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Research Paper

Ambiguous identities of drugs and people: A scoping review of opioid-related stigma

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ABSTRACT

Background: Human beings have long consumed opiates and opioids for pleasure and as a treatment for numerous ailments, most notably pain. North America is currently in the grips of a crisis of opioid-related overdoses, and stigma is considered a major driver of the harms. While it is well established that substance use in general is highly stigmatized, stigma is a complex concept and opioid-related stigma is not well understood. A lack of clarity on opioid-related stigma has practice and policy implications in terms of understanding the sources of opioid stigma, how it manifests in various contexts, its impact on affected groups, and the development of effective strategies to redress it.

Methods: We performed a scoping review of the academic literature to develop a typology of opioid-related stigma. A charting process identified the type, agent, and recipient of stigma as well as the methodology and substances considered.

Results: Our search yielded 8,543 articles, from which 49 were included in the analysis. Based on the findings, we developed a typology of four main themes: (1) interpersonal and structural stigma toward people accessing opioid agonist therapy (OAT); (2) stigma related to opioids for the treatment of chronic pain; (3) stigma in healthcare settings; and (4) self-stigma.

Conclusion: How opioid-stigma is (re)produced depends on the context of opioid use, the social identity and networks of the person who is consuming the opioid, and what type of opioid is being consumed, including medically-sanctioned forms of treatment. Opioid-related stigma permeates intrapersonal, interpersonal, structural, and societal levels, and people who consume opioids are marginalized at all levels. Our review describes our typology of stigma and illuminates multi-level considerations for reducing opioid-related stigma in healthcare settings.

Introduction

Opiates (e.g., naturally occurring compounds like codeine, morphine) and opioids (e.g., semi-synthetic and synthetic compounds, like oxycodone, heroin, methadone) bind to opioid receptors in the brain and spinal cord, generating effects such as analgesia, slowed respiration and heart rate, and euphoria. These actions make opioids effective for the treatment of pain, but also render them highly addictive. In the past decade, opioid-related morbidity and mortality has become a major public health crisis in the United States and Canada (Fischer & Rehm, 2017; Hadland & Kertesz, 2018; Kolodny et al., 2015). North America is experiencing a "triple wave epidemic of overdose deaths" (Ciccarone, 2019), that started with prescription opioids, followed by heroin, and now fentanyl analogues (Ciccarone, 2019; Kolodny et al., 2015). Researchers and front-line workers suggest a fourth wave is occurring based on the rise in polysubstance consumption, and stimulant consumption in particular (Kariisa et al., 2019); a factor present among the majority (83%) of overdose deaths (Barocas et al., 2019). Since the early 20th century, consumption of opiates, opioids, and other psychoactive substances have seen increasingly heavy, but variable, regulation, and the use of opioids even in some medicalized spaces is highly stigmatized. In the context of the war on drugs, stigma is not

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only a consequence of the current overdose crisis but is a driver of the crisis itself (Buchman, Leece, & Orkin, 2017). The impact of stigma within the context of opioid consumption may lend important insights into understanding its influence on individuals, thereby potentially affecting the efficacy of policies and practices that aim to minimize the harms of opioid consumption.

Stigma

Stigma studies were popularized by Goffman's (1963/1986) classic text, where he defined stigma as an attribute that is socially discrediting; a moral blemish of character. According to Goffman, the stigmatized person assumes a socially assigned "spoiled" identity. Neale, Nettleton, and Pickering (2011) critically review Goffman's spoiled identity concept and argue that the notion that one transitions from a 'spoiled identity' to 'normal identity' is inadequate when applied to the recovery process from problem drug use. A person's identity is contingent upon social relationships and is 'performed' or 'achieved' versus being considered innate. Similarly, Fraser et al. (2017) interrogate Goffman and consider stigma in addiction as a politically productive; they ask what does stigma achieve? These authors argue that stigma, for people who identify as having an alcohol or drug addiction, dependence, or habit, is a contingent biopolitically performative process rather than a fixed marker of deviance. Sociologists such as Link and Phelan (2001) emphasize that stigma is dependent on power structures. On their account, stigma contains diverse aspects of labeling, stereotyping, separation, status loss, and discrimination (Link & Phelan, 2001). The stigma process involves a moralized enactment of social stratification and normative judgment(s) of deviance (Goldberg, 2017). Stigma arises at inter- and intrapersonal levels, and is enacted structurally through policies, laws, and cultural norms that constrain the stigmatized individual's ability to thrive in society (Link & Phelan, 2001; Scrambler, 2009). Stigma is considered a fundamental cause of population health inequities, and some scholars argue that stigma is an independent social determinant of health (Hatzenbuehler, Phelan, & Link, 2013; Link & Hatzenbuehler, 2016; Link & Phelan, 2006).

Stigma is a complex concept and opioid-related stigma has not been explored comprehensively in the literature. A recent review in this journal described stigma in both mental health and substance use disorders and identified areas for stigma reduction in context of the opioid overdose crisis, including broad education initiatives, addressing discrimination against people who consume drugs, and improving self-worth (Corrigan & Nieweglowski, 2018). The sociopolitical context of opioid consumption suggests that opioid-related stigma may differ between illegal and/or injected drugs and medically sanctioned opioids (Bourgois, 2003; Rhodes et al., 2007; Rivera et al., 2014; Simmonds & Coomber, 2009). For example, in context of the war on drugs, the shame associated with experiences of injecting opioids such as heroin in public spaces may intensify a sense of 'otherness' among people who use drugs, as the public space becomes a site of symbolic violence—a feature of stigmatization (Rhodes et al., 2007). This otherness may be entrenched given that injection drug use is often characterized as affecting predominantly poor and racialized groups, as well as populations that already experience densely woven patterns of systemic disadvantage and the associated stigma (Goldberg, 2017; Hatzenbuehler et al., 2013; Morone, 1997; Powers & Faden, 2008; Room, 2005). The stigma a person experiences that is associated with a diagnosed prescription opioid use disorder (OUD) may be qualitatively different than the experience of substance use stigma in general. For example, some authors speculate that the stigma associated with a prescription OUD may be lower than substance use stigma in general because of the legality associated with prescribed opioids (Kennedy-Hendricks et al., 2017). In the context of opioids in chronic pain management, stigma may be exacerbated by policies and procedures stemming from attempts to curb imprudent prescribing (Antoniou et al., 2019).

Limited clarity on the nuances of opioid-related stigma has practice and policy implications in terms of understanding the sources of opioid stigma, how it manifests in various contexts, its impact on affected groups, and the development of effective strategies to redress it at individual and structural levels (Khenti et al., 2017; Kulesza, Larimer, & Rao, 2013). Furthermore, people working in the area of stigma prevention may benefit from understanding the range and intersections of stigmatized identities represented among people consuming opioids (Radcliffe & Stevens, 2008). To provide direction that is more concrete for policymakers, we believe it is necessary to examine the multitude of contexts, populations, and stigma types that exist under the umbrella of opioid-related stigma. To achieve this aim, we conducted a scoping review of the literature to develop a typology of opioid-related stigma.

Methods

A comprehensive search strategy was developed by a medical librarian (AOC) to identify published, English language literature from January 1st, 1996 to the date of the search (January 19, 2018) on the topic of opioid-related stigma. The initial strategy was developed for Ovid Medline by using a combination of database-specific subject headings and text words, and was later customized for each of the following databases: Ovid Medline, Ovid Medline In-Process & Other Non-Indexed Citations, Ovid EMBASE, Cochrane Database of Systematic Reviews, Cochrane Central Register of Controlled Clinical Trials, CINAHL, Ovid PsycINFO, and Philosopher's Index (full search strategies detailed in Supplementary File). We also searched bibliographic references of included publications.

To guide our data analysis and interpretation, we employed the scoping review framework outlined by Arksey and O'Malley (2005).

Identifying relevant studies

Our search yielded 12,356 articles; one article was included through manual search. After we removed duplicates, there were 8543 articles remaining.

Selecting the literature

We applied our inclusion and exclusion criteria to the title or abstracts of all 8543 articles. Author DV reviewed the titles and abstracts (or, if no abstract, the first three paragraphs) of all papers from the databases search. Following this, DV and DZB reviewed the full text of the articles deemed potentially relevant from their titles/abstracts to ensure they met inclusion criteria. We retained the publication if the title or abstract included the term "stigma" (or related term) and mentioned any opiate or opioid substance and referenced a specific person or group. We included both empirical and non-empirical publications. Commentaries, editorials, letters, and dissertations (theses) were excluded, as were articles discussing substance use in general (i.e., not specific to opioids). This resulted in 195 papers meeting the criteria for full-text review. Upon a full text review of each paper, only those which contained a significant discussion of stigma (i.e., more than one sentence referencing opioid-related stigma against an identifiable person or group) were included for the next step. Fifty-one articles were included for data analysis. Please see Fig. 1 for the PRISMA diagram documenting the review process.

Charting the data

To describe the literature, we identified the methodology, substance (s) discussed, and the type, agent, and recipient of stigma to elucidate the typologies (i.e., themes) that we identified. We grouped our findings into common stigma levels described in the literature: interpersonal, intrapersonal, and structural levels (e.g., Cook, Purdie-Vaughns, Meyer,

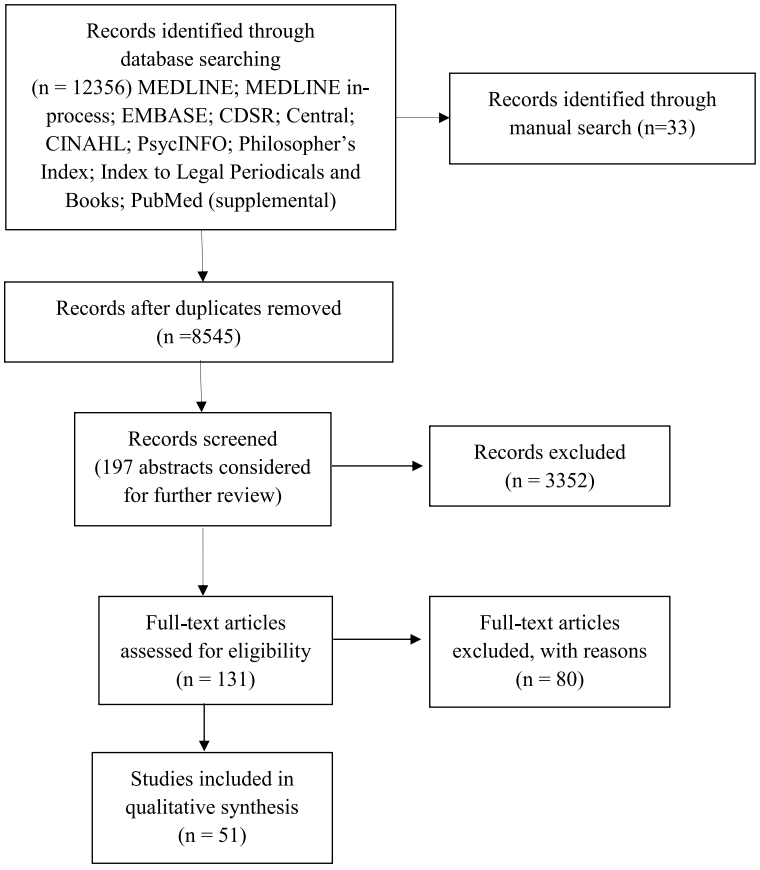

Fig. 1. PRISMA Diagram of scoping review process.

& Busch, 2014). Over a series of meetings between the authors, four main typologies were established.

Terminology

The publications included in our review use a multitude of concepts to refer to a range of behaviours, substances, medical diagnoses, and identities. We acknowledge the contested and stigmatized nature of many of these concepts. We offer the following clarification for our intended use of terminology in this paper. We use people-first language (e.g. people who consume drugs) whenever possible. We use 'client' to indicate the choice exercised by people who consume opioids when pursuing e.g. opioid agonist treatment (OAT) for OUD. However, we acknowledge Woods and Joseph's (2018) critique that the term client appears to distance the individual from a healthcare context and separates OAT from other forms of medical treatment. Moreover, while an individual who consumes opioids may be a client or patient on one or more occasions, there are many times when "patient" is not the adopted identity (Zola, 1973). Indeed, the patient experience is not necessarily analogous to the illness experience (Conrad & Barker, 2010).

We acknowledge that the term addiction has varied throughout history and cultural contexts (Room, 2003). Associated terms such as physical dependence have also varied. How various publics have defined addiction historically as a medical, social, legal, or moral issue has often depended on the substance, and influenced by intersecting factors such as race, gender, political, cultural, and geography (Fraser, Moore, & Keane, 2014; Keane, 2002; 2012). Such definitions of addiction are complicated further by widely promoted neuroscientific accounts in which advocates argue that addiction ought to be labelled a brain disease in order to eradicate stigma; a notion that seems counter-intuitive given the long history of disease stigma (Buchman, Illes, & Reiner, 2011; Fraser et al., 2017; 2017). Addiction, despite its common usage, is not an official diagnostic term. Its potential inclusion in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) generated intense debate because some thought leaders believed addiction was incorrectly conflated with physical dependence, especially in pain medicine when people are prescribed long-term opioid therapy (Keane, 2012). When we use the term addiction in the manuscript, we use it if this is the term used in the included publication. We recognize that 'addiction' is clinically imprecise and does not always reflect the experiences of people who consume alcohol and other drugs. Furthermore, various medical, lay, and consumer groups may eschew the term 'addiction' entirely and use terms such as substance use problem or habit (Fraser et al., 2014). We use the term opioid use disorder (OUD) to highlight the current DSM diagnostic label; however, we acknowledge the normative dimensions of this medicalized terminology as well.

Findings

The summarized findings including methodologies, types of substances, and agents of stigma are represented in Table 1. Please see Fig. 2 for a table of included publications by year. Many articles discussed multiple opioid substances as well as agents of stigma; these quantifications are not mutually exclusive. Seventy-seven percent (n = 37) of the articles were from North America; 42% (n = 21) from Europe; 15% (n = 8) from Australia and Asia (n = 7), respectively; 4% (n = 2) from Africa; and one (2%) from Other.

Four main typologies emerged across the included studies: (1) OAT-related stigma; (2) stigma related to opioids for the treatment of chronic pain; (3) stigma in healthcare settings; (4) self-stigma.

Table 1
Summarized results describing included studies' methodologies, types of substances, and agents of stigma (n = 51).

Methodology		N
Quantitative	*Extraction of medical records*	9
	Survey/Questionnaire	2
	Content analysis	2
Qualitative	*Interviews*	35
	Focus groups	5
Review/Analysis		11
Mixed Methods	*(E.g., self-report questionnaires, interviews, standardized instrument)*	7
Type of substance		N
All opioid substances	*(Including all prescription, legal, and illegal opioid substances)*	19
OAT	*Methadone*	11
	Buprenorphine	6
	Buprenorphine/Naloxone (Suboxone®)	2
Prescription opioids	*(E.g., oxycodone, hydrocodone, oxymorphone, codeine, morphine, fentanyl)*	11
Heroin		7
Opioid antagonist	*(Naloxone)*	3
Agents of stigma identified		N
Intrapersonal	*Self*	12
Interpersonal	*Healthcare providers*	25
	In-group/peers	9
	Family	5
	Friends	4
	Employers	2
External	*Society*	21
	Systemic/structural	7
	Media	2

Typology 1: OAT-related stigma

Twenty-seven (53%) of articles described stigma toward individuals regarding their use of OAT (please see Table 2). Sometimes referred to as opioid substitution therapy, opioid replacement therapies, opioid pharmacotherapy treatment, or medication-assisted treatment, OATs are medications that bind to opioid receptors in the brain and spinal cord and work to prevent withdrawal and reduce cravings related to opioids. Examples of OAT include methadone, the partial agonist buprenorphine, and buprenorphine/naloxone (Suboxone®), which is a partial agonist and antagonist.

In the included empirical studies, research participants reflected interpersonal stigma in statements that opioid agonists used for treatment were morally equivalent to the use of illegal opioids such as heroin. As a result, people accessing OAT were unable to avoid stigma either for drug use itself or their pursuit of OAT, given the overall perception that these individuals were merely replacing one addictive substance with another (e.g., Chaar et al., 2013). Stigma in this context contributed to client lowered self-esteem by reifying their association with a stigmatized identity of someone who uses illegal drugs (please see Typology 4), which may have concurrently disincentivized some people from accessing OAT.

The instability of OAT as a medically-sanctioned treatment

Articles describing the views of expert groups on the treatment and research of pain conditions (Lewis, 1999; Savage et al., 2003) and qualitative interviews with healthcare professionals (Baldacchino, Gilchrist, Fleming, & Bannister, 2010; Chaar et al., 2013; Haroun El Rasheed et al., 2016; Woods & Joseph, 2012) indicated that some healthcare professionals believe that OAT does not represent a legitimate form of treatment. Some OATs (methadone in particular) were perceived by some pharmacists as a "cheap fix" (Chaar et al., 2013) due to the cost by obtaining them through a prescription versus purchasing it on the street. Physician discomfort with prescribing and managing OAT left clients feeling ashamed and unsupported, which was not conducive to managing their substance use (Andraka-Christou & Capone, 2018). OAT clients reported being told that OAT is a short-term solution only—the underlying disorder is not resolved—and reported pressure from healthcare professionals (Chaar et al., 2013) and family members (Gatewood, Van Wert, Andrada, & Surkan, 2016; Woo et al., 2017) to come off the medication. This external pressure seemed to erase the distinction between the medicalized 'legitimate' OAT consumption and illegitimate illegal consumption since it caused clients to feel they were doing something wrong; by consuming the medication they were engaging in a behaviour that was morally equivalent to taking illegal drugs (Allen & Harocopos, 2016). People accessing OAT described a sense of changed identity (e.g., feeling in control of medication use, better self-esteem) which was undermined from the persistent stigma they experienced (Notley, Holland, Maskrey, Nagar, & Kouimtsidis, 2014; Pedersen, Sandberg, & Copes, 2016).

Stigma relating to specific types of OAT

Several empirical studies reported participants felt less stigmatized on either buprenorphine or buprenorphine/naloxone than methadone because fewer people were familiar with the names of these medications (Larney, Zador, Sindicich, & Dolan, 2016; Mauger, Fraser, & Gill, 2014; Tanner, Bordon, Conroy, & Best, 2010). In contrast, the

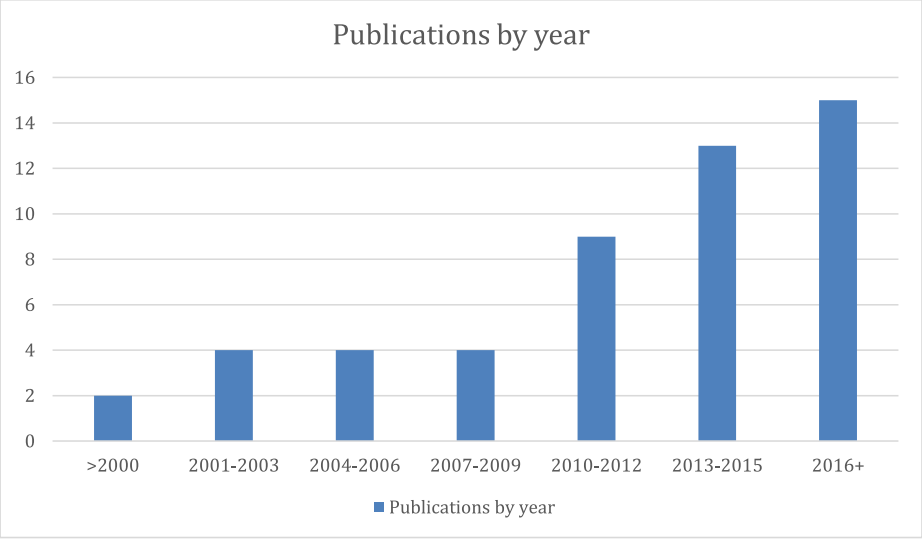

Fig. 2. Included publications (N = 51) grouped by year range indicates a rise in research interest in opioids and stigma.

Table 2
Summary of findings regarding OAT-related stigma (theme 1, $n = 27$).

Stigma type	Study design	Methodology	Key points
Interpersonal/Societal	Qualitative ($n = 11$) Quantitative ($n = 2$) Mixed ($n = 4$) Analysis ($n = 1$)	*Interviews* *Focus Groups* *Extraction of medical data* *Questionnaire/ survey* *Literature review*	• Strongest stigma for methadone (vs. other OATs) • Label of 'addict' remains despite effort to cease problematic drug use • Ubiquity of knowledge of methadone's purpose yields more stigma • Acceptance of OAT mediated by *how* a person became addicted (e.g., prescription vs. illegal use) • Moral ambiguity surrounding whether OAT clients are 'drug-free'/abstinent
Structural/Systemic	Qualitative ($n = 1010$)	*Interviews* *Focus groups*	• Barriers to certain methods of OAT perceived as arbitrary and burdensome • Some choose to self-treat due to difficulties in accessing OAT • Supervised OAT administration highly stigmatizing, implying distrust • Lack of treatment programs for people under the age of 18 years • Programs frequently close due to loss of funding • Paucity of providers willing/able to provide OAT services

Full reference list available in Supplementary file, Table 1.

awareness that methadone is associated with treatment of heroin addiction was felt to be a reason for higher stigma (Larney et al., 2016).

Some research participants also perceived the muted side effects of buprenorphine as a benefit (Mauger et al., 2014; Tanner et al., 2010). Participants observed that they were less likely to appear 'high,' thus buprenorphine (more so than methadone) had the effect of moving their identity further away from stereotypes associated with people with an addiction (Tanner et al., 2010). Oft repeated in the literature by authors and research participants was that buprenorphine presents more opportunity to reduce stigma due to its method of administration (i.e., not consumed in a pharmacy) and more favourable side effect profile (Allen & Harocopos, 2016; Tanner et al., 2010; Woo et al., 2017; Woods & Joseph, 2012). For example, while some participants reported that methadone gave them a "fuzzy" or "woozy" feeling (Tanner et al., 2010), alternative forms of OAT (e.g., buprenorphine) did not, giving them more confidence to engage socially with others.

In-group stigma against OAT

Findings from some qualitative studies suggest that OAT clients' peers stigmatized them for not being 'clean' (i.e., abstinent). For example, and consistent with the other sub-typologies in this section, studies reported that some people who consume drugs perceive prescribed methadone as equivalent to illegal and 'dangerous' substances like heroin or fentanyl (Allen & Harocopos, 2016). This perception, and its relationship to addiction, prompted some peers to shame methadone clients (Ronel, Gueta, Abramsohn, Caspi, & Adelson, 2011). The literature describes these perceptions to be a common barrier to seeking OAT as a method of treatment (Allen & Harocopos, 2016; Culbert et al., 2015; Pedersen et al., 2016), which can intensify feelings of isolation, depression, and a loss of self-efficacy among people attempting to access or accessing OAT (Ronel et al., 2011).

Attending a 12-step based recovery group was daunting to some participants, as some 12-step group members reported that individuals taking any form of OAT (e.g., methadone, buprenorphine) are not truly abstinent (Greenfield, Owens, & Ley, 2014). The notion that OATs are morally and pharmacologically equivalent to the opioid to which one was addicted is reflected by opioid-using peers, friends, family, and even healthcare providers (Allen & Harocopos, 2016; Chaar et al., 2013; Gourlay, Ricciardelli, & Ridge, 2005; expanded below). In-group stigmatization was linked strongly to foregoing or stopping OAT.

Among prisoners, the consumption of OAT was considered a threat to the prison drug economy. Drug suppliers encouraged the active ostracization of prisoners who were consuming OAT (Culbert et al., 2015; Larney et al., 2016; McKenzie, Nunn, Zaller, Bazazi, & Rich, 2009). The social exclusion of people on methadone created barriers for people in prison who wanted to access OAT but feared losing their social status (Culbert et al., 2015). Culbert's et al.'s (2015) interviewees reported that most people in prison prioritized their social standing, and in so doing consumed substances intravenously, thus increasing the risk of acquiring blood-borne infections (e.g., hepatitis C, HIV) through the sharing of injecting equipment.

Structural stigma and OAT

Structural stigma was reflected in the multitude of ways in which policies, drug courts, laws, and procedures worsened stigma and generated barriers for individuals attempting to access OAT. Extensive documentation requirements, administration procedures, and regulatory considerations for physicians qualified to administer OAT, worked to disincentivize and stigmatize persons seeking pharmacological treatment for an OUD. Extensive demands on OAT clients such as the ability to present with little notice to drug courts and multiple unannounced drug tests left patients feeling without much control over their fate. The process of receiving methadone in specific, limited pharmacies was noted to be particularly stigmatizing and disempowering, and research participants reported that they felt like they were in a 'factory line,' unable to escape the reminder that they were 'addicts' (Csete & Catania, 2013; Greenfield et al., 2014; Hatcher, Mendoza, & Hansen, 2018). Such social control measures have been noted to increase stigma by reinforcing visibility of difference and deviance by exposing 'undeserving' individuals to the public gaze (Harris & McElrath, 2012). Woods and Joseph (2012) noted that procedures operationalize stigma in that OAT clients are more heavily regulated as compared with people who have committed a felony.

Typology 2: Stigma related to opioids for the treatment for chronic pain

Thirteen (26%) studies reported on stigma against the prescribing practices pertaining to people who consume opioids to treat chronic pain (Table 3).

Attitudes among healthcare professionals and the family and friends of people consuming opioids helped to establish what methods and means of receiving opioid pharmacotherapy is considered legitimate and by whom. The literature describes how some clinicians create a line with 'addicts' on one side and 'pain patients' on the other by determining whether the pain is associated with an objective pathology (e.g., acute injury or cancer) and whether opioid therapy is treating 'legitimate' physical pain vs. a so-called 'illegitimate' reason such as emotional dysregulation, stress, or drug-seeking. Clients themselves sometimes made this distinction (Stumbo, Yarborough, McCarty, Weisner, & Green, 2017). Certain studies suggest that the distinction between clients who have legitimate/illegitimate pain and those who are thus deserving/not deserving of treatment tend to fall along class and racial lines (Bell & Salmon, 2009; Larjow, Papavasiliou, Payne, Scholten, & Radbruch, 2016; Spitz et al., 2011).

In the literature, people living with chronic pain reported a hesitancy or discomfort in consuming opioid medication for their pain despite its potential efficacy. The stigma associated with the label of 'addict' was a key deterrent, and clients who chose to pursue opioid therapy reported feelings of guilt. Guilt may be related to a prevailing notion that one is 'morally weak' for utilizing opioids to treat pain

Table 3
Summary of findings regarding stigma in the context of opioid treatment for chronic pain (theme 2, $n = 13$).

Stigma type	Study design	Methodology	Key points
Interpersonal/Societal	Qualitative ($n = 3$) Quantitative ($n = 3$) Mixed ($n = 2$) Analysis ($n = 5$)	*Interviews* *Focus Groups* *Questionnaire/ survey* *Systematic review* *Content analysis*	• 'Opiophobia' exhibited by providers and patients limits effective pain treatment • Estimation of pain's veracity influence severity of stigma • Need for opioids associated with moral failure, particularly long-term • Suspiciousness of patients when fulfilling opioid prescriptions • Media exacerbates stigma by over-representing negative outcomes
Structural/Systemic	Quantitative ($n = 2$)	*Survey*	• Regulatory barriers prevent or delay effective pain control • Need for verification of 'legitimacy' of opioid prescription • Alternative prescription forms effectively 'othering' patients taking opioids

Full reference list available in Supplementary file, Table 1.

which was reflected in clients' perceptions of attitudes of family and friends (Brooks, Unruh, & Lynch, 2015; Vallerand & Nowak, 2010). Some people consuming opioids reported that friends and family somewhat accepted their use of the medication as a short-term solution only, with many reporting being told to "get off this garbage" (Vallerand & Nowak, 2010). This negativity prompted individuals to conceal or minimize their consumption of opioid pharmacotherapy.

The negative feelings about consuming opioids for pain relief prompted some individuals to impose measures of self-control to restore a sense of strength. They seemed to reclaim a feeling of strength by engaging in a "power struggle" with themselves (Brooks et al., 2015) whereby they would delay taking their medications as long as possible. This internal fight was viewed as them versus the pain, with opioids representing the white flag of surrender. Ultimately, some participants acknowledged they "never win though" (Brooks et al., 2015), which, for most, eventually lead to acceptance of needing the medications. Notably, acceptance did not necessarily imply approval – rather, most participants appeared only to accept opioid therapy as the preferable option to the alternatives of severe loss of functionality, excruciating pain, or, for some, suicide (Brooks et al., 2015).

Typology 3: Stigma in healthcare settings

Stigma in healthcare settings was represented in 19 studies (37%) which described the stigma enacted by healthcare professionals (including physicians, nurses, and pharmacists) toward people who use opioids (Table 4). Articles identified multiple settings within healthcare where stigma was perceived, including within clinical encounters, in pharmacies, and in hospital emergency departments.

Trust and the clinical encounter

Several studies noted a lack of trust both from the perspectives of people who consume opioids and from healthcare professionals. Some studies noted a tendency among individuals consuming opioids to describe efforts to hide, or fail to disclose, their substance use (Bourgois et al., 2006; Savage et al., 2003). Some authors attributed an association between stigmatization in the healthcare setting to the poor health status of people consuming opioids (Bourgois et al., 2006). High levels of trust can reduce stigma by minimizing the perceived deviance of people who inject drugs and making them feel like "any other person" (Treloar, Rance, Yates, & Mao, 2016, p.142).

The stigmatizing treatment identity as someone who consumes opioids elicits negative labeling among healthcare professionals who often term these clients as "difficult to treat" (Greenfield et al., 2014), p.6). The 'difficult patient' label was associated with behaviours described as "manipulative," "dishonest," "squirrely," and "demanding" (Andraka-Christou & Capone, 2018). Healthcare professionals with considerable experience managing OUD in their clients described these behaviours as being "symptoms" of the "disease" of addiction (Andraka-Christou & Capone, 2018, p.12).

One study noted that even in the absence of outright mistreatment, mothers who consume or who previously consumed opioids felt judged by healthcare professionals (Howard, 2015). Other people who consume opioids described receiving inadequate pain management, having services withheld, and receiving improper medical treatment (Baldacchino et al., 2010; Day, Ross, & Dolan, 2003; Woo et al., 2017). Some studies described a general reluctance on the part of healthcare professionals to provide OAT due to concerns about the perception within the medical community as well as from their other patients (Andraka-Christou & Capone, 2018).

Hospital emergency departments

People consuming opioids for pain conditions reported the need to "put on a show" and "never be grumpy or grouchy" (Brooks et al., 2015) when presenting to hospital emergency departments. Several studies noted participants adopted these behaviours due to previous encounters where they were refused pain medication prior to even a medical evaluation of their presenting complaint. This type of stigmatization prompted fears about expressing any sort of dissent or confrontation out of concerns they would be treated unfairly. Widespread labelling with terms such as "drug seeking" is a key part in the stigmatization and "othering" of people who use opioids by healthcare providers (McCaffery, Grimm, Pasero, Ferrell, & Uman, 2005; Morgan & White, 2009).

Pharmacists and pharmacies

Participants in studies who identified as consuming OAT such as methadone reported receiving negative comments from pharmacists such as referring to methadone as "garbage" and yelling "we don't have any methadone" in pharmacies (Spitz et al., 2011). This behaviour dissuaded some individuals from seeking treatment, and was reported more frequently by research participants with marginalized identities

Table 4
Summary of findings pertaining to stigma in healthcare settings (theme 3, $n = 19$).

Stigma type	Study design	Methodology	Key points
Interpersonal	Qualitative ($n = 1010$) Quantitative ($n = 3$) Mixed ($n = 1$) Analysis ($n = 5$)	*Interviews* *Focus Groups* *Literature review* *Content analysis*	• 'Difficult' and 'drug-seeking' patient labels propagate stigmatization • Intersection of negative labels with prejudices regarding class and race • Perpetuation of 'weak-willed addict' stereotype • General suspicion of individuals taking opioids for any reason • Some providers withhold service or dropped clients due to opioid use • Providers limit opioid prescribing due to fear of causing addiction

Full reference list available in Supplementary file, Table 1.

(Spitz et al., 2011). Barriers such as the pharmacist refusing to fill and/or refill a prescription, requiring additional confirmation from the prescribing physician, being told by the pharmacist not to take the medication, and a general feeling of suspicion was noted by clients (Donner, Raber, Zenz, Strumpf, & Dertwinkel, 1998). Pharmacists display substantial variability in their perceptions of OAT clients (Chaar et al., 2013; Hill et al., 2014; Howard, 2015) with some demonstrating compassion and empathy while others viewing OAT (namely, methadone) as morally equivalent to heroin (Chaar et al., 2013), as described earlier. Clients receiving opioids for cancer pain report feeling compelled to disclose their cancer diagnosis at the pharmacy to avoid stigma as an 'addict' and barriers to receiving their medication (Donner et al., 1998).

Insufficient education

Multiple studies indicated that clinical experts in pain management and OUD have long argued there is insufficient education provided to healthcare professionals regarding substance use disorders, opioids, and OAT. Lack of understanding surrounding neurochemical substrates of addiction, tolerance and dependence, is evident in the language used by health professionals (Woods & Joseph, 2012). One survey of medical students reported that nearly all felt that their education regarding opioid-related issues such as addiction and management of prescription opioid use was insufficient (Gatewood et al., 2016). Some physicians reported that they are not confident in their knowledge regarding treatment of people with addictions (e.g., whether to refer to psychiatry versus management by primary care providers), which may contribute to the hesitancy of treating these clients (Andraka-Christou & Capone, 2018; Greenfield et al., 2014). A study by Haroun El Rasheed et al. (2016) found that the degree of stigma toward people using a given substance expressed by medical students and mental health professionals is correlated with the amount of knowledge they have about that substance.

Some studies suggested that some physicians utilize their power and privilege to combat stigma in healthcare settings. For example, Brooks et al. (2015) describes a client whose pain was improperly managed and was treated with more compassion after their physician put a direction on the chart to "stop harassing [patient's name]" (p. 18), accompanied by specific instructions regarding dispensation of their opioid medication.

Typology 4: Self-stigma

Twelve (24%) of studies described self-stigma (Table 5). Self-stigma does not originate from within; rather, the concepts were internalized by many study participants and may reflect society's views, and, sometimes, the views conveyed by their friends, family, and peers.

Many research participants in the studies reviewed used the words "addict" or "junkie" specifically when describing their negative self-worth and loss of self-efficacy. These terms were used in connection with feelings of powerlessness against their substance use, their conformity to stereotypes about people who consume drugs, and their need of medication to avoid 'problematic' opioid use. For example, Sun, Chen, and Marsiglia (2016) described self-stigma as resulting in a constellation of guilt, self-loathing, shame, and despair.

Participants in the studies identified meaningful relationships as important social supports (Cornford, Umeh, & Manshani, 2012). Self-stigmatization in the form of a negative self-image undermined participants' abilities to draw on pre-existing relationships for support and inhibited development of new ones, as they felt unworthy of positive regard. Many participants reported the need to get well – meaning, receiving treatment for or stopping opioid consumption – before believing they were worthy of interpersonal relationships (Cornford et al., 2012). OAT often helped with this effort, but the stigma against these medications further undermined their social support. Similar to what we described in Typology 1, people consuming OAT characterized themselves as neither "genuine addicts" nor were they "normal" (i.e., abstinent; (Richert & Johnson, 2015). This indeterminant distinction reflected the notion that participants sometimes escaped stigma only by appearing physically and 'functionally' similar to their non-opioid-consuming peers, but knowing that the internal, unseen presence of opioids in their body maintained their apparent deviance.

Compounded self-stigmatization

Among women who consumed opioids during pregnancy and/or in the postnatal period, they reported negative feelings toward themselves and they aligned themselves with the so-called 'junkie identity' (Chandler et al., 2014; Savage et al., 2003). These women conveyed a sense of failure to be strong enough to avoid addiction but also a failure to live up to the standard of being a 'good mom' (Chandler et al., 2014; Howard, 2015). Both fathers and mothers expressed self-stigma (Cornford et al., 2012), and reported the label of 'drug addict' was believed to be a cause of their depressed mood. While these studies hint anecdotally at potential areas of similarity and difference in the apparent gender binary, none specifically differentiated in their analysis by gender.

Particularly strong negative feelings toward the self were reported among people consuming opioids who suffered a sexual trauma in the context of substance use (Jessell et al., 2015; Sun et al., 2016). Participants in these studies avoided accessing treatment due to the perception that their opioid use made them feel unworthy of receiving help, and they generally reported that stigma against people who consume opioids is compounded by a culture where there are few repercussions for perpetrators of sexual violence.

Participants who consumed opioids for chronic pain exemplified how strongly the 'addict' identity generates self-stigma. OAT clients clung strongly to the 'pain patient' identity when they had to take their medication in pharmacies alongside those they perceived as 'addicts' (i.e., people addicted to heroin) by quickly declaring their pain-related diagnosis or condition, without having been asked (Stumbo et al., 2017). Clients with chronic pain further reported self-associations with the 'junkie' identity at times when they felt they consumed any medication beyond what was needed to treat their pain alone, which usually occurred in the context of emotional disturbance or stress.

Table 5
Summary of findings regarding self-stigma (theme 4, $n = 12$).

Stigma type	Study design	Methodology	Key points
Intrapersonal	Qualitative ($n = 9$) Mixed ($n = 2$) Analysis ($n = 1$)	*Interviews* *Focus Groups* *Extraction of medical data* *Structured assessments*	• Negative self-views originate externally, propagated internally • Self-blame, loathing, despair, shame • Compounded stigma among groups with other marginalized identities • Engage in identity management to combat perceptions of 'junkie' • Psychological burden to taking opioids for pain conditions • Internalization of 'moral weakness' for needing medication • Difficulty leaning on social supports, which worsens negative feelings

Full reference list available in Supplementary file, Table 1.

Discussion: Practice and policy implications of our stigma typology

In this scoping review, we developed a typology of opioid-related stigma based on our analysis of the literature. How opioid-stigma is (re) produced may depend on the context of opioid use, the social identity and networks of the person who is consuming the opioid, and what type of opioid is being consumed, including medically-sanctioned forms of treatment. There are multiple possible permutations and combinations as opioid-related stigma is enacted from intrapersonal, interpersonal, and structural levels. While people who consume opioids may be marginalized at all levels, there are certain treatment identities (e.g., a client with chronic pain who has 'legitimate' pain) that actively resist other associated stigmatized identities (e.g., 'the addict' with 'illegitimate' pain). We can see, then, what opioid-related stigma achieves: it is "a biopolitical technology of power that allows certain subjects legitimacy and not others and…constitutes the conditions under which legitimate subjects emerge" (Fraser et al., 2017, p. 195). Our findings suggest that opioid-related stigma is far from stable; it does not function as a fixed marker of deviance or difference (Fraser et al., 2017). The political dimensions of opioid consumption have been long recognized (Bourgois, 2003) and contribute to the defining and re-defining of identities along prevailing assumptions of social deviance.

Our review identified stigma against OAT, and methadone in particular, as the most prevalent theme within our typology. This finding may be reflective of a medical culture that relies on a pharmacotherapy-first approach. However, this finding is concerning given the overdose crisis in North America where there have been calls for increased access to certain forms of OAT (e.g. buprenorphine) as the gold standard for treatment. OAT-associated stigma may lead to further harms as individuals may avoid OAT or attempt to self-treat by accessing opioids from the illicit sources (which itself can be associated with harms such as using in potentially unsafe ways and in hazardous contexts (Allen & Harocopos, 2016; Richert & Johnson, 2015). It is likely that OAT-stigma functions much like the way Fraser and valentine (2008) have described methadone as a "metaphor for heroin" (p.35) – that is, how OAT is represented and given meaning as a substitute or replacement for a pharmacologically similar and stigmatized substance. Methadone, and perhaps all OAT, is doubly stigmatized, paradoxically: in resembling (pharmacological structure and action) illegally-accessed opioids such as heroin and fentanyl, OAT is dangerous and disorderly; but in not being like illegally-accessed fentanyl, but a medically sanctioned treatment that is consumed in regulated doses and spaces, OAT is an inauthentic 'substitute' for fentanyl (Fraser & valentine, 2008).

Keane (2013) observes that medical discourses attempt to distinguish discursively between methadone as an analgesic and methadone as an treatment for addiction, while simultaneously attempting to separate methadone clients as 'addicts' vs. 'non-addicts' and pain sufferers vs. non-pain sufferers. This separation, as we identified in our findings, is not only discursive but may also occur in practice. Accordingly, treatment-seeking for an OUD, which is considered health promoting and rational, and involves medically legitimized forms of treatment, may not alleviate stigma as healthcare professionals often rely on the distinction between who is 'worthy' of treatment and who is not. This may encourage healthcare professionals to consider the testimonies of pain that OAT clients report as illegitimate, which also works to stigmatize and marginalize them (Bell & Salmon, 2009; Buchman, Ho, & Illes, 2016; Buchman, Ho, & Goldberg, 2017). Opioid agonist treatment, a medically-sanctioned therapy that its proponents claim will help destigmatize addiction, in an ironic and perhaps unintended way, operates to entrench the stigma and marginalization of people labeled as 'addicts'.

Similar to what Keane (2013) describes vis-a-vis methadone, the production of stigma in chronic pain contexts works to construct a moral binary between 'good' and 'bad' opioid consumption (Bell & Salmon, 2009). Opioids and OAT in particular, are reflective of the logic of Plato's *pharmakon,* what the philosopher Derrida (1995) describes as a drug that is both an antidote and a poison. As such, the pharmakon cannot be fixed in oppositions of e.g. good and bad but disrupts these binaries. Indeed, opioids are substances that can be beneficial for treating pain but can also be a poison insofar as they can contribute to an OUD and can increase the risk of overdose (Derrida, 1995). Central to this discussion are anxieties amongst healthcare professionals and even clients about the role pleasure, intoxication, and euphoria—psychoactive and bodily effects that are attributed to opioids when consumed for ('illegitimate') recreational purposes, but are antithetical to the potential therapeutic benefits of opioids for patients with 'legitimate' pain as well as an agonist treatment for an OUD. It is this unstable dichotomy that allows OATs to be medically sanctioned forms of treatment, but also the target of stigma because of the association with illegal behaviour and unauthorized pleasure (Anstice, Strike & Brands, 2009; Fraser & valentine, 2008; Keane, 2008; Kofi, Sud, & Buchman, 2018).

Scholars have called for multilevel interventions to target and reduce stigma (Cook et al., 2014). Such an approach may be helpful for opioid-related stigma, which is multilayered and enacted at all ecological levels. Drawing from Cook et al. (2014) framework, we map out stigma-related issues at the intrapersonal, interpersonal, and structural levels that may be amenable to future research directed at drug-related stigma reduction.

Intrapersonal level

A key feature of stigma is how it socially discredits those who are its targets, thereby diminishing an individual's or groups' power within society (Link & Phelan, 2001). Our findings suggest a confluence of stigma processes that perpetuate self-stigma, namely how broader social structures (e.g., racism, classism, colonialism, attitudes toward people who use drugs) may inflict a kind of systemic oppression on individual self-identities. In our findings, self-stigma was associated with a loss of self-efficacy and self-worth that affect a person's perception of the value of seeking treatment. Fear of stigmatization from others pushes individuals to hide their opioid or OAT consumption, which can be psychologically burdensome to maintain (Woods & Joseph, 2012)). The stress of acting out this alternate identity and feeling as though one has inauthentic relationships may further contribute to negative secondary health effects. Psychological supports for people with persons with opioid use disorder should provide specific support to the person regarding the mental burden associated with carrying stigma.

An important intrapersonal avenue for intervention is therefore addressing the susceptibility to lowered self-esteem and self-efficacy among people consuming opioids. OAT clients have identified this strategy (Gourlay et al., 2005), stating the need to focus on the positive aspects of OAT and choosing to feel confident that they are making the best choice for themselves. We do not intend to emphasize that intrapersonal-level responses to stigma should be prioritized over structural responses, the latter of which is often considered harder to modify. Rather, stigma can be a major source of chronic stress in people's lives that can negatively affect their health (Major & O'Brien, 2005), such that psychological supports may provide benefit to the stigmatized who are experiencing coping difficulties at the micro level. Healthcare professionals can play a key role in reinforcing these self-beliefs, but there is still a gap in interprofessional substance use education.

Interpersonal level

Within healthcare settings, opioid-related stigma may prevent individuals from seeking treatment, feeling safe in healthcare settings, and receiving appropriate care. People consuming opioids for pain, OAT clients, and people who use drugs all reported mistrust, suspicion, and even verbal aggression from healthcare professionals (Anstice,

Strike & Brands, 2009; Baldacchino et al., 2010; Spitz et al., 2011).

Our review highlights the wide spectrum of attitudes and varying scientific knowledge surrounding opioids and addiction medicine among healthcare professionals. Limitations in clinician education regarding addiction likely both reflect and propagate stigma. Some clinicians feel their expertise regarding addiction treatment is often insufficient (Andraka-Christou & Capone, 2018), and either tell the patient they are unqualified to treat them or refer them elsewhere. Despite the good intentions of not wanting to provide a treatment beyond their scope of practice, these actions may leave clients with the impression that their concerns are not as deserving as other medical problems. Increasing capacity and compassion among healthcare professionals requires evidence-based addiction medicine education (Woods & Joseph, 2018).

Those who face stigma from peers may be most vulnerable to the negative effects of opioid-related stigma, given that rejection from people with similar challenges is likely to be deflating and prevent them from accessing important services. Addiction treatment programs and 12-step mutual aid programs have an important role in promoting in-group acceptance of people pursuing all modalities of addiction treatment to avoid ostracizing the very people they intend to support.

Structural level

Stigma scholars have described how structural forms of stigma are perhaps the most harmful (Goldberg, 2017; Hatzenbuehler et al., 2013). As social disadvantages often co-occur, opioid-related stigma can intensify the multiplicity of stigmas borne by those who are already marginalized, which can exacerbate health inequities (Powers & Faden, 2008). Beliefs about people who consume opioids are likely exacerbated by media representations of opioid use. For example, a recent study by McGinty, Stone, Kennedy-Hendricks, and Barry (2019) found that 49% of U.S. news stories from July 1, 2008 to June 30, 2018 on the opioid overdose crisis included one or more stigmatizing terms (e.g. “addict”, “substance abuser”) in its coverage. Other studies have found that media coverage of OxyContin tends to focus on negative sequelae exclusively (e.g., addiction, crime, death; Whelan, Asbridge, & Haydt, 2011). Structural factors that construct these individuals as ‘others’, by situating their apparent deviance within the public gaze, reify these beliefs and may help increase barriers to implementation of evidence-based public health solutions (Fraser, 2006; Harris & McElrath, 2012; McGinty et al., 2019). Indeed, studies in our review identified the media as one actor in perpetuating opioid-related stigma.

Further structural barriers that interlock with stigma included excessive regulation, documentation, and requirements specific to prescribing opioids (e.g., different paperwork as compared with paperwork for similar, non-opioid substances; Donner et al., 1998). This includes regulatory barriers in prescribing OAT as a form of treatment, as well as how stigma is a major barrier in accessing these medications (Wakeman & Rich, 2018). This kind of “structural iatrogenesis”—the harms done to patients by bureaucratic systems within healthcare—may intensify the stigma experienced people who use opioids (Stonington & Coffa, 2019). Ensuring people have reasonable access (e.g., financial/insurance, availability in pharmacies) to the full spectrum of OAT options may decrease some of these structural barriers (Woods & Joseph, 2018). Low barrier services are crucial to maximizing the number of individuals who are able to access treatment, which is particularly important for structurally vulnerable populations who face formidable barriers in accessing healthcare. Accordingly, recognizing and altering the institutional structures that systematically harm patients, and focusing on the structural determinants of opioid consumption and opioid stigma, is necessary (Dasgupta, Beletsky, & Ciccarone, 2018; Stonington & Coffa, 2019). Specific points of consideration may include some relaxing of the regulatory, bureaucratic, and social control factors (e.g., the use of requisition forms that are only forms used for opioids, ‘queuing’ for methadone treatment, and clearly differentiated locales) in the delivery of OAT to lessen the visibly different treatment of these individuals (Bourgois, 2006; Fraser, 2006).

An important area for further structural research involves more directed attention to the intersectional stigma of opioid use. Some scholars (Bell & Salmon, 2009; Spitz et al., 2011) indicate that stigma against individuals consuming opioids may be exacerbated by structural factors such as race and class. With regard to gender, we identified only one paper (Chandler et al., 2014) that addressed specifically gender differences in perceptions of the acceptability of taking psychoactive medications, but not specifically opioids. The only papers identified in our review that address women's experiences of stigma and opioid use were in the context of pregnancy (Chandler et al., 2014; Howard, 2015; Jessell et al., 2015) and sexual assault (Jessell et al., 2015). Tracking the work of scholars in this area, we suggest that policy making and analyses in chronic pain and opioid consumption can be conducted with an intersectional lens to identify how social structures and power relations may entrench inequalities in health (Lapalme, Haines-Saah, & Frohlich, 2019). We echo others (Woods & Joseph, 2018) in identifying medical education as one potential avenue for addressing stigma, which requires an improvement in the quantity and quality of evidence-based addiction medicine. Within medical education, for example, teaching structural competency may help address some of the intersectional concerns pertaining to structural stigma and health-related inequalities (Hansen & Metzl, 2016; Metzl & Hansen, 2014). To improve the health status of all individuals by enhancing access to compassionate and effective interventions requires a careful attention to the specific structural barriers generated by multiple, intersecting identities.

Limitations

Given the high number of results yielded by our database search, from a data management perspective we did not conduct an additional search of the grey literature. We may have missed relevant contributions from the grey literature, as well as book chapters, editorials, and other non-peer-reviewed publications. These documents could be a focus of future research. Another limitation of this study is that the articles included in this review reflect the perspectives of people who consume or who have consumed opioids who felt comfortable to participate in a research study. These individuals may be different from those who did not choose to participate or were not approached for participation in a study. However, by including reviews and analytic papers we have been able to incorporate the perspectives of other participants (clinicians, policymakers, personnel working in drug courts) who may be able to represent some of the experiences of a broader population.

A definition of stigma was reported in a minority of studies, and not defined in most. The operationalization of stigma was inconsistent and imprecise across studies, and it was not always clear how research participants conceptualized stigma. A consistent definition with clearly defined operationalization would be helpful in quantifying the experience of stigma in context of substance type, population, and setting. A further limitation may involve our choice of terms in the search strategy. Inclusion of terms such as ‘marginalization,’ ‘shame,’ ‘prejudice,’ and ‘stereotyping’ may have increased the number of reports, but we reasoned thought that broadening criteria too far could diverge significantly from the scope of our study and its focus on the stigma concept.

Conclusion

Opioid-related stigma involves a unique interaction of medically-sanctioned therapeutic consumption with stigmatizing attitudes toward people who consume illegal opioids as well as people who consume prescribed opioids for non-medical purposes. This is further complicated by associations between certain forms of treatment and illegal

opioid consumption, socio-cultural attitudes in the West about pain and 'addiction' and the stigma associated with marginalized identities that produce inequalities in health. The complexity and ubiquity of opioid-related stigma presents a substantial challenge. Future research can explore the potential benefits of contact-based strategies that can help reduce social distance (Bahora, Hanafi, Chien, & Compton, 2008; Livingston, Milne, Fang, & Amari, 2012; Meng, Rayburn, Ramirez-Cacho, & Rayburn, 2007). Such interventions may have the dual effect of individualizing and humanizing the people who use drugs (Livingston et al., 2012). Research that focuses on ways to increase the sustainability of contact-based interventions and stigma reduction, as well as ways to remove the structural barriers that create and intensify opioid-related stigma, would be a logical next step.

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CRediT authorship contribution statement

Melissa D. McCradden: Writing - review & editing. **Denitsa Vasileva:** Data curation, Formal analysis, Writing - original draft, Writing - review & editing. **Ani Orchanian-Cheff:** Methodology, Data curation, Writing - review & editing. **Daniel Z. Buchman:** Conceptualization, Formal analysis, Writing - review & editing.

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