Reducing stigma within pharmacy opioid agonist treatment encounters

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Reducing stigma within pharmacy opioid agonist treatment encounters (Accepted version)

Abstract

Although community pharmacies are the primary site for opioid agonist treatment (OAT) dispensing in Australia, little is known about the service experiences of consumers and pharmacists. This study aimed to explore how OAT consumers experienced social inclusion and stigma in this setting, and how pharmacists can dispense OAT in ways that minimise perceived, enacted, and felt stigma. Semi-structured interviews were undertaken with fifteen consumers and ten pharmacists in New South Wales, between 2021 and 2022. Questions explored perceptions and experiences in OAT pharmacy dispensing, and findings were thematically analysed. Consumers described being subjected to pervasive stigma in their lives, and OAT stigma had harmful impacts on their perceptions, behaviours, and sense of self. Within the pharmacy, consumers aligned dismissive or discriminatory practices with negative perceptions of the treatment and poor relationships with pharmacists. Pharmacists were aware of possible stigma impacts in OAT dispensing and spoke of making efforts to better understand the hardships that consumers face, uphold privacy, and demonstrate a caring approach—characteristics identified by consumers as being very helpful. While the pharmacy was considered to be a site of social acceptance and support for many, at times it also reinforced perceptions of stigma and social exclusion. More awareness of stigmatising behaviours and stigma effects may assist pharmacists in making the pharmacy environment and their service processes equitable, person-centred, and empowering.

Keywords: opioid agonist treatment; community pharmacy; qualitative research; stigma; methadone
Health impact statement

Opioid agonist treatment (OAT) is a medication program that helps people who have developed a tolerance to opioid drugs to maintain their health and wellbeing. OAT consumers can feel that they are treated poorly when accessing their medication, which is experienced as stigma. This study interviewed pharmacists who deliver OAT and people who access OAT to investigate their experiences of this treatment service. It found that OAT consumers experienced less stigma when their pharmacist was understanding and sensitive to their life circumstances, communicated in supportive ways, upheld their privacy, and did not treat them differently to other pharmacy customers.
Reducing stigma within pharmacy opioid agonist treatment encounters

Stigma refers to the processes by which individuals and groups are devalued and social inequalities are reproduced (Addison et al., 2022). Link and Phelan (2001, p.382) define stigma as “when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold.” Using this definition, the experience of stigma is contingent on the ways that power is held and exercised within particular settings, between individuals and through the cultural, structural, and institutional systems that are operating. Stigma can be perceived (i.e., identified or expected), enacted (e.g., expressed through dismissive behaviours or discriminatory rules), internalised (i.e., produce negative feelings and self-concepts); and it can operate interpersonally (i.e., in social interactions), publicly (i.e., as a common and normative attitude), or structurally (i.e., within cultural or institutional policies and practices) (Addison et al., 2022). In social encounters, stigma can be felt without any deliberate actions or intentions from those present as stigma-related cognitions and behaviours, like other thoughts and actions, are usually automatic, preconscious, culturally learned, and implicitly operating within social structures and environments (Devine, 1989; Kaiser et al., 2006; Major & O’Brien, 2005). Using these understandings, this research investigates how stigma is experienced within pharmacies by people accessing opioid agonist treatment (OAT) services.

Opioid agonist treatment refers to the medically monitored consumption of long-acting opioid medications, currently provided as methadone or buprenorphine formulations. It is an effective and commonly prescribed program for reducing illicit or non-prescribed opioid use and
related mortality (Burns et al., 2009; Pearce et al., 2020; Sordo et al., 2017). Since the expansion of OAT provision in the 1980s, half of all OAT dispensing in New South Wales (NSW), is now performed in community pharmacies (Australian Institute of Health and Welfare, 2022; Caplehorn & Batey, 1992). Treatment with oral OAT medications (usually requiring daily consumption) involves prescriber initiation, monitoring, and ongoing script authorisation; the medications are accessed at varying frequencies (from daily to monthly) and mostly involve some level of supervised consumption with other doses provided as takeaways (NSW Ministry of Health, 2018). At the time of this study, pharmacy consumers paid an unsubsidised dispensing fee (e.g., $5 per day), which constitutes a significant cost for people with low incomes (Vishwanath et al., 2019) and has since become government-subsidised (Australian Government, 2023).

In contrast to other prescribed medications, which are generally believed to be healthy and trustworthy, OAT medications have more contested understandings by the public, health workers, and consumers themselves (Madden et al., 2021; Neale, 1998; Pasman et al., 2022). OAT use is often associated with discrediting personal characteristics, such as being socially deviant or weak-willed, and the tight regulation of OAT systems reflects this association (Bourgois, 2000; Conner & Rosen, 2008). OAT consumers subject to these discrediting attributions may internalise them (as self-stigma) and view the treatment itself negatively (Carlisle et al., 2023; Damon et al., 2017; Woo et al., 2017). Additionally, the restrictive means by which OAT treatment is formulated, authorised, dispensed, monitored, and experienced exacerbates feelings of disempowerment, shame, or injustice (Anstice et al., 2009; Harris & McElrath, 2012; Radley et al., 2017). The supervised consumption and collection of doses is a
critical site of potential OAT stigma in that it is the most frequent and publicly visible aspect of treatment; and for many this occurs at a local pharmacy.

Negative stereotypes create social distance and discredit the character and integrity of people with histories of illicit or injecting drug use, positioning them as a deviant group marked by unhealthy, uncaring, compulsive, and criminal behaviours (Goffman, 1963; Lloyd, 2013; Radcliffe & Stevens, 2008; Room, 2005). These stereotypes are often extended homogenously to people receiving opioid pharmacotherapy treatments by individuals and the media, and within policies and community discourses, creating socially learned, culturally normative forms of public stigma (Corrigan & Penn, 1999; Järvinen & Andersen, 2009; Woo et al., 2017). OAT consumers may perceive and feel the operations of this public stigma personally, whether directly as stigma that is enacted (in the behaviour of other people towards them, such as a disparaging look) or indirectly as structural stigma (in the conditions that constrain their agency within a setting, such as a pharmacy practice of serving non-OAT customers first) (Hatzenbuehler, 2016; Link & Phelan, 2001).

According to social identity theory, discrimination directed towards someone perceived to hold a stigmatised social identity may motivate that person to accept or reject the discredited attribution, and align themselves with or against it, in order to protect or increase their self-image and social standing (Tafjel & Turner, 1986; Treloar et al., 2007). Furthermore, as described by modified labelling theory (Link et al., 1989a), the stigmatised identity can be self-applied or ascribed by others, internalised or resisted, reified but distanced from using strategies of ego-preservation and impression management, felt or assumed to operate as a primary status that predicts or explains aversion by others, and be relatively static or fluctuate (Room, 2005; Simmonds & Coomber, 2009). These theories describe how the behavioural and emotional
responses that people have to stigma cognitions are multifaceted, and highlight how stigma can impact people in differing ways and with varying intensity (Major & O’Brien, 2005). These theories also focus on the interplay between personal characteristics, the social environment, and the cultural context in constituting and problematising social identities and statuses, which is important for understanding the cognitions, emotions, and behaviours of OAT consumers within the pharmacy setting.

Additionally, clinicians that facilitate access to drug treatment have traditionally encouraged consumers to see themselves as cognitively altered, unable to exercise self-control, and needing interventions that act to dampen impulses and promote responsibility (Brookfield et al., 2019; Järvinen & Andersen, 2009). For many, this process can evoke distress, a sense of self-blame, or a defeatist attitude (Radcliffe & Stevens, 2008). It can be particularly acute when entering treatment, as this may be the event that exposes a person to a stigmatised label (i.e., of drug ‘addiction’) that had not previously been applied to them (Brookfield et al., 2019; Radcliffe & Stevens, 2008). Consequently, people receiving OAT have been described as having heightened stigma consciousness when in the pharmacy, in that they may be particularly attentive to other people’s behaviours and expect to perceive stigma (Anstice et al., 2009; Harris & McElrath, 2012; Matheson, 1998; Pinel, 1999). Furthermore, as mainstream drug treatment services in Australia are mostly populated by people experiencing poverty and disadvantage (Network of Alcohol and Other Drug Agencies, 2023), additional classist stigma attributions are likely to be perceived (particularly by people who hold conventional social values), occurring alongside other intersectional stigma influences based on gender, race, ability, etc. (Fraser & Valentine, 2008; Radcliffe & Stevens, 2008; Room, 2005).
The operations of social control inherent in opioid pharmacotherapy treatment systems are sources of structural stigma that constrain consumer autonomy and potentially limit treatment benefits (Fraser & Valentine, 2008; Neale, 1998; Radcliffe & Stevens, 2008). Treatment can be difficult to access or entered coercively (particularly in cases of child protection or criminal system involvement); initiation involves some period of daily supervised dosing, and ongoing treatment requires frequent prescriber visits and urine drug screening (Damon et al., 2017; Jeske & O’Byrne, 2019). The medication formulations are synthetic, long-acting analogues of euphoria-inducing opioids such as heroin; they activate the neurological opioid receptors enough to produce mild sedative effects and prevent opioid withdrawal symptoms, but also act to blunt any pleasurable effects of other drugs (Bourgois, 2000; Holt, 2007). OAT is reported to induce strong symptoms of dependence—withdrawal symptoms can be more severe for methadone compared to heroin (Gossop & Strang, 1991)—and some experience debilitating medication side effects, but treatment discontinuance is discouraged because the ensuing drops in opioid tolerance intensifies overdose mortality risks and relapsing illicit opioid use is assumed (De Maeyer et al., 2011; Holt, 2007; Jeske & O’Byrne, 2019). As such, subjection and threat are imbued in almost all aspects of OAT initiation and continuance, with the implicit aim of thwarting or penalising additional substance use and maintaining medication compliance. Over time some people develop regret about commencing OAT, as they may not necessarily be aware of these restrictions and potential adverse impacts beforehand (Damon et al., 2017).

In NSW, consumers are categorised by prescribers by evaluating adherence to medication consumption timings and treatment appointments, polydrug use indications, mental health and cognitive functioning, pregnancy status, and social circumstances (i.e., homelessness, child protection issues, or release from incarceration). Those flagged as ‘high need’ are limited to daily
supervised dosing and frequent clinical reviews. After showing ‘stabilisation’ in these areas for usually three months, consumers that are evaluated as having moderate or low treatment needs may be eligible to receive some doses as takeaways (NSW Ministry of Health, 2018). Takeaways are highly valued—signalling a level of earned trust, reducing costs related to time and travel, and increasing consumer autonomy and privacy—but access to takeaways can easily be rescinded by the prescriber (Levander et al., 2021; Treloar et al., 2007). Employment or travel are temporally and geographically limited by takeaway authorisation limits or locations of alternative dosing sites, and people are dissuaded and can be sanctioned for making any strategic or autonomous decisions to modify the frequency, amount, and timing of takeaway dose consumption (Fraser & Valentine, 2008; Holt, 2007; Neale, 1998).

Despite these constraints, many consumers do find that OAT makes life easier in other ways. The treatment can subdue distress and pain, assisting people to take on work or other responsibilities and better manage day-to-day tasks (Karasz et al., 2004; Neale, 1998). People that are able to sustain an adequate quality of life, with meaningful activities and relationships, can feel treatment maintenance as empowering; however, for those that experience continuing social exclusion and disadvantages, the restrictiveness of the treatment regime can deepen feelings of social exclusion and despair (De Maeyer et al., 2011; Gourlay et al., 2005). Therefore, the frequent interactions required for OAT may increase the salience of either positive or negative emotions and self-concepts, depending upon that person’s social capital, life circumstances, and sense of agency, in addition to the biomedical effectiveness of the treatment itself (Jeske & O’Byrne, 2019).

Pharmacists are in a unique position to support OAT consumers build stronger perceptions of personal empowerment and social inclusion (Caruana, 2024b). The dynamics of
structural, interpersonal, and internalised stigma are important considerations in understanding consumer experiences of OAT services, and having an awareness of these can assist pharmacists in modifying their service setting and approach to operate in ways that reduce discrimination and perceived stigma. This study analyses the perceptions and experiences of OAT consumers and pharmacists to explore how OAT dispensing encounters can reduce stigma.

Method

Study design

This qualitative study was derived from a doctoral research project that used mixed social research methods to explore the attitudes and experiences of OAT consumers and pharmacists in reference to OAT dispensing within NSW community pharmacies. Interviews gathered detailed information using questions that aimed to elicit positive and negative observations of the treatment experience. The broad research paradigm was critical realism: this approach employs realist ontology, relativist epistemology, and retroductive techniques to identify potential causal mechanisms that may explain the operations of observed and inferred social phenomena (Bhaskar, 2016). The author has a clinical social work background and has a grounded understanding of the stigma-related experiences and harms that people who use drugs can encounter, developed from two decades of working in harm reduction services. In consultation with a supervisory team, the author undertook all research activities related to recruitment, interviewing, transcribing, and coding. Ethics approval was obtained from the Human Research Ethics Committee at UNSW (HC200836).
Recruitment and data collection procedures

Semi-structured, audio-recorded interviews were conducted with NSW opioid agonist treatment consumers and pharmacists in Sydney, the Northern Rivers region, and one pharmacist in a remote area. These occurred between February 2021 and March 2022; in-person recruitment was interrupted by COVID-19 movement restrictions for six months of this period. The inclusion criteria were to have delivered or received OAT at a community pharmacy for more than two weeks, be aged over eighteen, and ability to converse in English. Purposive sampling strategies were used, aiming for a diversity of participant characteristics (including location, experience, and gender), and recruitment involved emailing and then visiting target pharmacists. Study information was provided to pharmacists who then passed these on to OAT customers, and interested persons contacted the study team directly. Recruitment was ended when the temporal and financial resources allocated for the study recruitment had been exhausted.

Written information about the study was provided and discussed prior to scheduling interviews, with informed consent obtained prior to commencing the interview. Questions in the interview guide were developed in consultation with a peer advocate and piloted with six participants. Pharmacist questions included how OAT consumers differ to other pharmacy customers, and barriers to people receiving or pharmacists providing OAT. Consumer questions included if their pharmacist had always treated them with respect, if they had experienced negative reactions from others in reference to OAT, and how they feel about negative depictions of OAT consumers in the community, media, etc. (see supplemental material). Interviews lasted 30 minutes on average, ranging 15 to 90 minutes. Upon interview completion, consumer participants were provided with $20; pharmacists were not remunerated.
Data analysis

Interview transcripts were analysed using reflexive thematic analysis (Braun & Clarke, 2006, 2019, 2021). Transcripts were de-identified (with pseudonyms ascribed), corrected by checking the audio, re-read, summarised, and manually coded using NVivo (12.7.0). The initial inductive codes were organised into domain themes, i.e., patterns of meaning drawn together by a central concept (Braun & Clarke, 2021), which were informed by the research literature. These codes and themes were then reanalysed to draw out observations from both consumer and pharmacist perspectives that were relevant to differing stigma perceptions and effects, and to the interpersonal and structural aspects of pharmacy OAT service that produced or mitigated these. Possible shared meanings that could be read across the collated observations were identified to generate richer themes, and these were iteratively refined by going back through the earlier analytic stages to cross-examine the connections, overlaps, and assumptions that informed these meanings. The final themes (see Table 1) were then described and checked for coherence and comprehensiveness against the initial codes and transcripts.

Findings

Fifteen opioid agonist treatment consumers (aged 40 to 65) and ten pharmacists (aged 25 to 82) participated in interviews. Three consumers were currently receiving buprenorphine formulations, all had experience with methadone pharmacy dosing, and all had access to takeaway doses (except one, who had transitioned to receiving OAT as a monthly depot buprenorphine injection at a public clinic). Current dispensing fees were discussed by about a third of the participants; these ranged from $20 (rural pharmacist) to $50 (city consumer) a week.
Pharmacists reported servicing between 5 and 70 concurrent OAT customers ($M = 28$, $SD = 18.9$). More than half of the pharmacists had provided OAT since the 1980s, and half of the consumers had been receiving OAT for over twenty years, but there was one pharmacist and two consumers that had less than two years’ experience with this treatment modality. Further participant details are provided in Tables 2 & 3.

**Stigma is pervasive and harmful**

People receiving opioid agonist treatment commonly described being subjected to social stigma because of their treatment status, and many carried painful feelings and expectations of poor treatment into the pharmacy setting. As attending the pharmacy for treatment was a frequent and unavoidable event, consumers were especially alert and sensitive in that setting to potential expressions of stigma that related to their treatment status. However, the most damaging instances of stigma and discrimination tended to come from other environments and experiences. Hearing denigrating language from within their own families, as well as from friends, neighbours, health workers, their communities, and the general public was common. When in settings where their identity as an OAT consumer is exposed, these words and perceptions became salient and gave rise to feelings of judgment and identity threat. This was particularly emphasised by rural consumers, who described stigma as occurring in public spaces more frequently and pervasively than city consumers. Anonymity was described as being harder to maintain in small towns, and one’s OAT status (with its frequent pharmacy visits) was considered to be more difficult to conceal.

One pharmacist, who had worked in a number of urban and remote pharmacies, noted that she had known pharmacists that had stigmatised OAT consumers and would not offer the
service. She described this as having negative impacts on the public perception of the service, and in compromising consumer privacy and discretion.

“Lots of pharmacists turn their nose up at [OAT consumers], oh yeah. […] Look at the number of pharmacies there are versus the number of them that do methadone. It’s a fairly small minority. Which is a real shame, ‘cause if everyone did five it’d be a much better program than a number of pharmacies doing big numbers. […] Much less impact for everybody, and allows more normalcy for [consumers].” (Michelle, pharmacist, remote)

More generally, instances of discriminatory behaviour related to OAT were described by consumers as generating feelings of anger, hurt or defeat, inducing attributions of cruelty or ignorance against those that stigmatise, and motivating self-preservation reactions such as secrecy and social withdrawal. Negating experiences attributed to histories of illicit drug use or current OAT use were portrayed as having devastating effects on self-esteem and wellbeing, leading to self-defensiveness, self-stigmatisation, and loss of hope. Stigma attached to treatment-seeking itself, including its constraints on autonomy, was thought to act as a barrier or worsen self-stigmatising thoughts when receiving OAT. Systemic barriers, including a lack of service availability, discriminatory rules, and the excessive requirements needed to maintain OAT access, further contributed to a sense of futility and despair. Harmful experiences and hurtful perceptions coloured consumers’ engagement with the world generally, and this was reflected for some in their treatment experiences in the pharmacy.
“I can think of three people in my whole lifetime that have become heroin addicts without any abuse or whatever in their background, right? Everyone else I know has come from a background of damn trauma. [And the public] see use as bad and evil and defected. [So people] become defensive, okay? And they probably become their worst enemy because they just spent so many years of being powerless, of being treated badly, that they have this armour on.” (Naomi, consumer, rural)

“I pay them, I’m there all the time, you know, but [the pharmacist] can’t trust me. […] Because of my medication. It just makes me, I don’t know, it hurts sometimes.” (Shaun, consumer, rural)

Pharmacists act in fair and unfair ways

Within the pharmacy, consumers gave examples of being subjected to differential and demeaning service processes, high dispensing fees, and impersonal or disrespectful communication, which they attributed to their treatment status. However, not all consumers experienced OAT stigma there—for those that described positive and supportive relationships with their pharmacist, the pharmacy was a safe place where they felt cared for and a part of the community. Pharmacists’ approaches were generally portrayed as either alleviating or worsening experiences of OAT related self-stigma and distress.

Consumers observed that the poor behaviour of a few unfairly created larger negative impacts for OAT consumers as a whole, and saw this stereotyping as unfair. For instance, Stephanie described her rural pharmacist as being wonderful, “a sweetie”, but that she was selective in who she discussed the pharmacy with because she didn’t want for it to be overrun
with other consumers “swearing, just being rude” as this might then cause service problems for those already there. This illustrates the cascading nature of stigma effects, and how consumers act to protect their personal status in response to negative stereotyping, which may involve perpetuating processes of social exclusion.

Pharmacists also worried about the perceptions of their general customers towards OAT consumers, and at times felt vulnerable and dismayed by the behaviour of some:

“I don’t like it when they lose their patience or are angry at us.” (Warren, pharmacist, rural)

Poor consumer behaviour was seen by pharmacists as justifying specific OAT service rules, such as consumer contracts and separated consumer areas, and as a disincentive to providing the service, or as a reason to only accept people who they judged were likely “to behave” (Paul, pharmacist, city). Pharmacists reported that customer selection was common, and not just with OAT services (“the average customer, some of them can be a real problem”, Stuart, pharmacist, city). While this raises issues of service equity and accessibility—especially for people who may be more likely to display emotional dysregulation because of trauma or mental illness—some pharmacists believed that they had few other options with which to increase their sense of safety.

“When I first took over, [there were some OAT consumers] I can’t handle, or don’t want to. […] I sent them back to the clinic. […] I didn’t want to take any risk because I’ve got a young family [living] upstairs.” (Paul, pharmacist, city)
“I’ve always cherry-picked my clients as well. Like [not accepting] very unstable, very aggressive or um, people that are likely to crack.” (Heather, pharmacist, rural)

However, city pharmacist Stuart said that in his four decades of dispensing OAT, for to up to seventy people at a time, he rarely experienced poor behaviour. Rather than being selective in accepting consumers, he put this down to having efficient systems (“they wouldn’t be in the pharmacy for more than two minutes”), clear but fair conduct expectations (“they’re given a set of rules like what time is the service open, when they’re expected to pay, any credit details, the fact that the pharmacist is part of the treatment team and so on”), and a personable approach. His advice to other pharmacists was to “learn how to avoid conflict, and as conflict comes, how to handle it”.

**Connection and understanding helps**

The interpersonal approach of pharmacists contributed most to perceptions of OAT service quality and equity (excepting perhaps the issue of high dispensing fees). Consumers wanted pharmacists to understand the hardships they face ( “[know] where we’re coming from, you know? Like how we’re suffering”, Rick, consumer, city) and show care for them (“a bit of empathy is really good”, Shaun, consumer, rural), or at least not subject them to further stigma (“I don’t want any special treatment, just don’t want to be treated differently”, Adam, consumer, city). Pharmacists reflected this need for understanding; for instance, Michelle described how she took time to develop rapport with new OAT customers, to help them feel welcomed and supported, and how this was particularly necessary as her pharmacy was in a remote area where
stigma can be felt more acutely. Other pharmacists remarked on how OAT consumers may need acknowledgement and support for their decision to be in treatment.

“I actually think they should be treated more, more lovingly—if you want to use that word—than other clients. Because they often come from a history of trauma or, you know, a tough life. And sometimes I think they need more support.” (Christie, pharmacist, rural)

“If they’ve gone to the effort to […] make some changes in their lives, we want to support that as best as we can.” (Blake, pharmacist, rural)

Christie described educating herself and her staff when she decided to start offering OAT. This gave her a deeper appreciation for the role, enabled positive and rewarding relationships with consumers, and provided a safer and more supportive environment for them.

“I think that a lot of people don’t take the time to get to know what these people have been through. […] I had in-staff training [to make] sure that my staff were also on the same wavelength as me, and not being judgey or anything like that.” (Christie, pharmacist, rural)

Josie described how her pharmacists took time to get to know her, and to check in with her about her life, and this helped her feel valued and supported.
“They know me so well that they know all of the little nuances. And if I’m pretending to be okay they know. […] So they’ll be like, “Are you okay, what’s up? Do you want to come and sit down and have a chat?” You know, so they’re amazing!” (Josie, consumer, rural)

**Privacy is key, but needs negotiation**

The pharmacy is a site that can potentially expose OAT consumers to a feeling of being judged, particularly if they are observed by other customers when consuming their medication.

“I have had to take [my dose] over the counter, and it’s not nice. Everybody sees you. You feel bad enough as it is, […] your self-esteem is low. You’re not very confident. So having other people, you can feel them almost judging you. Or it’s paranoia, either or.” (Josie, consumer, rural)

Unhelpful strategies to address this issue were the creation of visible but separated dispensing areas or making OAT consumers wait until other customers had left. Although consumers differed in their preferences, they appreciated where pharmacists were inclusive and discrete in counter dosing or where they provided doses in a clinical room, and were grateful when given a choice in this.

Considerations of privacy extended to the personal information that consumers shared with their pharmacists. While some pharmacists wanted more information, consumers generally only wished to speak about their life or personal issues if they felt welcomed and not expected to, and if their pharmacists responded in supportive ways. Pharmacists tended to appreciate
consumer openness about their struggles and wanted to build helpful relationships with them, describing benefits to this in providing clinical care and in supporting wellbeing improvements.

“The thing that I like most is [if] they’re honest. […] The vulnerability makes it easy for a health care worker to help them, you know. Whereas if someone is arced up and blank, walled off, it’s very hard to help them. Um, and they’re all very, very grateful usually. You know, for some kindness.” (Heather, pharmacist, rural)

“I guess you see them so often you get, you definitely get involved in their sort of personal lives and, and sort of create those beneficial relationships.” (Malcolm, pharmacist, rural)

OAT consumers could be sensitive to intrusion with their private information, particularly if it provoked feelings of discomfort or shame. Illicit drug use was at times characterised as traumatic, arising from the vulnerabilities to stigma, abuse, sickness, and policing that its criminalisation entails. Having to frequently expose personal information in accessing or maintaining treatment, without recognition of the difficulty it can entail and without necessarily perceiving any benefit for doing it, was seen as detrimental to psychological wellbeing.

“I’ve always been really honest. […] I haven’t really hardly used any drugs for years and years, [but] I don’t know how many times I’ve had to give a history of my using, you know. And it’s, it’s, it’s fucking traumatising.” (Sophia, consumer, rural)
**Empowerment counters internalised stigma**

Consumers who showed a greater level of personal empowerment (and who usually identified themselves as financially stable, employed, or as having long-standing and supportive intimate partners) tended to not describe feeling stigmatised in the pharmacy. For instance, while Matthew observed that other opioid dependent people can “take on that persona” of being unworthy when worn down by stigma, he attributed his good treatment experiences to his personal sense of being empowered.

“I can stand up for myself; […] I know how to get my needs met. […] I never allow myself to be stigmatised for being an opiate user.” (Matthew, consumer, city)

On the other hand, some consumers that described being negatively impacted by stigma also experienced pharmacy OAT dispensing positively, mainly attributing this to the supportive approach of their pharmacists. Additionally, consumers wanted pharmacists to have better understanding of the ways in which OAT can increase personal agency and support harm reduction, which did not necessarily mean abstinence from other drug use. Though some acknowledged that they wanted “a certain amount of discipline” (Jaden, consumer, city), others made personal decisions about how they consumed their takeaway doses in ways that increased their sense of control, and about the use of other substances.

“When I am reducing myself, which I do sometimes, I’ll break my dose up over the day because then I won’t feel so bad, you know. So it staggers it.” (Sophia, consumer, rural)
“I’m still a current heroin dabbler, um, and methadone is just a really good sort of back up, […] to make sure we don’t go into withdrawal. So that you can go to work and can sort of perform, you know, your functions in life.” (Beth, consumer, city)

Pharmacists did express awareness of these practices, but only one explicitly endorsed an enabling attitude towards consumers’ exercising agency within treatment.

“Some people can’t give up heroin altogether and so they have a taste of it every now and then. And that’s acceptable for someone in treatment. They shouldn’t be punished for doing that.” (Stuart, pharmacist, city)

Consumers appreciated when they could be honest about substance use with their clinicians and were understood rather than judged or penalised for this.

“I went through a bit of a psych stage [i.e., was mentally unwell] and sort of started drinking a bit. And like taking, buying extra ‘done and that. And I told [my prescriber and pharmacist] that I was doing it. And they were fine, they were cool, they get it. I’m just honest to them.” (James, consumer, rural)

Although consumers generally described a current level of OAT service that was adequate, those that gave the most glowing appraisals tended to differ in the higher degree of honesty, support, and understanding that they gave and felt from their pharmacists. But, as pharmacists noted, there are tensions between the time and financial constraints of running a
business, complying with legal regulations, wanting to provide optimal consumer care, and having OAT expertise that incorporates clinical and consumer perspectives—it may not be possible for pharmacists to excel in all aspects. However, just as consumers are sensitive to being treated poorly they are also sensitive to kindness and understanding. The short, consistent instances of supportive engagement in dispensing encounters were characterised by consumers as very beneficial in countering stigma.

Discussion

Pharmacy OAT provision was recognised as an important service that could reduce perceptions and experiences of OAT stigma. However, consumer access is constrained when pharmacists are not prepared to offer the service, which can potentially increase exposure to public stigma (and was of particular concern within smaller towns). OAT consumers described themselves as being vulnerable to discriminatory behaviours, social exclusion, and trauma effects; with some feeling anger and shame frequently or at times communicating in defensive or withdrawn ways within and beyond the pharmacy setting. Service processes and interpersonal communication behaviours that negatively stereotyped, selected, and separated OAT consumers were experienced as unfair, but some pharmacists justified aspects of these as necessary for increasing their sense of safety. On the other hand, having efficient systems, understanding and supporting OAT consumers in coping with the difficulties they faced, demonstrating respect, and upholding privacy were important ways that pharmacists acted to mitigate stigma.

Internalised disdain of stigmatising labels linked to drug use has been shown to worsen social isolation and disadvantage, deepen shame and other negative self-perceptions, impair
social functioning over time, and increase perceptions of chronic pain (Broman et al., 2023; DeBeck et al., 2017; Karasz et al., 2004; von Hippel et al., 2017). As being a person who has engaged in illicit drug use or experienced dependence becomes a primary status when accessing OAT, these cognitive and affective processes may inform consumer behaviours in the context of receiving treatment, as well as influence the appraisals they make of service provider behaviours (Anstice et al., 2009; Caruana, in press; Fraser & Valentine, 2008; Radcliffe & Stevens, 2008). In line with modified labelling theory, OAT consumers may come to expect social rejection and devaluation or have increased sensitivity to potential stigma when in the pharmacy (Link et al., 1989b; Vishwanath et al., 2019; Woo et al., 2017). For instance, Shaun felt his pharmacist treated him with less trust than other customers, and the only explanation he had for this was the medication he was accessing. A person may feel internalised stigma, fear potential status loss, and perceive interpersonal and structural stigma if they are subject to discriminatory service rules and processes, or if their pharmacist or others in that setting behave in subtly or overtly negative ways towards them (Anstice et al., 2009; Caruana, 2024b; Woo et al., 2017). Consumers that display or reciprocate poor communication and conduct may be reacting defensively to stigma perceptions or expectations and require a more person-centred and caring service approach (Damon et al., 2017; Fatani et al., 2019; Murphy et al., 2016).

Structured stigma is embedded within the broader OAT program, including its state-level rules and processes, the behaviour of other clinicians involved, and community discourses that devalue both the treatment model and those that participate in it (Anstice et al., 2009; Bourgois, 2000; Caruana, 2024a; Conner & Rosen, 2008; Harris & McElrath, 2012; Madden et al., 2021; Neale, 1998; Pasman et al., 2022; Radley et al., 2017). Pharmacists who do behave in exclusionary, dismissive, and stigmatising ways are often justified by the social policies and
norms that permit them to. They may be acting from a conscious aversion to OAT consumers, or they may not have insight into their behaviours and its effects. Structural stigma constrains pharmacists’ abilities and motivations to improve consumer OAT service experiences, such as in providing adequate privacy (as Josie experienced when she had to take her dose at the counter) and in consistently demonstrating positive regard (Fatani et al., 2019; Murphy et al., 2016). Program and societal-level changes are needed to address broader negative attitudes and punitive pharmacy practices. However, for those pharmacists who lack awareness, education or other interventions that enable self-reflection and promote understanding of the ways that OAT consumers feel stigmatised (like how Christie trained her staff) may assist in reducing enacted stigma within the OAT dispensing encounter and enable more positive perceptions of the service, for both consumers and pharmacists (Fatani et al., 2019; Mackridge & Scott, 2009; Yadav et al., 2019). Stuart, who saw punitive treatment compliance measures as unacceptable and explained how his efficient and inclusive systems helped to avoid and manage conflict, provides a good model here for a less stigmatising service approach.

Though pervasive, OAT stigma is not fixed—there were differences in how consumers cognitively aligned themselves with and against its forms and operations, and in how it affected them, which are theorised as efforts to protect self-esteem and social status (Tafjel & Turner, 1986). These differences can be observed by comparing Josie, who when taking her dose either felt or thought she could feel people judging her, with Matthew, who stated he refuses to be stigmatised for taking OAT. These dynamics were influenced by how empowered people felt and, in the context of OAT dispensing, by the quality of relationship they had with their pharmacist. Consumers believed that pharmacists could enable better treatment encounters by designing dispensing areas to protect privacy, showing an interest in people’s lives without
prying or expecting disclosure, and demonstrating trust. Consumers who considered themselves to be empowered or who reported less sociomaterial disadvantage tended to perceive and feel less stigma in the pharmacy. This aligns with research which has shown that positive ingroup perceptions or perceiving stigma attributions to be illegitimate have predicted less self-stigmatisation among people with mental illness (Chan et al., 2018; Rüsch et al., 2009). To encourage perceptions of empowerment, pharmacists could aim to communicate in ways that reduce the power imbalance of the service relationship (such as showing more of an interest in consumer's lives), as well as recognise and respect the ways in which consumers engage with health service systems to improve their wellbeing (Damon et al., 2017; Harris & McElrath, 2012; Holt, 2007; McNeil et al., 2015).

**Recommendations**

The findings discussed here suggest that there may be a need for more training and information-sharing between pharmacists to increase awareness of ways to offer more equitable, inclusive, and efficient OAT services, and for training in trauma-informed care approaches to better support people with histories of substance dependence (Center for Substance Abuse Treatment, 2014; Mackridge & Scott, 2009). In this, opportunities for pharmacists to gain a deeper understanding of the difficulties that OAT consumers face within the treatment system, as well as in their lives generally, and to develop greater respect for people’s privacy and more acceptance of their right to be self-determining should be promoted. Future research could aim to provide clearer evidence of what features and approaches to OAT service are most conducive to creating positive experiences for both consumers and pharmacists, and to supporting consumers improve their sense of empowerment within treatment.
Limitations

This study recruited small pharmacist and consumer samples from a limited number of NSW pharmacies. The obtained study sample was less diverse than had been envisioned in applying a purposive sampling method. For instance, recruitment involved only one participant from a remote location, no consumers aged under forty, and no consumers with less than three takeaway doses per week. Resource limitations prevented further recruitment and the restricted recruitment method, which relied on pharmacists making study information available to OAT consumers, was likely to produce participant selection biases. The interview format possibly induced social desirability or acquiescence biases. This limits the rigour and transferability of findings, in reference to the study context and limitations outlined.

Conclusion

Opioid agonist treatment promotes better wellbeing, and its provision in community pharmacy can either strengthen or mitigate self-stigmatising thoughts, perceptions of social exclusion, and feelings of disempowerment. People with histories of drug dependence or trauma can experience OAT as subjectifying and harmful where service processes are discriminatory or insensitive to their circumstances. Within the structural constraints of the service model, pharmacists can enable positive treatment encounters by upholding consumer privacy, minimising differential service processes, and communicating in supportive ways that help OAT consumers feel validated and understood.
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Data availability statement.

The data that support the findings of this study are available from the Centre for Social Research in Health (CSRH), but restrictions apply to the availability of these data, which contain potentially sensitive information and so are not publicly available due to ethical restrictions. The de-identified data are, however, available from the author upon reasonable request and with the permission of University of New South Wales Human Research Ethics Committee.
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