, and some variables that contribute to this trend could be changed: moral model of addiction, health professionals' negative beliefs, lack of training, time, and role support. Teaching addiction specialty according to a medical model of chronic disease, and developing stigma-focused training, could enable caregivers to improve their attitude and remain faithful to the fundamental principles of medical deontology.

Mots-clés : Stigma, Attitude of health personnel, Beliefs, Health professionals, Substance use disorder, Addiction

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