International Journal of Drug Policy 66 (2019) 15–22

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research paper

"Like being put on an ice floe and shoved away": A qualitative study of the impacts of opioid-related policy changes on people who take opioids

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ARTICLE INFO

Keywords:
Opioid prescribing
Qualitative research
Health policy

ABSTRACT

Aims: To characterize the impacts of policies intended to improve opioid prescribing and prevent opioid-related overdose and death on individuals who take opioids.

Methods: We conducted a qualitative study using focus groups with 48 adults aged 18 years and over who had experience taking opioids. Participants were recruited from across Ontario, Canada, and separate focus groups were held for individuals taking opioids for chronic pain and individuals taking opioids for other reasons. We drew upon stigma theory to interpret participants' accounts.

Results: Following analysis and interpretation, we generated three themes describing the impacts of recently implemented opioid-related policies and harm reduction interventions on people who take opioids: 'propagating stigma: addict as dominant status', 'loss of autonomy' and 'producing/reproducing structural vulnerabilities'. Specifically, participants characterize an environment in which 'addict' has become the dominant social identity ascribed to people who take opioids, and where relationships with providers have become strained as participants perceive themselves to be powerless when decisions regarding opioid use and pain management are made. These shifts in identity and relationships had negative repercussions when help-seeking and exposed larger vulnerabilities related to poverty and criminalization.

Conclusions: The introduction of opioid-related policies had unintended consequences for people who take opioids. Potential measures for mitigating these consequences include ensuring that people who take opioids are involved in all facets of policy development and implementation, integrating peer workers into the care of these individuals, and respecting patient agency when decisions about pain management and opioid use are made.

Introduction

Rates of opioid-related harm continue to increase in North America, accounting for 42,245 deaths in the United States in 2016 (Gomes, Tadrous, Mamdani, Paterson, & Juurlink, 2018). In Ontario, Canada, opioid-related deaths have increased from 19.3 deaths per million people in 2000 to 53.1 deaths per million people in 2015, and now represent 1 in 6 deaths among Ontario residents between the ages of 25 and 34 years (Gomes, Greaves et al., 2018). Historically, these increases occurred largely in tandem with escalating rates of opioid prescribing, driven by marketing from pharmaceutical manufacturers and a historic view of these products as being safe when used long-term for managing chronic pain (American Academy of Pain Medicine & the American Pain Society, 1997; Jovey et al., 2003; Kolodny et al., 2015; Manchikanti, Fellows, Ailinani, & Pampati, 2010). In response to these trends, many jurisdictions have implemented legislation targeting various drivers of the over-use of opioids, including delisting selected opioids from public drug formularies, prescription monitoring programs and opioid prescribing guidelines (Hollingworth et al., 2013; Jones, Lurie, & Throckmorton, 2016; Morin, Eibl, Franklyn, & Marsh, 2017). Ontario specifically has responded by removing long-acting formulations of oxycodone and high-strength opioids from the provincial drug benefit program and establishing the Narcotic Monitoring System, a central database to facilitate oversight of opioid prescribing in the province

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https://doi.org/10.1016/j.drugpo.2019.01.015

(Morin et al., 2017). These changes have occurred in concert with the publication of guidelines for the management of chronic noncancer pain recommending the use of nonopioid alternatives, tapering opioid doses in individuals already receiving these drugs and restricting maximum prescribed doses (Busse et al., 2017; Dowell, Haegerich, & Chou, 2016). Studies examining the impact of these initiatives demonstrate that opioid-related deaths continue to increase, despite changes in some measures, such as volume of opioids prescribed (Al Achkar et al., 2018; Chang et al., 2016; Gomes, Greaves et al., 2018; Gomes, Juurlink, Yao, Camacho, & Paterson, 2014; Guan et al., 2018; Jones et al., 2016). Importantly, recent studies suggest that the drugs implicated in causing opioid-related deaths have also changed during this period, with synthetic opioids (i.e. fentanyl and fentanyl analogs) accounting for an increasing proportion of these deaths (Jones, Einstein, & Compton, 2018; Martins, Sampson, Cerdá, & Galea, 2015; O'Donnell, Halpin, Mattson, Goldberger, & Gladden, 2017; Roxburgh et al., 2017; Special Advisory Committee on the Epidemic of Opioid Overdoses, 2018).

Despite the existence of broad, population-based evaluations of policy impacts, little is known about the individual impacts of legislative attempts to counter the rise in opioid-related deaths on people who take opioids. Specifically, attempts to curb opioid prescribing and institute systems of opioid vigilance may have undesirable consequences for individuals who take these drugs. It is therefore important to understand how patients have experienced the effects of policy change to ensure that unintended physical and social harms have not been produced or reinforced with the passing of opioid-specific legislation. For example, a significant body of literature has demonstrated the existence of negative attitudes among health care providers towards individuals with substance use disorders, with lower regard for and less motivation to work with these patients relative to other patient populations, including those with other mental health illnesses (Henderson et al., 2014; van Boekel, Brouwers, van Weeghel, & Garretsen, 2013; van Boekel, Brouwers, van Weeghel, & Garretsen, 2014). A more recent study extends these findings specifically to people who take opioids, documenting negative attitudes towards these individuals among primary care physicians (Kennedy-Hendricks et al., 2016). Whether the implementation of new policies and guidelines played a role in fostering and/or reproducing such stigmatizing attitudes in healthcare providers towards people who take opioids is unclear.

In order to address this gap in the evaluation of recently introduced opioid legislation and to inform evolving policy on how to best care for individuals who take opioids, we undertook a qualitative study that sought to understand the impacts of policy changes from the perspectives of people who take or have taken opioids.

Methods

Theoretical framework

Although we did not develop our study from a particular theoretical standpoint, the pervasiveness of stigma in the accounts of the participants oriented us towards the theoretical frameworks of stigma articulated by Erving Goffman and Link and Phelan when interpreting our findings (Goffman, 1963; Link & Phelan, 2001). For Goffman, stigma is an "attribute that is deeply discrediting, but it should be seen that a language of relationships, not attributes, is really needed" (Goffman, 1963). Rather than being a static 'thing', stigma is therefore conceptualized as a social process that is enacted through everyday face-to-face interactions embedded within prevailing discourses of 'deviance' and 'normal'. Because stigma reduces the individual "from the whole and usual person to a tainted, discounted one", individuals who may become stigmatized undertake various strategies of impression management to conceal attributes that may provoke social sanction and status loss (Goffman, 1963). Link and Phelan expand on Goffman's work by integrating an examination of the power differentials that allow labelling, stereotyping and discrimination to occur (Link & Phelan, 2001). In this manner, Link and Phelan argue for an examination of individual and structural discrimination that can accompany status loss, and how individuals may resist stigmatizing processes (Link & Phelan, 2001).

For this study, we employed theory primarily as an analytic device rather than as the impetus for driving the study and data generation (Sandelowski, 1993). That is, stigma theory was used to conceptualize the findings following the inductive process of generating preliminary categories from the data. This approach is consistent with the multiple 'guises' of theory in qualitative research (Sandelowski, 1993). Specifically, theory may enter (and in some cases, leave) a study at various points in the research process, and may fill various roles that range from acting as the underlying rationale for the study to being brought into a study for interpretive purposes (Sandelowski, 1993). Drawing upon the perspectives of Goffman and Link and Phelan, we were specifically interested in how the implementation of opioid-related policies may have inadvertently created conditions in which stigma could be enacted, the consequences associated with labelling and stereotyping, and how participants drew upon and/or resisted specific discourses when characterizing their experiences.

Data generation

We conducted eight focus groups (4–8 participants per group) with 48 adults aged 18 years and over, who had experience taking opioids. Because people who take opioids are not a homogenous population, we partnered with a variety of organizations across urban, suburban and rural regions of Ontario to purposively recruit a diverse sample of participants, including pain management clinics, public health units, pharmacies, drug treatment facilities and Community Health Centers (Kuzel, 1999). Eligibility criteria included being an Ontario resident 18 years and older who is currently taking or has a history of experience taking opioids. Recruitment details with contact information for the study coordinator were posted at each participating site. Prospective participants who followed-up with the study coordinator underwent a screening interview to confirm their eligibility and briefly describe their experiences with opioids. Through this approach, participants primarily self-identified as individuals who currently take opioids for chronic pain and those taking opioids for other reasons. This latter group was a heterogeneous group of individuals that included people self-identifying as living with an opioid use disorder or taking opioids for recreational or other purposes. A total of 89 prospective participants underwent preliminary screening, of whom 48 could be subsequently contacted to confirm study participation. Because we were concerned that people living with opioid use disorder or taking opioids for other reasons could experience inadvertent harm or stigma in groups that included people with chronic pain, separate focus groups were conducted for these two groups of participants. Thus, four focus groups were comprised of individuals with chronic pain, and four groups comprised people who were taking opioids for other reasons. Participants received a $50 gift card as an honorarium.

While we used a semi-structured focus group guide to address key areas of interest and to stimulate discussion, we allowed participants to steer the discussion toward aspects of their experience that were most important to them. Example questions for data generation included "Have you been affected by any recent changes to government rules, policies or laws related to opioids, such as the delisting of high strength opioids or the fentanyl patch-for-patch program?", "Do you thing that recent changes in physician behaviour and media attention on this issue have impacted how opioids are being prescribed? Is this a good or bad change?" and "Have you noticed a change in the way doctors deal with and prescribe opioids over the past few years? What about pharmacists?". Six in-person focus groups were conducted in large urban centres, while two focus groups were conducted by teleconference with participants from other regions of the province.

Data analysis

As a first step in the analysis, the transcripts were read multiple times and text was coded in NVivo based on the high-level ideas expressed therein (Pamphilon, 1999). Codes were then categorized into groups representing participants' experiences with policy changes. Next, an inductive, iterative process of constant comparison was applied using our theoretical framework to explore participant accounts using questions such as "What is this an instance of?", "What discourses are reproduced and/or resisted?", "How is this particular health care encounter being characterized?", "What are participants doing in this segment of data?" and "How are identities constructed/reconstructed by participants?". We therefore applied a form of constructionist grounded theory when analyzing our data, beginning with coding that stayed close to the participant accounts to generate initial categories and then used theoretical coding and memo writing to conceptualize the findings after the preliminary stages of data analysis (Charmaz, 2006). While one research team member had primary responsibility for this analysis, the concepts generated and the evolving analytic framework were reviewed regularly with members of the research team to ensure coherence of interpretation (Kvale, 1996).

Ethical considerations

We obtained written informed consent from all participants. This study was approved by the Research Ethics Board of St. Michael's Hospital (REB# 17–244).

Results

Participant characteristics

On average, focus group participants were 53 years of age, and 60.4% were female (Table 1). Over half (58.3%) self-identified as currently taking opioids to manage chronic pain, and nearly two-thirds (64.6%) indicated that they were taking opioids for a reason other than chronic pain. Among this group, approximately half (48.4%) described being first exposed to an opioid through a prescription from a physician to manage pain.

Themes

Three overarching impacts of the policy changes were generated from the participant accounts. The first impact was a *propagation or deepening* of stigma experienced, particularly during encounters with health care providers. Second, participants described a *loss of autonomy*, whereby their ability to engage in shared decision-making with their providers was curtailed. Finally, participants described how policy changes both *produced and reproduced structural vulnerabilities* among people who take opioids. These three themes are elaborated on further below.

Table 1
Characteristics of Focus Group Participants.

Characteristic	Focus Group N = 48
Age [years] (Mean, SD)	53.3 (11.9)
< 30	3 (6.3%)
30-39	4 (8.3%)
40-49	4 (8.3%)
50-59	21 (43.8%)
60+	16 (33.3%)
Gender	
Men	18 (37.5%)
Women	29 (60.4%)
Other	1 (2.1%)
Location of Focus Group	
Toronto	11 (22.9%)
Ottawa	12 (25.0%)
Kingston	11 (22.9%)
Teleconference	14 (29.2%)
Current Chronic Pain Patient	28 (58.3%)
Taking opioids for reasons other than chronic pain	31 (64.6%)
First exposure to opioids through prescription	15 (48.4%)

Propagating stigma: 'addict' as dominant status

Participants taking opioids for chronic pain described changes in their interactions with physicians and pharmacists following the implementation of stricter opioid prescribing policies, such that they were increasingly viewed with suspicion and accused of specific acts of dishonesty by these providers including seeking opioids from more than one physician or for purposes other than pain management. Together with a perception of opioid-related policies being implemented to target 'problematic' aspects of opioid use such as overdose and substance use disorder, participants prescribed opioids for chronic pain perceive that they have been 'lumped in' with the 'real addicts', resulting in the creation of 'addict' as a dominant status for all individuals who take opioids. For these individuals, this perceived transformation in their identity from 'legitimate chronic pain patient' to 'addict' was further reinforced in the public sphere by images of individuals dying of opioid overdose on the streets of major Canadian cities and dominant media representations of opioids as dangerous and threats to communities (Whelan, Asbridge, & Haydt, 2011).

In response, participants taking opioids for chronic pain resisted this reframing in identity in several ways. First, participants invoked a historic discourse in which opioids were considered lacking in addictive potential for people with chronic pain, rendering it highly unlikely that such patients could develop 'problematic' opioid use.

> "I live with chronic pain, I don't have addiction. I never have, I never will."

A key consequence of this discourse was the liberal prescribing of opioids for people with chronic pain, a practice widely endorsed at one time and which created a perception of safe and responsible opioid use so long as these drugs were used in a medical context (Manchikanti et al., 2010). As a result, the second means by which participants with chronic pain resist the identity of 'addict' is through distancing themselves from problematic imputations associated with opioids by drawing upon a discourse that distinguishes between the 'responsible' patient who uses these drugs for 'the right reasons' and individuals who 'chose' to use opioids for euphoria and pleasure (Bell & Salmon, 2009). This is very much consistent with the work of Goffman, in that focus group participants were undertaking a form of impression management to avoid the stigma associated with recreational or 'problematic' use of drugs.

In keeping with prior literature describing health care associated stigma, (Henderson et al., 2014; van Boekel et al., 2013, 2014), participants who were taking opioids for other reasons characterized stigma as being central to their experiences in the years pre-dating policy changes, largely reflecting previously described views of 'responsible' versus socially unsanctioned drug use. In many cases, such experiences reflected stigma institutionalized within the healthcare system.

> "…what's bad is like physicians and people in power that are stigmatizing people and saying things to people they wouldn't say to their own family members frankly or colleagues. And the way some people are treated by so called professionals it's uh, it's, it's almost criminal, it's um, well, it's terrible."

As with the participants prescribed opioids for chronic pain, participants who were taking opioids for other reasons also resisted stereotypes associated with non-prescribed opioid use as reflecting individual moral failings by situating such use within their personal histories of trauma, mental illness and poor medical oversight following

the initial prescription of opioids for pain. In other cases, opioid use was framed as being a symptom of the larger social inequities and structural problems inherent in the lives of these individuals, including poverty and lack of housing. In doing so, participants reframed the nature of 'legitimate' pain to encompass emotional pain produced by their life circumstances and resisted the characterization of opioid use for these reasons as being somehow less valid than physical pain.

> "Most people when they're talking about chronic pain don't recognize anguish as pain. Pain is pain, doesn't matter if it's emotional or spiritual or physical. And anguish is a horrible, horrible type of pain. I had a friend commit suicide and basically his anguish is such that he just couldn't tolerate life anymore."

For both groups of participants, being labeled an 'addict' created problems seeking health care. Specifically, chronic pain participants perceived a downgrading in their credibility as responsible stewards of these medications and an associated loss of legitimacy to their claims of being in pain following the introduction of the new policies. Consequently, these participants expressed frustration at having to continually 'prove' their pain to physicians.

> "…my family doctor at one point did not understand the pain that I was in. I actually had to go to a pain specialist and the pain specialist had to write a letter to my family doctor and said 'this girl really does have pain' and I was very frustrated. I will be honest with you, I was pissed. I was like you don't believe me? Look at the surgeries I've had. I have chronic pain and I have chronic nerve damage."

In addition, because of their reconstitution as 'addicts', chronic pain patients perceived themselves as being increasingly ostracized by physicians, who were now distancing themselves from them in order to avoid the increasing professional scrutiny that they might receive as a result of prescribing opioids for pain.

> "Does it [doctor no longer treating them] have something to do with my doctors getting scared because of current policies? You darn well bet. Have I lost a doctor because of that? Are doctors scared of me? You darn well bet. When I go to the ER I get shunned, like they are terrified of me and why?"

For participants who were taking opioids for other reasons, help-seeking experiences were characterized as occurring in a context where health care professionals considered substance use to be a permanent discreditable attribute that was central to defining their identity, a phenomenon described as 'identity engulfment' by Goffman. Individuals were especially concerned that a past or present diagnosis of opioid use disorder would disqualify them from receiving treatment for pain at later times, particularly if they required surgery or developed chronic pain conditions associated with aging. In this manner, the label of 'addict' may cause individuals to forego help-seeking entirely.

> "I was quite ill…but I didn't go because of the stigma and I thought well like as soon as I go on methadone I am not going to get the medical help I need from doctors because they are going to judge me and I experienced that… I didn't get that medical attention because I was an addict and judged…"

Loss of autonomy

As part of our theoretical orientation and in keeping with the approach of Link and Phelan, we were interested not only in how stigma may be experienced by participants and the 'work' they do to counter such stigma, but also the impacts of the associated status loss. From this perspective, a key consequence of reconstituting individuals as 'addicts' with questionable legitimacy to claims of pain was the amplification of power differentials between providers and patients, such that focus group participants described a loss of input and autonomy in treatment decisions as new policies were implemented by physicians. For some, this was most striking when precipitous reductions in opioid dose were imposed without their input and seemingly informed by policy rather than their experience of pain.

> "..my doctor just he showed me this paper and he says 'I have to cut you down or cut you right off' and I am going 'how could you do that you know?' I've been going to him for 35 years? … and he is showing everything to me you know, like how much you are supposed to take and I am going 'how could they do that?' Like they don't know how your pain is. They don't know what you do. Like I could be working in, in a, a field somewhere you know?"

For individuals who were taking opioids for other reasons, power differentials were enacted not only in the form of dose reductions, but also as pressure to accept opioid agonist therapy or risk losing access to the opioid they had been prescribed for many years.

> "And then I ended up getting a new doctor and she wouldn't give me Percocets any longer [Um hmm] told me I could go on methadone, I didn't want to do that."

In addition to loss of autonomy in treatment decisions, some participants also characterized a sense of powerlessness associated with exclusion from policy formulation and implementation, and a perceived unilateral transfer of responsibility for the overprescribing of opioids from clinicians to patients. Participants recounted how, despite being prescribed opioids for many years and managing their use in accordance with their physicians' instructions, they were now being treated as if they had done something wrong.

> "..now you have got me hooked on them and you can't give me any"

Participants felt this shift in the burden of blame was not limited solely to physicians, but extended to pharmaceutical companies, pharmacists and governments, each of whom was perceived to have benefitted from the over prescription of opioids, and yet did not bear the negative consequences of the shift in policy change or the responsibility for creating an opioid 'crisis'. These experiences are exemplars of Link and Phelan's argument that stigma is dependent on power, such that those with social, economic and/or political capital are best positioned to create conditions in which stigma and its discriminatory consequences can unfold.

As participants reported feeling increasingly powerless when it came to treatment decisions about opioid prescribing, a breakdown in therapeutic relationships was described, manifesting itself not only in mistrust and suspicion between patients and providers, but also experiences of paternalism and disrespect. In some cases, relationships were strained to the point where physicians were seen to be abdicating their responsibility to provide patient care, with ensuing interactions characterized as hostile and in need of disciplinary action for the provider:

> "…she lectured me like I was two years old and then I said you know I will call the College of Physicians and Surgeons. Like, I couldn't believe it. It's like, are you kidding me? It's [opioid] saving my life."

The loss of autonomy in treatment decisions was reinforced by a perceived lack of suitable alternatives for the management of pain. Consequently, some participants were compelled to seek out clinicians who were more comfortable prescribing opioids. However, this process exposed what participants characterized as inter-professional power dynamics, with patients able to obtain opioids from one physician only to have a second refuse to extend such care or a pharmacist refuse to dispense the medication. For participants, this inconsistent application of opioid policies resulted in disruptions in care.

> "There is a huge disconnect in the medical community. You've got GPs over there saying 'we're going to restrict your medication or take it away.' Then my pain doctor says 'yeah, what I can do to help you here is a prescription but you know, there's still those

restrictions'…having to regularly go out and renew your pain prescription [with a GP] is brutal."

Taken together, the loss of autonomy, lack of pain alternatives, shift in blame and ensuing adversarial relationships with providers have fostered an environment of uncertainty for participants, who characterize themselves as increasingly abandoned and isolated when seeking care. As summarized by one participant:

"It's like being put on an ice floe and shoved away, and now we have to go out on our own and try and figure things out"

Restoring the power balance: the role of peer workers

The integration of peers in the provision of care for individuals taking opioids was suggested by participants as a mechanism for diffusing the power differential between provider and patient. This was especially notable in the accounts of individuals who were taking opioids for other reasons, for whom peer workers with similar life circumstances were framed as being better able to empathize with their challenges and provide care in a manner that was less judgmental and conflict-laden than that offered by physicians.

"Yeah, but the problem is that the people that are trying to help us can't relate to your story where I can relate to their story of eating out of garbage cans, I can relate to being a prostitute, I can relate to being all of these things because I did all these things right? But when you go into someone's office and you try to put all that out there, their blinders automatically go up and they stop taking you seriously… Hire some people that are still using".

Producing and reproducing structural vulnerabilities

In addition to unmasking power differentials and discrimination, Link and Phelan describe how stigma, labelling, status loss and discrimination can expose individuals to untoward situations. This was evident in our study, in that participants also characterized the new opioid policies as having introduced, unmasked or exacerbated vulnerabilities in their health or safety. For some participants, recent policy changes had resulted in a deterioration in pain control that was further amplified by structural vulnerabilities related to chronic pain, such as under-employment and lack of health insurance. Consequently, non-pharmacologic pain treatments that were not covered by public health insurance became increasingly out of reach, even as they were recommended by providers as replacements for opioids.

"…that holistic approach hasn't really worked for a lot of people because they are usually unemployed by the time this pain has taken over their life and they haven't gotten anything else to control it. They can't afford physical therapy because they have lost their insurance. They can't afford any of those treatments."

Participants also suggested that the potential impact on the mental health of people who take opioids was not considered before policies were implemented and expressed concern that particularly vulnerable individuals might actually take their own lives on account of untreated pain.

"I was horizontal on my couch, I couldn't move. In Depends because when I was trying to get to the bathroom all I could do is crawl. I had a family to look after that I couldn't. My eldest son has all kinds of mental issues {Cries}… the family impact from your suffering is greater on the people that love you. And then the doctors are being threatened and you're frightened again because they are going to take them [opioids] all away and how the hell are you supposed to survive? Should you kill yourself so that you are not the burden and the family can grieve and get over it? I am devastated by the impact."

In addition to worsening pre-existing circumstances, participants perceived that the implementation of new opioid policies has effectively forced many individuals to access opioids from illicit sources, despite known uncertainties about the purity and safety of these products. This reality was endorsed by some chronic pain participants, who characterized a process of ongoing criminalization of people who take opioids in the face of policies which have increasingly restricted access to these drugs. For many of these individuals however, procuring drugs in this manner requires the navigation of unfamiliar social networks with rules of engagement that differ markedly from those to which they are usually accustomed.

"…these doctors that put people on opiates and then cut them off and then they are thrust into a subculture that they have no social skills to navigate. Like it's so fucking horrible. I remember seeing this young kid one time. His doctor cut him off Oxys and, and now he is forced to the street and some wise guy steals his cell phone and he wanted to call the cops like because where he came from like that's the normal thing you do if people steal from you. Like he could get killed and it's all just so wrong."

Apart from issues of safety, some participants suggested how the high cost of procuring drugs from illicit sources might also reinforce vulnerabilities related to under-employment and low income by depleting their already limited financial resources:

"I have to go to the street just to survive…I am constantly broke because of this. I can't work anymore because I don't have enough of a supply [of opioids for pain] that I can get back and forth to work."

For participants who were taking opioids for other reasons, there was concern that the new opioid prescription policies and concurrent harm reduction programs hindered action on addressing structural drivers of opioid-related overdose. Although generally supportive of new funding for take-home naloxone programs and supervised opioid consumption sites, participants characterized these initiatives as being potential distractions from social structural issues such as poverty and affordable housing. Consequently, participants felt that structural inequalities were being reinforced.

"…it's, it's going to take a number of measures not just, not just naloxone, not, not just prescribing guidelines and, and I, I think it's going, it's going to take a, a, a, a large campaign and a strategy that's going to encompass different approaches for, for people and I think housing is a big deal…"

Discussion

In our qualitative study, we have identified several unintended consequences of the recent introduction of opioid-related policies and interventions aimed specifically at preventing overdose and death. Most notably, individuals characterize an environment in which 'addict' has supplanted 'patient' as the dominant social identity for people who take opioids, and relationships with providers have become strained as participants perceive themselves as powerless when clinical decisions are made. These shifts in identity and relationships had several negative repercussions with respect to help-seeking and exposed additional structural vulnerabilities.

Our study builds upon previously published work examining the impact of opioid policy changes. Specifically, a qualitative study of nine patients with chronic pain and five primary care providers found that legislated opioid prescribing rules in Indiana, USA, were perceived to disrupt pain management and patient-provider relationships (Al Achkar et al., 2017). Although our findings were broadly similar, our theoretically-informed analysis demonstrated how the implementation of otherwise well-intentioned policies that are situated within a social and historical context that dichotomizes people who take opioids into 'deserving patients' and 'undeserving addicts' can have deleterious down-

stream effects (Bell & Salmon, 2009). Specifically, interactions with providers and dominant media representations of opioids as dangerous and 'threats' to communities converged to re/produce the stigmatizing label of 'addict', with the consequence that patients' claims to experiencing pain were challenged. These findings are consistent with Goffman's work conceptualizing stigma as a social process dependent on language and prevailing discourses (including images) to produce a loss of status for individuals. Expanding on these findings, we then drew upon Link and Phelan's work to examine the consequences of status loss and power differentials on people who take opioids. Specifically, we found that the resultant status loss and lack of power relative to health care providers produced experiences of discrimination during encounters with the health care system and reinforced structural discrimination related to criminalization, poverty and housing. From the perspective of participants, power differentials were enacted through interactions with providers, the unilateral transfer of the responsibility for opioid-related deaths from providers and manufacturers to patients and being excluded from opioid-related policy making. Taken together, our study is illustrative of the importance of considering social context when policies are implemented and aligns directly with Link and Phelan's description of how labelling, status loss and discrimination can co-occur within a series of power differentials to allow stigma and its consequences to unfold. It was of interest that chronic pain patients challenged stigmatizing processes by distinguishing between 'legitimate' uses of opioids and 'irresponsible' opioid use, thereby exercising their relative power as 'legitimate pain patients' to reproduce the dichotomy between themselves and individuals taking opioids for euphoric or other purposes (Bell & Salmon, 2009).

Because stigma was enacted at micro (i.e. intra/interpersonal), meso (social/systems) and macro (political) levels, potential solutions must correspondingly disrupt power dynamics at each level to be effective (Pescosolido, Martin, Lang, & Olafsdottir, 2008). At the micro level, this would involve changes in the language used to characterize individuals who take opioids, avoiding labels such as 'addict' in favour of less judgement-laden terms such as 'people who take drugs' (Broyles et al., 2014). In addition to changes in language, interventions designed to address knowledge, attitudes and practices of health care workers who work with people who take opioids are required to challenge and mitigate interpersonal stigma related to the care of these individuals. Although studies have demonstrated that specific interventions can improve knowledge and attitudes of physicians towards individuals who take drugs, these findings were limited by short durations of study follow-up and selection bias (Henderson et al., 2014; van Boekel et al., 2013). Furthermore, most intervention research has focused on improving professionals' knowledge and attitudes, rather than behaviours and practices that may produce stigma (Henderson et al., 2014; van Boekel et al., 2013). Further research in this area is therefore needed. In addition, clinicians need to be wary of an 'over-correction' when applying opioid guidelines to individuals who have been receiving these drugs for many years. Although recently introduced Canadian guidelines caution against rapid opioid tapering (Busse et al., 2017), this experience was nonetheless endorsed by participants in our study, suggesting that a disconnect may exist between practice and guidelines. Ensuring the primacy of patient agency when decisions about opioid tapering and transitions to opioid agonist therapies are made is critical for preventing unintended consequences of these practices, such as reproducing structural inequalities and driving individuals to seek opioids from less trustworthy sources. Because respecting patient agency is predicated in part on challenging power differentials between clinicians and people who take drugs, the need to develop and evaluate interventions that aim to change stigmatizing practices is again reiterated. One possible strategy is the integration of specialists who care for people who take drugs in primary care and general psychiatric settings (Drake et al., 2001; Samet, Friedmann, & Saitz, 2001; Weisner, Mertens, Parthasarathy, Moore, & Lu, 2001). Such shared care models have been shown to increase perceived knowledge and confidence in treating people who take drugs (Drake et al., 2001; Samet et al., 2001; Weisner et al., 2001). In some jurisdictions, physician mentorship programs have been developed to assist clinicians in partnering with individuals who take opioids to optimize care in a rapidly shifting policy landscape (Mentoring program that gives primary care providers (PCPs) (2015); Medical Mentoring for Addictions & Pain, 2019). However, whether these approaches overcome the low regard for working with people who take drugs that has been documented among some clinicians remains unknown and is an avenue for further research.

At the meso level, the integration of peers (Bardwell, Kerr, Boyd, & McNeil, 2018; Turner, Arismendez, Liang, Simmonds, & Pugh, 2017) in the care of people who take opioids was suggested by participants as one mechanism to rebalance power between patients and providers and promote empathy in the delivery of care. Several studies have examined the role of peers in supporting people who take drugs (Bassuk, Hanson, Greene, Richard, & Laudet, 2016). Most often, peers were defined as individuals who had abstained from drugs and/or alcohol for some specified period of time. Although inferences from these studies have generally been limited by variability in the programs and outcomes examined and limited descriptions of peer roles, the available literature suggests that peers can facilitate engagement and retention in care for people who take drugs, decrease inpatient and emergency department use among these individuals and promote housing stability (Bassuk et al., 2016). Additional areas of research in this area include the impact of providing peer support on the workers themselves, identifying individuals most likely to benefit from peer support, and successful workplace integration of peers into various settings and practices.

Finally, at the macro level, people who take drugs must be involved in the formulation and implementation of policies that will impact their lives to prevent unintended downstream consequences. Such engagement must reflect the heterogeneity and diversity within the population of people who take drugs, as well as the multiple challenges that may hinder meaningful inclusion of these individuals on boards and committees where decisions affecting their lives are made. These challenges include a lack of reasonable accommodation when considering meeting times and locations, 'hand-picking' community members who may not be representative of the population, and tokenistic involvement with limited engagement. Building on the principles of the Greater Involvement of People with HIV/AIDS, recommendations to facilitate meaningful inclusion of people who take drugs have been developed and could be used as a starting point for involving this population in policies and programs that will directly impact their care (Canadian HIV/AIDS Legal Network, 2019). Furthermore, and as noted by participants who were taking opioids for other reasons, attempts at curbing opioid-related overdose and death through policy are unlikely to be effective if structural drivers of these problems, such as housing, criminalization and poverty, are not addressed (Bohnert et al., 2011; Grigoras et al., 2018; Sherman, Cheng, & Kral, 2007).

Several limitations of our study merit discussion. First, it is unclear if our sample is representative of all individuals who are seen at pain clinics or community organizations. A review of prescription records from Ontario indicates that the median age of individuals who were dispensed an opioid for pain in 2016 was 55 years (interquartile range 39 to 68) and that 55% of these individuals were women (Gomes, Pasricha, Martins, & Greaves, 2017). Respective figures for those with a substance use disorder were 36 years (interquartile range 29 to 46) and 37% (Gomes et al., 2017). However, as with all qualitative studies, our research is not intended to be generalizable to the entire population of persons who take opioids. Moreover, we believe that our concepts of propagating stigma, loss of autonomy and producing/reproducing structural vulnerabilities are conceptually generalizable to other jurisdictions where opioid-related policies have been implemented in a context where use of these drugs remains highly stigmatized. Second, because we did not interview clinicians and policy makers, we were unable to consider the perspectives of these stakeholders. However, we elected to focus on the impacts of policy on people who use opioids

because this area has not been well studied. Third, our sample was comprised of individuals accessing care at clinics or pharmacies and our findings may therefore not be transferable to individuals who are less engaged with the healthcare system. Finally, we did not explore the manner in which various determinants of health (e.g. gender, race) intersect to produce stigma and inequality. However, this was not a focus for the current study, where we sought to produce a theoretically-informed overview of the impacts of policy changes on people who take opioids. Intersectional-informed scholarship on this topic is therefore an avenue for future research.

In conclusion, our work expands upon existing research evaluating the impact of opioid-related policies. By focusing on individuals rather than populations, we demonstrate that the implementation of such policies can create conditions in which stigma and its negative repercussions can be re/produced. Disrupting these conditions requires ensuring that people who take opioids are involved in all facets of policy development and implementation, and subsequently respecting patient agency when decisions about pain management and opioid use are made.

Conflicts of interest

Tony Antoniou has no competing interests to declare. Kari Ala-Leppilampi has no competing interests to declare. Dana Shearer has no competing interests to declare. Janet Parsons has no competing interests to declare. Mina Tadrous has no competing interests to declare. Tara Gomes has no competing interests to declare.

Funding

This study was funded by the Ontario Drug Policy Research Network which is supported by grants from the Ontario Ministry of Health and Long-Term Care (Grant#06673), the Ontario Strategy for Patient-Orientated Research (SPOR) Support Unit, and the Canadian Institutes for Health Research (Grant#153070). Tony Antoniou is supported by a New Investigator Award from the Canadian Institutes for Health Research (CIHR) and a Clinician Investigator Award from the University of Toronto Department of Family and Community Medicine.

Acknowledgments

We are grateful to the participants of the study for their time and contributions, and to the staff at the participating sites for supporting this study.

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