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Professional stigma towards clients with methamphetamine use disorder – a qualitative study

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ABSTRACT

Background: Methamphetamine use disorder (MUD) is associated with poor health outcomes. Pharmacists play a role in delivery of substance use treatment, with several studies having examined their attitudes to people with opioid use disorder, but little is known about their attitude towards people with MUD. This study aimed to explore pharmacists' perspectives on the provision of services to clients with MUD.

Methods: A convenience sampling strategy was used to recruit community pharmacists across Sydney, Australia. Semi structured interviews examined views and ideas of pharmacists surrounding the treatment and management of MUD, followed by coding of transcribed interview data by all members of the research team.

Results: Nineteen pharmacists completed the interviews. The main theme identified was stigma held by healthcare professionals. The almost unanimous perception amongst pharmacists was fear and apprehension towards people with MUD, including underlying assumptions of criminality, misinformation regarding people with MUD, and lack of education and knowledge surrounding MUD.

Conclusion: A substantial amount of stigma towards people with MUD was found in this study. Negative attitudes by healthcare professionals can perpetuate healthcare disparities and impede the accessibility of future treatment programs for people with MUD. Appropriate educational interventions on MUD for pharmacists are needed.

KEYWORDS Methamphetamine use disorder; substance use disorders; qualitative studies; pharmacy; stigma

Introduction

Methamphetamine use disorder (MUD) can lead to several health problems, including cardiovascular and cerebrovascular diseases, and is associated with

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a range of poor mental health outcomes (American Psychiatric, 2013). There are health consequences of MUD for both individuals and community, adding to the burden on healthcare systems (Lee et al., 2022; McKetin et al., 2018). Australia has one of the highest past year prevalence of methamphetamine use in the world, with 50% of respondents to self-report surveys listing the potent crystalline methamphetamine as the main form of methamphetamine used in the past twelve months (Health & Welfare, 2023; UNODC, 2022). Increased risk of dependence and subsequent harms to the individual and society have been compounded by the rise in availability of more potent forms of crystalline methamphetamine (hereafter referred to as 'methamphetamine'), colloquially known as 'Ice' (Degenhardt et al., 2017; McKetin et al., 2006).

To date, there is no approved pharmacotherapy for MUD. However, promising studies assessing effectiveness of pharmacotherapies for the treatment of MUD are currently underway (Leidl et al., 2023; Siefried et al., 2020). Healthcare professionals, particularly physicians, pharmacists and nurses, should be prepared for the introduction of new treatment protocols, which will likely require a multidisciplinary approach.

In Australia, as part of the Australian Qualifications Framework, social accountability in pharmacy is described as '*a knowledge and skill set expected from registered pharmacists*' (Stupans et al., 2016). The contemporary role of pharmacists has also evolved over the past 50 years to include implementation of healthcare interventions and client-centred services within pharmacy practice (Garcia-Cardenas et al., 2020). The opioid treatment program in community pharmacy is one example of a service where pharmacists have played a prominent role in the supervised dosing of opioid agonist treatment (OAT) for opioid use disorder (OUD) for decades (Chaar et al., 2011). Data from the Australian Institute of Health and Welfare for 2021 demonstrated that over two-in-three OUD clients received OAT from a pharmacy (Health & Welfare, 2022). Previous studies have shown most clients feel satisfied with their pharmacy OAT (Lea et al., 2008). However, stigma has been cited by some, as a common barrier to receiving adequate healthcare by clients receiving their OAT in pharmacy and other healthcare facilities (Hall et al., 2021).

Stigma, as described by Link and Phelan (2001), involves: labelling, stereotyping, separation, status loss and discrimination, co-occurring in a power situation that allows these components to unfold (Link & Phelan, 2001). These components of stigma manifest in the different conceptualisations of stigma, such as social stigma, self-stigma, and structural stigma (Ahmedani, 2011).

Social stigma involves a stigmatised group of people being labelled and stereotyped as inferior in the social framework. This is endorsed by people with prejudiced negative attitudes, who elicit a negative emotional response (such as fear and anger) towards the stigmatised group (Brouwers, 2020;

Corrigan & Watson, 2002b; Link & Phelan, 2001). This leads to behavioural responses in others, such as avoidance and withholding help, resulting in social exclusion of those stigmatised, which then generally affects their access to treatment services. Social stigma can impact policy change towards the stigmatised group, and cause discrimination (Ahmedani, 2011; Corrigan & Watson 2002b; Stangl et al., 2019).

Social stigma may then cause self-stigma as a result of internalised stereotypes and negative images anticipated or perceived by some stigmatised individuals. This initiates feelings of inadequacy, thereby impacting on the individual's quality of life and participation in treatment services (Corrigan & Watson, 2002a; Crocker, 1999).

Furthermore, Hatzenbuehler and Link (2014) proceeded to expand the stigma construct, describing macro-social forms of stigma, and defining structural stigma as 'societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized' (Hatzenbuehler & Link, 2014). The intersectional nature of these stigma conceptualisations and their dependence on power relations and socio-cultural contexts, reinforces discrimination and social inequalities (Parker & Aggleton, 2003; Stangl et al., 2019).

Cook and colleagues postulate that a reciprocal relationship exists across socio-ecological levels of healthcare that include affected individuals, their social interactions, and structural level forces and institutions, whereby targeted stigma interventions at any one of these levels may affect other levels by way of 'mutually reinforcing reciprocal processes' (Cook et al., 2014). The Health Stigma and Discrimination framework by Stangl et al. (2019) breaks down the stigmatisation process into components such as drivers and manifestations that influence health outcomes across the socio-ecological spectrum in the healthcare setting (Stangl et al., 2019). The framework stresses the need for interventions that target components of the stigmatisation process at multiple socio-ecological levels.

Healthcare professionals are not immune to the effects of social stigma. Various studies document labelling and stereotyping of patients to undesirable characteristics, due to a specific health condition (Ahmedani, 2011; Subu et al., 2021). Healthcare professionals have been reported to enact both implicit and explicit forms of bias towards marginalised groups of people (Brener et al., 2007; FitzGerald & Hurst, 2017; Maina et al., 2018), thereby impacting clinical decision-making and care, contributing to healthcare disparities in marginalised populations (Chapman et al., 2013; Peris et al., 2008; Zestcott et al., 2016). The presence of 'extreme' stigma towards people who use illicit drugs within social contexts that include healthcare professional interactions, has been shown to contribute to self-stigma. This can result in negative effects and the perpetuation of structural stigma and marginalisation of people with substance use disorders (Livingston et al., 2012; Lloyd, 2013).

Stigma left unmanaged in the context of patient-centred care, goes against fundamental ethics of healthcare. Bioethical principles of 'justice' and 'respect for patient autonomy (including dignity and self-esteem)' are renowned foundational pillars of codes of ethics for healthcare professionals (Childress & Beauchamp, 1994). Healthcare providers have a duty of care to be self-aware of and self-regulating about implicit and explicit biases in the provision of healthcare services to the public.

Deen et al. (2021) reported widespread social stigma towards people with MUD, with a substantial amount of self-stigma by such people in Australia (Deen et al., 2021). Increased media reporting and news coverage of methamphetamine misuse, depicted as an 'epidemic' in Australia, and the highly pejorative nature of this reporting has been attributed, in part, to rising public stigmatisation of methamphetamine use (Chalmers et al., 2016). Chalmers et al. (2016) reported that this kind of media coverage may have resulted in underreporting of methamphetamine use in the general public to avoid association with this stigmatised group of people (Chalmers et al., 2016). Another study cited examples of healthcare professional stigma towards clients with MUD in an inpatient withdrawal management setting in a health service in Western Sydney, Australia (Farrugia et al., 2019).

There is a lack of literature reporting experiences of people with MUD in the pharmacy setting, however, accounts of healthcare professional stigma experienced by clients receiving OAT in pharmacy have been reported. Client encounters of perceived discrimination included longer waiting times to receive their dispensed OAT than people with other medical conditions, and limited timeframes within which they can receive their OAT, and segregation from other people in the pharmacy (Lea et al., 2008; Radley et al., 2016). Professional stigma of pharmacists towards clients receiving OAT services has also been reportedly demonstrated by some pharmacists' reluctance to assist in the provision of healthcare services to clients with OUD (Chaar et al., 2013; Werremeyer et al., 2021). The stigma experienced by clients receiving OAT, along with negative attitudes portrayed by healthcare providers, can be an impediment to adequate provision of healthcare and compromise treatment outcomes (Hall et al., 2021; Horner et al., 2019; Stone et al., 2021; van Boekel et al., 2013).

There is a paucity of literature surrounding healthcare professionals' perspectives about MUD, and more specifically, the perspectives of pharmacists. With the ever-expanding role that pharmacists have in contemporary healthcare delivery, and the likely future implementation of MUD treatment services in pharmacy, examining the perspectives of pharmacists is essential for identifying gaps so they may be addressed early on, to improve treatment services and optimise healthcare outcomes. This study aimed to explore pharmacists' perspectives on the provision of services to clients with MUD. This is part of a larger study exploring pharmacists' perspectives about their potential role in the treatment and management of MUD.

Method

The study was approved by the University of Sydney Human Research Ethics Committee (Reference number 2022/594). All participants provided informed consent and were not compensated for their participation.

Sampling

A convenience sampling strategy was used to recruit community pharmacists across different regions of Sydney to capture a diverse range of pharmacist perspectives. Recruitment involved approaching thirty community pharmacists face-to-face at their respective community pharmacies to provide them with an invitation and make an appointment for the interview. The only inclusion criterion involved being a practising pharmacist registered with the Australian Health Practitioner Regulation Agency, to broaden the range of perspectives being sought.

Researchers' reflexivity

Researchers BC and AM are registered pharmacists and academic researchers with a deep understanding of the role of pharmacists in provision of services to clients with illicit drug use disorders. The researcher (CD) is an expert in addiction research. Throughout the study, the researchers made every effort to remain neutral to the data collected and the ensuing thematic analysis, choosing to be particularly sensitive to nuances that could invoke bias.

Design

This qualitative study was based on interviews with practising pharmacists in Sydney, Australia. The semi-structured interview schedule was informed by the literature, standards of pharmacy practice and the expertise of the research team. Interview questions explored topics ranging from pharmacists' knowledge pertaining to MUD, to their possible experiences dealing with this condition and their perspectives surrounding future MUD treatment programs. Initial pilot-testing of the open-ended interview questions involved a practice run between members of the research team and some practitioners, which allowed for further refining of questions to enable a comprehensive and diverse insight into participants' perspectives about potential MUD treatment programs involving pharmacists. To ensure a uniform interviewing process, one researcher (AM) conducted all interviews after initial pilot-testing with other members of the research team. The interview process took place in quiet spaces within pharmacies or at a venue chosen by the pharmacist. Interviews took on average 20-30 min. Each recorded

interview was de-identified for anonymity, with measures in place to ensure participants would not be re-identifiable.

Transcribing of de-identified recorded interviews was conducted utilising the transcribing platform Otter (Otter.ai, 2023). Transcribed data was then entered into the software NVivo for coding into themes (NVivo, 2020).

Analysis

The thematic analysis method utilised, involved an inductive approach, where initial codes were generated iteratively from the data collected. Inductive analysis is regarded as the purest form of qualitative content analysis (Strauss & Corbin, 1998). It is particularly suited to allowing themes to emerge from the data rather than imposing set categories for themes prior to data collection. Iterative induction is a deeply reflexive process, well suited to analysing the depth of the data and creating meaningful themes (Corbin & Strauss, 2014; Richards, 2005; Srivastava & Hopwood, 2009).

A primary coder was responsible for initial familiarisation and coding of the data through multiple readings of the transcripts. Following this, other members of the research team independently coded a sample of the transcripts. Coding involved grouping passages of transcribed data linked by a common concept throughout the transcribed interviews. Each of the research team developed themes emerging from the coded data. Once themes began to emerge, consultation with the broader research team allowed for further refining. The research team members compared and analysed the themes together until consensus was achieved.

Results

Demographics

Nineteen out of thirty pharmacists approached were recruited from different regions within Sydney, Australia. This encompassed Western Sydney, the Inner-West, Central Business District, and North Sydney. Participants' years of pharmacy practice ranged between 1–20 years. Eleven participants identified as women and eight as men. Repeating themes and thematic saturation occurred at the 15th interview, however, the interviews continued until the nineteenth interview was completed for further confirmation of saturation.

Thematic analysis

Professional stigma was a prominent theme emerging from the data collected from the interviews. Sources of the stigma appeared to be mainly from prevailing social stereotypes generating negative attitudes towards

people with MUD. Most stigma manifested without any personal experience dealing with such people.

There were two cases in which the pharmacist had experienced an encounter with a MUD client. These interviewees described incidents of challenging presentations of people under the influence of methamphetamine, describing people using methamphetamine as aggressive, violent, lacking control and frightful:

My experience dealing with and managing such patients is from my work in the Emergency Department. People are completely out of control, brought in by ambulance, or public who call the police and usually they're very combative. (Interview #16)

We would say: next time you want to use, please don't come back in here, because the walls can't take you beating them up! ... very aggressive when they come through. (Interview #12)

Most participants had no direct experience with people living with MUD, however their stigma was clearly evident and manifested in many forms with varying degrees of intensity. The main emerging themes from the thematic analysis were the following:

1. Fear and apprehension;
2. Misinformation;
3. Lack of knowledge;
4. Underlying assumptions.

A driver diagram (Figure 1) was generated to provide a visual depiction of the different drivers of stigma relating to pharmacists' perspectives on their prospective role in treatment programs for MUD. The diagram presents a conceptualisation of the perspectives and ideas expressed by the participants, and the subsequent emerging themes, as drivers of the manifested stigma.

Driver 1: Fear and apprehension

Fear and apprehension were the most common drivers of stigma that participating pharmacists expressed towards clients with MUD. Some overtly expressed their fear as a deterrent to their participation in providing health-care to this group of people. Many research participants used language commonly employed to label and stereotype people with MUD, describing them as criminals, harmful and dangerous, emulating the stigmatising media portrayal of people with MUD (Douglass et al., 2017; Rawstorne et al., 2020). For example, one interviewee had no experience in handling issues related to MUD, yet had formed a strong, albeit confused and misinformed fear of people with MUD, citing the media as their only source of information.

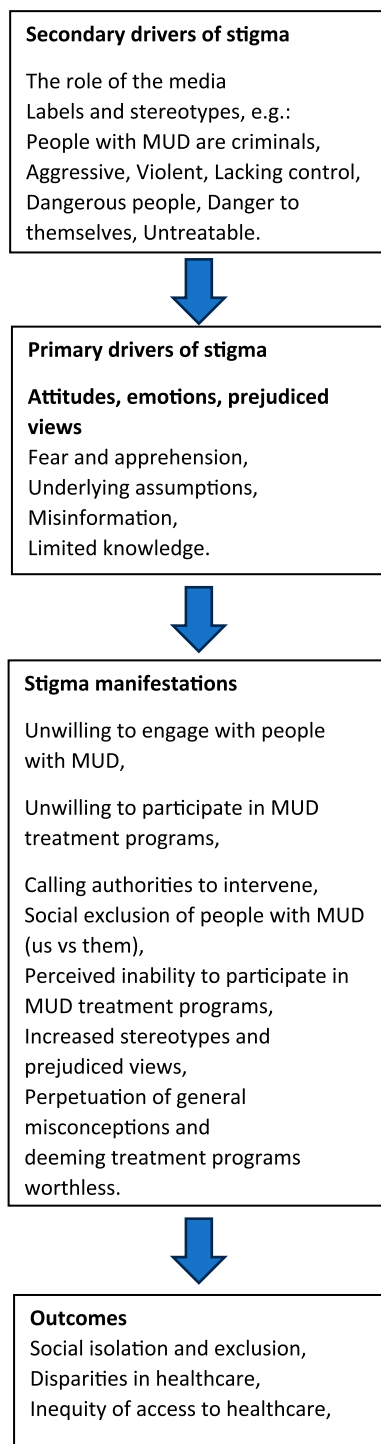


Figure 1. Stigma Driver diagram.

They might, definitely unintentionally, but most certainly, harm. I haven't dealt with it. Not at all. I've actually never ever knowingly had an interaction with a person who's an 'Ice addict'. All my answers come from what I've heard in the media. I've heard ... those people on Ice do all these crazy things. That's all I know and that's what actually freaks me out. And, as a pharmacist, I honestly would be worried to implement it in the pharmacy as a program to help addicts. (Interview #2)

This fear was also portrayed in the casual description of people with MUD as '*Ice addicts*' suggesting an explicit bias likely to influence their behaviour towards this population. Two interviewees clearly articulated their apprehension of having to deal with the perceived range of problems that MUD clients may present. Both participants' statements were peppered with fearful impressions of what people with MUD might do, a general attitude that suggested barriers already exist to introducing new treatment options when made available.

What would I give someone on Ice? Nothing! A can of coke? Please don't murder me or half the store!(Interview #4)

What on earth can they (clients with MUD) get from a retail pharmacy apart from taking out half the store and the pharmacist being scared to death? Because they (pharmacists) don't know how to treat them and even if they do, there's a barrier. (Interview #12)

Safety was of high concern, but also the fear of confrontation appeared to be an impression embedded in the psyche of most participating pharmacists. For example, the assumption made by one interviewee that people under the influence of methamphetamine will require intervention from security, highlighted the prevailing perception that people with MUD are dangerous and violent. Another interviewee expressed concern for safety, not only for themselves, but also their other clients. Whilst treatment options are currently few, the fear and apprehension appeared to drive these pharmacists to avoid clients with MUD, rather than search for solutions or offer assistance, as is the norm for healthcare providers.

I guess it would be very, very confronting. It depends on how the patient presents. I assume they would present potentially aggravated ... potentially very, very confronting. You may, unfortunately, have to call either security or ambulance depending on their state. But I don't know that it's something currently that would be within my scope ... Obviously, it's a safety concern. (Interview #7)

I don't know if there could be a pathway or a service programme in place to allow pharmacists to offer in common drugs to get the patient out of it, and it's really disruptive to the business as well. And, as a community pharmacist, you worry about your staff well-being, your customer, other customers' well-being. This is probably more of an immediate concern when confronted by a patient or a customer under the influence of stimulants. I found it very

difficult and challenging. I just imagine it'll be very difficult when they're high, screaming and shouting ... I don't think I have the skill set in the pharmacy to do so. I would fear for my own safety. (Interview #16)

Many participating pharmacists expressed fear of clients with MUD, painting them as menacing and aggressive. The impression one interviewee gave was of potential encounters with people under the influence of methamphetamine as 'taller', 'scary' and 'yelling', and is similar to the stereotypes fuelling social stigma surrounding MUD.

You get very scared because they usually come at night. When there are no people, imagine it. This patient who's like, much taller than you. Like, doesn't look right. They start yelling at you ... (Interview #15)

Driver 2: Misinformation and the influence of the media.

The second driver of professional stigma was the theme of misinformation generated by the media, driving the fear and apprehension. The portrayal of clients with MUD tended to be dramatic and somewhat sensationalised, with research participants often citing a documentary or program they had seen, rather than personal experience. For example,

Ice is associated with crime and that's why we all have a bad image of Ice. And the other problem with Ice is that it makes them feel like they can do anything. They can jump off buildings, they are a hazard to themselves, gives them unbelievable confidence. They actually do more harm to themselves than anyone else. And I've seen that happen in a documentary, where people have been at work sites, and they think they can fly. And so, they jumped off work sites. That's scary. They're not harming other people. And it's a waste of life. That's what's happened. I'll be honest with you. It's not a great drug. (Interview #10)

Driver 3: Underlying assumptions

The third driver of professional stigma was underlying assumptions made by pharmacists. Assumptions of non-adherence and non-compliance with treatment services by people with MUD appeared to stem from preconceived ideas and views research participants had of people with MUD due to generalised stereotypes. For example, one pharmacist believed that lack of understanding of their own disease state by people with MUD, and self-stigma surrounding their condition would be a barrier to their participation in future treatment programs.

These patients are on drugs that are highly addictive. I don't think they want to go (to drug and alcohol clinics), because first, they know they can't do it when they go inside. Second, they don't know how serious the problem is. And three, they have serious stigma about it, I don't think they'd want to go. (Interview #15)

Stereotypes of people with MUD being disruptive to the work environment drove some participants to take a vigilant approach to the issue. They expressed they would be calling the police and taking a protective role in the face of any disruptions to pharmacy operations they assumed would arise from people under the influence of methamphetamine.

Participants' assumptions of people with MUD being 'dangerous' highlighted generalised preconceived views of how people under the influence of methamphetamine may present to a pharmacy and interact with the general public.

Trying to get them away from the pharmacy itself. And try to be an open area where there's other people around to witness what is surrounding. And always try to focus on minimizing conflict. If you find that there is a risk, they are quite dangerous or harmful, you can always call the police as a result or call the nearest hospital services. (Interview #3)

Driver 4: Lack of knowledge

The fourth driver of professional stigma was pharmacists' lack of knowledge. Many interviewees pointed to the clear lack of education and background knowledge surrounding MUD as a hinderance to treatment services being provided by pharmacists for this condition. Although being aware of some of the stigma that clients with MUD are subject to, interviewees still labelled and stereotyped people with MUD as '*just scary people*', highlighting the importance of education surrounding MUD for reducing this kind of stigma.

I don't know how to approach it. In general, community pharmacy doesn't have the education or support to handle this. Even a workshop would be helpful. (Interview #16)

Regarding education: We're only hearing stigmas. We need knowledge not only about treatments, but also how to protect yourself. Or how to really see them as a person rather than having a stigma. Because to us they're just scary people. (Interview #15)

Some participants, however, believed they knew enough to deter them from offering any future services. One pharmacist believed there was no more information to be had about MUD other than the spectrum of knowledge in hand.

I don't know that I really need to know a lot of information. People who are on Ice often have psychological problems, as well as physical problems, as well as financial problems because Ice is not cheap ... They are often criminals. I'm not saying that all are, but they often are. You know, they take Ice to feel normal. So, they can present to us as 'normal' ... But, it's a dangerous drug. I don't particularly want to handle that sort of patient in a shop situation. (Interview #10)

Other participants believed people with MUD are also being stereotyped as 'junkies' by other healthcare professionals resulting in labelling and discrimination. Many believed tailored educational interventions were necessary for healthcare professionals to gain a better understanding of the condition and the optimal delivery of healthcare catered to the specific needs of people with MUD.

And I think the lack of understanding from GPs, I don't think they understand how to deal with it. To not use a derogatory term, 'Ah, he's just a drug addict', and they treat it and see it like that. (Interview #5)

Discussion

To the best of our knowledge, this is the first study to investigate perspectives of pharmacists with regards to potential treatment services for people with MUD. Findings indicated a predominantly fear-driven perception of people with MUD, labelled as 'aggressive' and 'confrontational' in the healthcare environment. As a result, many pharmacists wanted to distance themselves from the issue. Some participating pharmacists were reluctant, or outrightly refused, to engage with or participate in future treatment services for people with MUD, based on assumptions that people with MUD are dangerous and out of control. This kind of bias-driven stigma by healthcare professionals towards people with substance use disorders is reportedly widespread, and contributes to suboptimal health outcomes, and perpetuates structural stigma (Livingston, 2020; van Boekel et al., 2013).

The misinformation and dramatisation by the media helped shape pre-suppositions about people with MUD. Several pharmacists believed there was lack of knowledge and understanding of the medical condition that could obstruct implementation of and compliance with future treatment programs in pharmacy.

Driver diagram – Associations

To better understand stigma highlighted in this study and its application to current healthcare professional practice, each emerging theme, and other components of the stigma process, are discussed utilising The Health Stigma and Discrimination Framework (Stangl et al., 2019). The framework helps place emerging themes and components of stigma from this study in constituent domains (drivers and manifestations) of the stigmatisation process across socio-ecological levels of the healthcare system in the context of MUD. Utilising this framework allows for the implementation of interventions at these constituent domains within the organisational and individual socio-ecological levels identified in this study, and may ultimately

help with an effective response to a stigmatisation process that drives health inequities and social disadvantage for people with MUD.

Driver 1: Fear and apprehension

The main driver of stigma was that of fear and apprehension driving implicit and explicit biases enacted by many pharmacists towards people with MUD. For many, stigmatising language was used to label people with MUD, and prevalent negative stereotypes of people with MUD being aggressive and violent. Prevailing stereotypes elicited an emotional response of fear and apprehension as a driver for the stigma process, manifesting in participants explicitly wishing to discriminate against and distance themselves from people with MUD. They often explicitly stated they did not want to participate in healthcare interventions for this population. In this study, drivers and manifestations of the stigmatisation process are similar to those postulated by Stangl and colleagues and likely influence outcomes of social exclusion and structural stigma by further marginalising people with MUD and contributing to inequitable access and poor provision of healthcare to these people (Livingston, 2020; Stangl et al., 2019).

Similarly, a recent study (2020) demonstrated that negative stereotypes of people with MUD as being more dangerous and unpredictable was a driver for healthcare professionals' greater desire to distance themselves from people with MUD who had a dual diagnosis of schizophrenia, compared to people with alcohol use disorder and a dual diagnosis of schizophrenia or schizophrenia alone (Francis et al., 2020). Stigma manifestations of this kind have also been demonstrated by physicians wanting to distance themselves from people with OUD, resulting in lower levels of prescribing OAT, and less support of appropriate healthcare policies for better access to OAT (Stone et al., 2021).

Similarly, negative attitudes by non-OAT providing pharmacists in Australia resulted in reluctance to provide healthcare services to clients with OUD (Chaar et al., 2013; Werremeyer et al., 2021). Healthcare professionals' negative attitudes towards clients with substance use disorders and unfounded fear, appear to drive this stigma, which reportedly results in consequences to clients' self-esteem and perpetuates self-stigma. This highlights the interconnection between healthcare professionals stigmatising behaviours and the vulnerability of the stigmatised individual and resultant hindered access to and engagement with healthcare professionals and treatment services (Nyblade et al., 2019; Stangl et al., 2019).

The influence of the media on pharmacists' perspectives was voiced by some pharmacists, due to negative portrayal of people with MUD being dangerous and harmful. Cohn et al. (2020) found that the media in Australia frequently used stigmatising language to frame methamphetamine users as

criminals and deviants, (Cohn et al., 2020) language similarly used by many participants in this study. Years of media portrayal of an 'ice epidemic' and the use of powerful language and images to stereotype people with MUD is an example of drivers and manifestations of the stigma process at the organisational level. This contributed to a great degree of social stigma towards people with MUD, with fear and apprehension clearly demonstrated as a driver of the stigma process by healthcare professionals in this study (Chalmers et al., 2016).

Drivers 2 and 4: Lack of knowledge and Misinformation

Two drivers of stigma by this group of pharmacists were lack of knowledge, leading to misinformation regarding MUD. Some pharmacists in this study considered their lack of knowledge of MUD as a driver of the stigma process subsequently leading to stigma manifestations that include negative stereotypes and enacted biases. Similar to these concerns, lack of education has been cited by nurses taking care of people with OUD, as a driver of stigma towards people with OUD, which thereby negatively impacted healthcare delivery (Horner et al., 2019).

There is a plethora of literature describing the negative impact of poor education by healthcare professionals on client healthcare outcomes in pharmacy and nursing (Bell & McCurry, 2020; Gilchrist et al., 2011; Mahon et al., 2018). In line with this body of literature, data from this study of participating pharmacists strongly suggested that a better understanding of MUD and an education intervention at the healthcare organisational level would be of benefit. Also, due to misinformation regarding people with MUD, there is little evidence of professionalism, empathy (a cornerstone of patient-centred care) or social accountability to care for MUD clients. This brings forth a plethora of questions about the social responsibility of media outlets towards professional stakeholders, the social accountability of pharmacists, their professional judgement, and their knowledge of the reality of the condition.

Efforts are being made to ensure healthcare professionals receive contemporary medical education that emphasises components of social accountability in their provision of healthcare to the community they serve (Boydell et al., 2019; Kelly et al., 2022). Recent literature suggests that the incorporation of social accountability aspects and a population health approach to the current pharmacy education and practice framework may help address health disparities seen in marginalised and socially disadvantaged populations (Bheekie et al., 2019; Saka et al., 2021).

Driver 3: Underlying assumptions

Other accounts of stigma were portrayed by pharmacists on account of underlying assumptions towards people with MUD. The drug

methamphetamine constituting a problem, and people that engage in the use of this drug being criminals that need intervention by police, were common perceptions held by participants in this study.

Findings of this nature seem to resonate with the Australian population, with methamphetamine being ranked as the drug of most concern to the community and the drug most likely to be associated with a 'drug problem' in the 2019 National Drug Strategy Household Survey (NDSHS) (Health & Welfare, 2020). In this study, the underlying assumptions by pharmacists of criminal behaviour was a driving factor to cloud professional judgement with explicit bias, resulting in the isolation of and discrimination against people with MUD by not wishing to participate in future MUD treatment programs.

This highlights the issue of criminalisation of drugs and the negative consequences it has on people with substance use disorders and the stigmatisation process involved at the organisational level (Bonn et al., 2020). The risk of criminalisation and the anticipation by people with substance use disorders that they will be poorly treated, has been identified as a barrier to their participation in otherwise helpful harm-reduction programs and interventions. (Davis et al., 2022; Wallace et al., 2020).

Implications

Manifestations of stigma by healthcare professionals present in the form of bias/prejudice and discriminatory behaviour towards people in their care, ultimately denying them the care or providing low quality or delayed care (Nyblade et al., 2019). Subsequently, stigmatisation is an impediment to people engaging with healthcare professionals seeking treatment for physical and mental illnesses, thereby worsening health outcomes, and adding to the burden of disease (Ahmedani, 2011; Subu et al., 2021).

Pharmacists are easily accessible healthcare providers and should be at the forefront of equitable healthcare delivery. However, there is a plethora of literature about existing healthcare disparities in pharmacy practice. These disparities stem from structural inequity, social determinants of health, and practitioner-based biases towards marginalised and socially excluded populations (Hurley-Kim et al., 2022; Wenger et al., 2016). The WHO (World Health Organisation), lists many social determinants which can influence health equity, such as socioeconomic status, education, housing, food, social inclusion and non-discrimination. The most relevant to healthcare professions and MUD clients in the context of this paper, is social inclusion and non-discrimination.

To ensure the provision of healthcare is guided by the principal of justice and health equity, it is important that these healthcare disparities are addressed at different socio-ecological levels. This can be achieved by

tailoring interventions and solutions at the organisational level towards gaps in knowledge of pharmacists towards marginalised populations. Such interventions should target the enhancement of the role of pharmacists in addressing and understanding social determinants of health, starting with social inclusion and non-discrimination (Foster et al., 2021; Hurley-Kim et al., 2022; Kiles et al., 2022; Wenger et al., 2016).

There have been attempts at interventions to address stigma by healthcare professionals towards their clients. According to Nyblade et al. (2019), these interventions have been delivered in various approaches, such as skills-building activities, contact between health staff and stigmatised groups, changing healthcare policies and facility restructure, active engagement in learning activities by health staff, and the provision of information (Nyblade et al., 2019).

In preparing the healthcare workforce for pharmacotherapies for MUD, there appear to be several obstacles that need to be addressed to avoid unethical behaviours that seriously impact on client outcomes. Education about MUD and other substance use disorders at the organisational level is imperative to prevent jeopardising future treatment programs, and to also address any current stigma by healthcare professionals that hampers the provision of healthcare towards clients with MUD and other substance use disorders. Further research is needed to design and implement interventions at different socio-ecological levels which can enable healthcare professionals to provide people with MUD equitable access to treatment in a manner that preserves human dignity and self-esteem.

Strengths and limitations

Given the paucity in literature on the perspective of pharmacists surrounding MUD, this study provided detailed perspectives of community pharmacists in Australia surrounding MUD and prospective treatment programs they may be involved in. The qualitative nature of this study allowed for probing and in-depth understanding of perceptions and concerns that pharmacists have on this topic.

A limitation to this study was the small sample size of nineteen pharmacists, however thematic saturation was reached swiftly – by the 15th interview – and so recruitment of more pharmacists was not required, but we continued to nineteen to confirm the general themes emerging. Also, a convenience sampling strategy may have limited representation of the diverse range of participating and non-participating pharmacist perspectives in this study, and therefore impacted on generalisability of findings. However, the sample was not intended to be representative of all pharmacists, rather to provide meaningful insight into the matter. Larger scale studies would confirm findings and support more generalisation.

Pharmacists interviewed in this study were practicing in Sydney, so the inclusion of pharmacists from beyond Sydney to include other Australian regions could have captured a more diverse range of pharmacists' perspectives. Additionally, the incorporation of pharmacists practising in other areas of the profession, such as the pharmaceutical industry or hospital pharmacy could provide more generalisable data. However, the almost unanimous nature of the comments observed in the interviews, imbued confidence in the findings concerning the level of stigma in the healthcare system warranting intervention, despite the physicality of the venues/regions.

Conclusion

We found stigma of and bias against people with MUD by practising pharmacists in Sydney. Driven by fear and apprehension in most cases, negative attitudes by pharmacists towards people with MUD mirror the widespread reporting of stigma by healthcare professionals towards those with other substance use disorders and medical conditions. Such attitudes from healthcare professionals can impede participation in treatment programs and perpetuate healthcare disparities. It is therefore necessary to develop appropriate interventions to address this to ensure current and future treatment programs are more accessible. The incorporation of an educational intervention on MUD for pharmacists and other healthcare members may form one of the means to address healthcare related stigma and improve healthcare delivery and quality of care.

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No potential conflict of interest was reported by the author(s).

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