# Addiction stigma and the production of impediments to take-home naloxone uptake

## Abstract

Opioid overdose deaths are a major health issue in Australia and around the world. Programs to provide opioid consumers with ‘take-home’ naloxone to reverse overdose exist internationally, but uptake by mainstream health services and consumers remains inconsistent. Researchers have identified a range of important educational, training and logistical impediments to take-home naloxone uptake and distribution; yet they have focused less on the social dynamics that can enhance or limit access, such as stigma. In this article, we also explore impediments to uptake, drawing on qualitative interview data gathered for an Australian research project on take-home naloxone. Mobilising a performative approach to stigma, we argue that overdose and prevention are shaped by the social dynamics of stigma and, as such, responsibility for dealing with overdose, as with take-home naloxone, should also be considered social (that is, shared among peers, the public, communities and governments). Our interview data illuminate the various ways in which addiction stigma limits the possibilities and capacities of take-home naloxone and overdose prevention. First, we focus on how stigma may impede professional information provision about take-home naloxone by limiting the extent to which it is presented as a matter of interest for *all* opioid consumers, not just those who consume opioids illicitly. Second, we explore how stigma may limit the scale-up and expansion of programs and access points. From here we focus on how stigma co-constitutes the politics of overdose and prevention, rendering take-home naloxone ill-suited to many social settings of overdose. In closing, we point out that stigma is not just a post hoc impediment to access to and use of take-home naloxone but is central to opioid overdose production itself, and to effective prevention. While take-home naloxone is an excellent life-saving initiative, uncritically valorising it may divert attention from broader goals, such as the de-stigmatisation of drug consumption through decriminalisation, and other ambitious attempts to reduce overdose.

**Keywords:** Take-home naloxone, overdose, stigma, Judith Butler, qualitative research

## Introduction

Opioid overdose deaths are a major public health issue in Australia and around the world. In many places, the scale-up and expansion of ‘take-home’ naloxone prescribing, dispensing and education programs have become focal points of opioid overdose prevention. In this approach, naloxone, an opioid antagonist used to reverse the respiratory effects associated with overdose, is provided to individuals who consume opioids along with training on overdose prevention (Kolla & Strike, 2019). However, despite decades of research demonstrating the effectiveness of naloxone, the reach of these programs remains limited. This ‘intervention inertia’ (Strang et al. 2019) raises urgent questions about obstacles and how to address them. Researchers have identified a range of practical impediments to the expansion of take-home naloxone programs, such as cost, funding constraints and knowledge of the medication (Dwyer et al., 2016). Awareness-raising or education initiatives targeted at people who consume opioids, their families and friends have been put forward as appropriate responses to these issues (Dietze et al. 2017). In the process, however, important social dynamics relating to stigma have received less attention. Attending to the influence of stigma on take-home naloxone programs seems to be essential in thinking through ways to improve access and uptake, both by mainstream health services and among individuals not usually targeted for overdose prevention. Moreover, highlighting the persistence of drug-related stigma – particularly in places we would least expect to find it, such as overdose prevention initiatives – reminds us of the need to scrutinise the social conditions under which drug-related harms occur, and their role in constituting harms that may then be attributed to other causes.

In this article we argue that impediments to take-home naloxone uptake are co-produced through the operation of stigma. Drawing on Fraser et al.’s (2017) performative account of stigma and qualitative data gathered for a project on take-home naloxone, we show how addiction stigma shapes and delimits uptake and access along with the functions and effects of take-home naloxone as a technology for overdose prevention. To begin, we introduce our theoretical approach and the methods used to construct our dataset. We then explore how addiction stigma operates in ways that may co-produce less careful healthcare encounters. As we will argue, addiction stigma may limit the expansion of take-home naloxone into a mainstream public health intervention and matter of interest for *all* opioid consumers. We then argue that addiction stigma further shapes the issue of access by generating concerns about exposure and discreditability when carrying take-home naloxone. Next, we explore interview data that indicate that participants consider sites for accessing take-home naloxone limited and prohibitive. We consider these limitations not as ‘neutral’ problems awaiting improvement but as the effects of politics and a social and cultural discomfort with drug use. These limitations in access function to further marginalise people who consume opioids and their healthcare concerns and needs from normative social life. In the final section, we draw on our interviews to argue that Australia’s criminalising drug policy and the stigma associated with it actively shape overdose events as isolated and secretive, such that take-home naloxone equipment may be irrelevant to many. In line with this, we argue that overdose prevention is conceived as an individual effort more than a public or community one. We conclude by calling for more attention to be paid to the stigmatising context in which overdose itself is produced and take-home naloxone operates.

## Background

Like many other nations, Australia is experiencing increased opioid overdose hospital admissions and deaths. Current Australian research identified 1045 opioid-induced deaths in 2016, with 65% of deaths (n = 679) attributed to pharmaceutical opioids, 24% to heroin (n = 247), and 11% (n = 111) to both pharmaceutical opioids and heroin (Roxburgh et al., 2018). A range of strategies to reduce overdose deaths focussing primarily on the knowledge and action of people who consume illicit drugs have been developed and implemented in Australia (Farrugia et al., 2017). In addition to expanding opioid substitution treatment, providing training in overdose recognition and response and dispensing the opioid antagonist naloxone to people who use drugs as ‘take-home naloxone’ is another initiative aimed at reducing lives lost to overdose (Dwyer et al., 2018). Australia’s first take-home naloxone program was established in 2012 (Lenton et al., 2015), and programs of varying size and approach are in place in most Australian jurisdictions (Dwyer et al., 2018). In Australia, at the time of writing, the naloxone distributed in take-home programs is primarily available in a multi-dose pre-filled syringe, or in glass ampoules with needles and syringes, for intra-muscular injection. A publicly subsidised intranasal product has recently been made available in Australia but is yet to be widely dispensed or used (Paola, 2019).

A growing body of research has focused on barriers to the wider implementation of take-home naloxone programs and uptake by consumers (Fraser et al., 2018; McDonald et al., 2017). These barriers are difficult to determine for several reasons, not least because no single model of take-home naloxone delivery exists (Strang et al. 2019). Program and training models vary (Dwyer et al., 2018), naloxone is distributed in different settings with distinct requirements (McDonald et a., 2017) and, as already noted, multiple take-home naloxone formulations are available, and these are continually subject to change and reformulation. While this area of work is highly unstable, several barriers are consistently cited as decisive in the literature. The first is the legal frameworks that shape take-home naloxone distribution, including laws concerned with indemnity for consumers and medical prescribers (McDonald et a., 2017; Strang et al. 2019). As Strang et al. argue, ‘a conducive legal environment is a prerequisite for widespread implementation’ (2019, p. 1410). Also identified as a key barrier are workforce and logistical impediments (Dwyer et al., 2016; Lacroix et al., 2018; Olsen et al., 2019). Workloads and time constraints, limited knowledge and awareness of the products, low confidence about dispensing, inadequate prescribing and dispensing systems and procedures, and confusion around staff roles and responsibilities have all been identified as limiting the incorporation of naloxone distribution into professional environments and workflow (e.g. Chun et al., 2019; Dwyer et al., 2016; Lacroix et al., 2018; Lenton et al., 2015; Olsen et al., 2019; Straus et al., 2013).

Research has also identified implementation barriers to do with prescription and formulations. Until recently, naloxone was only available as a prescription medicine in Australia, meaning those wishing to access it needed to see a medical practitioner. While it can now also be accessed over the counter at pharmacies (Lenton et al., 2016), the price can be prohibitive (Farrugia et al., 2017). In Australia, when bought on prescription, naloxone is subsidised under Australia’s Pharmaceutical Benefits Scheme and, at the time of writing, costs AUD $6.20 for those holding a government concession card, and $40.30 for others. Over-the-counter access is not subsidised, with cost varying dramatically (AUD $20–$80), making it too expensive for many (Pricolo and Nielsen, 2018). When naloxone is accessed through established take-home naloxone programs, it is generally provided free to consumers, with the costs borne by the service or agency, sometimes with additional funding from state governments. Lastly, some modes of administration limit uptake (Dunn et al., 2018). Formulations requiring intra-muscular injections can be unappealing to people who consume opioids orally or are less familiar with injecting.

While access and availability have expanded, knowledge of take-home naloxone among people who consume opioids and who may witness an overdose remains inconsistent, varying depending on, among other things, availability and level of public promotion (Dietze et al., 2017). Because take-home naloxone programs have focused to date on people who consume illicit opioids and their families and friends, awareness of take-home naloxone is thought to be especially low among people who primarily consume prescribed opioids (for example, for chronic pain) (Coe and Walsh, 2015; Nielsen et al., 2018), the general public and mainstream health services.

## Literature review

While impediments to the uptake of take-home naloxone have received a significant amount of attention from researchers, less work has been done on the role of stigma. The stigmatisation of alcohol and other drug consumption and treatment across a range of settings is well known. These include general healthcare services (Paquette et al., 2018; Simmonds and Coomber, 2009; van Boekel et al., 2013), specialist drug health services (Earnshaw et al., 2013; Treloar and Holt, 2006) and workplaces (Lloyd, 2013), media representations (Cape, 2003; Hickman, 2002), anti-drug campaigns (Linnemann and Wall, 2013) and policy (Lancaster et al., 2015; Stevens, 2018). More recently, researchers (Fraser et al., 2017; Paquette et al., 2018) have argued that people who inject drugs experience stigma at ‘every turn’, for example, when utilising general medical care or specialist drug health services and when engaging in treatment.

Stigma is known to negatively affect the health and well-being of people who use illicit drugs, and the need to address it across different healthcare settings, including mainstream health care and specialist drug services, is well established (Radcliffe and Stevens, 2008). Equally, illicit drug-related stigma shapes the experiences of people who are not generally targeted by specialist drug health services, such as those consuming prescribed opioids for chronic pain (Werner and Malterud, 2003), and also those who could benefit specifically from methadone for chronic pain (Shah and Diwan, 2010; Keane, 2013). Notably health professionals often relate to people with chronic pain and those thought to have an ‘addiction’ as intrinsically difficult patients (Buchman et al., 2016).

To date, stigma has been broadly identified as a factor potentially limiting the uptake of take-home naloxone (Banjo et al., 2014), but it has yet to receive detailed attention. Nearly a decade ago, Dietze and Lenton (2010) noted the existence of professional ‘scepticism’ surrounding the provision of take-home naloxone in non-medical settings. According to Matheson et al. (2014), negative attitudes towards people who consume drugs led Scottish general practitioners (GPs) to resist delivering take-home naloxone. Meanwhile, recent research involving Australian community pharmacists identified negative perceptions of the patient group as a barrier to increased dispensing (Olsen et al., 2019). A study of Australian emergency department physicians and pharmacists also reported that some thought take-home naloxone might increase ‘risky behaviour’ (Holland et al. 2019). Similarly, other studies have found that mainstream health practitioners were concerned that take-home naloxone might be seen by consumers as a ‘safety net’ against overdose, thereby escalating opioid consumption (Beletsky et al., 2006; Green et al., 2013; Strang et al., 2019). This perception has been referred to elsewhere as the ‘moral hazard’ problem (Greene, 2018).

Questions have additionally been raised about whether people who use opioids can safely administer take-home naloxone (Beletsky et al., 2006; Drainoni et al., 2016). As might be expected, evaluations of take-home naloxone programs indicate that people who inject drugs competently distribute and use take-home naloxone to manage complex overdose events (Neale et al., 2019; Olsen et al., 2015). Questions about competency likely reflect unexamined assumptions about the agency and abilities of people who consume drugs, and the presence of broader prejudice shaping understandings of opioid use and overdose. However, as we go on to explore in this article, stigma exists not only in and through ‘negative’ attitudes. It is also usefully understood as a foundational process through which social conceptions of health and responsibility are constituted. Strang et al. (2019) observe that more work needs to be done in ensuring that take-home naloxone is seen as compatible with other more established health care roles. As we argue in this article, this work extends to linking naloxone distribution to personal health and dignity more broadly.

Our article builds on prior research through an exploration of the role of addiction-related stigma in relation to the uptake of take-home naloxone both for people who inject illicit drugs and for people who consume prescribed opioids primarily for chronic pain. Further, we explore how addiction stigma is in turn shaped through health initiatives and technologies such as take-home naloxone, modulating the very conditions of possibility for overdose and prevention. To this end, the relevance of our analysis likely extends beyond take-home naloxone specifically, offering insights for other initiatives, such as overdose response training, aimed at reducing the loss of lives to opioid overdose, and for health measures more generally.

## Approach

Our approach to stigma is based on Fraser et al.’s (2017) recent theorisation of addiction stigma as a performative biopolitical process (see also Buchman et al., 2017; Seear et al., 2017). Reworking Goffman’s (1973/1963) analysis of stigma through the insights of feminist poststructuralist scholarship on subjectivity and gender, Fraser et al. generate a more dynamic and processual account of stigma than is suggested by Goffman. While highly influential, Goffman’s account focuses primarily on how individuals manage their discredited status in encounters with ‘normals’ (Fraser et al., 2017), and ‘pays little attention to questions of why particular features or issues come to be stigmatised, or what is achieved at a political level by stigmatisation’ (Fraser et al., 2017: 194). One effect of this inattention is that stigma is presented as an inevitable and natural effect of social relations that inevitably discredit some identities (Fraser et al., 2017). This proposition is concerning in the context of opioid consumption, as the lived effects of stigma are often severe and sometimes fatal.

In addressing how stigma might be conceptualised to avoid this kind of fatalism, Fraser et al. (2017) present an account that can explain the enduring ‘resilience and persistence’ of addiction stigma over time but also its disruption and change. They draw on Judith Butler’s feminist work on the performativity of gender, in which the biology of sex is not given in nature but made through performative, repeated and iterative socio-material practices across a wide range of social, institutional, legal and political settings. Subjects are admitted into legitimate social life through the accession into, and adoption of, a recognisable and normative sexed identity (Fraser et al., 2017: 195). However, ‘the subject is [also] formed through the force of exclusion and abjection, one which produces a constitutive outside to the subject’ (Butler, 1993: 3). In this sense, it is only through the identification, production and exclusion of a range of abjected Others who ‘circumscribe the domain of the subject’, that the legitimate and intelligible subject comes to be formed (1993: 3). But this abjected Other haunts the domain of legitimate subjectivity and indeed is enfolded ‘inside’ the subject as ‘its own founding repudiation’ (Butler, 1993: 3). As Fraser and Seear argue, ‘[t]he abject is a “site of dreaded identification” for the subject, thus the abject exists in counterpoise to the subject, against whom it is produced through forces of exclusion’ (2011: 118).

Butler’s insights into the political productivity of abjection underlie Fraser et al.’s conceptualisation of addiction stigma. While they observe similarities between Goffman’s claim that the normal and the stigmatised form part of the same complex, and Butler’s account of the constitutive outside of the subject, they also argue that stigma is a foundational process necessary to the constitution of normative social relations in liberal modernity: ‘the outside of legitimacy comprises all those whose relationship to drugs does not align with normative understanding of autonomy, sobriety, freedom and rationality’ (2017: 194). In this way, the operation of addiction stigma serves an essential political purpose by reproducing the normative conceptions of human reason, rationality and objectivity that underpin liberal social processes and societies. In relation to take-home naloxone, much has been written about the ‘intervention inertia’ (Strang et al., 2013; Strang et al., 2019) impairing its implementation and uptake. In this article, we understand this inertia not as a ‘neutral’ problem but as the effect of broader politics, and a social and cultural discomfort with drug use, which undermines overdose prevention efforts and public attention.

Taking up this understanding of stigma, this article examines what addiction stigma achieves in relation to take-home naloxone uptake and administration, and overdose prevention. In what follows, we examine accounts of addiction stigma and its effects on the uptake of take-home naloxone. To begin, we focus on how the operations of addiction stigma shape information provision about take-home naloxone. We then explore the ways addiction stigma curtails access to it, limiting willingness to occupy publicly visible stigmatised identities, thereby producing inequitable and inconvenient access. Finally, we explore the ways stigma co-constitutes the politics of overdose, rendering take-home naloxone ill-suited to overdose environments, and understating shared responsibility for its uptake. In conducting our analysis, we explore the performative biopolitical effects of stigma on take-home naloxone access and uptake, and argue that this process reinscribes a classic distribution of power in which people who use drugs are simultaneously responsibilised *and* marginalised in the service of normative social relations. In making our argument, we reiterate Fraser et al.’s (2017) observation that stigma is not a series of discrete moments or intentional acts, but thoroughly shapes and orders everyday life for drug consumers in many contexts.

## Method

Our analysis draws on data gathered for a qualitative research project investigating the meanings and experience of take-home naloxone for opioid consumers and health professionals. Using a purposive sampling strategy, we interviewed 46 people who consume opioids (28 people with experience of injecting drugs and 18 who consume opioids primarily for chronic pain). Twenty-four men, twenty women, one trans-woman and one gender fluid person participated in interviews. Gender was based on self-report and was self-defined. We also interviewed 37 health professionals across New South Wales (NSW) and Victoria (Vic). However, this article includes only the consumer perspectives on, and experiences of, stigma as they relate to take-home naloxone access, uptake and overdose prevention. A recruitment flyer (‘Would you like to share your views on opioid overdose and naloxone?’) was circulated through drug health services, drug consumer organisations and social media. Potential participants who responded were screened to ensure variation in the types of opioid consumed, experience with take-home naloxone, gender, age, ethnicity and socio-economic background. The study was approved by Curtin University’s Human Research Ethics Committee (HRE2017-0168/2017).

All participants provided informed written consent. In-depth semi-structured interviews explored experiences of opioid consumption and overdose; awareness of, and experience with, take-home naloxone; access to take-home naloxone; experience with, and opinions of, overdose response and take-home naloxone training; and preferred modes of administering take-home naloxone. Interviews ranged from 25 minutes to 100 minutes in length. They were conducted in private rooms at alcohol and other drug services, university offices or public places such as libraries and cafes, and several were undertaken by telephone because of distance. Interview recordings were transcribed verbatim and the transcriptions were imported into NVivo 11. A coding framework was developed by the second author in response to themes and gaps identified in the existing literature and the broader project aims. These codes were reviewed and further developed with the entire research team (authors one to six). The main codes included: experiences of access and administration of take-home naloxone, knowledge of and attitudes to take-home naloxone; experiences of opioid consumption and overdose; social relationships and stigma; and interactions with health and criminal justice systems. All data were coded by the first and second authors. Following further reading and analysis of the stigma node through the approach described in the previous section, the first author generated several smaller codes identifying sites and practices where stigma appeared to be present.

## Analysis

### *Impeding information provision*

Healthcare settings have been found to be key sites in the stigmatisation of drug use (Fraser et al., 2017; Paquette et al., 2018). This makes them complex settings to negotiate both for people who use illicit drugs and people who consume prescribed opioids for chronic pain (Newton et al., 2013; Werner and Malterud, 2003). Consistent with our approach, we argue that information provision about the availability and importance of take-home naloxone should be viewed as taking shape within a pervasive dynamic of addiction stigma, a dynamic that separates overdose prevention and take-home naloxone initiatives from mainstream public healthcare.

A key theme in participants’ accounts was the role of information provision about overdose prevention. Importantly, people who use illicit opioids and people who consume prescribed opioids commonly described thinking about overdose, and some saw themselves at risk of it. For example, Bobbi (female, 35 years old, NSW) regularly injects illicit opioids. In her interview, she explained that she thought about overdose ‘every time [she] had a shot [injection]’. Similarly, Ghassan (male, 37 years old, NSW) explained that he was ‘really, really aware of it’ after overdosing in a public toilet. Despite these concerns, some participants reported that health professionals did not inform them about the availability of take-home naloxone. For example, Tony (male, 44 years old, NSW) explains, ‘It’s not very widely pushed or advertised I don’t think, and the doctors never mention it’. Simone (female, 48 years old, Vic) makes a similar point:

When you’re in the doctor’s and getting your prescription [… for opioid substitution treatment] the doctor never asks you if you want a script for naloxone, which they should, or [asks] ‘are you educated around it’ or ‘would you like to be?’ That’s never mentioned, which I think is wrong.

Similarly, Kate (female, 34 years old, NSW) explains that she only recently heard about take-home naloxone through the residential rehabilitation service that recruited her for our study:

No. I didn’t even know there were take-home packs until the girl in here told me […] It was always hush hush with me, so you know, I didn’t know. Nothing was said at the [methadone] clinic, or anything about this.

Although Kate does not explicitly describe feeling stigmatised, she refers to her previous experiences of treatment as ‘hush hush’. Potentially relevant, even life-saving, information was not provided. Our point here is not to suggest that healthcare practitioners intentionally withhold information, although this is of course possible (see Green et al., 2013). Some may not be adequately informed about take-home naloxone (Chun et al., 2019; Matheson et al., 2014). While we do not have access to the thoughts and processes of the practitioners involved, these accounts of absence and oversight are striking, particularly when considered alongside comments made by participants who had learned about take-home naloxone access and administration from peer-organisations and peer-run media (Dwyer et al., 2018). By way of contrast, the provision of information about take-home naloxone in harm reduction and peer-run organisations tended to be routine and widespread. Bobbi (female, 35 years old, NSW) and Valentina (female, 42 years old, NSW), for example, spoke about learning about take-home naloxone in the User’s News (a targeted harm reduction publication by the NSW Users and AIDS Association [NUAA]). Many other participants described learning about take-home naloxone through peer-run overdose education programs, Needle and Syringe Programs (NSPs) and other harm-reduction services. As sociological research on other epidemics and public health interventions suggest (Epstein, 1998; Pienaar, 2016; Rosengarten, 2009), capacity limitations and/or inertia in addressing public health problems are not neutral or apolitical states. Public health interventions and their uptake are shaped by politics, practices of resourcing, and assumptions about race and gender, all of which act to constitute responsibility, urgency and importance. Readable from these examples is the way in which operations of opioid and addiction stigma implicitly impede information transfer (Bounthavong et al. 2019; Olsen et al., 2019; Paquette et al., 2018). As we go on to discuss in more detail, education about take-home naloxone is treated in primary health settings as ancillary to core business. This results in the concentration of responsibility for overdose prevention among peers and within peer-run organisations, obscuring the broader contexts (such as the legal context) that facilitate rather than help prevent overdose.

Unlike the subtle renderings of absence described above, some participants suggested that they were not offered information about take-home naloxone because they were not seen as consumers of illicit drugs. For example, Cameron (male, 47 years old, NSW) consumes prescribed opioids for chronic pain. In his interview he explains that he has never been offered take-home naloxone when filling his opioid prescription at a pharmacy. He speculates that this may be because he does not ‘look’ like someone (a consumer of illicit drugs) who needs take-home naloxone:

I’m not sure whether it’s something that none of them [pharmacists] would’ve thought to mention, or whether it was just a case of, ‘He doesn’t look like someone who’s going to need to know this, so I won’t say it.’

Worth noting here is that pharmacists currently receive little training or guidance about when and how to dispense take-home naloxone. Indeed, in some research, health professionals report being concerned about offering take-home naloxone in case doing so causes offence (Binswanger et al., 2014). In any case, if there exist practical constraints that promote ‘intervention inertia’ (Strang et al., 2013), we need to ask why. As we argued above, silence about risks and issues is not neutral. It is not merely a gap, rather it is always to do with what (and *who*) counts as important in particular social institutions and settings. Such assumptions about the legitimate subjects of take-home naloxone are worth exploring because they have implications for how broader responsibility for overdose prevention is conceived.

Other participants were reluctant to *ask* for information about take-home naloxone for fear of discrimination, especially from general practitioners. When Farez (male, 43 years old, NSW), who was taking prescribed opioids, was asked whether he had ever spoken to his GP about take-home naloxone, he replied:

No. No. No. The reason why I don’t do that is that will get the doctor thinking that I’m using illegal drugs. [Take-home naloxone has] got nothing to do with normal medication. The first thing they’d be thinking is, ‘Why are you asking about this? This is a drug we give to people that have overdosed’. This is just why I would never bring it up.

In this example, Farez speculates that he might be demoted to the status of illicit drug user if he asks about naloxone. Likewise, Karen (female, 34 years old, Vic), who consumes heroin regularly, explained in her interview why she does not discuss take-home naloxone with her GP:

I haven’t gone to my normal GP and spoken to him about it because the judgmental side comes up all the time. And you think, okay, I’m going to get judged because I’m carrying this around, which means people might think I’m a druggie.

Here Karen describes two different concerns relating to stigma: she does not want to expose herself to judgement from her GP, and she fears carrying take-home naloxone because she might be targeted by members of the public. We return to the second point in the next section. For now, we wish to highlight the performative association that exists between take-home naloxone and stigmatised phenomena such as opioids and addiction (rather than, for example, medicine, life-saving or heroism). This association means participants are discouraged from asking for information about take-home naloxone for fear of being labelled ‘druggies’. Importantly here, we do not merely critique stigmatising ‘attitudes’ or ‘behaviours’ but instead we wish to draw attention to the ways in which addiction stigma operates in mainstream health services to establish a life-saving public health intervention as shameful and marginal via its association with addiction.

### *Ordering access*

So far we have argued that addiction stigma may impede information provision about take-home naloxone, especially in the pharmacy and general practice. Next we wish to consider the ways in which the operations of addiction stigma may also impede the expansion of take-home naloxone programs and access. As discussed above, some participants describe concerns about being publicly identified as consumers of illicit drugs. It seems that the threat of discreditability functions as a barrier to accessing take-home naloxone in various healthcare settings, but for prescription drug consumers this dynamic was especially pronounced in the pharmacy context. Simon (male, 34 years old, Vic), for example, explains that he would feel uncomfortable buying naloxone at a pharmacy:

Well, if you’re going in to ask for naloxone […people might] know what it is, and even if they don’t and they hear it […] they’re going to go home and research, aren’t they? And they’re going to go […] ‘well, that person’s using illicit drugs’. So, you know, again that stigma of people not understanding either.

While Simon has a prescription for his medication, he is sufficiently concerned about how he may be viewed by others to avoid enquiring about take-home naloxone. Our data suggest that this concern about discreditability constitutes a significant barrier to accessing take-home naloxone through pharmacies for people who use opioids for chronic pain.

Reciprocally, we would also argue that as a biopolitical performative process, addiction stigma functions to reinforce the pharmacy as a normative healthcare and social setting in which people who use illicit drugs do not belong. Farez (male, 42 years old, NSW), a prescription drug consumer and also a trainee pharmacist, makes this point:

A lot of pharmacists will not stock [naloxone] because they don’t want to … how do I state it ... they don’t want to invite the wrong crowd into the pharmacy. […] Naloxone could go a long way in preventing a lot of deaths [but] due to the stigma associated with it [some pharmacists avoid stocking it].

In both these extracts, stigma simultaneously pre-exists and is reciprocally performed in and through specific technologies of healthcare, such as take-home naloxone. In this process, mainstream health services and legitimate healthcare subjects are mutually reaffirmed.

Unsurprisingly, many participants who consumed illicit drugs explained they preferred to access take-home naloxone via needle and syringe exchanges, ‘foot patrols’ (drug consumer outreach services) and methadone dosing clinics – spaces in which they typically felt comfortable and welcome. For example, both Bobbi (female, 35 years old, NSW) and Julia (female, 54 years old, NSW) explain they would prefer to do overdose training and access take-home naloxone through needle and syringe exchanges. As Bobbi says, ‘they’re not judgemental and they want you to use it [heroin] in the best way’. Dylan (male, 33 years old, Vic) spoke highly of the peer-based naloxone training in Victoria, saying it was ‘fantastic’, and aligned with his stance on harm reduction. Of course, these healthcare sites are not themselves wholly free of the operations of addiction stigma, but in them, take-home naloxone was typically performed as useful, pragmatic and life-saving.

We highlight these tensions not to argue against the expansion of take-home naloxone availability to pharmacies, nor the provision of take-home naloxone in peer-based services, but instead to draw attention to how tensions around access and availability are implicated in the production of stigma. The very presence of take-home naloxone in mainstream health services has the capacity to render certain consumption practices less shameful, while its absence or invisibility renders the consumption of opioids and associated health concerns marginal, unwelcome and illegitimate. Indeed, the wider availability of take-home naloxone in pharmacies may do much to perform and realign take-home naloxone as a health-promoting object and a legitimate concern of mainstream public healthcare.

Intersections between stigma and take-home naloxone access also extend beyond availability and acquisition to the capacity of consumers to safely carry and administer it. As noted earlier, some participants reported being dissuaded from accessing take-home naloxone because they did not want to carry it in public. Jamie (female, 32 years old, NSW), for example, says she is not ‘comfortable’ carrying take-home naloxone in case she gets ‘pulled up by the police’. Julia (female, 54 years old, NSW) relates an experience with the police that made her ‘quite reluctant to carry it’:

I have come across the police and they’ve actually been quite rude about it […] very rude. You know, ‘Who’d you get it from?’ ‘You can get it for nothing.’ ‘No, you can’t.’ […] ‘Well, yes, you can.’ They know, they’re trying to trick me into something.

Julia explains that police harassment affected her decision not to carry take-home naloxone. As she reflects later, ‘it’s not going to be useful if I’m not able to carry it. It’s no good at home’. Here, the issue of take-home naloxone may serve as an exemplar of ‘doubled’ or ‘circular’ abjection (Fraser et al., 2017: 199). People who consume drugs are enjoined to undertake complicated and challenging activities such as saving lives through the administration of take-home naloxone. In doing so, they are expected to perform as exemplary liberal subjects, despite being denied legitimate subject status. Instead they may find themselves subjected to scrutiny and questioning around carrying the very life-saving resource they have been called upon to carry. In this sense, the stigma and loss of legitimacy reported by participants cannot readily be remedied by take-home naloxone. Indeed, it may be magnified by it if associated legal and social conditions are not also addressed.

### *The social production of overdose*

While access to take-home naloxone and issues of confidentiality and stigma are central to uptake, it is also important to adopt a more global vantage point. A major obstacle to uptake is politico-legal, namely the practices that shape the socio-material conditions of opioid consumption and overdose. Most obviously, the criminalisation of non-pharmaceutical opioids directly shapes the social settings of use, the production of overdose risks and the utility of take-home naloxone. Importantly, many participants who inject illicit drugs report experiencing overdose in isolated settings such as parks, toilets, vacant buildings, stairwells, streets and cars. In such contexts, use of take-home naloxone is often not possible or likely because people are alone. Ghassan (male, 37 years old, NSW) and Tony (male, 44 years old, NSW) both describe overdosing alone in public toilets. Similarly, Adele (female, 40 years old, Vic) explains that she overdosed in a stairwell where ‘lots of overdoses occur’. The relationship between criminalisation and the politics of overdose here could not be more stark, with many consumers obliged to inject in spaces that magnify the risk of overdose (see also, Fadanelli et al., 2019). Indeed, one of the key arguments underpinning the expansion of supervised injecting sites is the heightened overdose risk attached to street-based injecting (Kerr et al., 2007). Due to the stigmatisation of injecting drug use, other participants described deliberately consuming opioids alone in private or secluded settings, without the safety of the presence of friends. For example, Riley (male, 26 years old, Vic) explains that he would consume his heroin in a place ‘that was secluded enough’ or at home. Similarly, Lenny (male, 40 years old, Vic) explains that he has been injecting his heroin ‘mostly on the street […] in alleys and places where people don’t normally go, so, like, out of sight’. Although some participants injected in secluded places close to the purchase site (reportedly to manage withdrawal symptoms), their descriptions of secluded, isolated and remote locations also speak to the shame and stigma associated with injecting drug use. Russell (male, 50 years old, Vic) speaks explicitly about how feeling ‘dirty’ leads him to consume in secluded places:

Well, when you’re in between houses and all the rest of it, I won’t put myself in a position where I’m using intravenous drugs where the public can see me, for the simple fact that I don’t think the public should be exposed to it […]. I feel dirty when I do it, so I go under the bridge.

As we noted earlier, stigma is a biopolitical process in which legitimate and illegitimate subjects are constituted, and the latter are mobilised in the construction of the former. This dynamic is also produced and reinforced structurally in and through laws and legal practices that criminalise people and render particular consumption practices shameful and stigmatised and others normal. Importantly, stigma operates here among other stigmatised phenomena including marginalisation, homelessness and inequality. This mix of forms of disadvantage, criminalisation and stigmatisation facilitates ‘hidden’ and isolated consumption (Aitken et al., 2002; Fadanelli et al., 2019; Maher and Dixon, 2001) and, in some cases, highly dangerous overdose events that are ill-suited to take-home naloxone. Put simply, where people inject or consume opioids in isolation, administration of overdose reversal medication is less likely to happen (Stam et al., 2018). Moreover, the kinds of complex intersections we are describing here, between disadvantage, suffering and inequality, are unlikely to be remedied by overdose reversal medication alone.

In addition to curtailing the utility of take-home naloxone for illicit opioid consumers, stigma also functions to discredit it as a legitimate healthcare initiative for other opioid consumers, including people who consume prescribed opioids. Many of those interviewed who consumed prescribed opioids for chronic pain did not perceive themselves as vulnerable to overdose because the risks had not been raised by their medical practitioners, and were largely articulated in relation to illicit drug use and ‘addiction’. Maxine (female, 38 years old, NSW), for example, explains that although she was taking more than the prescribed levels of prescription opioid medications daily, the possibility of overdose ‘never even crossed [her] mind’. Similarly, Cameron (male, 47 years old, NSW) notes that although he consumed prescribed opioids, he did not view himself as risking overdose. Although he had heard naloxone was a drug used by emergency services, he did not think any further about it ‘because my life doesn’t involve the need to administer it’. It seems that perceptions of *who* is at risk of overdose shape attitudes towards take-home naloxone. Claudia (female, 28 years old, NSW) directly suggests that prescription opioid consumers resist seeing themselves as risking overdose because of its association with addiction:

[They] would be very resistant to seeing them[selves] as an addicted person because they’ve got, like, a ‘legitimate addiction’ […]. To then be saying ‘well, I’ve got a concern about your opioid use and so I want you to do this training. Go to the drug and alcohol treatment centre down the road’, like I think that would just piss a lot of people off and they would not participate.

Here, familiar distinctions between legitimate (prescription) and illegitimate (illicit) drug use function to ascribe rationality, legitimacy and safety to people who consume prescribed opioids (even if they also consume illicit drugs regularly or take more than their prescribed dose) (Bell and Salmon, 2009). In turn, those who consume illicit opioids are rendered irrational, dangerous and risky. Of course, cultural perceptions of overdose risk are shaped by more than just take-home naloxone. They emerge from lengthy histories of addiction stigma, finding expression in legal arrangements and public discourse. The social relations co-produced by prescription opioid consumption are different from those co-produced by illicit opioid consumption, with significant implications for how overdose risk is articulated. For this reason, it is understandable that some consumers articulate take-home naloxone as both irrelevant *and* stigmatising, and that raising the risks associated with licit opioid consumption may be difficult for health professionals to initiate.

Finally, addiction stigma also impedes access to take-home naloxone through the tropes of individual responsibility constituting overdose prevention. Unlike, say, anaphylactic shock, which can be similarly addressed through the use of intramuscular injections by lay responders (via the EpiPen®), to which take-home naloxone was sometimes compared by our participants, responsibility for overdose prevention is overwhelmingly conceived individually. Whereas the EpiPen® is targeted towards the general public, and is broadly available in various social and commercial settings, take-home naloxone is articulated as relevant only to people who inject drugs (and increasingly their family members [Williams et al., 2014]). This focus on illicit consumers as both the custodians and recipients of overdose prevention is striking because it calls upon them to mobilise mutual aid and community in a context where they experience systematic exclusion from these very resources (Fomiatti, in press). On this point, several participants commented that take-home naloxone was not publicly promoted like other forms of healthcare. As Fraser (male, 43 years old, NSW) explains:

Well it’s not out there enough. You’ve got to put an ad on the TV about it and get people out there and tell them, ‘have this at home and if you see someone down the street or in the pub, grab your kit and you can save a life’.

Here, Fraser suggests that overdose prevention might be better targeted towards the general public. His comments also suggest that the language of overdose prevention is more appropriately couched in terms of shared responsibility for the local community rather than targeted at individual consumers of opioids. While other participants agreed that take-home naloxone should be more widely advertised, they also observed that stigma would likely negatively inform attitudes to it. Zippy (male, 59 years old, Vic), for example, says:

Giving it [take-home naloxone] to everyone would probably be a good idea, mate, you know, but how do you do that? Do you have big signs everywhere when people walk into chemists and that, you know, ‘Would you be a participant in carrying naloxone in case you ever come across a person who’s overdosed?’ I’m sure you’d get a few people saying ‘yeah’, but most people would probably go ‘Ugh druggies, I don’t want to’.

In sum, our interview data highlight a range of ways in which stigma may shape the constitution of overdose risk and who is responsibilised for responding to it. To date, it seems stigma around illicit drug use has meant that the deaths of people who use illicit drugs have not warranted the creation of a sufficient range of overdose prevention resources in mainstream health services and environments in Australia.

## Conclusion

This article has analysed the operations of stigma in the uptake of take-home naloxone by mainstream health services and consumers in Australia from the perspectives of those who consume opioids and risk overdose. A growing literature has usefully identified a range of practical impediments to uptake. Our task has been at once more specific and more abstract. While we have not chosen to focus on the ontology of disease states or injury, our argument is undoubtedly predicated on the knowledge that such entities are not natural or inevitable (Fraser, 2011). They are constituted within the very terms of discourse mobilised to counter them. This dynamic could not be more evident than it is in the issue of overdose and its reversal. Stigma co-produces particular overdose events, risks and responses, as well as obstacles to accessing these responses. We have analysed interview material demonstrating how stigma helps shape the ways in which information about take-home naloxone is circulated (or potentially neglected), how it helps shape scope for, and concerns associated with, accessing take-home naloxone, and lastly, how it helps shape particular patterns of responsibility for using take-home naloxone and saving the lives of others. This is not to suggest that we consider individual service providers or mainstream health services the source of the issues described here. Broader structural conditions, such as the lack of a nationally coordinated framework for implementation, limited training for prescribing and variable dispensing guidelines, urgently need scrutiny. However, as we have argued, these persistent issues reflect, to some degree, a dynamic cultural atmosphere in which the issue of overdose and those affected by it are routinely neglected.

Fraser et al.’s performative theorisation of stigma treats it not as a set of post hoc judgments and practices that attach to existing phenomena, but as a constitutive biopolitical process that can bring into being these very phenomena. Addiction stigma effectively renders the lives of people who consume drugs less important than the lives of others (such as people at risk of anaphylactic shock), and, further, as objects of disgust. These meanings have direct relevance because a key avenue for increasing take-home naloxone uptake is largely eclipsed by this stigma, namely, the sharing of responsibility for responding to overdose among mainstream health services and the broader community. As we have argued elsewhere, the lives of marginalised opioid consumers are not valued and their deaths are rarely recognised as ‘grievable’. More consistently effective responses to overdose may struggle to take hold unless this changes (Fraser et al., 2018).

Finally, it is worth observing that the stigmatisation of overdose and take-home naloxone identified here also works to bolster and consolidate the symbolic legitimacy of non-opioid consuming subjecthood and sociality. Efforts to address overdose rates require more than the supply of an opioid antagonist to marginalised groups to achieve the level of traction to which those of us passionately opposed to further deaths aspire. Take-home naloxone initiatives vary in their assumptions and the relations of responsibility they instantiate, with some but not all connected into broader campaigns seeking change to the ways in which opioid consumption is viewed, both in relation to illicit consumption and prescription consumption. Further work linking take-home naloxone to these more searching agendas for change is surely needed.

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