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Commission de la santé mentale du Canada

Stigma and the Opioid Crisis

Final Report

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EXECUTIVE SUMMARY

Introduction and Background

Canada is in the midst of an opioid crisis. Yet, while broad agreement exists that the stigma surrounding opioid use is both significant and consequential, several questions remain before we can have a comprehensive understanding of how it affects persons with opioid use problems:

- What does opioid-related stigma look like?
- Where does it come from?
- How is it expressed?
- How might it interfere with seeking or accessing help?
- How might it affect the quality of care and the availability of services?
- How might it be successfully combated?

Since answering these questions is essential for delivering effective interventions to improve the quality of first response services, the Mental Health Commission of Canada (MHCC) undertook an 18-month research project (funded by Health Canada) under its *Opening Minds* anti-stigma initiative. The project had three main objectives:

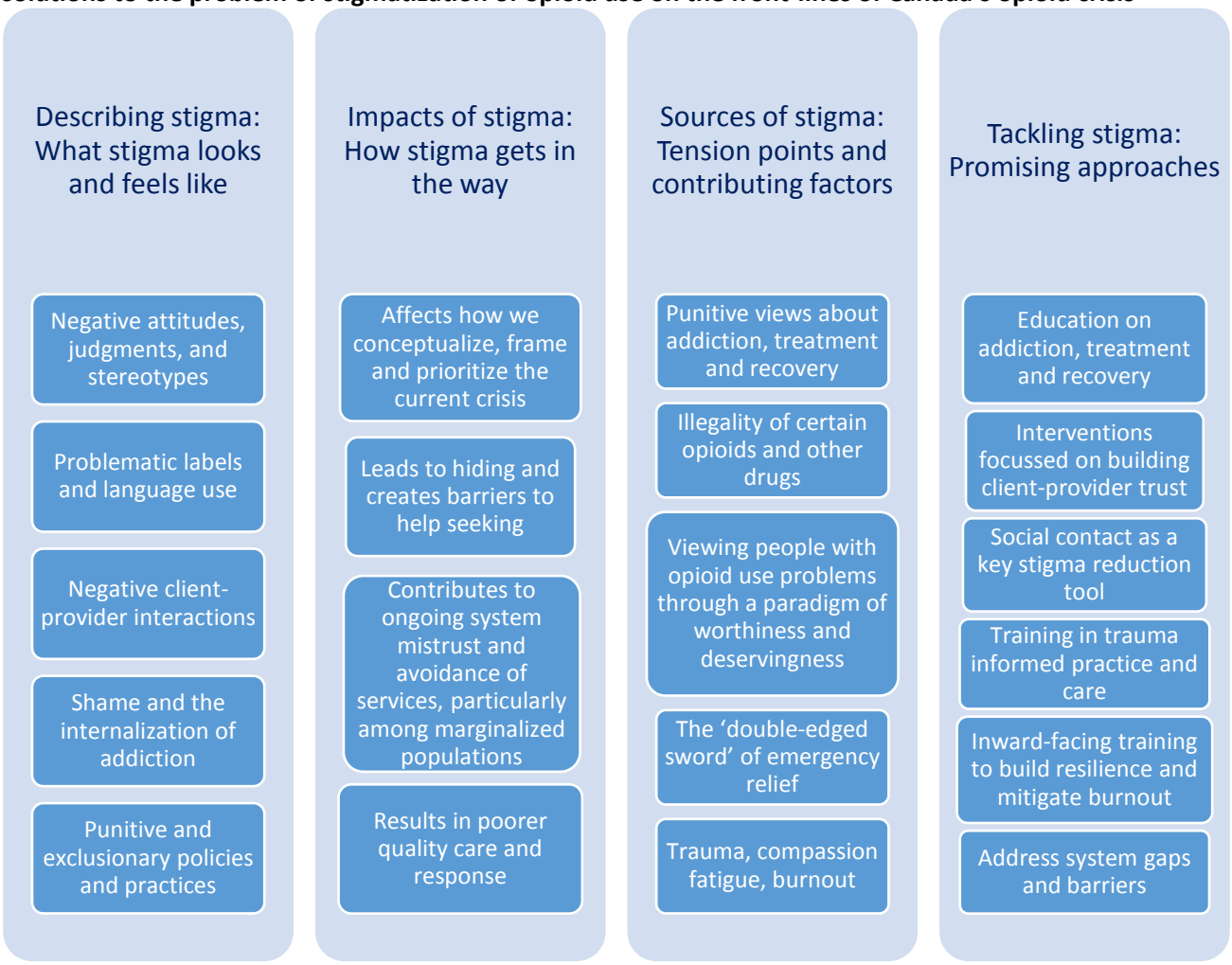
1. Develop a better understanding of the role of stigma in opioid (and other substance) use problems to assist governments (and others) with service delivery and policy decisions.
2. Identify learning needs among first responders (e.g., emergency department staff, fire and police services, paramedics, and outreach workers or other front-line service staff) regarding stigmatization to help create appropriate and effective interventions.
3. Establish a measure for evaluating anti-stigma initiatives that are directed toward first responders on the front lines of Canada's opioid crisis.

The project included a scoping literature review as well as key informant interviews and focus groups involving first responders, persons with lived experience of substance and/or opioid use, policy makers, and other service providers. The group meetings were held in each of Canada's five regions to ensure they included sites with particularly high rates of opioid-related deaths or hospitalizations and had a broad representation of opinions, perspectives, and experiences. From these activities, we developed and tested a new scale for assessing opioid stigma interventions among first responder groups.

Key Findings

Heather Stuart, PhD, from Queen's University completed the scoping review in March 2018. In January 2019, she published an invited article based on its findings in Healthcare Management Forum, called "Managing the Stigma of Opioid Use." The full article is included in Appendix A, while the main issues from the key informant study are highlighted below (Figure 1).

Figure 1. Summary of Findings from Key Informant Study: Descriptions, sources, consequences and solutions to the problem of stigmatization of opioid use on the front-lines of Canada's opioid crisis



The following interview excerpts help to illustrate some of these key findings, themes, and categories:

What stigma looks and feels like

- "Addiction is one of the only health-care problems where you're more likely to be thrown out of a hospital for showing symptoms of your illness than you are to receive care."

— focus group participant

How stigma gets in the way

- "Well, it dehumanizes people. People don't access services. People aren't taken care of when they do access services. There are assumptions made. And people use alone — because they don't want anyone to know."

— key informant

- “In emerg . . . [if] an IV-drug user is there with their cellulitis, or some older gentleman is there with cellulitis, maybe because he’s a diabetic, and you got one space; I can tell you who’s going to get it, right? — even if that IV-drug user’s cellulitis is much worse — because that’s a druggie. He did it to himself.”

— focus group participant

Tension points and contributing factors

- “We still see addiction as being a choice or just this bad thing and . . . why should I be paying for your lifestyle choices that you’re making? . . . But the reality is that, every day, people are in hospitals getting treated for lifestyle-related [things], right? — you know, we don’t shame people who have diabetes because you ate too much ice cream or too much sugar. We don't shame people who have cancer because of smoking. We just treat them.”

— key informant

- “How can you fight stigma when you are labelling patients as criminals?”

— key informant

- “This population is seen as more difficult, hard to treat, maybe even less deserving of care.”

— key informant

Promising approaches

- “What I’d love to see is, somehow, people with lived experience or even current people who are working through an addiction to come and talk to first responders [and] health-care workers and help us navigate how we can better care for them, better decrease the stigma.”

— focus group participant

- “Really, it’s that [front-line workers] don’t have enough compassion satisfaction in their work. The more compassion satisfaction you have, the less likely you are to engage in distancing or other behaviours.”

— key informant

- “Connection with people — peers, people with lived experiences — is so important. . . . A lot of health providers don’t really know people who are using substances, other than alcohol; they can make assumptions. Connection, bringing people together, is important. But you can’t just bring anyone together, because if they’re not trauma-informed, they will cause harm.”

— focus group participant

- “We know from research that stress tolerance in the workplace . . . leads to social distance. Contemplative practices to help tolerate stress in the workplace, which keep people open and engaged and more able to deliver good care, [reduces stigma].”

— key informant

Key Recommendations

Based on the findings in this report, we recommend the following strategies:

1. **Develop comprehensive stigma reduction and intervention strategies for front-line providers.** These strategies could address stigma as a major barrier to help-seeking and quality of care and the high level of mistrust people with lived experience have toward the health system. To do so, organizations could
   - use this research and the framework developed through the key informant study to guide their plans, designs, and interventions
   - draw on lessons learned and evidence-based knowledge for combating mental illness-related stigma in health care (including implementation models/guidelines[1] and key ingredients[2]), while giving people with lived experience a central role in creating interventions
   - focus on improving attitudes and behaviours among first responders and cultivating greater compassion satisfaction, understanding, and trust
   - include a robust evaluation and monitoring framework in interventions to ensure they are meeting their objectives.

2. **Evaluate the effectiveness and efficacy of the promising approaches and strategies in this project.** Successful approaches and interventions can then be replicated, shared, and promoted countrywide.

3. **Address the ethical dilemmas experienced by some first responders and front-line providers regarding high-recidivism clients and the emergency relief measures (e.g., Narcan) that may increase risk behaviours in some circumstances.** It would be important to address these in greater depth, ideally as a separate study.

4. **Increase the use of non-stigmatizing language and establish best practice guidelines for opioid-related terminology and language.** Policy makers, professionals, and organizational leaders would be particularly effective in leading this initiative.

5. **Prioritize attention to system-level barriers and service and treatment gaps.** This strategy includes the need to capture, understand, and systematically address issues related to
   - punitive or barrier-creating care practices and policies
   - inadequacies related to access and quality of treatment options
   - the allocation of resources
   - other policy and system level barriers to quality care and support for people with opioid use problems.

6. **Ensure that efforts toward prevention and prevention policies are stigma-informed.** Anti-stigma initiatives are also required for the public. While we recommend research to better understand and address public stigma toward people with opioid and substance use problems, we can use existing knowledge of best practices for reducing mental illness-related stigma,[3] along with relevant findings from this study.

[1] See, e.g., Knaak & Patten (2016).
[2] See, e.g., Knaak, Modgill, & Patten (2014).
[3] See, e.g., Corrigan, Morris, Michaels, Rafacz, & Rusch (2012).

1. INTRODUCTION AND BACKGROUND

Canada is in the midst of an opioid crisis. In 2016, there were approximately 3,014 apparent opioid-related deaths in Canada, which translates into a death rate of 8.3 per 100,000 population (Government of Canada 2018). And the numbers have continued to increase. In 2017, deaths were estimated at 3,998 (death rate of 10.9 per 100,000 population), with 2,066 opioid-related deaths in the first six months of 2018, 94% of which were accidental (Government of Canada, 2018). Data further indicate that Western Canada is experiencing the highest number of deaths on a per capita basis, with rates of over 10.0 per 100,000 population for Yukon, Northwest Territories, British Columbia and Alberta (Government of Canada 2018). Further, the Canadian Institute for Health Information (CIHI) estimates that the rate of hospitalizations for opioid-related poisoning has increased 53% to 15.6 per 100,000 population over the past 10 years, with nearly half of the increase occurring over the last 3 years (CIHI 2017a). Again, the highest rates are in areas of Western Canada, although there are certain metropolitan areas in Ontario and Eastern Canada that also show particularly high rates, such as London, Peterborough, Thunder Bay, and Saint John (CIHI 2017b).

Little is known about the stigmatization of substance use disorders by Canadians, including Canadian first responders and health care providers who are on the front-lines of this crisis. Negative public perceptions of people with mental and substance use disorders are of concern because they can seep into professional and organizational practices where they have the potential to undermine effective health care responses Stuart 2019). In the case of substance use problems, the dominant cultural norm in countries such as the United States has been a mix of criminal and disease perspectives. Despite longstanding attempts to embed substance use disorders into a medical model, they continue to carry a heavy load of negative symbolism and are highly stigmatized (Room 2005). People with drug problems are frequently blamed for their addictions and viewed as untreatable and unable to recover (Crisp, et al. 2000). Also, it is difficult to know how much of the US's 'war on drugs' mentality has crept into the Canadian consciousness or whether this has affected the way in which those at risk of an opioid overdose are currently managed in our health system and among first responders.

In order to design appropriate interventions to reduce stigma and improve the quality of first response services, it is thus necessary to better understand the qualities and characteristics of stigmatization related to opioid and other drug use problems from the perspective of first responders, people in key policy and program positions, as well as people with lived experience of opioid use and addictions. We must learn what stigma towards persons with opioid and other substance use problems looks like, where it comes from, how it is expressed, how it might interfere with seeking or accessing help, how it may affect the quality of care and availability services, and how it might be successfully and effectively combatted.

To begin to address these issues, *Opening Minds*, the anti-stigma initiative of the Mental Health Commission of Canada, undertook a research project in partnership with funding from Health Canada. The project had three main objectives:

- To gain a better understanding the potential role of stigmatization processes in service delivery for opioid use and other substance use problems, that may assist governments and others with various service delivery and policy decisions.

- To identify and explicate specific learning needs of front-line providers (e.g., emergency department staff, fire services, police services, paramedics, and outreach workers/other front-line service staff) relating to the stigmatization of persons with opioid and other substance use problems, that can be used to guide the development of appropriate and effective anti-stigma interventions.
- To develop a measure that may be used to evaluate anti-stigma initiatives targeting first responders working on the front-lines of the Canada's opioid crisis.

It is expected that findings will be of use to governments and others to assist with various service delivery and policy decisions. Also, as this research identifies specific learning needs of first responders and other front-line health and social care providers in relation to the stigmatization of persons with opioid and other substance use problems, findings may be used to guide the identification and development of appropriate anti-stigma interventions. Thirdly, the scale developed through this research will be offered as an open-access measurement tool, which may be used to help evaluate the effectiveness of interventions targeting issues related to stigmatization, and which can also be used to measure attitudes and behaviours of first responders and other providers working on the front-lines of the opioid crisis.

2. METHODS, KEY ACTIVITIES, TIMELINES

The project was a one and a half year mixed-methods program of research, commissioned by Health Canada. Work began in the Fall of 2017 and was completed at the end of March 2019. The project involved three main components: a scoping review of the academic and gray literature; a key informant study; and a scale development study. Ethics approval was granted from the University of Calgary (Calgary) and Queen's University (Kingston).

2.1 Scoping Review

The purpose of the scoping review was to understand the nature of opioid (or more broadly substance use) stigma, and the extent to which stigma may undermine the effectiveness of responses to the opioid crisis. This review was completed by Dr. Heather Stuart of Queen's University and submitted to Health Canada in March 2018. Key highlights of the findings from this scoping review are provided in **Section 3** below. In addition, an invited manuscript based on the review's findings called *Managing the Stigma of Opioid Use* was recently published in Health care Management Forum (https://journals.sagepub.com/doi/full/10.1177/0840470418798658). A copy of the article is contained as **Appendix A.**

2.2 Key Informant Study

This component of the project involved the completion of focus groups and key informant interviews with health professionals and first responders, as well as people with lived experience of drug and/or opioid use, policy makers and other service providers, to gain a clearer picture of the key issues relating to stigmatization on the front-lines of this crisis.

Focus groups were held in each of Canada's five regions, ensuring a selection of some sites where opioid-related deaths or hospitalizations have been identified as being particularly high, while also ensuring a broad representation of opinions, perspectives and experiences from many different key informant groups (i.e., front-line health professionals, police services, paramedic services, fire services, outreach and social care services) to ensure appropriate rigour in data triangulation (Breitmayer, Ayres & Knafl 1993). The perspectives and opinions of people with lived experience of substance and/or opioid use problems were also sought.

A total of eight focus groups were conducted between January and March 2018, six with first responder groups and two with people with lived experience of substance and/or opioid use problems (see **Table 1**). Informants were identified through a method of snowball sampling, mainly through contacts at our selected focus group sites, and were selected based on the identification of additional information needs arising from the focus group data and/or themes identified in the focus group data that had not yet achieved saturation (meaning that new information continued to emerge). A total of 15 interviews were completed, at which point saturation had been reached. Interviews with key informants were conducted between January and July 2018, with the majority of interviews being completed between January and March 2018. **Table 1** provides details for the focus groups and key informant interviews completed.

Main topics for the interviews and focus groups were:

- Key issues with substance use and opioid poisoning in their community,
- How opioid use is different and/or not different from other kinds of substance use problems,
- What stigma looks like and how it gets in the way of helping or working with people with opioid use problems,
- Identification of learning needs for first responders and front-line providers, and identification of promising practices or approaches for combating stigma.

A thematic analysis was performed for the qualitative data, using steps outlined by Braun and Clarke (2006). These include: 1. data familiarization/immersion; 2. Initial code generation; 3. Interpretative analysis of collated codes into main themes and subthemes; 4. Reviewing of themes in relation to coded extracts and generation of a thematic map; 5. Refining and defining themes and potential subthemes to further unify the emerging story of the data; and 6. Reporting the results of the analysis in a way that demonstrates the merit and validity of the analysis by using appropriate extract examples that relate to the themes, the research question(s), and the existing literature (Braun and Clarke 2006). Transcribed discussions from focus groups and interviews were organized by question to facilitate the coding and analysis process.

All coding and analysis were conducted by principal researchers Dr. Stephanie Knaak and Dr. Heather Stuart. Aggregated findings from this portion of the study are described in **Section 4** below. Any focus group or interview extracts have had personal identifiers removed to retain the promise of participant anonymity. Excerpts have been indicated simply as either 'key informant interview' participant or a 'focus group participant.' A 'PWLE' designation was also added to excerpts provided by participants who identified as a 'person with lived experience' of opioid or other drug use.

Table 1. Details of Focus Group and Key Informant Interviews

Date	Location	# of participants	Participant type	Details
Jan 15	Winnipeg	10	FR*	EMS, police, health care (nurses, physicians; treatment, ER), public health, shelter/outreach
Jan 15	Winnipeg	5	PWLE*	All male, currently in treatment
Feb 1	St. John's	6	FR	Fire, police, ER, shelter
Feb 15	Calgary	10	FR	EMS, police, health care (nurses, physicians; treatment & ER), shelter/outreach
Feb 22	Toronto	4	FR	Fire, EMS, police
Feb 23	Quebec City	6	FR	Police, health care (conducted in French)
March 5	Lower Mainland (BC)	6	FR	Shelter/outreach, EMS, police, health care
March 5	Lower Mainland (BC)	18	PWLE	Self-advocacy group; focus group conducted during group's regular meeting time
Jan 15-July 12	Throughout Canada	15	various	Key informants occupied roles relating to lived experience, stigma reduction, mobile response/FR support, policy, training/programming, rural/remote communities, advocacy, recovery, Indigenous perspectives

*PWLE – people with lived experience; FR – first responder

2.3 Scale Development Study

The third phase of this project built on findings from the qualitative research and scoping review. It involved the development of a measure (i.e., a scale) that can be used to assess the impact of initiatives or programs designed to address the learning needs of first responders relating to the perpetuation of stigmatizing attitudes or behaviours towards people with opioid use problems and people at risk of opioid-related poisoning/overdose. No such scale currently exists. This component involved three main activities: construction of key domains and generation of item pool; expert consultation meetings and cognitive interviews with first responders for examination and review of proposed domains and items; and scale finalization and testing. Construction of key domains and item pool generation was completed in July 2018. Expert consultation meetings and cognitive testing took place between September 2018 to January 2019. Three group expert consultation meetings were held, each with between five and eight participants, and four one-on-one cognitive interviews were completed.

Once the draft version of the scale was completed, it was pilot tested as an anonymous online survey with approximately 50 first responders – including police officers, health care providers, paramedics and fire fighters – in February 2019. Data analysis, including an assessment of psychometric properties, was completed in March 2019. Results of the psychometric testing will be described in a forthcoming paper, to be published in a peer-reviewed journal. The final version of the scale is called the Opening Minds Opioid Scale for First Responders and Front-line Providers.

3. SCOPING REVIEW SUMMARY OF KEY FINDINGS

Provided below is a summary of the key findings of the scoping review completed as a part of this study. The full report [Report title (suggested citation): Stuart H. (2018) Opioid Stigma, Ottawa: Opening Minds Initiative of the Mental Health Commission of Canada] was submitted to Health Canada previously. The subsequently published version of this report, called *Managing the Stigma of Opioid Use* can be found in **Appendix A.**

- The emergence of fentanyl has given rise to a public health crisis in Canada and elsewhere that requires urgent action. The unknown potency of fentanyl and other synthetic opioids, and the fact that users are often unaware that they are taking them, means that individuals who are involved in drug use are at risk of overdose and death.
- The Government of Canada has been closely monitoring the opioid crisis and regularly updates surveillance data describing apparent opioid deaths. In 2017, the majority (92.2%) of the opioid deaths were rated as accidental (unintentional)
- The literature dealing with stigma related to drug use is generally sparse and largely qualitative. Scientific studies focussing on opioid use are difficult to find, though the topic is much discussed in the news. With respect to drug use in general, population data from various countries, including Canada, paint a consistent portrait. People with drug use disorders are the most stigmatized of any minority group. Negative stereotypes emphasize blameworthiness and dangerousness.
- Studies of the public's response to people who use drugs highlight a propensity to favour punitive approaches that limit their activities and violate individual rights and freedoms. Stigmatizing measures have been considered an acceptable deterrent and often are adopted as a means of reducing harmful behaviours. Harm reduction approaches have not been a favoured public health response, despite evidence showing their effectiveness.
- Opioid use carries all of the negative moral connotations of illicit drug use and more. In light of the opioid crisis, news organizations have increased the public's exposure to images of people overdosing in the streets, which reinforces the narrative of unpredictability, dangerousness, and that the crisis can only be dealt with effectively using a criminal justice approach. Often police and other first responders are on the scene. There is little recognition that a large proportion of people who have become addicted to opioids did so as a result of physician over-prescribing.
- Medication maintenance treatment is widely recognized as a best practice in the treatment of opioid addiction. However, it is also highly stigmatized, and only about one in four individuals with an opioid use disorder receive medication maintenance.

- The stigma associated with drug use in general, and opioid use in particular, has made it difficult to reframe the opioid crisis as a public health issue. Law enforcement interventions targeting illicit drug dealing are often preferred over approaches that emphasize prevention and treatment.
- There is some evidence that portraying people who have been successfully treated and targeting specific groups such as employers, health care providers or first responders is a promising anti-stigma strategy. This is consistent with a considerable body of literature from the mental health field that uses contact-based education and recovery stories to reduce stereotypic attitudes and social intolerance. The experiences of the Opening Minds anti-stigma initiative of the Mental Health Commission of Canada showed that stigma reduction programs that used contact-based education involving people with lived experience were effective in a variety of settings, with larger effects than population based educational campaigns. Therefore, it is likely that a similar approach applied to opioid stigma would yield promising results.
- Stigma avoidance is an issue that must be addressed to ensure that individuals are accessing available services; particularly given Canada's emphasis on providing a broader range of treatment services. An important consequence of stigma is that people will avoid seeking appropriate treatment, even when it is available, in order to escape being labelled and subsequently stigmatized. They experience shame and embarrassment and try to conceal their condition.
- Groups that may benefit from targeted opioid-related stigma reduction strategies include opioid users themselves (to combat self-stigma), at risk youth (such as university students), first responders, dispensary personnel, media, and health care professionals (particularly physicians and emergency room personnel).

4. FINDINGS: KEY INFORMANT STUDY

Findings from key informant study have been organized into four major categories, aligning closely with the main topic areas discussed in focus groups and key informant interviews. The results provide insight into key opinions, experiences, tension points, promising strategies for stigma reduction efforts, as well as key learning and support needs of front-line providers and first responders with respect to the opioid epidemic. Findings are summarized in **Figure 1** and described in greater detail below.

4a. Describing Stigma: What Stigma Looks and Feels Like

Discussions with first responders and key informants revealed many facets to stigma. Provided below are the main ways participants described what stigma 'looks and feels like' in relation to the current opioid epidemic, opioid and drug use problems more generally, and interactions with first responders and front-line providers.

Figure 1. Summary of Findings from Key Informant Study: Descriptions, sources, consequences and solutions to the problem of stigmatization of opioid use on the front-lines of Canada's opioid crisis

4a1. Negative Attitudes, Judgments and Stereotypes

Stigma was described by study participants as taking shape through numerous negative attitudes and judgements about people with opioid and other drug use problems. These attitudes and judgments tended to coalesce around a general belief that opioid and other drug use problems were based in individual choice, and that people with opioid use problems were personally responsible and to blame for their problems. The sentiment of negatively judging people with opioid and other drug use problems was a key theme in this regard. These negative attitudes and judgments were described as being both felt and enacted, in public interactions as well client-provider interactions, as well as in public encounters more generally.

The following comments help illustrate:

> *It's the overall attitude. Everybody gets it. It's like, everybody is judging you. (focus group participant, PWLE)*

> *I think the first assumption that people make, correct me if I'm wrong is, you're misusing. There's a danger of misusing. And so, anybody with an addiction issue is suspect. And so, we can't treat it like a legitimate health issue. (focus group participant)*

> *I mean, as soon as somebody is labelled as an addict or a user they're just written off. Not probably everybody but for the most part they're written off and the reason why is they say because that person had a choice … it's very easy to judge that person, to say they made a choice and write them off, when you're sitting in your nice cottage and your nice perfect life, to pass judgement on that person. So, I think that's what we find, kind of, front-line, is these people are just simply written off because they made a crappy choice. Not appreciating the gambit of reasons why they went down that drug road, right? (focus group participant)*

Negative attitudes and judgments were also described alongside common stereotypes of who is perceived to be a 'user' or 'at risk' of poisoning. Specifically, respondents described how stereotypical associations of drug use with marginalized, street-entrenched populations as the main image of people who use drugs and/or are at risk of opioid poisoning, both draw on and reinforce stigmatizing attitudes and judgements:

> *We think it only happens to stereotypes like the homeless people who shoot up, while actually many homeless people don't inject drugs. (focus group participant)*

> *There is that stigma around users and what users appear to look like. (focus group participant)*

> *As I see it, there are two things going on with respect to stigma. There's one group of users that are more occasional, like a suburban kid getting poisoned with fentanyl at a party. There's lots of compassion for this group. The second group is the heavy user, marginalized population group. There's much less compassion there. (key informant interview).*

> *I had a car accident a couple of years ago, and I ended up in the hospital. The doctor, as soon as he found out I was holding [an NFA form], he wouldn't even touch me. He didn't even want to take my shirt off to check my respiratory or anything like that. And I had just been hit by a car at 65 miles an hour. And because that piece of paper says NFA on it, which is 'no fixed address,' you're a piece of shit. You're stigmatised, and the assumption is I must be a junkie too. And I was not. I was not an IV drug user or anything like that…. But that's one of the pieces of information that the doctor utilised right away…is the fact that this says no fixed address. 'He's homeless. He must be in here just to get drugs.' They associate things – one with the other, you know what I mean. (focus group participant, PWLE)*

Importantly, participants noted that reliance on negative stereotypes tended to be particularly pronounced for Indigenous populations:

> *Stigma comes from mainstream. As a whole. I mean a lot of people refer to [Indigenous people] as 'the drunk Indian.' So, there's a lot of stigma from mainstream towards our First Nations people who use and they feel that. (key informant interview)*

> *For example, when someone's Indigenous, when someone's on the street and passed out, they are judged. But a non-Indigenous person might be passed out at home on their couch – the only difference is that one has a place to live and the other doesn't. If I go out and have a glass of wine with my friend, she's non-Indigenous and I'm Indigenous, there will be judgments made or some awkwardness or discomfort about me drinking as compared to her. It happens all the time. And that's just not right. (key informant interview)*

4a2. Problematic Labels and Language Use

Participants also described stigma as something that showed up in the language and terminology used to describe people with opioid and other substance use problems. Many terms remain common in everyday language to describe problems with substance use – terms such as 'dirty, clean, misuse, drug abuse, addict.' However, these were felt to be increasingly outdated and as carrying stigmatizing connotations. As the following comments illustrate:

> *Addict – I have an issue with that: this notion that "I am an addict" as if it's your identity and defines who you are. 'Abuse' I don't like because it individualizes the problem and puts the blame on them. I think the biggest thing for me is that we need to use first person language always. (key information interview, PWLE)*

It was in this vein that some respondents also felt that reliance on the term 'overdose' to describe poisonings and unintentional toxicities was problematic:

> *Anything that we can do to reduce the stigma that's associated with [the crisis], that's what we're trying to do. So just things like our media releases. We're trying to get away from that term of overdose …. If there is a…death that [the police] have to report on they're going to call it an 'unintentional opioid toxicity.' Like the real term, a medical term. So, people are not, like oh, so it was an overdose. (focus group participant)*

> *I use the word 'overdose' because it is engrained. I personally don't see it as a word that charges for me or is stigmatizing but I can see how some people would. Poisoning…is probably is a better term. It really is more of a poisoning if you don't know what you are getting. (key informant interview)*

Other examples of stigmatizing language were less subtle and clearly more derogatory, as illustrated in the following comments:

> *The…hospital has an acronym for people with overdose and addictions issues, ANDY. Anybody heard that? ANDY? Addict Not Dead Yet. So, he's an ANDY. (focus group participant, PWLE)*

There's this perception and language floating around these days in paramedic and other circles is that the opioid crisis is part of the process of natural selection. (key informant interview)

Stigma can be especially felt in a small town -- people openly talking about 'druggies' on [local social media page]. (key informant interview)

Importantly, many respondents emphasized that -- with the exception of overtly negative phrases or terms – the crux of the problem was not that of language per se, but rather how language is used to reinforce social distance and/or devalue people with lived experience of opioid or other drug use. As the following comment shows:

Language use is an example of how biases show up ..... "these" people, "them", "they" – the othering language. The intent of the language is more important than the words themselves. (key informant interview)

4a3. Negative Client-Provider Interactions

As much as stigma was described as something reflected in attitudes, perceptions, and language, respondents also described stigma as something that showed up prominently and acutely in client-provider encounters and interactions. As the following comments illustrate, respondents described stigma as expressed through experiences of feeling devalued, degraded, and dismissed in their encounters with first responders and care providers.

I've been [in recovery] for a few years now and I still am flagged at a hospital. So, when I go in, I'm treated really well upon presentation. As soon as my name goes into that system, it's a completely different story. It's shitty. It really sucks. (focus group participant, PWLE)

We see a lot of our clients that we're bringing, let's say, to the hospital, and they tell us, 'no, I don't want to go there, it's degrading.' (focus group interview)

I know a situation where a man – he overdosed -- noticed a big bump on his head, didn't know where it came from. It turned out to be an abscess of some kind .... He's got like a gaping wound on the top of his head and paramedics would come and like they were so rude – This person could die but they're so rude and so judgemental – just so rude. And they literally left and wouldn't take him with them. "What have you used?" (focus group participant, PWLE)

We hear in the community about, you know, lots of trouble when people come in to the Emergency Department and just the way that they're treated, feeling like they're not, you know, they're bumped in line… you know, it's not a pleasant experience for people who are labelled as a substance user…and that's even if they're, you know, they're needing some kind of treatment that's not necessarily correlated to their substance use, the label takes over. (key informant interview)

There are a lot of staff in our department that don't care, they couldn't give two craps about it and they treat people probably worse than people treat their animals and these are human beings. And so, there is a huge, huge stigma…especially if we maybe saw someone that morning and it would be like, "We already Narcan-ed you today and now you're back." (focus group participant)

[When someone arrives at a place to get help], you know that [staff] are throwing dirty looks. They're not welcomed or accepted … clients feel that resentment, they feel judged. So, it's even harder to bring them places. You convince them to go somewhere, you open the door, they get there and they're judged and sent away. (focus group participant)

4a4. Shame and the Internalization of Addiction

Another important facet of stigma that emerged in discussions with focus group and interview participants was that of internalized stigma and the experience of shame. As the following comments demonstrate:

All the time I would tell myself I'm worthless, I don't deserve any of this, I should just go and off myself, or something like that. Lots of people around me eventually were telling me that I'm a piece of shit, that you're doing really bad things, and we hope nothing good for you. And eventually I started to believe in it, because I heard it so much. (focus group participant, PWLE)

Where the biggest problem is right now [is] you have these middle-class suburban users who would not identify themselves as drug users or as drug addicts because of the stigma. (focus group participant)

People often very much internalise addiction - it's 'I'm [name], I'm an addict' - as opposed to 'you're [name] and you have an addiction issue.' And to me there's a big difference -- like you know you don't say 'I'm [name] and I am cancer – it's just 'I am [name] and I have cancer.' …it could make you stuck when it becomes such a central part of your identity…where that stigma kind of stays with you, right? (focus group participant, PWLE)

Stigma is what kept us silent. [My husband's] professional reputation [in business] was incredibly important. You hide a lot. There is a lot of shame. (key informant interview, PWLE)

4a5. Punitive and Exclusionary Polices and Practices

The last major theme described by respondents in terms of 'what stigma looks and feels like' was that of stigma as experienced and expressed through formal and informal policies and practices. Known in the literature as 'structural stigma' (e.g., see Knaak & Ungar, 2017), the examples respondents provided were many and varied, but typically coalesced around two main types of stigmatizing policies and practices -- those that created barriers or restrictions to services or care, and those that were experienced as penalizing and discriminatory rather than helpful or supportive.

The following examples help illustrate this theme:

> *We have definitely denied access to the shelter for people because they were drug users, not even IV. (focus group participant)*

> *In some communities the bylaw officers are part of the solution, but in most they're probably part of the problem. In [city] for example…bylaw officers become the sort of enforcement arm of discrimination. And so, they will go to where people are camped and confiscate their possessions, take them away, and then fine them, and they won't give them their possessions back until they pay the fine, which of course, is very difficult for them to do. And one of the impacts of doing this, is that groups of people have broken up and dispersed [because] they don't want to attract attention from the bylaw officers. Which has made the work of the street nurse extremely difficult, 'cause now instead of going to one or two or three locations in the community, she now has to sort of look under every bridge and behind every shopping mall, et cetera, et cetera, et cetera, to find people to give them the supplies they need or the medical attention they need. (key informant interview)*

> *'If you've used drugs today, please come back tomorrow.' That seems like a perfectly reasonable thing to put on the wall. But if you use drugs every day, it's like that means I can never come to your service, even though you're a service provider and you've just been so brazenly unthinking that you would use a model like that. (focus group participant, PWLE)*

> *You can't access health care when you have your buggies[4], 'cause you can't leave them anywhere. How can you go in the doctor's office?...There's a big barrier, right? There's no buggy barns. Nobody's allowed to help you take the buggies inside and help you out. (focus group participant, PWLE)*

> *When we're assessing for withdrawal we only assess if the mother admits to medication use. That is our policy. …[but] occasionally we have some people who don't follow that guideline and they'll start the assessment based on infant behaviour. 'This kid's kind of cranky, let's start assessing for withdrawal.' I've never seen a baby assessed for withdrawal who wasn't Aboriginal. I've never seen a colicky white baby assessed. That's just not okay. (focus group participant)*

4b. Impacts of Stigma: How Stigma Gets in the Way

Another major topic of exploration in focus groups and interviews was that of the consequences of stigma, or 'how stigma gets in the way' of providing high quality care and response to people with opioid or other drug use problems and people at risk of opioid-related poisoning. The consequences of stigmatization were described as severe and many. One respondent, for example, said this:

[4] Referring to grocery carts and other portable containers people without homes might use to hold their possessions.

We treat people like it's us and them. It affects their health. They die sooner, they are not treated for illnesses, they can't find a place to live, nobody wants to rent to them, they end up outside, yeah…then there are all those risks from being outside. (key informant interview)

Another respondent, who was asked to comment specifically on how stigma impacted people of Indigenous heritage, summarized the main consequences of stigmatization as follows:

How does the stigma get in the way? Well, it dehumanizes people. People don't access services. People aren't taken care of when they do access services. There're assumptions made. And people use alone – because they don't want anyone to know. (key informant interview)

In general, these opinions were reiterated across all focus groups and key informant interviews, and came to comprise four main categories of consequences:

- Stigma affects how we conceptualize, frame and prioritize the current crisis
- Stigma leads to hiding and creates barriers to help seeking
- Stigma contributes to ongoing system mistrust and avoidance of services, particularly among marginalized populations
- Stigma results in poorer quality care and response

Each of these themes is described in greater detail below.

4b1. Stigma Affects how we Conceptualize, Frame and Prioritize the Current Crisis

One theme that emerged though the analysis was that of the relationship between language and perception. Namely, participants commented on how the language and terminology used to describe the crisis played a crucial role in shaping how first responders and others think about people who use opioids and/or who are at risk of unintentional overdose, as well as perceptions of how best to address the crisis.

One commonly expressed opinion, for example, was that the labelling of the current situation as an 'opioid crisis' failed to adequately capture the full complexity of the phenomenon. Many respondents emphasized that the tainting of the drug supply with fentanyl, carfentanil and other similar substances goes well beyond the contamination of the opiate supply. They stressed that *anyone* who uses illicit drugs is at risk for poisoning, a fact not fully recognized if the term 'opioid' remains the primary defining descriptor for the crisis:

It's the cross-contamination, the Russian roulette and all that, it's winding up in more and more cut drugs. Maybe they were regular, social cocaine users, did it when they went out to the bars on the weekend and that time, they got some cut with fentanyl and died. (focus group participant)

Basically, anybody who is buying drugs off the street has the risk of being poisoned. (key informant interview)

We worked very hard…to try to create a collective mind around how we positioned this crisis. So, because of the risk factors which was certainly fentanyl. But there was [a lot of discussion] around people who were going to use cocaine or other accelerants who were thinking that "Oh, I don't use heroin, therefore I'm not at risk." So that's where we saw that we needed to start to shift from 'opioid' to 'overdose' so that people understood that we're talking about everything available on the illegal market. So, it really was to get that broader net kind of out there of understanding. (key informant interview)

Many respondents also discussed how common stereotypes – such as the association of drug use with marginalized, street-entrenched populations -- contributed to an overall mis-conceptualization and framing of the true nature of the fentanyl/poisoning crisis as well as the broader epidemic of opioid use. As the following comments illustrate:

They say 82% of overdose events now are behind closed doors [in private]. (Key informant interview)

I think what happens is we're not relating to the people who drive to the Downtown Eastside from very prestigious places...to go get drugs because their prescription drugs are no longer administered; so now you've got very wealthy people coming down to the Downtown Eastside or out to the Surrey Strip or out to the Valley looking for drugs, then they take them in the car on the way home, they overdose and then they kill somebody. (Key informant interview)

Sometimes it's pretty shocking to us the range of clientele that utilize and subsequently overdose on opioids. We go from low income housing to fairly affluent people who end up overdosing … I think people need to know that on the forefront. You'll have college kids that get fentanyl and overdose on that stuff. So that's something that I think is not quite out there. (focus group participant)

Another main concern discussed by respondents was that stigma affects the way in which the crisis is prioritized and resourced, which was believed to stem directly from how it has been conceptualized. Many respondents emphasized this point by comparing the opioid crisis to other actual or predicted public health epidemics that have occurred in Canada:

You know, if you compare this response to something like SARS, which was a crisis, an epidemic, and the response is so immediate and so comprehensive. But this is no where near the same response. (key informant interview)

Two summers ago, when there was infinitesimally small risk of Ebola coming into Canada, right ... you know what? I couldn't believe the resources that were mobilised so quickly, right, and it was nonsense. Like, are you kidding me? We're doing all this for what? You know, like I was dealing with airplanes that were landing and people were being quarantined and I'm, like hold on a sec, you know, stop the insanity, and yet this, people are dropping dead left, right and centre and it's everywhere and virtually nothing's happening. You know, like we're worried about something coming from Africa, that's ... there were no cases of Ebola in Canada, you know, and yet we spent millions and, you know ... so, like what the heck? Wake up. (focus group participant)

I think we have to look at why, as a western country, a very rich country, are we in this crisis, when there's other countries that have done well with this piece, you know. We shouldn't be in this kind of crisis. We have the capacity to not be in this kind of crisis. So, again…this patch it up here or patch it up there isn't the best way to handle this situation. We need to go all in. (key informant interview)

[In a committee I sat on] they talked about ED wait time reductions and they talked about wait time reductions for key surgeries, like hip replacements and stuff. It's disappointing that they didn't talk about wait times for opioid and other types of addictions because I think that's just as big a problem, trying to get people onto that but, again, that's the stigma, right? (focus group participant)

4b2. Stigma Leads to Hiding and Creates Barriers to Help Seeking

Another major consequence of stigma that was discussed in focus group and interviews was how it creates barriers to both help-seeking and disclosure. One of the main ways in which stigma was described as interfering with help seeking was through the effects of self or internalized stigma, where shame and fear of being labelled as an 'addict' keeps people from coming forward or seeking help:

We've created such an environment of shame we almost need to go out and find them. They will not come forward, many addicts. Because they are too ashamed. (key informant interview)

There's so much stigma that First Nations people live with that they don't even interact with mainstream a lot of the times because of that. (key informant interview)

[Some people are] more at risk because they don't want to seek out services because they, you know, they feel like, again I'm not that kind of family or we're not that kind of person so they don't want to self identify, especially with the stigma coming from health care providers. (key informant interview)

There's a huge barrier to seeking care. In a small town it's even worse. Like I know many people who would never walk into the [organization name] because they know what its for. Or because they have a social connection – because relationships are so close. There's no way to seek help anonymously. (key informant interview)

Even more, many respondents spoke about the effect of stigma as leading many people to actively conceal or hide problems with opioid use:

It seems to me that one of the unintended consequences of the opioid discussion is we've demonized it to the point where there are people that are taking [opioids] and won't tell you they're taking them. (key informant interview)

My biggest factor with it – all of this opioid crisis -- is the fact that we're so highly stigmatized that we do hide. (focus group participant, PWLE)

[Indigenous women] tend to be more isolated and there's more stigma to our women…our younger women who are trying to keep their kids, who are at home …they're not getting the support from their community. So, they're home alone and they hide what they're doing for the fear of the repercussions if they get found out. So, they use in privacy or secrecy. So, the rates of actual use are not necessarily higher, it's just the risk, it's the overdose. (key informant interview)

Barriers to help seeking were also frequently mentioned in regard to harm reduction. Specifically, it was believed that many people do not access publicly available emergency relief kits (e.g., naloxone or Narcan kits made available to individuals for their own personal use), use supervised consumption sites, or use in the company of others, because of stigma:

They're still having deaths skyrocket because of the stigma attached to going to a safe injection site. Mr. Joe Blow businessman, who lives in the suburbs, who wants to shoot his heroin up or whatever isn't driving…and parking his car and walking into [a safe consumption site]. He's doing it alone in his car or where he's living. That's all about the stigma. When I talk to their inspectors, all the deaths are the result of suburbs, people dying alone in their car, dying alone in their basements, dying alone in their bedrooms. There's nobody dying at those safe injection sites, but those safe injection sites have basically limited the population to who uses them. (focus group participant)

If you're hiding your addiction you're probably not going out of your way to get yourself a naloxone kit. But if you use alone…it's not a good technique anyway. (key informant interview)

We know from the research…that people only go within 1 kilometre, not beyond a 1-kilometre zone in terms of seeking a safe consumption service site. So …the problem is the 90 percent out there who aren't [near a safe consumption site]. (focus group participant)

People are sneaking around and getting opiates from wherever they can get them from and using them secretly. Which is risky. But there's this huge fear people have of getting found out. (key informant interview)

4b3. Stigma Contributes to Ongoing System Mistrust and Avoidance of Services, Particularly Among Marginalized Populations

Another key consequence of stigma that emerged in interviews and focus groups was the existence of high levels of system mistrust and fear among many people who use opioids or other drugs. Many people with lived experience commented that this mistrust and fear stems from previous negative encounters with care providers and first responders. Sentiments of mistrust and avoidance of health care and other services was believed to be most strongly felt among more marginalized populations and was described as another way in which stigma created barriers to help seeking.

The following comments help illustrate:

The bottom line with marginal populations is that they do not trust health care. There's huge mistrust. (Key informant interview)

I think that there's a really old and continuing 'us versus them' mentality. And that's huge. … And I think, because of that mentality, there has been extraordinary amounts of trust broken, right? And so, I think one of the key factors here in improving this circumstance is focusing on that building relationships and that power sharing, because there's been such a violation of rights. (focus group participant)

We had a woman [in our building] who her ring got stuck on her finger and she did not want to seek outside help due to how she's been treated in the past. And her finger, she ended up losing her finger. (focus group participant, PWLE)

Notably, several participants spoke specifically of system mistrust among mothers who avoid services for fear of having their children apprehended:

We can't go into a place and ask for help. I had babies, I had kids. I avoided any health care like the plague because you were going to take my child. (focus group participant, PWLE)

Many of [the mothers] won't come seek treatment because of fear that it's going to lead to apprehension. And we also see…some workers…saying 'well, if they're on methadone then they can't have their children.' And that's just…misconception, you know, where 'you're just replacing one drug with another drug' and that's not the case, but that's what happens and it's a huge stigma. (focus group participant)

4b4. Stigma Results in Poorer Quality Care and Response

Another major consequence of stigma was that it results in poorer quality care and response. This sentiment was expressed by providers and clients alike. The following is a sample of comments from key informants, first responders, and people with lived experience of drug use:

In emerg…[if] an IV drug user is there with their cellulitis, or some older gentleman is there with cellulitis maybe because he's a diabetic, and you got one space, I can tell you who's going to get it, right, even if that IV drug user's cellulitis is much worse, because that is a druggie. He did it to himself. (focus group participant)

I question whether or not care is being provided at its optimum by front-line practitioners given the circumstances. (focus group participant)

From my personal experience, for many, many years, I was stigmatized due to being an addict and how I presented. I would go to the hospital super sick and because I had track marks, I was 100 pounds. I got treated like shit. And once out of many, many hospital stays, I had one doctor who was willing to work with me and work with the addiction so that he could treat the physical illness that was going on with me. (focus group participant, PWLE)

People with addictions are being treated as second class citizens in our health care system – hugely. (focus group participant)

I'd say for sure there's a sense of apathy for all of us. And for sure, there's less of a sense of urgency to get that patient treated. We'll treat them but we're not going to rush in and go kneeling in needles and killing ourselves to treat them. (focus group participant)

4c. Sources of Stigma: Tension Points and Contributing Factors

Research participants were also asked to discuss where they believed stigmatization towards people with opioid use and other drug problems comes from, and what the tension points were for first responders and front-line providers in this context. Analysis of focus group and interview data revealed several tension points that were identified as contributing factors to the manifestation and expression of negative behaviours and attitudes. These included:

- punitive views about addiction, treatment and recovery;
- ambivalence about harm reduction;
- the illegality of certain opioids and other drugs;
- viewing people with opioid and other drug use problems through a paradigm of worthiness;
- trauma, compassion fatigue and burnout among first responders and other front-line providers; and
- system inadequacies.

These sources of stigma fell into two main categories: direct and indirect. Direct sources may be thought of those that aligned closely with negative stereotypes and beliefs about people with opioid or other drug use problems. Indirect sources of stigma were more experiential in nature, deriving from the difficulties and challenges of front-line work in the opioid crisis. Practitioner trauma and burnout, the ethical challenges of the intensive use of emergency measures with high recidivism clients, and system inadequacies were highlighted as indirect sources of stigma.

4c1 Direct Sources of Stigma

4c1a. Punitive Views about Addiction, Treatment and Recovery

One main tension point or source of stigmatization had to do with increasingly outdated yet still-prevalent views of addiction, treatment and recovery. Many respondents believed there continues to be a lack of understanding about the illness of addiction, its root causes, its status as a health condition, best practices for treatment and care, and what the recovery process looks and feels like -- even among first responders and health care providers. Many respondents acknowledged that a 'moral failings' paradigm remains dominant, even in many health care environments, along with 'failure-based' understandings of the recovery process and negative perceptions of non-abstinence-based treatments (e.g., medication maintenance therapy). The following comments illustrate how respondents described these various information and knowledge gaps:

Views about addiction:

> *We still see addiction as being a choice or just this bad thing and…why should I be paying for your lifestyle choices that you're making?....But the reality is that every day people are in hospitals getting treated for lifestyle related - right, people are - you know we don't shame people who have diabetes because you ate too much ice cream or too much sugar. We don't shame people who have cancer because of smoking. We just treat them. (key informant interview)*

> *We're not treating addiction the same way we would treat cancer or that you have an illness. We're treating it as you have a failing. (focus group participant)*

We still aren't yet at a point from a systemic perspective where we all see addiction the same way. So, if we polled any health care provider they would all see probably, to a certain degree, right, they would see diabetes, they would see hypertension, they would see cancer, they would see epilepsy kind of all in the same way. But whereas I think with addiction and health care providers specifically, like nobody has kind of completely weighed in from above and gone 'this is how this disease works, this is what best practice treatment looks like, this requires us to work with people to aid them in supporting them in a journey of managing what's happening in their lives.' (key informant interview)

Views about treatment, recovery and harm reduction:

Huge stigma regarding methadone and other medication treatment…they see it that you are using a crutch – substituting one drug for another. So, there is a lot of stigma around it even in the recovery community, like you are not 'doing the work'. (key informant interview)

[when relapse happens] the belief is that you've failed, you know? Our language has to change. The way we view recovery has to change. (key informant interview, PWLE)

I think there are some really good presentations on harm reduction…but it's not yet mainstream. It's not getting to the front-line people. There's still the stigma. Even the small number of staff that we have at [organization], there's still the stigma because of the lack of understanding. (focus group participant)

A good example with the [lack of understanding is] that just this week we had someone in who had an opioid addiction, and she had chosen to smoke week instead of opioids. So, the staff came and said, "She's out in the parking lot smoking weed every single day." And I went "Excellent, because she's not shooting up." And they're like "That's just wrong. She shouldn't be doing…" So, the stigma is very much a lack of understanding. (focus group participant)

4c1b. Illegality of Certain Opioids and Other Drugs

Another major theme in regard to the sources or root causes of stigma was that of the illegality of certain opioids and other drugs. In particular, many respondents believed that stigma towards illicit drug use would likely not be eradicated as long as use and users of such substances continued to be viewed and treated as criminals. The following comments illustrate:

How can the government put money towards an anti-stigma program and expect it to work when the government itself denotes someone who is addicted to opioids a criminal? How can you fight stigma when you are labelling patients as criminals? (key informant interview)

I think it's the illicit part that makes it reattach it to criminality – that you can't be doing that, it's bad. Yet we give people morphine all the time in hospital settings. (key informant interview)

There is a cultural system of deeming some drugs 'good' and some drugs 'bad'. We need to understand that we all have a drug of choice – wine, beer, coffee, nicotine…it's not like you made some great moral choice. You just picked a drug that was deemed culturally acceptable … the judgment becomes justified when the substance is illegal. (key informant interview)

They treat us like criminals...it shouldn't be a law issue, it's a health issue. We're sick people, it's a disease…let's address the problem, the real problem. Send them to rehab, they shouldn't be put…in jails. (focus group participant, PWLE)

4c1c. Viewing People with Opioid Use Problems Through a Paradigm of Deservingness and Worthiness

One of the most concerning themes that arose in the context of understanding the sources of stigma towards people with opioid use and other drug problems was what one respondent called a "discourse of disposal", and what other respondents described as a paradigm of "deservingness." More specifically, what emerged in focus group conversations and key informant interviews was an acknowledgement by providers, policy makers, and people with lived experience that underlying much of the stigma towards people with opioid and other drug use problems is a belief system that both justifies and rationalizes poorer treatment and care.

As the following comments illustrate:

This population is seen as more difficult, hard to treat, maybe even less deserving of care. (key informant interview)

One hundred percent…'those people don't deserve treatment as much as others' -- that was actually articulated [in a hospital I visited]. Like think of all the things that weren't said when things like that are actually said, right? (key informant interview)

I think that one of the big stereotypes, one of the biggest problems we have it's that…in the eyes of society, [people with drug use problem], they're not worth much. Some might even say, 'one less drug addict is one less financial drain on society.' (focus group participant)

I keep saying that it's a discourse of disposal. It's like this where we're believing that there's a deserving and an undeserving population. (focus group participant, PWLE)

Like the deserving and the undeserving victim of violence. The belief justifies the policy that … if you show up and you're visibly under the influence of anything, we go hands off, we can't help you. (focus group participant)

If I only have X number of minutes or time to give to people, well why should I give it to that person who's choosing to do that thing that hurts them, whereas you know, that kid fell and broke his arm and he didn't mean to do that, right? (focus group participant)

4c2 Indirect Sources of Stigma

4c2a. The 'Double-Edged Sword' of Emergency Relief

Another key tension point or source of stigma described by participants pertained to a somewhat ambivalent stance towards harm reduction. In general, harm reduction was a highly discussed topic of conversation in the focus groups, especially that of the intensive use of emergency relief measures (i.e., Narcan), which emerged as a hotly debated and deliberated theme.

On one hand, most respondents strongly supported the idea that harm reduction approaches -- such as supervised consumption sites and the availability of emergency relief measures -- were important and effective life saving measures for people at risk of accidental poisoning. However, there was also a strong sentiment of harm reduction being a 'double edged sword' in that the widespread availability and administration of emergency relief measures was believed to encourage riskier drug use behaviours, particularly among some street entrenched users. As the following respondent commented:

> *So, the big push has been for Narcan, Naloxone. The survivability is better I guess and that's a win, right? People aren't dying as often. However, it's had a spinoff of actually making the usage more common. I think too is the fact that I've had addicts tell me, "I overdosed. So, what? Narcan's there." So Narcan all of a sudden is the safety net. "I've got my Narcan kit. It's okay if I overdose." … That's a shift I've seen in addicts over this last year that they're more willing to take the chances with higher doses or different products that they know are more pure because they know their friend has the Narcan kit or they know they can get Narcan from the drop in or they know that EMS will be called or police or fire. They've said that to us. So, the behaviour becomes riskier. Absolutely. (focus group participant).*

> *The frustration isn't necessarily about the fact that we're attending an intervention or an overdose and administrating Narcan. It's about the fact that Narcan in and of itself sometimes feels like a double edge sword because … it's almost like it takes away the danger in taking something like fentanyl, which is – I mean it's just absolutely crazy. So, we're actually seeing addicts that are pursing fentanyl that has a reputation of killing individuals because they know it's a better product or it's a guaranteed product based on other things. (focus group participant)*

Respondents also described that the experiential strains associated with reviving the same client on multiple occasions – sometimes within the same day or week – not only feed into and reinforce a belief among many respondents that the intensive use and availability of these measures 'enables addiction' and may actually encourage riskier behaviours – but also contributed to a sense of apathy disconnection, and despair:

> *I can say in the last three years since the crisis has started, I had found myself and I'll admit to going, "Why? Why this time?" Because I've seen this individual three times this week. So again, it's that ability to check in. I think the mental health of not only the patient, but of the practitioner's coincides almost exactly. The apathy just erodes confidence and you get sucked dry. (focus group participant)*

I think there's a sense of – I don't know what you say, apathy at times in regard to treating opiate overdoses in general like, "Oh, here's another one. Here's another one." (focus group participant)

And there's a huge detachment too…like I have been in my building for a year and a half and I responded to over 50 overdoses at work and my personal life being an addict in recovery, there's been a lot as well. So, you become detached and it becomes the norm. And like out of all those overdoses that I responded to, I've lost one. So thank god for naloxone but it's like people become super detached and it's of the norm….I'm so desensitized to it, you know what I mean? So, it's like even if somebody close to me passes away like it doesn't faze me at this point. There's so much detachment. It's super shitty because it's being dehumanized and loss and all that stuff. (focus group participant, PWLE)

You start to examine your conscience. And you're like, "This isn't why I went into nursing. What's wrong with me now that my emotion level is so blunted to this?" (focus group participant)

For a staff member to feel like, "Maybe we just shouldn't do it this time." Obviously, that's not something that people would actually do in practicality but emotionally, that's a place that this crisis can take you to. So yeah, the recidivism is a major, major challenge. The same person over and over again. (focus group participant)

Importantly, the 'double-edged sword' of emergency relief measures was not described as a direct source of stigma in that it was based in inherently negative attitudes towards people with opioid or other drug use problems, but rather as an indirect source of stigma in that it came largely from a place of frustration and helplessness, and the feeling of being on a never-ending hamster wheel.

The staff perspective is really, really hard because they can go to someone who's overdosed once and provide an intervention and be okay with that and feel like they've done something successful. But when they see that same individual maybe 10 or 20 times…the same individuals where the staff members are going back to those people. And it's really, really challenging because not only are we in a position where it feels like this hopeless kind of journey because we're not addressing the root causes of why that person is an addict to begin with. We're really just giving it temporary intervention. (focus group participant)

Yeah. I don't find that our staff have stigmas. I find they are frustrated. Especially in certain areas. I mean, we, you know, we have stations that don't deal with it ever. And we have, you know, crews that deal with it every day, five times a day. And it's new for them, right? And then, you know, when issues popped up over the years here and there, and, you know, you kind of go through some cycles. But now it's every day, all the time….and that is frustrating. And I know some staff who have even said like I don't want to work down here anymore. Like I'm tired of this. It's frustrating. You know, I need to get out to a quiet hall because this is not … (focus group participant)

As further indicated in the following comments, the tension that first responders and front-line workers experience with respect to emergency relief and helping high recidivism clients was also described as a personal ethical concern for many:

> *I know some of our staff, they actually feel like they are contributing to the problem, right? Yeah, specifically related to the Narcan, the naloxone, they are almost enabling some of the people. Nobody wants to see somebody pass away, but it's like, yeah, you know what, the fire hall is right there, the ambulance is right there, you know what, I'm good. I got my safety net built in over there so, you know, away we go. And that's what they feel like and, you know, nobody wants to say, well we're not going to do it then but they are like, you know what, we're not making this better. Like we are, we're making it worse. We're not having any impact. (focus group participant)*

> *It questions your ethics and values when somebody gets revived and then you do it again and you do it again and you do it again. And the relationship, they feel so comfortable in the relationship to literally take it for granted that this is just your job to revive me. It's like this is your gig, you understand what you signed on for in doing this…How do you speak to that in your heart and in your mind to be able to provide that same level of service every single time to that individual? (focus group participant)*

4c2b. Trauma, Compassion Fatigue, Burnout

Another indirect source of stigma that emerged strongly in focus groups and interviews is the reality that many first responders and front-line workers are experiencing high levels of compassion fatigue, vicarious trauma, and burnout from working on the front-lines of the crisis, including the stresses and challenges associated with helping high recidivism clients, witnessing multiple numbers of poisonings and poisoning-related fatalities, and continuing to struggle with ongoing system inadequacies such as lack of resources, understaffing, as well as inadequate access to treatment and care for users.

Respondents recognized that experiences of vicarious trauma and burnout were a major contributor to low levels of compassion satisfaction and emotional and behavioural distancing from clients. They also recognized that these experiences were negatively impacting their own mental health and wellbeing.

The following comments illustrate the mental and emotional toll faced by providers working on the front-lines of the opioid crisis, and how this was discussed as another 'indirect' -- albeit key -- source or contributing factor to the stigmatization of people with opioid use problems and people at risk of opioid-related poisoning:

> *One group asked us to come in and do some training on how to help their people be empathetic and then they said to us, "you know I'm an animal control guy and I go home and kick my dog, like what's with that?" And they don't understand that it's trauma, you know and they're saying, "I'm a good guy, I got kids, why am I going home and yelling at everybody?" and "I'm a good person, why am I doing this?" and it's really difficult for some of them to name it. They just don't - they know something's not right but they don't know what, they don't know why going to work is having this impact on them. (focus group participant)*

What creates distress, frustration, feelings of helplessness? It's not necessarily a negative belief system of lack of information. It's that they cannot show up in a preferred identity because of the situation. (key informant interview)

This endless cycle of overdosing and returning and overdosing and the inability to get people further down on the path towards recovery…[is] one of the reasons why our team was formed. Because paramedics are leaving the job in droves. Police officers, firefighters are stressed to the max because of the multiple overdose calls that they make. Emergency room workers are frustrated and of course, shelter workers, harm reduction workers, outreach workers, peer support workers are just burning themselves out like crazy trying to stick the finger in this massive hole that we have in this situation. (focus group participant)

You need to support your front-line workers…most of us join these organizations to work with people. We're social, we like people, we want to make a difference. But when you're dealing with the same situation over and over and over and the stress goes up and the fatigue goes up and your personal life issues start to creep in, you lose those soft skills. (focus group participant)

We wind up working in survival mode, all the time. That's often what's so hard. (focus group participant)

In the field with the first responders…one of the big concerns is burnout and compassion fatigue. Because they're getting numb and when you hear about the people that don't like the bylaw officers and the people that don't like the police and the paramedics, it's - they've just seen so much that I think they don't even have time to do self-care. (focus group participant)

I think the other concern too for the service providers that work in the core with us, homeless population is I know there's some academic work that was recently done around – that found that the service providers only manage about 4.5 years of work with them before they burnout. And so that's a big concern, particularly if they – they now have additional responsibilities they have to deal with. (focus group participant)

Because of lack of treatment options and other kinds of supports it puts people who really care about their clients into a very stressful situation. (key informant interview)

The one point of view or issue I'd like to maybe draw your attention to as a result of the absolutely atrocious and ineffective response we generally make to treatment. One of the consequences of that is first responders, front-line workers are burning out like crazy. The stress on them is unbelievable. (focus group participant)

4c2c. System Inadequacies

Finally, ongoing system inadequacies were also identified as an important source of stigmatization. Chronic underfunding of addiction treatment, understaffing and low pay in many front-line sectors, inconsistencies in practice standards and other system inadequacies were commonly highlighted. Importantly, system inadequacies were not only identified as an indirect source of stigma in that they created a stressful, challenging and ill-equipped environment in which to provide care and response to people with opioid use problems and people at risk of opioid-related poisoning, but also that system inadequacies were themselves a product of long standing systemic and structural stigma towards addiction and people who use drugs.

The following comments help illustrate this theme of system inadequacies being both a source and consequence of stigmatization:

> *I've had people in the backseat of the cruiser car…when the person says 'okay, I want help.' You've got a very small timeframe to get that help for them, right, and I've had guys in the back of my car, crying, saying 'okay, please take me, please take me, I want help now.' And we know, it's like well, we're going to take you to [organization]. You're going to sit there for six hours and be told okay, you're on the list, call this number in seven days. Go detox ... you know, because there's a waiting list to detox and you tell them all that and right away you've ... they're, like ah and it kind of furthers that stigma, that ... because they already feel that they're worthless. So now you're adding stigma to, like oh ... so I've heard, 'what's the point? Then just drop me off on this truck corner here.' (focus group participant)*
>
> *In a small town, local care is totally inadequate – most of them don't want to go to a specialist appointment in [a city three hours away]. We have counselors, but no intensive treatment. There are two beds in [a city three hours away] but they are often not available….and {health authority] admin not very supportive of harm reduction – so there's barriers there. [Health authority] doesn't fund any public health hours for harm reduction. We have no beds for detox. No nurse outreach. (key informant interview)*
>
> *Our biggest challenge...is that the system isn't prepared to provide support to every individual that needs help. (key informant interview)*
>
> *[Addiction and mental health treatment] is seen as not as important, there's no status attached to it unlike if you're working in cardiology or orthopedic surgery. So that's why one of the reasons working conditions are so difficult I think is because they're working with that population. (focus group participant)*
>
> *The indifference is because the way the system goes…You become indifferent when you say, 'because what's going to change from the last time? Nothing, right?' (focus group participant)*
>
> *The problem is I don't think it's getting the attention it needs because of the stigma attached to [addiction]. (focus group participant)*

One is an issue of access to care and the other is an issue of equitable distribution of quality of care…I have to traverse this labyrinth that is barriered by design because they want to keep people off the system…and I have to navigate my way through just to access something that looks like good care, which quite frankly in the public system is often extremely substandard and is probably hurting more people than it's helping. (focus group participant, PWLE)

I think the issue of discrimination raises its ugly head here too because … there's no more … stigmatized population than people with mental illness and addiction issues. And within the health care system, within the social welfare state, people who work with that population are also discriminated against. (focus group participant)

4d Tackling Stigma: Provider Learning Needs and Promising Approaches to Effective Stigma Reduction

The final main topic covered in focus group and interview discussions was that of strategies and approaches for combating stigma. Respondents were asked to discuss what they thought were key learning and support needs for first responders and front-line providers that would assist in improving attitudes and behaviours, as well as specific strategies or approaches they believed could effectively address various sources of stigma described above.

Respondents widely believed stigma reduction interventions were needed, including interventions that specifically focussed on the topic of stigmatization, as illustrated in the following comment for example:

My perception of that is that we all hold stigma, like everyone does. And to be conscious of your stigma so that you can be aware of how it's impacting your work and that to not feel guilty about it but to sort of face it and then maybe, you know, in your own head talk through that. Like, 'why am I thinking those things?' And it's okay if that thought comes up again but the next time you're faced with that situation…question yourself and realize and identify it as stigma in your own head…And then also there's like actionable things that people can do. (focus group participant)

That said, respondents also believed there were several important avenues for addressing the problems created by stigma at the level of provider-client interactions and care, some of which involved more indirect methods or approaches. As one respondent noted in this context:

How we conceptualize stigma has a lot to do with how we respond to it. (key informant interview)

Within this broader framework of how respondents were understanding and describing stigma, their suggestions about learning and support needs and their opinions about the most important foci for anti-stigma interventions tended to coalesce around one central idea -- that of cultivating, protecting and enhancing compassion and compassion satisfaction – i.e., the pleasure derived from first responders and front-line providers being able to do their work.

The following comments help illustrate:

> *If they knew more about addiction, then maybe it would support different behaviours. But this really only makes a small difference. Really, It's that they don't have enough compassion satisfaction in their work. The more compassion satisfaction you have, the less likely you are to engage in distancing or other behaviors. (key informant interview)*
>
> *Compassion goes a long way. Humanize a person, it goes – it goes leaps and bounds. (focus group participant)*
>
> *It's easy to drive by and to see certain things and have certain belief systems without knowing someone as a human being, a human story. (focus group participant)*
>
> *When I talk to our recruit classes I always say you might not have empathy, you might not have any understanding for what that person is going through, but don't lose compassion. You have to have your compassion. (focus group participant)*
>
> *It's all about having more of an open heart and kindness and less judgement. (focus group participant)*

Within this framework, analysis of interview and focus groups data revealed five main areas which were believed to be essential for stigma reduction, particularly to improve behaviours at the level of client-provider interactions and care. The main areas of focus identified by participants included:

- education and training that provides first responders and front-line providers with more progressive understandings of addiction, treatment and recovery;
- interventions designed to build trust and understanding between providers and clients;
- social contact-based approaches and interventions to increase human connection, understanding, awareness and to combat feelings of apathy and helplessness;
- education and training in trauma-informed care and practice; and
- inward-facing support and training to increase resiliency and mitigate provider burnout.

Importantly, respondents also emphasized that any comprehensive stigma reduction strategy also needs to address system barriers and inadequacies, although it was recognized that this was something that largely would have to be addressed at the level of policy, as opposed to through training interventions.

Each of these main themes is described in more detail below.

4d1. Education on Addiction, Treatment and Recovery

Respondents believed that more education on addiction – especially that which provided a lens through which addiction was understood as a treatable medical condition -- was important. This included more education on the causes of addiction, more knowledge about the scientific evidence on best practices for harm reduction and treatment, and a greater understanding about the process of recovery. The following comments illustrate respondents' beliefs about the value of education as a stigma reduction tool:

> *We're hoping that by helping them set aside their own negative attitudes and beliefs, by giving them accurate information about addictions and mental illness, that they'll become less punitive. (key informant interview)*

Many respondents also opined in this context, however, that the main issue was not that there was a lack of information or knowledge among first responders and front-line providers per se, but rather a lack of correct knowledge and information:

> *It's not that there's a lack of information, there's a lack of accurate information. (focus group participant)*

The following comments reflect some commonly-mentioned areas of mis-information, myths and education needs:

> *With regard to the use of Narcan [and the frustration with high recidivism clients]…is that when we use it, we're actually putting people into acute withdrawal. So, the urge to use is severe after they come out. So, it's not unusual for someone to try and actively use immediately after they've…been given Narcan. So that's an important education piece. (focus group participant)*

> *I think the other thing around education…is there's a view that Aboriginal people are natural addicts, that somehow their Aboriginal heritage means a natural progression to addiction, which is just not true. There's lots of evidence that says there's all kinds of social issues that causes that, which are weighted higher in that population, but there's no evidence that, you know, you're Aboriginal so of course you're an addict, right? And there has to be some peer public education around that. (focus group participant)*

> *We still preach abstinence for everyone without understanding the risks when it comes to opioids. People are dying in abstinence-based programs…because the people that are coming in and out in our recovery programs, they get lost to care again, right? They could show up and go to meetings for a while and then they leave and they die because their tolerance is impacted. (focus group participant, PWLE)*

> *They think that it's always society's less fortunate. Whereas if people knew the stories. Someone had an automobile accident, got started on opioids, his doctor cut him off and he wound up injecting because he was in too much physical pain. I find we're not correcting society's perceptions about what brings people to start using drugs. The suit and tie guy who shows up, nowadays. That's where it needs to happen. We should have a video, not promotional but educational. The suit and tie guy and the homeless person, see them both. (focus group participant)*

> *Safe consumption sites are just coming to [city]. One site is supposed to be at [hospital]. It would reach a lot of the marginalized population of users. Many within the hospital don't want it there. They worry that it will become a hood for junkies and dealers and will affect care. But the reality is that the data is clear that safe consumption reduces complications from addiction. It is a good thing….most people don't appreciate the data around safe consumption. (key informant interview)*

I was recently on a panel…and the topic of detox came up and the people were, like 'we need more detox facilities for opioids'…The panel members were saying 'yes, we're going to put more money into detox' and I actually had to interject and explain that 'detox is not for opioids.' And I explained [how you must wean off opioids differently than some other substances] and everybody in the crowd was, like 'so everything we've been told was wrong you mean?'…The scary part was even panellists who should know better were agreeing that yes, we need more detox facilities for it. So that's where education, I think…needs to be improved. (focus group participant)

This kind of bothers me a little bit because I think it shifts the focus of opioids, is there's a perception with these synthetics and opioids, that there's a risk to first responders, right? And so, if you look at a lot of the media stories, that seems to be the big story, right, is when we respond to these people, the people that are responding are at risk, which is really bunk…There's not a risk. Let's focus on the real problem. (focus group participant)

In addition to challenging myths and incorrect knowledge, respondents also felt more education and training on addiction and its causes was important. Many participants also commented on the importance of knowing what local resources and treatment options were available for clients:

They need better understanding of what addiction really is and what its all about – they have to move away from that 'moral failings' perspective. They need to know what treatment options there are and how people can access them. (key informant interview, PWLE)

…emphasizing that the opposite of addiction is connection. (key informant interview)

From a provider standpoint, they are not educated. About 10% of the population has substance use problems, yet most providers don't know who to deal with it when it walks through the door. How can you not know what to do when its affecting 10% of the population? (key informant interview)

I always like to compare ... when I'm educating, compare it to something we know, like diabetes for example. It's a chronic illness that someone's going to suffer with in their lifetime. There's going to be ups and downs, just like there's going to be in your lapses and intoxications and we need care to help support through that continuum. So, what that might look like, if someone with diabetes, if they go into diabetic shock or they end up having a heart attack, we have that acute response to manage those things, but then we also have those sustainable other portions to help them throughout that, which includes different forms of harm reduction. You need that education. (focus group participant)

I teach an addictions course at the local university here. And, you know, it's a physiological phenomenon. And it arises out, usually for the vast majority of people, it arises out of a context of trauma. And, so trying to raise their consciousness about how addictions develop and what maintains an addiction. (key informant interview, PWLE)

What do health care providers need? Know your resources really well. Better understanding and management of addiction. Greater level of comfort and training so as to not be freaked out by working with people with trauma and adverse experiences. (key informant interview)

Participants also frequently commented on the need for greater education and a more comprehensive understanding of treatment and recovery, and the proper role of harm reduction within this larger framework. Some also commented on more education and training on best practice standards related to harm reduction protocols. As the following comments demonstrate:

Better management of antidote processes. For example, when we when give the antidote, we can get negative reactions because you are killing their high. So, we need to know how to manage that better. (key informant interviews)

We've done tons of work around what recovery looks like for addictions…with stories from those with lived experience we've created like what works well for them, what they need and where they want to go, journeys. The one thing that we're getting is basically says that addiction is a symptom, it's not a cause. We don't treat addiction by itself in isolation. Because using is what we do to survive the trauma that we went through. So, we very much recognize that if we address the pain and hurt and grief and loss and historical trauma, intergenerational pain that we carry and our disconnect from land and our disconnect from culture and our disconnect from each other, our disconnect from community, if we solved all of that we wouldn't need to address addiction, it would just be gone. (key informant interview)

So, let's say we have a detox centre that has a soft practice of having people come back a couple or few times to make sure that they're ready to make that commitment, it's almost like a counter intuitive policy built into the system. But it actually shows they're moving along. That's the kind of way we need to get people thinking about recovery. (focus group interview)

You know, you can choose abstinence and those services if that's what you want, but not everybody is ready for that or wants that. In the meantime, our intention with harm reduction, is to try to keep people safe and live. And I think its important that we understand that some people will never stop using substances. (key informant interview)

4d2. Interventions Focussed on Building Client-Provider Trust

In addition to the call for more education, many participants believed that front-line providers and clients both would benefit greatly from interventions and opportunities that focussed specifically on building trust, understanding and communication between client and providers. Most participant comments in this context spoke to the value of listening to and respecting the voices and perspectives of people with lived experience, and also ensuring that interventions were organized in such a way as to ensure 'equal status' between clients and providers. The following comments help illustrate this theme:

We need to build trust with users – but how? By using people who can connect with them, whom they will trust. We are starting a program using peer navigators … They are getting their training upgraded as health workers. (key informant interview)

If someone is going to interact, on a professional level, with people who use drugs, it would be useful for them to, well, first…bring together people who use drugs in a place that's safe and where they set the rules of how they interact with each other. And then, when someone thinks, "Oh, there's a big problem going on with opiate overdose. We're not doing a good job of stopping it. We need more information and help with this," then go to this already formed drug user group and say, "Hey, there's a big problem. We're trying all kinds of things and they aren't working very well. What would you do?" (focus group participant)

I think, yeah, that there needs to be an aspect of humility. [PWLE], we're the experts, right…you know, they need to come to us. Or you know, like – everybody has their strengths and needs, and that goes for the professional community and our community, right? And so, mending those relationships while creating that collaboration. (focus group participant, PWLE)

Proper communication, Yeah, listen…There's serious problems, you know? Just because you don't have a broken leg doesn't mean you're not broken. You know? (focus group participant)

Another important concept iterated within this theme was the importance of providing culturally safe care, as well as the value of using peer outreach and coordinators in efforts to build greater trust with people of Indigenous heritage. As the following comments illustrate:

In terms of providing culturally safe care… what happens most of the time is we go to a community and we say, well how come you guys aren't working with the community mental health services? And they'll say, 'we have no relationship with them, they treat us horribly, none of our people can get this service there, they call us all drunks, it's horrible, we can't even go there.' Oh well that's a challenge. So, we'll go and we'll meet with the mainstream and they'll be like, 'we don't know how to talk to them, we don't know what to do.'…Oh okay, so there's a breakdown in relationship. So, we'll work with both to rebuild that relationship so that they can form that new relationship and work with each other in good ways. (key informant interview)

We're actually in the process of hiring a peer engagement coordinator that will work specifically with First Nations people…encouraging more First Nations people or Aboriginal people to be trainers, to go into communities….you know when you have somebody who can come into community and understand already a bit about the history and the world that they're living in and they get it, you know it makes a difference on how the people are going to relate and learn and trust. (key informant interview)

Ways to reduce stigma and discrimination -- we offer an eight-week Indigenous cultural safety course which we encourage all our staff to take. (key informant interview)

4d3. Social Contact as a Key Stigma Reduction Tool

In a similar vein to the above, many participants spoke of the value of social contact and recovery stories as an important stigma reduction tool, not only for building greater provider-client trust and communication, but also more broadly to address other aspects of stigmatization, such as shifting perceptions and attitudes, as well as combating feelings of apathy and helplessness. A sample of comments is provided below:

> *What I'd love to see is somehow people with lived experience or even current people who are working through an addiction to come and talk to first responders, health care workers and help us navigate how we can better care for them, better decrease the stigma…like sometimes what's the appropriate question to ask? Are you using illicit drugs versus recreational versus just straight up saying, "Are you using heroin?" Would people prefer if I said "dope"? Different things…But I think just in general like because there's no one better to educate than the people that are affected by the marginalization themselves. (focus group participant, PWLE)*

> *One educational piece that I have seen through CME rounds is where we brought in parents of kids who had succumbed to addiction to tell their story. That seemed to shift perspective in a positive way. (key informant interview)*

> *I also think connection with people – peers, people with lived experiences – is so important. …A lot of health care providers don't really know people who are using substances, other than alcohol, they can make assumptions. Connection, bringing people together, is important. But you can't just bring anyone together, because if they're not trauma-informed, they will cause harm. (focus group participant)*

> *I was feeling down about [the crisis] and there was an article in the [newspaper] at Christmas time about this guy that was apparently like accused of murdering some terrible criminal – he was going to kill himself or something like that. And he found god or whatever. And now he goes and helps addicts and tell them that, you can turn your life around. And he's now working – he spent 10 days at Christmas down in [city] talking to addicts. I was like – I had tears running down my face and I was like, "Okay, this is who I have to think of for the 24th time we've given the same guy a Narcan intervention. Maybe he's going to be this guy that eventually is going to clean himself up and go and help people. So that helped me for that week. (focus group participant)*

> *For me, working at a place like the [organization] where people are in recovery helps an awful lot with my burnout because I will see people come through on the other side where they're actually trying to get sober, have periods of sobriety. And you see them as completely different people. They are different people when they're not actively using. So that helps me to be able to be able to keep doing what I'm doing in the emerg….I just offer that as a bit of hope is that sometimes people do get better and when they do get better, they're different like amazingly different. (focus group participant)*

[Organization], for example…used sort of that approach. They had health professionals there talking about what an addiction really is, in terms of a health care issue, and they had a person with lived experience, who is in recovery, solidly in recovery, talk about how the addiction developed for them, and just talking about that journey to recovery, how challenging it was and what difficulties they encountered and how much discrimination played a role in creating obstacles for their recovery. (key informant interview)

In a previous life I worked with men who had committed sexual offenses. You know, the best way for me to sort of get over my repugnance at their behaviour was to hear their stories. When somebody who does behavior, or exhibits behavior that people don't understand, once you hear their story you can put it all in context. It's much more difficult to be judgmental about them. That applies for anybody who's marginalized, for sure. (key informant interview)

4d4. Training in Trauma-Informed Care and Practice

Another key learning need and stigma reduction strategy commonly mentioned by participants was a greater understanding of, and training in, trauma-informed practice and care. As illustrated in the following comments, training in trauma-informed practice and care was identified as an important stigma reduction strategy on two fronts – to provide a safer environment in which care and response are provided, as well as a tool or practice that would help first responders in their own work environments deal with vicarious trauma and experiences:

[My husband] missed a lot of appointments, I get it. But they need to understand the symptoms that come with the condition and work with them. Like, being able to recognize when a client or patient is lying to you is not impressive. Creating an environment where someone feels safe enough to not lie -- that's impressive. (key informant interview)

The trauma-informed care is really important. So that's starting to seep into some community agencies…but it's little tiny pockets here and there. It would be so much better to be able to have everybody coming from the same perspective, but we're not there at all. (key informant interview)

Re-traumatization by service providers can lead to individuals not feeling safe and by responding to providers as being threats or avoiding care all together. The tone of voice or words can trigger trauma responses. Then the person starts shouting at the provider or runs away… So, the education is about how do you provide care that promotes emotional as well as physical recovery and doesn't do more harm than good? (key informant interview)

The question that service providers need to ask themselves is not, 'how is this person expecting I'm going to be able to help them?'. Instead, they should be asking themselves, 'how is this person going to expect I'm going to - be hurting them?' And they need to learn how to interact in a way that really projects explicitly that they're going to– give that person choice, and they're not going to treat them as if they are a label. (key informant interview)

I see it not only for the people who are using drugs but I also see it for the people who are helping those who use…you know instead of saying, "What's wrong with somebody?" we need to say, "What happened to them?" (focus group participant)

[Program on trauma-informed care] takes into account providers' own trauma. It reminds them of the way they want to show up, helps them know how to be more mindful, not just "correct" behaviour, but see their interaction with patients as a relationship. It reminds people to be aware of the histories people carry with them – and reminds providers they don't want to inflict more harm. It reminds them of their desire to do no harm. (key informant interview)

4d5. Inward Facing Training and Support to Improve Resiliency and Mitigate Burnout

The final key learning need and stigma reduction strategy emphasized by participants was training and support to help mitigate the risks and experiences of burnout among first responders and to improve resiliency. To this end, the value of trauma-informed training was again emphasized, as were inward facing interventions that focussed on workplace mental health and resiliency. Importantly, respondents also emphasized that any such interventions also needed to be accompanied by appropriate organizational supports.

A sample of comments is provided below:

It's creating burnout among the front-line workers and we're struggling with how to deal with our own sort of-moral ethical conscience, and obviously, psychological health and safety. That kind of robust understanding's super, super important…and that's one of the training gaps…What kind of resiliency provisions can we look at for individuals to…be able to make it successfully if they choose to continue their career in the front-line? (focus group participant)

Supporting first responders in debrief and offering them healing. In this [name of course] course I took, every morning, we would sit in a circle and get anything off our minds that was bothering us. We cleared everything every morning. Sometimes it would take a bit longer. It was good because it taught us skills in how to support each other. But I thought wow, why don't we do this at work? Where there is so much trauma in our jobs. So, I think that's really valuable and important. (key informant interview)

My husband was an on-call fire fighter for a time and there was a horrific accident and two boys died. The next day they brought in supports – a team of people to take care of the firefighters who were there. I think that was really huge. It helped a lot to help them deal with their trauma. They want tools to allow them to help themselves and tools to help each other, so those tools were things like psychological first aid, understanding signs of trauma, that trauma-informed practice or care, and education. A lot of what we've been doing now with our education sessions is people going, "Oh now I get it, there's nothing wrong with me, I can get better, I just, you know, I have vicarious trauma", so for a lot of them they don't know what that is. (key informant interview)

Every person who works in first response needs to have taken a MBSR [mindfulness-based stress reduction] practice or have a meditation practice. (key informant interview)

We know from research that stress tolerance in the workplace through trauma exposure leads to social distance. Contemplative practices to help tolerate stress in the workplace, which keep people open and engaged and more able to deliver good care, then lessens social distance. This is what we focus on in our workshops. (key informant interview)

And a lot of times, that's the question they have is like from one of my guys is what tool – what can you provide us with that's going to make me tougher, make me stronger in their language, right? They're so upset with themselves that they're upset and that compounds the issue. And it's like, "I shouldn't be upset. I understand this issue. I've seen it. I've been through this. Why am I upset? Why at this time after having done 10 of them or 20 of them or 30 of them, why is it #31 that just totally breaks me somewhere or puts me in that position where that there's no resiliency left?" (focus group participant)

We've got a number of strategies within our health, wellness and culture that are looking to address and create resiliency within our front-line practitioners. What that looks like, we're still developing it…And it's still stumbling blocks within that stigma portion of what a psychological injury looks like, not only for ourselves but what is an injury or what is that contemplative move for clients that we're dealing with in this crisis. How do we change the language around how we're talking about clients? About our patients? Creating that, understanding that you are going to be stressed about this, you are going to feel apathetic, acknowledging this and teaching some resiliency pieces towards that. Also, providing that backend support. (focus group participant)

4d6. Address System Inadequacies

Finally, as mentioned above, focus group respondents and interviewees also emphasized the need to address system gaps and barriers if stigma was ever going to be truly and effectively combated. To this end, the need to understand, capture, and address stigmatization at a larger system level – in terms of quality care practices and policies, resource allocation, access to and availability of treatment options, and other system-level issues for example – was expressed throughout the interviews and focus groups. As the following respondents commented:

Let's not lose sight of the fact that effective treatment is one of the best antidotes to stigma. That, and prevention. Keeping people from falling into addiction in the first place……that'd solve a lot of the problems we've been talking about. (key informant interview)

If you give people real chances for recovery, stigma goes away." (key informant interview)

We need greater attention paid to structural stigma, right? I mean, you can do workshops till the cows come home, but really you need to actually be changing structures. (focus group participant)

A sample of additional comments is also provided below. These comments were from participants drawing attention to some of the specific system level issues they felt were of key priority:

> *We need doctors that do hydromorphone – prescribe hydromorphone, so that people stop getting poisons. (focus group participant)*
>
> *You need resources. You need to invest resources in it. Access to … treatment. Like, immediately. (focus group participant)*
>
> *If we talk about learning needs, we really do have to talk about the system and the amount of time that a curriculum allows for these conversations to take place. And where they don't take place – so if we just for a minute started to say, okay, when you learn about cardiology you're also going to learn about and understand and appreciate addiction…you know what I mean? (focus group participant)*
>
> *We need to address the upstream. The doctors are prescribing still. So, I think in terms of what we need…that's such a big part of it. (focus group participant)*
>
> *It's not a local issue, it's not a provincial issue, you know. The whole change of direction from an education and prevention standpoint, that's the only thing that fixes it. It's that all of us on the street level guys, like we're not going to fix this problem. So, you know, it is well above our pay scales and it has to be, you know, national education and prevention programs to change the direction…or at least prevent future people from being involved in this behaviour, right? And not to write anybody off. You know, sometimes things are very difficult to fix, but maybe you can prevent additional problems in the future from occurring. And that, to me, needs to be the absolute focus of the whole thing. (focus group participant)*
>
> *We don't have a treatment system. We have a discombobulated mess of nothingness that has created where we are at today. What needs to change? First, recognition that people are going to come into contact with the system at many different touch points. Start with the touch points. Each of those touch points needs to be a way in, and people need to be directed to where they can go from there. Also, I do not think people should go to jail for substance use. (key informant interview)*
>
> *One of the interesting things at a 30,000-foot level, as a big conversation around what to do, lots of conversation around, of course, the Portugal model,[5] right? Which I'm sure lots of us are onboard with many aspects of that. I think we should … consider variation of that model. They've been doing it in Switzerland, they've been doing it in Portugal for and other parts of Europe for decades with excellent results. (focus group participant)*

[5] More information on Portugal's strategy for addressing its opioid crisis can be found at https://www.theguardian.com/news/2017/dec/05/portugals-radical-drugs-policy-is-working-why-hasnt-the-world-copied-it. Key aspects of this model include decriminalization of illicit substances, greater access to harm reduction, and new approaches to treatment and recovery.

I love the Denmark model of clinical treatment. It starts with the person still using in the clinic…they literally start your recovery when you come inside and start trying to do things in a healthy way and then people triage into what they want…. it's not saying you're not worthy until you put that down. It says, "You're worthy and I get it and we're keeping you engaged in care." And then when the angst is gone…people can actually like settle, they don't have to make those decisions that are knee jerk and then they can make choices. (focus group participant, PWLE)

5. PROMISING PROGRAMS AND INITIATIVES

While the primary objective of the key informant study was to better understand the central issues, consequences and potential solutions related to the problems of stigmatization on the front-lines of the opioid crisis -- and not to identify specific programs -- conversations with focus group respondents and key informant interviewees nevertheless resulted in the identification of a number of specific programs and initiatives that currently exist in different jurisdictions and are offered to different front-line providers, which are believed to reduce stigma.

These programs represent many of the strategies described in Section 4d above as being important to improving front-line care and response. Identified programs include: a training program in culturally safe practices; a program for front-line providers on trauma and resiliency-informed practice; a multi module web-based educational program; and initiatives and programs that utilize contact-based education as a key ingredient. What emerged through the research, however, is that most of these programs and initiatives have not been systematically evaluated for efficacy, and not all initiatives exist as ongoing programs. The establishment of formal partnerships with identified programs in order to evaluate outcomes and assess the extent to which they meet their intended objectives thus forms the basis of the next phase of this research, to begin in April 2019 (see **Section 7** below).

6. RECOMMENDATIONS

Findings from this research resulted in the identification of several key priorities for addressing stigmatization and meeting the learning and support needs of first responders and others working on the front-lines of Canada's opioid crisis. Based on the findings described in this report, we provide the following recommendations.

1. Stigma emerged as a major barrier to help-seeking and to the quality of care received by people with lived experience of opioid and drug use. High levels of system mistrust among users was another identified impact of the stigmatization experienced by clients in their interactions with health care providers and first responders. As such, the development of a comprehensive stigma reduction strategy and the delivery of interventions to front-line providers is recommended.

    - As a starting point, organizations could draw on learnings from this research and use the framework developed through the results of the key informant study as a guide for planning, designing and implementing interventions.

- Another strategy for implementing the above recommendation is to draw on lessons learned and evidence-based knowledge for combating mental illness-related stigma in health care, including implementation models/guidelines (e.g., Knaak & Patten, 2016) and key ingredients (e.g., Knaak, Modgill & Patten, 2014). When adapting or creating interventions, people with lived experience of substance use disorders must occupy a central position in planning, implementation, and evaluation.
- When designing and delivering anti-stigma interventions, they ought not be thought of as one-off interventions but as a comprehensive set of tools and approaches that could be implemented complimentarily and thoroughly within a larger framework or strategy.
- It would be important to ensure that interventions and approaches include a robust evaluation and monitoring framework to determine if they are meeting their objectives.
- Key guiding principles for the development and delivery of anti-stigma interventions for first responders and front-line providers include the cultivation of greater compassion, greater understanding and trust between clients and providers, and greater levels of compassion satisfaction for first responders in their work. A focus on improving attitudes and behaviours is also of central importance.

2. It is recommended that promising approaches and strategies identified through this project be systematically evaluated for effectiveness and efficacy. Successful approaches and interventions can then be replicated, shared and promoted nation-wide.

3. The ethical dilemmas experienced by some first responders and other front-line providers with respect to high recidivism clients and the concern that emergency relief measures (e.g., Narcan) may increase risk behaviours in some circumstances require attention. It would be important to address these in greater depth, ideally as a separate study with a focus on expert consultation, a thorough understanding of the evidence base in this area, and with a goal of generating recommendations for education and practice specific to this concern.

4. Policy makers, professionals, and organizational leaders are in a key position to take a leadership role in practicing non-stigmatizing language use and establishing best practice guidelines for terminology and language use related to opioid use, opioid and other drug use problems, and opioid-related poisonings and deaths. Non-stigmatizing language is a key content ingredient in anti-stigma to be included in interventions for first responders and front-line providers.

5. System-level barriers and service and treatment gaps require prioritized attention. This includes the need to capture, understand, and systematically address issues related to punitive or barrier-creating care practices and policies, inadequacies related to access and quality of treatment options, resource allocation, and other policy and system level barriers to quality care and support for people with opioid use problems. Undertaking first hand research to systematically identify the most important -- and most easily modifiable -- issues with respect to structural stigma in health and social care (e.g., barriers and issues related to access, equity, quality of care), along with recommendations and strategies for change, would be of benefit.

6. Prevention of opioid use problems is a key public health priority. Efforts towards prevention and prevention policy must be stigma-informed. Anti-stigma initiatives are also required for the general public. Although undertaking research to better understand and address public stigma towards people with opioid use and our drug problems is recommended, a starting point would be to use existing knowledge of best practices for mental illness-related stigma reduction, (e.g., see Corrigan et al, 2012) along with relevant findings from this study.

7. NEXT STEPS

The Stigma & the Opioid Project has been approved for Phase II research, which will be completed in 2019-2021. Activities for this phase include:

a) Formal identification of specific programs and initiatives that show promise for stigma reduction in that they employ the main strategies and approaches and target the main causes of stigma described in this report.

b) The establishment of formal partnerships with identified programs for the purposes of systematic evaluation of efficacy and other program outcomes.

c) Evaluation of partner programs using the newly developed Opening Minds Opioid Scale for First Responders and Front-Line Providers, as well as any other measurement tools identified through the establishment of the research protocol and evaluation methodology.

d) Reporting on effective programs as well as any gaps and challenges, and providing recommendations for the replication, adaption and scaling up of effective programs.

e) Adaptation, replication and scaling up, as appropriate, of the most effective programs so they can reach other targeted audiences and/or attain broader reach and impact.

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APPENDIX A

Check for updates

ORIGINAL ARTICLE

CANADIAN COLLEGE OF HEALTH LEADERS
COLLÈGE CANADIEN DES LEADERS EN SANTÉ

Managing the stigma of opioid use

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Abstract

Substance use stigma makes it difficult to reframe the opioid crisis as a public health issue and has been a barrier to accessing life-saving treatments. Interventions using people that convey recovery stories are promising practices. Groups that may benefit from targeted stigma reduction interventions include opioid users (to combat shame and blame), at-risk youth, first responders, dispensary personal, media, and healthcare professionals. The evidence supporting antistigma interventions is thin, with little Canadian research. Research is needed to establish the effectiveness of substance-related stigma reduction strategies. Health leaders should examine their own responsibilities to lead the public health debate, reduce opioid-related stigma, and actively engage members of the community of those with lived experience to become partners in these activities.

Introduction

The extent to which stigma undermines access to care and a coordinated public health response have become important topics of discussion in light of the growing opioid crisis in Canada and elsewhere. The minority of people with opioid use disorders receive life-saving medication maintenance therapy. Over the past 50 years, strong evidence has supported medication maintenance therapy, such that the World Health Organization has added drugs such as methadone or buprenorphine to its list of essential medications.[1] Despite this, fewer than 12% of Americans[2] and 25% of Canadians[3] with an opioid use disorder receive this treatment. Worldwide, the figure is less than 8%.[1] To better understand the role of stigma as a barrier to care and recovery for people who use drugs, this article examines the prevalence of drug use stigma, both generally and in relation to opioid use, and considers promising approaches to stigma reduction. In this context, "stigma" refers to a complex social process that creates social and health inequities for people who use drugs.[4] The article begins with an overview of mental illness-related stigma and evidence-informed strategies to address it, as these have implications for the substance use field. Following, it provides an overview of drug use stigma, then focuses on opioid stigma, and ends with some approaches that have been used in the fight against substance use stigma.

Mental illness stigma and strategies to overcome it

Negative societal responses to people with mental illnesses have been documented throughout history and have been identified as the single most important barrier to the development of mental health reforms worldwide. As such, governments have become increasingly aware of the heavy burden caused by mental illness stigma. In response, many countries have developed robust antistigma programs to improve public attitudes and promote better social inclusion for people with mental illnesses and their families.[5,6] The evidence base supporting promising and best practices in the field is growing rapidly. For example, Corrigan et al.[7] have conducted a meta-analysis of outcome studies examining three broad paradigms of antistigma programming: educational approaches that challenge inaccurate stereotypes by replacing them with factual information, interpersonal contact with people who have had a mental illness, and social activism or protest to highlight injustices of various forms of stigma and chastise offenders for their discriminatory behaviours. They found that both education and contact significantly improved attitudes and behavioural intentions toward people with a mental illness, though contact-based approaches appeared to be more effective, particularly among adults. The Mental Health Commission of Canada's Opening Minds antistigma initiative has used contact-based education extensively and found it to produce robust results across a variety of different target groups including youth, media, workers, and healthcare providers.[8,9] Arboleda-Flórez and Stuart[10] have identified three additional approaches that have been successfully used to combat mental illness-related stigma: legislative reform that is designed to prohibit discrimination on any grounds and improve protections and accommodations for people with a mental illness in areas such as employment, education, and housing; advocacy designed to ensure that people with a mental illness actually enjoy the rights and freedoms offered by legislation and have avenues of redress; and stigma self-management approaches that empower people with a mental illness to overcome their illness identities and move beyond the illness experience to find new personal meanings and valued social roles, consistent with a broader recovery philosophy. While these approaches have yet to be broadly applied to reduce substance use stigma,

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they can serve as an important reference point and evidence-informed foundation for action.

Public perceptions of drug misuse

Considerable research shows that members of the public hold negative and stereotypic views of people who use drugs. In a large population survey in the United Kingdom, for example, 78% considered people with "drug addiction" to be unpredictable, 74% described them as dangerous, and 68% thought they were to blame for their condition, reflecting greater stigma than any of the other mental health groups studied.[11] Similarly, in a US survey, the highest level of social intolerance was expressed toward people with "drug dependency" (78%). Americans also considered people who use drugs to be significantly more responsible for their condition, less often considered worthy of help, and less often considered deserving of assistance in finding a job.[12] In addition, few Americans (13.3%) defined drug use disorder as a health condition.[13] Little population research has been conducted in Canada, but publicly accessible data from the 2015 wave of the World Values Survey[14] paint a similar picture. The 2015 Canadian results show that people with drug use disorders are more highly stigmatized than any other stigmatized group, with approximately 80% of the respondents indicating they would not want someone with a drug use disorder living in their neighbourhood.

There has been a long-standing tendency to view drug use as a moral and criminal issue, rather than a health one.[15] Room[16] talks about the "heavy load of symbolism" and "moralization" that surrounds drug use disorders making them among the most stigmatized of any health condition. As a result of these strong moral and criminal justice overtones, the field of substance use has been divided. Proponents of the view that drug use is a health condition focus on the harms that stigma carries for an individual's health and identity and support harm reduction approaches. Proponents of the view that drug use is a moral issue tend to see stigma as a key public health tool. Stigmatizing measures are considered to be an acceptable deterrent and adopted as a means of reducing harmful behaviours.[17] Stigma-as-social control tactics are fuelled by negative public perceptions, which in turn drive punitive and overly restrictive organizational behaviours.[18,19] In Canada, there is a growing awareness of the limitations of a punitive approach and a movement toward harm reduction interventions.[20]

Opioid stigma

Opioid use carries all of the moral connotations of drug use, with some important differences.

The stigma of medication maintenance therapy

One factor that sets opioid use apart is that medication maintenance, which is considered a best practice for the treatment of opioid use disorder, is also highly stigmatized and judged to be morally wrong. The common misperception is that a legal medication is being substituted for an illegal one—a view that has been attributed to the slow response of governments and health agencies to promote harm reduction strategies.[21] In one US qualitative study of 16 women and 6 men receiving opioid therapy for chronic non-malignant pain, participants reported feeling pressure from family and friends to halt the use of their prescribed pain management routines. They reported being stigmatized as "addicted" and "morally weak."[22]

Even among health professionals, the understanding of opioid use disorder as a medical problem remains overshadowed by its portrayal as a moral weakness or willful choice. Historically, this stigmatized view has separated opioid use disorder from other parts of medicine. There remains a belief that recovery depends solely on an individual's willpower to abstain from all opioids, including medication maintenance treatments. From this perspective, "medication therapy" or "medication substitution therapy" is considered to be a character weakness and people on medication therapy may be treated as if they are still using illicit drugs. Some mutual help groups, recovery programs, and halfway houses do not allow participants to be on maintenance therapy. Members of the public have opposed locating medication-assisted treatment services in their neighbourhoods and, in some locations, have changed zoning codes to exclude them.[23]

In qualitative studies, methadone clients have described stigma as a common feature of maintenance therapy.[3,24,25] Methadone clinics are portrayed as environments filled with stigmatized identities, where staff may sit behind bulletproof glass and where dosing hours are "less flexible than a good dealer." Studies of clients in New Zealand, Ireland, Canada, and Australia all have reported paternalistic one-sided relationships between staff and clients with excessive rules reinforcing a power imbalance,[26] restrictive dispensing schedules (eg, a 2-hour window each day), lack of privacy, and unfriendly dispensing staff.[21] Clients have complained of "punishment policies" where doctors terminate treatment for using any drugs (such as marijuana), long wait times, and a lack of knowledgeable doctors. The staff were described as ignorant, condescending, patronizing, arrogant, and ingenuine. They believed that the stigma of being a "drug addict" followed them into the treatment environment. None of the clients could attest to knowing anyone who had achieved long-term success.[27] The requirements for daily visits, frequent and unannounced urinalyses, and mandatory group counselling sessions were uppermost in the minds of many individuals who felt they had lost control. They spoke of the total institutional character of the clinic, the shame of being an inmate, and the "liquid handcuffs" that required one to go to the clinic every day. One of the most demeaning features of clinic life was the random, frontally observed urinalyses.[3,24] Having to defend methadone doses to other patients was another source of shame. Patients on low doses (55 mg and under) held patients on high doses (typically 90 mg or greater) with great distain. Those on high doses were depicted as "methadone lifers" who had simply substituted one addiction for another.[27] Finally, pharmacies also have been identified as stigmatizing. Some individuals

have felt "outed" and humiliated by their visits because it seemed obvious to others why they were there. Drinking green liquid from a small cup or exchanging syringes, for example, revealed their "addicted" identities.[28] However, in at least one Canadian study,[21] methadone clients spoke highly of pharmacy and dispensing staff who were friendly and flexible. When negative accounts of interactions were reported, they focused on feelings of discrimination that included feeling patronized, being treated with suspicion, or being made to wait unnecessarily.

Prescribed opioids also stigmatized

A second difference that sets opioid stigma apart from other substance use stigma is that a large proportion of opioid users are prescription drug users. According to the US National Institute on Drug Abuse[29] 21%-29% of patients who are prescribed opioids for chronic pain will misuse them and 8%-12% will develop an opioid use disorder. Approximately 80% of people who use heroin first misused prescription opioids. Recent data from Statistics Canada[30] show that almost a third of Canadians (29%) used some form of opioid in the 5 years prior to the survey and one quarter of these kept their leftover opioids in their homes. Fourteen percent of those using opioids with a prescription would not want their family and friends to know. Qualitative research conducted in the United Kingdom with people who used over-the-counter codeine found that participants often referred to themselves as "addicted." They felt "dirty," "guilty," or "addicted" as "much as a heroin addict." As a result, people often hid their opioid use for fear of reactions from family and friends.[26]

In a large US study (N = 1,071; 17% recruitment to the survey; response rate 75%), respondents rated their support for punitive verses public health-oriented policies.[31] A third reported having had personal experience through a family member, close friend, or themselves. Unlike stigma associated with other mental illnesses, there was no evidence that personal experience reduced prescription opioid stigma. Instead, respondents with personal experiences expressed higher levels of stigma on several of the measures used. In addition, higher levels of stigma were associated with greater public support for punitive policies and lower support for public health-oriented policies. Despite the fact that respondents were rating prescription-based opioid use disorder, and not illicit opioid use, a large majority (78%) considered that individuals with prescription opioid use disorder were to blame for their problem and lacked the self-discipline to use prescription opioids without becoming addicted (72%). They were unwilling to have a person with prescription opioid disorder marry into their family (68%) or work closely with them (58%) and considered them more dangerous than the general population (56%). They thought that employers should be allowed to deny employment (55%) and landlords should be allowed to deny housing (39%) to someone with a prescription opioid disorder.

Substance use stigma management approaches

Improving access to life-saving treatments is an important goal, but there also must be a parallel effort to normalize access to these interventions because stigma can act as a barrier to care.[32] For example, free naloxone kits have been offered to students at the University of British Colombia, the University of Calgary, and Mount Royal University, but so far, no one has picked one up. Students may not want to be identified as an illicit drug user or they may not see themselves at risk. This example illustrates that there needs to be more work directed to help at-risk populations understand the dangers of fentanyl and the availability of naloxone and other treatments.[33] Toward this end, awareness campaigns have been launched in a number of places to make people more aware of the public health aspects of the opioid crisis. However, these often concentrate on reporting the number of overdoses and fatalities in an effort to reinforce the growing scope of the crisis. Continually reporting on the magnitude of the public health crisis may be missing the mark,[34] missing the opportunity to break down misconceptions, such as "once an addict, always an addict," and change the dialogue away from the moral narrative to a healthy one.

Similarly, news organizations and media channels across Canada and the United States have increased public exposure to the opioid crisis by providing images of people overdosing in the streets or near death, sometimes with their children and others looking on and police standing in the wings. Such videos may lead to greater shaming and humiliation of victims or retraumatizing those who have lost loved ones to opioids, to say nothing of publicizing an individual's health crisis without their consent.[35] There is a long history of "drug scare journalism" that shares shocking pictures on a daily basis, which reinforces the narrative that these crises are unpredictable, dangerous, and can only be dealt effectively with a criminal justice approach.[36] In the area of mental illness-related stigma, members of the media have developed reporting guidelines that are intended to minimize stigma.[37] Such guidelines could be easily expanded to include substance-related reporting.

The contributions of people who use drugs must be at the forefront of action plans to address the opioid crisis and they should be actively involved in planning and implementing solutions.[32] The importance of storytelling from community members who are in long-term recovery is an important and underused strategy,[34] and one that has been widely and successfully used in addressing stigma related to other mental illnesses.[89] Results from at least one large randomized trial[38] portraying people with successfully treated substance use disorders had shown that this is a promising strategy for stigma reduction. Vignette portrayals of people with a mental illness or substance use problem who underwent successful treatment elicited significantly more positive attitudes and reduced social intolerance compared to portrayals of the same individuals without treatment. Not only do such stories model recovery, they provide a source of hope for people who are living with substance use disorders and for those who treat them. Additional qualitative research describing the lived experiences of

people who are on the frontlines (both responders and people with a substance use problem) would be helpful to better understand and mitigate stigma. Such a study is currently underway through the Opening Minds initiative of the Mental Health Commission of Canada.

What health leaders can do

There is much that Canadian health leaders can do to reduce stigma in their daily interactions with people who have substance use disorders and promote non-stigmatizing public health and organizational policies. First and foremost, they must recognize that client perceptions of stigma are a major barrier to treatment access and recovery and accept that they are in a unique position to take leadership in stigma reduction. In addition, health providers are often unaware of the facets of their own behaviours that contribute to stigmatization and they must become more aware of these.[23] For example, at the simplest level, they can commit to using person-first language in order to deliberately reframe stigmatizing representations away from morality narratives to ones that recognize substance use disorders as a health issue.[32] Educational approaches, particularly those incorporating contact with people who have used substances, can increase awareness and help health professionals understand the importance of using accurate and non-judgmental language to describe substance use disorders. Terms such as "dirty" to reflect a positive urine test or "abuse" must be replaced with terms that are non-perjorative, to say nothing of terms such as "addict" or "junkie." Other stigmatizing words include "replacement" or "substitute" therapy as these suggest that treatment medications are equal to street drugs or convey the notion of a lateral move from an illegal addiction to a legal one.[39]

As previously described, the substance use field has long been divided between a "get tough" philosophy that uses stigma as a means of reducing substance use and a "harm reduction" philosophy that views stigma as morally unacceptable.[17] Canadian health leaders have an important role to play in educating the public, policy-makers, and new generations of students about the long-term ramifications for individuals and groups that are stigmatized and help advocate for the importance of adopting a public health (rather than criminal justice) approach that promotes harm reduction and recovery.

Despite strong evidence for its efficacy, many psychosocial and community support programs continue to be opposed to medication treatment for opioid addiction and may limit individuals from access or full participation. In 2016, the Report on the Standing Committee on Health[40] made a number of recommendations for how to address the opioid crisis in Canada, including improving access to and broadening the nature of current health and addictions services to include a full spectrum of promotion, prevention, and treatment interventions. Canadian health leaders can help remove organizational and policy-related barriers to care that make it impossible for people with substance use disorders to access a full range of health and mental health interventions and supports.

Individuals who work in methadone clinics and dispensaries also must be attuned to the potential for stigmatizing interactions with their clients, particularly because client perceptions of discrimination have been linked to poor treatment outcomes.[27] Ensuring that dispensing policies are flexible, maintain privacy, and that dispensing staff recognize the importance of avoiding negative stereotyping would help reduce clients feeling that they are being shamed because of their addiction. Incorporating the perspectives of people who are receiving methadone and other medication maintenance therapies would be a useful starting point.

Finally, physicians have been particularly criticized for not taking leadership in ensuring that treatment approaches are driven by science rather than stigma.[41] However, stigma prevents all health providers, including physicians, from getting training to treat patients who have become addicted to opioids, either illicit or controlled. It is no longer acceptable to be ill informed about addiction treatments or to stigmatize patients receiving maintenance therapies. Awareness raising and educational approaches are needed.

Conclusions

Substance use stigma has made it difficult to reframe the opioid crisis as a public health issue and has acted as a barrier to accessing evidence-based medication maintenance and other life-saving treatments. Interventions that use people who are in recovery from substance use and who are able to convey stories of hope are promising practices supported by work in other areas of mental health and should be applied to reduce substance use stigma. Groups that may benefit from targeted substance or opioid-related stigma reduction interventions could include opioid users themselves (to combat shame and blame), at-risk youth, first responders, dispensary personal, media, and healthcare professionals.

So far, the evidence base supporting antistigma interventions in this area is thin, with little Canadian research. Best practices from mental health-related stigma reduction, though relevant and useful, have not been applied to the field of substance use. Therefore, intervention research is needed to establish the effectiveness of stigma reduction strategies to the substance use field. Until such time as there is a more robust body of evidence, interventions should be piloted and evaluated to ascertain whether they produce the desired effects, are free from negative and unanticipated consequences, and whether they are generalizable to varied populations and contexts. In the meantime, much stigma has been associated with healthcare delivery and healthcare professionals. Educational and awareness initiatives aimed at health professionals may help them identify the policies, language, and behaviours that are considered by people who use opioids and other substances to be demeaning and damaging. Modelling better practices through recovery stories and first-person accounts may help health professionals better understand how to become part of the solution at individual, organizational, and societal levels. Certainly, healthcare organizations, decision-makers, and

professionals should examine their own responsibilities to lead the public health debate, reduce opioid-related stigma, and actively engage members of the community of those with lived experience to become partners in these activities.

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