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# Acceptance and Commitment Therapy-Based Intervention to Manage Stigma toward Substance use Disorders

## *Intervenção baseada na Terapia de Aceitação e Compromisso para Manejo do Estigma relacionado aos Transtornos por uso de Substâncias*

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## Abstract

**Objective**
Stigma of health service professionals toward people with substance use disorders seriously compromises quality of care. A worldwide agenda points out how crucial it is to invest in evidence-based interventions to address stigma. This study aimed to describe the development process of an innovative intervention protocol to manage stigma based on Acceptance and Commitment Therapy.

**Method**
This is an empirical qualitative study. Phase 1: Guiding axes from evidence-based literature to define the active components. Phase 2: Protocol preliminary version and reporting based Template for Intervention Description and Replication guide. Phase 3: Expert judges to assess the first step of the content validation.

**Results**
We present 10 active components we achieved through a 12-hour face-to-face intervention, evaluated by expert judges.

**Conclusion**
This intervention is notable in terms of its coverage, accuracy, and suitability for health service professionals, and seems promising to be implemented for testing and replication.

**Keywords**: Delivery of health care; Health personnel; Psychosocial intervention; Social stigma; Substance-related disorders.

## Resumo

### Objetivo

*O estigma dos profissionais dos serviços de saúde direcionado às pessoas com transtornos por uso de substâncias compromete seriamente a qualidade do cuidado. Uma agenda mundial aponta como é fundamental investir em intervenções baseadas em evidências para lidar com o estigma. Este estudo teve como objetivo descrever o desenvolvimento de um protocolo de intervenção inovador para manejo do estigma baseado na Terapia de Aceitação e Compromisso.*

### Método

*Este é um estudo empírico qualitativo. Fase 1: eixos norteadores da literatura baseada em evidências para definir os componentes ativos. Fase 2: versão preliminar do protocolo e apresentação baseada no Template for Intervention Description and Replication. Fase 3: juízes especialistas para validação de conteúdo.*

### Resultados

*Apresentamos 10 componentes ativos contemplados por meio de uma intervenção presencial de 12 horas, avaliada por juízes especialistas.*

### Conclusão

*Esta intervenção mostrou-se notável em termos de cobertura, acurácia e adequação para profissionais de saúde e promissora para implementação e replicações.*

**Palavras-chave**: *Atenção à saúde; Pessoal de saúde; Intervenção psicossocial; Estigma social; Transtornos relacionados ao uso de substâncias.*

Public stigma consists of prejudice and discrimination when people systematically endorse negative stereotypes about a specific group (Corrigan, Schomerus, Smelson, 2017) and is related to different health conditions. It is one of the most severe obstacles faced by many people globally, having been well documented over the past decades (Stangl et al., 2019; United Nations Office on Drugs and Crime [UNODC], 2019). When compared to others, the stigma related to Substance Use Disorders (SUDs) is even more accentuated (Crapanzano et al., 2018; Silveira et al., 2018). Among the numerous negative consequences for people with this condition are psychological, social, family, and professional difficulties, low adherence to treatment in general and specialized health, high rates of incarceration, and loss of fundamental rights, which in turn are also linked to social and racial aspects (Avery, 2019; Corrigan, Schomerus, Smelson, 2017).

This scenario is further aggravated as far as studies have shown that these attitudes are often linked to health professionals' negative perceptions about prognosis, choice of treatments, and beliefs about how real the health condition is. Besides, they can compromise the therapeutic relationship, empathy, and personalization of treatment. The quality of care, therefore, declines substantially (Avery, 2019).

New public actions and agendas are necessary and urgent, considering the challenges that this reality represents to health, well-being, social security, safety, and sustainability (Corrigan, Schomerus, Shuman, et al., 2017; UNODC, 2019). Therefore, it is essential to plan and make feasible the implementation of interventions to minimize the indicators of stigma toward people with SUDs focusing, above all, on professionals working in health services (Nyblade et al., 2019).

The literature has broadly pointed out some strategies to address the issue of stigmatization: contact and familiarity (Knaak et al., 2014), education and knowledge ( Corrigan, Schomerus, Shuman, et al., 2017; Gronholm et al., 2017), and protest and advocacy (Corrigan, Schomerus, Shuman, et al., 2017). Recently, some systematic review studies have mapped the strategies used to reduce stigma and examined the evidence of their effects related to different conditions and populations (Rao et al., 2019), including specifically related to drug use (Tostes et al., 2020).

There was no overwhelming evidence for the effectiveness of the strategies used, although some positive indicators were observed in studies that used multilevel interventions, combining individual, interpersonal, community, and structural aspects (Rao et al., 2019). Added to this is that methodological problems remain a significant obstacle to evaluating results in the studies identified (Rao et al., 2019; Tostes et al., 2020). Questions like these point to how fundamental it is to invest in evidence-based interventions and to be diligent to report the procedures and results (Hoffmann et al., 2014).

Considering such gaps, we propose an innovative intervention to minimize the impact of stigma on people with SUDs. The use of Acceptance and Commitment Therapy & Training (ACT) stands out as an integrating perspective for the intervention protocol and one of its central guiding axes (Hayes et al., 2004; Varra et al., 2008). The ACT is one of the "third wave of cognitive behavioral therapies". It is based on contextual concepts and emphasizes individuals' relationship with emotions and thoughts rather than their contents, aiming to promote behavioral and mental health, as well as psychological flexibility (Hayes & Hoffman, 2017). Some ACT-based studies have already been conducted to reduce stigma, showing good indicators (Hayes et al., 2004; Krafft et al., 2018; Masuda et al., 2012).

This protocol was developed by selecting the active components that we believed to be important from evidence-based interventions. We also defined these active components considering the objectives to be achieved from them in the field of substance use disorders. The detailed presentation is aligned with the search for "unpacking the black box" in the process of investigating the effects of an intervention, as a first step. In the literature related to interventions, especially those involving behaviors, "unpacking the black box" refers to the attempt to face criticism about the low frequency with which active ingredients are adequately specified in studies. There is also a propensity to consider the identification of improvements as a sufficient result, without understanding and evaluating well the process that gave rise to these changes (Ramaswamy et al., 2018). Therefore, this study aimed to describe the development process of an innovative intervention protocol to manage stigma based on Acceptance and Commitment Therapy.

## Method

This is an empirical qualitative study focused on the theoretical development of the active components that underlies the proposed intervention. It is based on the consistent call for interventions constructed with more specific details and more consistent in terminology (Michie et al., 2018). We did not intend or perform the effectiveness assessment, even though this is an important next step we considered as relevant to understand the core active components that are supposed to generate some effect (Donabedian, 1990).

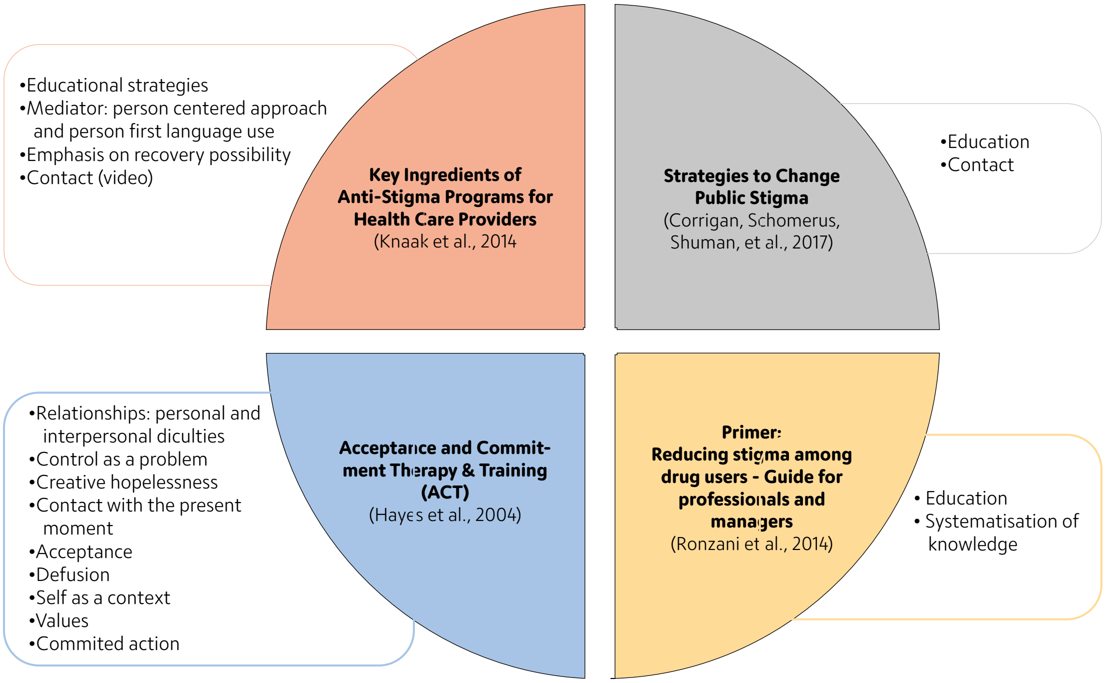
In a summarized way, in this study we delimited four guiding axes based on the literature review, so that we could select and define the active components that would be part of the intervention (Phase 1). To reach these active components, we proposed activities structured in a protocol applied to pilot groups. We reported the intervention using a consolidated scientific guide (Phase 2). To assess theoretically if the activities were indeed able to contemplate these active components, we presented the protocol to the expert judges for content validation (Phase 3).

This study was approved by a Human Subjects Committee and followed all ethical parameters (Universidade Católica de Petrópolis - CAAE: 75747617.5.1001.5281).

## Phase 1 – Delimitation of the Guiding Axes from Evidenced-Based Literature to Define the Active Components

Theoretical and empirical references were adopted based on an extensive literature review on stigma. Four axes were selected to guide the protocol development process and the definition of the active components, specifically in the context of SUDs and stigmatization process. The axes are sets of strategies established in the literature of stigma and which have already demonstrated prior evidence of effectiveness: 1) Key Ingredients of Anti-Stigma Programs for Health Care Providers (Knaak et al., 2014); 2) Strategies to Change Public Stigma (Corrigan, Schomerus, Shuman, et al., 2017); 3) Primer: Reducing stigma among drug users - Guide for professionals and managers (Ronzani et al., 2014); 4) Acceptance and Commitment Therapy & Training (ACT) (Hayes et al., 2004; Varra et al., 2008) (Figure 1).

**Figure 1**
*Guiding axes for the intervention protocol development*



## Phase 2 – Development of the Protocol Preliminary Version and Reporting Based on the TIDieR Guide

To contemplate and reach the active components (Phase 1), we proposed activities structured in a protocol and applied to pilot groups. We chose to report the intervention using the Template for Intervention Description and Replication (TIDieR), to ensure that the relevant data to characterize the intervention were adequately described with potential to be replicated (Hoffmann et al., 2014). The intervention mediating researchers took courses with Brazilian therapists specialized in the ACT. For contextual adaptation concerning language, understanding, and feasibility, pilot groups were made up predominantly of psychologists and students, accompanied by local researchers' presence for adjustments.

## Phase 3 – Evaluation of Expert Judges for Content Validation

We also carried out a first step of the content validation (Polit, 2015), through the consecrated method of qualitative evaluation carried out by expert judges (Souza et al., 2017). Three ACT experts with experience in the clinical, supervisory, research, and training context were invited as independent judges (Polit, 2015). The evaluation process was carried out online using an electronic form developed in the Qualtrics software. In this form, general information about the study, the context that justifies its realization, the guiding axes, the active components, and other resources used in Phases 1 and 2 were entirely presented. Regarding the evaluation, general and specific instructions were provided to detail the tasks to be performed. For each of the activities/exercises described, the judges were asked to assess whether and which active components were covered, how accurate they were, and how appropriate they were to healthcare professionals' target audience. Blank spaces for suggestions and comments were also made available.

# Results

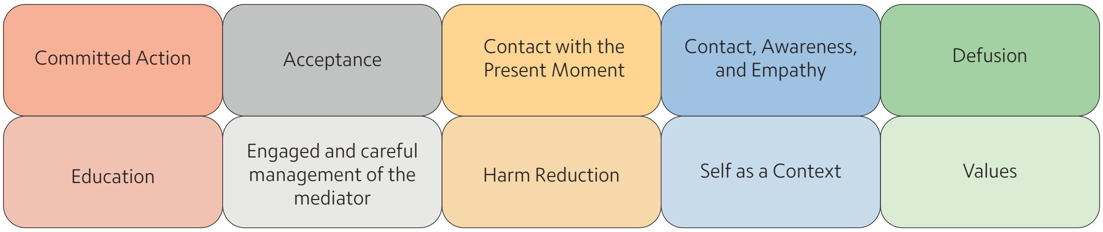
The results are presented according to the active components defined through the intervention protocol development, and to the preliminary version described according to the TIDieR guide and checklist. Finally, to the evaluation of this specific version by the expert judges.

## Active Components

Figure 2 shows the ten active components proposed, which will be defined in sequence together with the desired objectives in the context of the stigma of health service professionals and related to SUDs.

**Figure 2**

*Ten active components defined for the intervention protocol*



| | | | | |
|---|---|---|---|---|
| Committed Action | Acceptance | Contact with the Present Moment | Contact, Awareness, and Empathy | Defusion |
| Education | Engaged and careful management of the mediator | Harm Reduction | Self as a Context | Values |

*Committed Action (1)*: is the behavior consistent with the individual's values. Grounded on the understanding that it is important to regulate behavior based on these values, the committed action is the path to be taken. Therefore, it shows behavioral patterns that allow living the responsibility for actions daily, through objective and concrete goals in the short, medium, and long term. In this process, consistency between behavioral patterns and values must be assessed on an ongoing basis. Professionals who have the value of providing adequate care need to persist in acting committed to it. Working on this process can operate as a facilitating mechanism for the professional to remain, review or start to take an action committed to the value, even though she or he may encounter unpleasant public and hidden events in their professional contact with people with SUDs. Even though difficult thoughts and feelings appear in this contact, the behaviors when coherent with the values and not with these unpleasant events, tend to achieve a quality care (Hayes et al., 2016; Westrup & Wright, 2017).

*Acceptance (2)*: is to receive situations as they arise and with the thoughts and emotions they produce. It is an active disposition to perceive and allow psychological responses without trying to suppress or avoid them. Acceptance is the voluntary adoption of an intentional, receptive, flexible, and non-judgmental opening attitude in the experience of each moment. Part of the process includes understanding that it is more viable to consider the emotions and thoughts labeled "negative" as "natural". However, it is an unconventional approach, insofar as our culture and some aspects of mental health action suggest that people can control thoughts and emotions, although most of the time, the evidence does not demonstrate this practical ability. In contact with people with SUDs, various emotions often arise, often being judged as negative and subject to suppression attempts. Anxiety, euphoria, anger, frustration, and pity come to the fore, guiding the care offered by professionals, sometimes discriminatory, authoritarian, condescending, and/or superficial. Working on acceptance with professionals can favor the gradual abandonment of unnecessary struggle to control these emotions and thoughts, aggravating even more emotional and cognitive discomfort (Hayes et al., 2016; Masuda et al., 2012).

*Contact Present Moment (3)*: is to be as fully aware as possible of the events that are happening at the moment, realizing the circumstances to enable more effective behaviors. It is to identify the experience of being here and now, acknowledging that the behavior occurs only in the present moment, not in the past or the future. For health professionals, getting in touch with the present moment can help them to connect with the experience of being present for someone who is in the service searching for welcoming and care. It can promote greater resilience in difficult situations and crises with people with SUDs, in which difficult thoughts and emotions appear, but can be perceived and observed without compromising the flow of committed actions. In addition to these benefits, working with the present moment can reduce anxiety, tension, and fatigue symptoms, and enhance interpersonal relationships (Hayes et al., 2016).

*Contact, Awareness, and Empathy (4)*: contact with another person (face to face, video, report) can challenge and contest previous judgments, assumptions, and generalizations disseminated by other people or by our own experiences. Specifically in the context of people with SUDs, when this contact is positive and sensitizing, it can reduce the desire for social distance and facilitate a genuine approach. Especially for health professionals who are faced with situations of intense vulnerability and severe consequences of use, working on contact, awareness, and empathy are essential parts of the assistance. It creates greater opportunity to openly know the stories of the people who are there, sharing many of the most challenging moments and emotions of their lives, such as dependence, pain, guilt, misery, hunger, abuse, and violence suffered and practiced. It allows professionals to see individuals with difficulties and qualities beyond SUDs and understand the relationship between the barriers they must deal with these people at work and similar barriers in their personal lives (Corrigan, Schomerus, Shuman, et al., 2017); Knaak et al., 2014; Westrup & Wright, 2017).

*Defusion (5)*: is the process of distancing between the experience and the report about it (spoken words or words like thoughts). It is the transformation of the literal function that we establish in our life history based on some events and the language we use to describe them. It is seeking to describe more and evaluate less. In other words, through defusion, there is an attempt to reduce the control of these internal events over behavior, which maximizes contact with the present experience as it presents itself. Several stigmatizing stereotypes are widespread through the undervalued labeling and categorization of people with SUDs, such as dangerous, violent, unreliable, underhanded, criminals, without character. Working the defusion with professionals allows them to recognize that they do have negative thoughts and emotions toward these people, and they often guide their professional practice literally from these internal events. They are invited to understand that context and current experience with the people they assist are often ignored and thoughts and feelings, forcefully merged with previous negative experiences and negative evaluations disseminated in the culture, become the primary source of behavior regulation (Hayes et al., 2004; Hayes et al., 2016; Masuda et al., 2012).

*Education (6)*: has as one of its purposes to replace the myths propagated about health conditions through more precise conceptions. The accumulation of systematic scientific knowledge over decades, added to the current evidence on various health conditions, supports the dissemination of adequate information, which may include symptoms, etiology, risk factors, social determinants, prognosis, and types of treatment. However, some health conditions are strongly stigmatized as SUDs. The dissemination of false information contributes to aggravate stigma, which has not manifested itself differently among health service professionals. Although they have training in other areas, they often lack education and experiences in the area of SUDs. Therefore, working on education is essential so that professionals feel technically more prepared to provide care to people with SUDs, can base their actions on data consistent with reality and on the most significant evidence, and to encourage using more appropriate and less stigmatized language. Besides, knowledge allows them to act as propagators of accurate information to the population, also promoting the use of health services to treat problems arising from SUDs (Corrigan, Schomerus, Shuman, et al., 2017; Ronzani et al., 2014).

*Engaged and careful management of the mediator (7)*: to ensure that the content, messages, and themes are addressed and reach the target audience appropriately, it is important that the mediating professional uses strategies and skills that bring him or her closer to that audience, like engaged and careful management. In the context of SUDs stigma, this management can be characterized by the enthusiasm and involvement of the mediator who uses a person-centered and first-person approach, as opposed to a perspective centered only on the pathology or stigmatized condition. Besides, engaged and careful management can be identified by creating a safe and non-hierarchical space, where feelings and thoughts can arise and be shared, welcomed, understood, accepted, and discussed without harsh judgments. When supported, professionals may be better able to reveal their reactions and negative experiences in contact with people with SUDs and more willing to work on them. Mainly because the mediators themselves, through modeling and shaping resources, will also share their own experiences and difficulties, approve initiatives by professionals to open up similarly, and reinforce the key messages that favor the minimization of stigma (Hayes et al., 2004; Knaak et al., 2014; Westrup & Wright, 2017).

*Harm Reduction (8)*: concerns a set of actions strongly supported by public health and human rights, aiming to reduce the negative consequences of using legal or illegal drugs of people who are unable or unwilling to interrupt this use. The focus then becomes prevention or harm reduction rather than the prevention of drug use. Contrary to myths that are widespread and rooted among many health service professionals, harm reduction complements other strategies that can decrease use, is not incompatible with abstinence (although recognizes that it is difficult to achieve) and seeks to protect people who use drugs from irreparable harm. It emphasizes that there is a possibility of recovery for people who use drugs and that can be more effective if the strategies consider the context, desire, and readiness to reduce the use, pattern, problematic consequences, and the role that this use has in each person's life. It allows professionals to rethink rigid and stigmatizing conceptions that abstinence is the only form of recovery, that its non-compliance is linked to lack of commitment, how much these repeated frustrations have affected the care provided, and how fundamental for adherence to treatment this care is (Hawk et al., 2017).

*Self as context (9)*: is the process of developing another notion of identity, more fluid, continuous in time, and observant of the experience itself. It occurs by moving away from concepts that end up being part of our lives, are linked to valuative adjectives, and are very rigid. The self as context or the observing self can also be understood as a self-conscious perspective over time, especially in the present moment. Working on this notion with health service professionals who deal directly and indirectly with people with SUDs is important so that when they develop a conscious "me-here-now" experience, they become more flexible in dealing with the different situations that arise and expand their performance repertoire. In this sense, the self as a context starts to present itself to these professionals as a place from which they will observe the experiences more openly, exercising empathy and communication (Hayes et al., 2016).

*Values (10)*: are desired consequences in the lives of people constructed verbally and they establish the context to define what are the essential elements behind the objectives. They differ from the objectives as far as they are not an outstanding achievement, they need to be experienced every moment. In other words, values are the course, and the objectives are the ports. Changing to questions, a person's values answer to: what do you want your life to be? What do you want your life to represent? How would you like to be remembered? For health professionals working with people with SUDs, elucidating core values is important to determine a point of orientation, through which they can always be guided to assess whether they should persist in their actions or change them toward the chosen direction. Working with values allows professionals to be open to the challenge of accepting difficult emotions and thoughts that may arise about themselves and about people with SUDs, such as disability, frustration, limitation, contempt, sadness, and anger. Clarifying these life directions allows professionals to identify whether their actions are committed to these directions (Hayes et al., 2004; Hayes et al., 2016).

## Preliminary Version Features – Template for Intervention Description and Replication (TIDieR)

Variations of more extensive versions of the protocol in duration and number of activities were tested in pilot groups, having been reduced according to feasibility concerning the time, performance, involvement, and availability of the participants. Table 1 presents the characteristics of the main elements that compose the preliminary version in a workshop format application, based on the TIDieR guide (Hoffmann et al., 2014).

**Table 1**

*Intervention reporting according to the Template for Intervention Description and Replication (TIDieR) guidelines*

1 of 2

| Items | Description |
|---|---|
| Name | ACT-based intervention to manage stigma of health service professionals toward people who use drugs |
| Why (rationale) | Stigma toward people with SUDs is one of the most pronounced (see Introduction and Method) |
| What – Materials | Computer and projector for slides, images, and videos; stereo, sheets, pens, and writing support; printed images. Large, airy, and light room with chairs. Activities prints to be done between 2nd and 3rd sessions |
| Procedures | 27 triggers activities are carried out for discussion, reflection, and reporting of experiences, based on the 10 proposed active components (see Active components). Participants must confirm in advance the availability to be in the three sessions |
| Who provided | Properly trained psychologists or healthcare providers; desirable experience in group management and introductory knowledge on ACT. Each group should have the same facilitators during the sessions |

**Table 1**

*Intervention reporting according to the Template for Intervention Description and Replication (TIDieR) guidelines*

2 of 2

| Items | Description |
|---|---|
| How (delivery) | Workshop: face-to-face, in a semicircle, and in a group context of up to 15-20 participants for greater involvement and participation |
| Where | Accessible places for the audience, provided by the service of origin or partner institutions |
| When and how much | During or after working hours (as allowed by management policies), or as agreed with participants. Approximate total duration of 12 hours divided into three 4-hour sessions and spaced for a week. 20–30-minute break in each session |
| Tailoring | The intervention is adapted to the individual, as it brings them closer to their experiences, thoughts, feelings and what they want to achieve individually. It is also geared toward the group as they recognize themselves as health service professionals with different functions, sharing the same space and being traversed by difficulties and potential |
| Modifications | Although there are time frames and formats for the three sessions and activities, variations and particularities are accepted depending on the socio-cultural context of each group, which may arise in the preparation and during the intervention. Flexibility, as one of the central concepts of ACT, must be understood as necessary and desirable if the general structure is maintained, and the active component worked |
| How well (fidelity) | A maximum of two independent observers must be present during the sessions to take notes and assess the accuracy of the intervention protocol application |

## Evaluation by the Judges: Coverage, Accuracy, and Suitability

From the preliminary version of the intervention protocol, the ACT expert judges assessed the coverage, accuracy, and suitability of the intervention to the target audience for each of the 27 activities proposed. All the 10 active components described above were covered by the activities. For added rigor, we specifically considered the data corresponding to the "highly" category for accuracy and suitability, in each of the components. This choice was justified by the intention to rethink the use of activities that were identified as capable of covering the component but did not do so in a highly accurate and suitable way to the target population by consensus among all three judges. Table 2 shows the results of this evaluation.

**Table 2**

*Number of protocol activities considered capable of covering the proposed active components in a highly accurate and suitable manner, in terms of consensus between judges*

| Active components | Coverage (Yes) | | Accuracy (Highly) | | Suitability (Highly) | |
|---|---|---|---|---|---|---|
| | 3 judges | ≥ 2 judges | 3 judges | ≥ 2 judges | 3 judges | ≥ 2 judges |
| Contact, Awareness, and Empathy | 5 | 11 | 3 | 7 | 2 | 8 |
| Acceptance | 5 | 10 | 0* | 7 | 2 | 6 |
| Defusion | 3 | 8 | 1 | 5 | 1 | 7 |
| Engaged and careful management of the mediator | 2 | 7 | 0* | 2 | 1 | 4 |
| Committed Action | 2 | 5 | 1 | 1 | 0* | 1 |
| Contact with the Present Moment | 3 | 5 | 2 | 5 | 3 | 5 |
| Education | 3 | 5 | 3 | 4 | 3 | 5 |
| Self as a Context | 1 | 3 | 0* | 1 | 0* | 1 |
| Values | 1 | 3 | 1 | 2 | 0* | 2 |
| Harm Reduction | 1 | 1 | 1 | 1 | 1 | 1 |

The results were promising and pointed out that all three judges agreed that the active components were covered through the proposed activities. In terms achieving high accuracy of the activities to the components, there was consensus among the three judges for all components except "Acceptance", "Engaged and careful management of the mediator" and "Self as a Context" although these components still obtained a high accuracy evaluation for at least one activity by two judges. In terms of achieving an assessment of high suitability of activities to components for the target audience, there was consensus among the three judges for all components except "Committed Action", "Self as Context", and "Values", although these components still obtained a high accuracy evaluation for at least one activity by two judges. These points signal the need to review what is proposed through these activities, and perhaps identify more suitable activities for this target population.

## Discussion

Attempting to deal with health service professionals' stigma toward people with SUDs has proved to be a significant challenge. It is a condition with a high degree of complexity and involves several factors. However, it is necessary to move toward better health care, more inclusive and which allows these people who already face numerous difficulties, to feel welcomed and less judged about the health condition they face (Corrigan, Schomerus, Shuman, et al., 2017; Crapanzano et al., 2018).

In this direction and based on ACT, the strategies proposed in the present intervention protocol aim to manage the stigma toward people who use drugs, considering that: (a) stigma is present in all of us, to a lesser or greater extent degree; (b) it is not something that only "others" do; (c) it is complicated to eliminate it, especially in short term; (d) it is necessary to be attentive and identify in what ways stigma has manifested itself in our daily lives; and (e) that it is important to then try to deal with it better and minimize its effect on the care we need and want to offer in health services (Hayes et al., 2004; Varra et al., 2008).

This intervention protocol achieved consensus among the judges as being capable of covering all the proposed components. From the evaluation carried out by the expert judges, it is possible to verify that at least one of the proposed activities was unanimously considered to be capable of covering each of the ten active components, and this is an important preliminary finding. Although all components were assessed as being covered through the proposed activities with maximum accuracy and suitability by two of the three judges, full consensus from all three judges was only achieved for seven of the 10 components. As such, it will be necessary to evaluate and compare these findings in practical contexts for application with official intervention groups. The impossibility of direct observation of the discussions and the content that the activities can produce in the participants' relationship presents itself as a limiting factor for the evaluation. If these activities prove to be of little benefit later in the implementation phase, they may be removed from the protocol or rethought in how they are applied.

On the other hand, some activities were considered capable of covering more than one active component, which indicates that it would be possible to plan and test a reduced version of the protocol. Changes in this sense would allow the intervention to be carried out with a shorter duration, allowing the expansion to a more significant number of specialized and primary care services, especially those that face a reduced team dynamic, limitations in training, and high demand for assistance, a reality present in numerous services around the world.

Considering these issues and the preliminary assessment results that have shown promise, a limitation and a question remains: is it possible to address all dimensions and aspects to minimize the impact of stigma? Possibly not, considering the multifaceted, psychologically complex, culturally ingrained, and sanctioned phenomenon (Corrigan, Schomerus, Smelson, 2017; Stangl et al., 2019). However, with the adoption of ACT as the intervention's guiding perspective, it is argued that cognitive and emotional changes may be possible in the medium and long term, mostly when they are oriented to individuals' values. It is what justifies taking the intervention as a possible alternative to manage stigma, not to suppress it, so that health service professionals can develop skills to deal with its presence and minimize its impact on decisions regarding healthcare provided, and on relationship and bonding they establish with the people they assist (Hayes et al., 2004; Masuda et al., 2012).

Some ACT-based studies have already been conducted to reduce stigma, showing good indicators (Hayes et al., 2004; Krafft et al., 2018; Luoma et al., 2008; Masuda et al., 2012). The present work expands this potential even further, as it involves other ingredients, knowledge, and experiences already established in the international literature in the field of stigma (Corrigan, Schomerus, Shuman, et al., 2017; Gronholm et al., 2017; Knaak et al., 2014), in addition to ACT interventions to reduce stigma (Hayes et al., 2004; Krafft et al., 2018; Masuda et al., 2012). It is also an improvement to combining and operationalizing active components concerning the desired objectives, specifically in the drugs field and with health service professionals. The daily healthcares practices are hard and make it difficult to implement some structured strategies. However, it is not impossible that through planning and adequate management of resources new training, interventions, and evaluations take place. Especially, when these strategies aim to help professionals to develop strategies to better deal with the challenges arising from the presence of stigma in their functions.

The "unpacking of the black box" of this intervention protocol (Ramaswamy et al., 2018) combined with the presentation of its main elements for application based on the TIDieR guide (Hoffmann et al., 2014) will allow the replication and evaluation not only by ACT expert judges, as in the preliminary content assessment carried out in this work, but also by other experts and researchers in the field of drugs. We are not evaluating effectiveness yet, but like any high-quality intervention study with theoretical consistency, it is crucial to go through this step of content validation.

## Conclusion

This intervention protocol has theoretical consistency on the key ingredients, some of which have already been used effectively in the mental health and substance use disorders field. In addition, the preliminary results showed a great performance regarding the experts' assessment. Therefore, this new stigma training program for professionals presents all the elements for testing and replication and seems promising to be implemented in daily healthcare practice of collaborating research centers in a multisite study.

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