Understanding the impediments to uptake and diffusion of take-home naloxone in Australia

Summary report of project publications and recommendations

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Report summaries

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This report presents summaries of research publications. Please read the complete published works to access the arguments in full and to cite the research or answer any questions about the content of the summaries. Further publications are currently in development and therefore not included in this report. To access later publications, please contact Adrian Farrugia (a.farrugia@latrobe.edu.au).

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Copies of this report or any other publications from this project may be obtained by contacting:
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Introduction

Background to the research

Like many other nations, Australia is experiencing increased opioid overdose hospital admissions and deaths. Australian research identified 1045 opioid-induced deaths in 2016, with 65% (n = 679) of deaths 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 have been developed and implemented in Australia, with most focussing on the knowledge and action of people who consume illicit drugs (Farrugia, Fraser & Dwyer, 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).

While successful take-home naloxone programs began to be implemented in parts of the United States and Europe from the mid-1990s, and successful country-wide pilot programs were conducted in Scotland between 2005 and 2007 and Wales in 2009, it was only in 2012 that the first take-home naloxone program was initiated in Australia in the Australian Capital Territory (Lenton et al., 2015). Take-home naloxone programs are now in place in all Australian states and territories, and a federally funded, take-home naloxone pilot in which subsidised free naloxone is provided through a special access system run by the Pharmaceutical Benefits Scheme (PBS) is running in three states. Despite these changes, impediments to uptake and diffusion remain. The literature identifies price and prescription requirements as key impediments. While rescheduling to over-the-counter status in Australia has increased accessibility, the price of the drug can be prohibitive (Farrugia, Fraser & Dwyer, 2017). When bought on prescription in non-pilot states and territories, take-home naloxone is subsidised through the PBS, 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 currently subsidised outside of the PBS pilot, with cost varying dramatically, making it too expensive for many (Pricolo & Nielsen, 2018). Alongside these issues, many others have been identified as impediments to uptake. These include: low health service provider awareness of take-home naloxone; high costs of running programs without additional funding (McDonald, Campbell & Strang, 2017); limited availability of relevant health professionals; lack of confidence and clarity around legal liability among professionals; unclear 'Good Samaritan' laws relating to administering naloxone to a third party; and stigma (Dwyer, Fraser & Dietze, 2016; Lenton et al., 2015; Nielsen, Menon, Larney, Farrell & Degenhardt, 2016).

Against this backdrop, this research project sought to:

1. Document for the first time in Australia the meanings given to take-home naloxone by people directly affected by opioid overdose, and any impediments they identify to uptake and diffusion;
2. Document for the first time in Australia the meanings given to take-home naloxone by relevant health professionals, and any impediments they identify to uptake and diffusion;
3. Investigate the role of stigma in the uptake and diffusion of take-home naloxone and the potential impact *on* stigma of wider availability and use of take-home naloxone.

Research design

This qualitative project gathered in-depth perspectives on the meanings of take-home naloxone for opioid consumers and health professionals. The study used a purposive data collection strategy to recruit and interview 46 opioid consumers and 37 health professionals across the Australian states of New South Wales and Victoria. Prospective participants were screened to ensure variation between types of opioids consumed (including for health issues such as chronic pain), experience with take-home naloxone, gender, age, ethnicity, and socio-economic background. Health professionals who work with people who consume opioids were recruited via relevant professional organisations who promoted the study through their networks. The recruitment strategy ensured a mix of pharmacotherapy prescribers, pain management specialists, general practitioners, pharmacists and other relevant professionals. All participants provided written informed consent. Among the 46 people who consume opioids, in-depth semi-structured interviews explored their 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 were conducted in private rooms of alcohol and other drug services, university offices or public places such as libraries and cafes. They were digitally recorded and participants were reimbursed AUD $50 in recognition of their time and contribution to the research. For the 36 health professionals, in-depth semi-structured interviews explored their work experience and its relevance to take-home naloxone, their knowledge of take-home naloxone, attitudes towards, and experience with, take-home naloxone provision, key professional issues related to take-home naloxone, access to take-home naloxone, and preferred modes of administration of take-home naloxone. Interviews were usually conducted at their place of work and over the phone if required, and digitally recorded. Health professionals were offered an AUD $50 gift voucher in recognition of their time and contribution to the research. All interview recordings were transcribed verbatim and the transcripts imported into QSR NVivo 11 for data management and coding.

The project's coding framework was developed by the research team in response to themes and gaps identified in the existing literature, and the broader project aims. These codes were reviewed and further developed as the project progressed. The main codes were: accessing take-home naloxone; attitudes to overdose; attitudes to take-home naloxone; contact with the criminal justice system; experiences administering take-home naloxone; experiences being administered take-home naloxone; experiences of overdose; interactions with health systems and emergency services; knowledge of overdose; knowledge of take-home naloxone; overdose response training; professional issues; and reducing harm beyond take-home naloxone.

The results of the project were analysed and published in a range of research articles and a book chapter, and also presented on a public website, Overdoselifesavers.org. The study was approved by Curtin University's Human Research Ethics Committee (HRE2017-0168/2017) and La Trobe University's Human Ethics Committee (HEC19339).

PUBLICATION ONE

Assembling the social and political dimensions of take-home naloxone

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Contemporary Drug Problems, *44*(3), 163-175.

Note: This article summary is not a complete work. Please access the complete published article if you have questions or wish to cite the research.

This commentary explores the complex position that take-home naloxone holds as a harm reduction strategy in contemporary public health contexts. Few socially-oriented studies of take-home naloxone raise questions beyond whether or not take-home naloxone 'works'. Until take-home naloxone efforts address overdose harms as effects of social context and policy regimes, the focus will fall too heavily on individual behaviour change. This will constrain the distribution of responsibility for tackling overdose, limit overdose prevention, and leave unchallenged a key driver of overdose: the stigmatisation of opioid consumption.

Research on consumer perspectives on take-home naloxone

Research on people who consume opioids shows they are readily able to learn overdose emergency response strategies and manage personal supplies of take-home naloxone (McAuley, Lindsay, Woods & Louttit, 2010), and are generally willing to participate in overdose response training and administer naloxone on their peers (Hill & McAuley, 2012; Lagu, Anderson & Stein, 2006; Lankenau et al., 2013; Seal et al., 2003; Sherman et al., 2008; Wright, Oldham, Francis & Jones, 2006). However, research also suggests that some opioid consumers choose not to engage with take-home naloxone (Dietze, Cogger, S, Malandkar, Olsen & Lenton, 2015; Stafford & Breen, 2017). Potential reasons for this include fear of stimulating withdrawal symptoms when administering naloxone (Neale & Strang, 2015; Wright, Oldham, Francis & Jones, 2006), fear of police involvement (Lagu et al., 2006; Sherman et al., 2008; Wright, Oldham, Francis & Jones, 2006) and feeling burdened by the responsibility to attend upsetting overdose events (Neale & Strang, 2015).

Research on health professional perspectives on take-home naloxone

Early research on health professionals' views on take-home naloxone pointed to concerns that it might be treated as a 'safety net' against opioid overdose and therefore encourage increased opioid consumption (Beletsky et al., 2006; Green et al., 2013; Hill & McAuley, 2012). Questions have also been asked by some health professionals about the capacity of people who inject drugs to properly identify an opioid overdose and administer take-home naloxone (Beletsky et al., 2006). Such concerns reproduce unexamined assumptions about the capacity and character of people who consume drugs, and emphasise that stigma remains highly relevant to the success or otherwise of any health intervention concerning opioid consumption (van Boekel, Brouwers, Van Weeghel & Garretsen, 2013).

The research in this area serves the important role of supporting and demonstrating the benefits of take-home naloxone. However, it rarely asks broader questions about such interventions. The social production of opioid overdose and responses to it is yet to be incorporated into any but a few analyses of take-home naloxone provision.

Social approaches to take-home naloxone

According to Faulkner-Gurstein (2017) take-home naloxone could be considered a perfect example of a neoliberal health program in that it places the responsibility for health care on individuals regardless of their circumstances and resources. Faulkner-Gurstein also argues, however, that naloxone provision complicates this picture by relying on the local knowledge and social networks of opioid consumers and thus recognising their social and relational selfhood. By drawing on rather than ignoring consumers' embodied knowledge and expertise developed through opioid consumption, take-home naloxone programs position target groups as responsible but also as politically active. For Faulkner-Gurstein, while take-home naloxone initiatives harness neoliberal techniques (p. 27), this strategic connection to neoliberalism does not exhaust their potential.

McLean's (2016) article entitled '"There's nothing here": Deindustrialization as risk environment for overdose' looks at how overdose risks and take-home naloxone

uptake are shaped by social forces in environments. Importantly, McLean argues that in impoverished contexts the emergence of take-home naloxone provision as a policy response is important. However, she also argues that without efforts to address broader forces producing opioid overdose, interventions that aim to empower opioid consumers as individuals will not be effective.

The purpose of this commentary is to analyse the relevant sociological research literature and to raise political questions about how it approaches take-home naloxone as a harm reduction intervention. Faulkner-Gurstein (2017) argues that, although individualising, take-home naloxone initiatives rely on social dynamics and complex coalitions of people, institutions, discourses, and tools for them to 'work.' These social arrangements have rarely been made the explicit focus of research. Attending to the broader context, as McLean (2016) underscores the need for interventions that reduce the likelihood of opioid overdose to begin with. Relying on the provision of take-home naloxone, she argues, may allow policy makers and governments to ignore the social problems such as inequality and criminalisation that coproduce overdose. These issues are not addressed by take-home naloxone programs or overdose response training.

New approaches for understanding take-home naloxone

Further exploration of take-home naloxone and these issues and questions requires an approach able to recognise the many differing forces active in overdose events, and ensure each is not abstracted from the event as a whole. Posthumanist theoretical approaches may be of use here (Barad, 2007; Deleuze & Guattari, 1987; Latour, 2005; Law, 2004). These approaches focus on the action of assemblages rather than individuals, decentring the agency of human subjects and raising questions about the risks as well as the benefits of humanist models and their tendency to devolve action to individuals, no matter how poorly resourced. Importantly, sociologically informed research on take-home naloxone is yet to benefit from the rich potential of these approaches.

Conclusion

Take-home naloxone has already been shown to be an effective lifesaving health intervention. The tensions between individual responses and larger social responses, between the recognition of local forces and of global forces in producing overdose events, remain poorly explored. Other key areas that would benefit from further research include:

1. the affective dimensions of overdose and naloxone administration and the impact of attending overdose events in a responsibilised role;
2. experiences of training in the use of take-home naloxone, including the ways in which overdose is presented, risk is discussed, and the trainees' status as opioid consumers is managed;
3. the potential for take-home naloxone provision and training to interrupt or reinforce stigmatising assumptions about people who consume opioids;
4. the embeddedness of the role and effects of take-home naloxone in peer social networks, and the implications this network model of effectiveness has for promoting uptake in equitable and sustainable ways.

PUBLICATION TWO

Grievable lives? Death by opioid overdose in Australian newspaper coverage

Fraser, S., Farrugia, A. & Dwyer, R. (2018).
Grievable lives? Death by opioid overdose in Australian newspaper coverage.
International Journal of Drug Policy, *59*, 28-35.

Note: This article summary is not a complete work. Please access the complete published article if you have questions or wish to cite the research.

Despite increasing overdose deaths in Australia and around the world, measures aimed at reducing these deaths such as safe injecting facilities and take-home naloxone continue to face obstacles to uptake. The reasons for this are manifold, but a key contributor is public discourse on opioid consumption and overdose. This article uses the work of feminist philosopher Judith Butler on 'grievable lives' (2016 [2009]) to analyse mainstream newspaper coverage of opioid overdose in Australia, mapping key articulations of overdose to consider how public understandings of overdose are shaped. Based on this analysis, the article concludes that until the lives of opioid consumers come to be considered grievable, measures known to reduce overdose deaths may struggle to find public support, and harmful measures such as prohibition may persist.

Approach

Speaking of deaths in war in a book partly aiming to address the Arab-Israeli conflict, Judith Butler argues that:

> *the frames through which we apprehend or, indeed, fail to apprehend the lives of others as lost or injured (lose-able or injurable) are politically saturated. (2016 [2009], p. 1)*

Here Butler draws attention to the intrinsically political knowledge-making processes that frame some lives as not visibly or perceptibly real and therefore not 'lose-able' or 'injurable'. In this analysis we ask how the lives of drug users are presented in media discourse and, in turn, how this discourse constitutes the character and value of life for drug users.

Method

This article is based on an analysis of Australian newspaper coverage of overdose deaths. The data were collected via searches undertaken in March and June 2017, using the Factiva database. The searches, conducted by a research assistant with assistance from the first author, were limited to three news outlets, *The Sydney Morning Herald*, *The Age* and *The Australian*. The resulting dataset (N = 47) was analysed thematically, based on the key questions this article asks and social science scholarship on stigma and representations of addiction.

To whom does death by overdose happen?

In the analysis we identified a pronounced lack of personal details about those who had died of overdose. None of the news items analysed included more than two or three biographical details beyond those directly related to the death. For example, in May 2012, an article entitled 'Parents feel agony of needle and damage done' (Hannon, *The Age*, 2012) reported on the death of 'Daniel'. We read that Daniel was 22 when he died, and that while his parents

> *were not blind to his bouts of low self-esteem and anxiety [...they] believed he was building the foundations for a happy, successful life. A Bachelor of Fine Arts from the University of New South Wales was proof.*

Who was Daniel? He was 22, had a university degree, and suffered from low self-esteem and anxiety. Beyond these few details, we learn nothing. What are the implications of this absence of detail about the lives of those who have died from opioid overdose? In Daniel's case, we encounter someone apparently in need of redemption, but who was ultimately denied the chance to redeem himself. Thus, his mother is quoted as saying,

> *'He battled so hard, he was so brave—and he was coming good. He just needed more time.'*

This story builds a very specific, narrow, account of why Daniel's death occurred, framing the drug, along with his mental health, as the causes of his death. This

political teleology of fatal overdose worth is querying since it tends to imply that overdose was, if not inevitable, the predictable outcome of Daniel's actions and character. In this way, Daniel's life is presented as somehow marked, and his loss is presented as somehow within the natural order of things.

How and why does death by overdose occur?

The analysis also identified a frequent use of natural disaster metaphors in coverage of death by overdose. These metaphors help constitute overdose again as ungovernable: as beyond the remit of governmental processes and within the natural order of things. An example can be found in a 2016 *Sydney Morning Herald* piece (Olding, 2016), which quotes a coroner dealing with a series of overdoses as follows: 'there is an urgency to bring this spate of drug-related deaths to the attention of the public prior to any inquest being held.'

What is a 'spate'? It is a river in flood. The same language appears in other related news items, such as in the summary description of a 2017 *Age* (Bucci & Preiss) article:

> *A coroner has recommended the Victorian government trial a supervised injecting room in north Richmond, amid an unprecedented spate of heroin overdoses.*

Here overdose is a natural disaster, signified as a river bursting its banks. It can be tackled and potentially avoided with the introduction of better infrastructure: a supervised injecting room. While this coverage of proposed structural measures is a welcome modifier of the fatalism implied by metaphors of natural disaster, it is important to consider whether these metaphors work at some level to undermine such proposals.

Whose loss is overdose?

The final analytical section explores the ways the loss associated with fatal overdose is depicted, finding it overwhelmingly concerned with the loss suffered by others, namely family members.

In one article (Bucci, *The Age*, 2016), we read that:

> *Ms A overdosed in a Hungry Jack's toilet in North Richmond. A needle and a spoon were beside her. That Sunday lunchtime, on May 29, was the end of a decade-long battle with heroin addiction. She was a 34-year-old mother. On Wednesday, her death took on new meaning. It became the subject of a coronial inquest into whether a supervised heroin injecting room in the Victoria Street area would reduce the incidence of fatal overdoses.*

Here Ms A's death is primarily a tragedy for others: other issues, and other people, overwhelmingly immediate family. Overall, these deaths are presented as mattering not because of the injustice of life denied the deceased, but because of the suffering they cause those left behind.

Making 'lives' lose-able

Is it possible to alter public discourse on overdose to overcome its fatalistic tendencies and its political teleologies that treat death by overdose as always already happening to people who consume opioids? Is it possible instead see such deaths as fundamentally a tragedy for those denied life, to foster recognition of these lives as fully lost, as fully grievable? Political interventions aiming to create change of this kind are underway in related spaces. One example of this work can be found in a public website, Livesofsubstance.org. This resource presents the personal stories of people who identify as experiencing an alcohol or other drug addiction, dependence or habit, and uses their accounts to also present key themes relevant to their lives: issues such as stigma, health and well-being, contact with the criminal justice system and so on. Overall, the website provides insights that can challenge the narrow political teleologies of overdose that treat it as the logical effect of individual flaws and deadly drugs. In turn it works to present lives as valid on their own terms – lives that would be fully grievable were they lost.

Conclusion

Media coverage of death by overdose hints at the marginalisation of drug user lives and the ungrievability of their loss. This marginalisation has a range of harmful effects, for example, drug prohibition is posed as a way to protect 'the living' even as it places at great risk the lives of others – those adjudged already lost. While efforts are underway to correct the misrepresentation of the lives of drug users as unlose-able and ungrievable, many more are urgently needed.

PUBLICATION THREE

Take-home naloxone and the politics of care

Farrugia, A., Fraser, S., Dwyer, R., Fomiatti, R., Neale, J., Dietze, P. & Strang, J. (2019).
Take-home naloxone and the politics of care.
Sociology of Health and Illness, *41*(2), 427-443.

Note: This article summary is not a complete work. Please access the complete published article if you have questions or wish to cite the research.

This article focuses on how care relations shape use of take-home naloxone and its effects. Working with recent Science and Technology Studies (STS) scholarship on care, we develop a politics of care approach to analysing take-home naloxone uptake. To do so, we analyse two complementary case studies: (1) a regime of care within an intimate partnership and (2) a political process of care. We conclude by exploring the political affordances of a politics of care approach for the uptake of take-home naloxone.

A politics of care approach

This article draws on recent work in STS particularly useful for analysing the interpersonal relations of care implicated in take-home naloxone provision. As explored by Martin, Myers & Viseu (2015), when care is put to work in STS-orientated research it produces two mutually implicated 'layers of care':

1. 'that which we, as STS scholars, teachers, and feminists enact in our relations with the worlds we study', and
2. 'that which *circulates among the actors* in the technoscientific worlds we encounter through our studies'. (original emphasis, p. 626)

In our analysis we consider how care is made and re-made in ways not generally accounted for in traditional approaches to naloxone administration, the aim being to enrich understandings of this technological field to better inform questions about uptake and diffusion.

Given the central importance of injecting equipment in accounts of overdose and its reversal, such as the needle, syringe and naloxone itself, we consider the role of technology in the forms of care generated through overdose responses. In doing so, we work with Latour's argument that subjects do not merely 'use' tools or 'master' technological objects, nor do tools or objects determine use, rather, the relationship between technologies and people is one of 'affordance' – non-determining possibilities for action (Latour, 2002, pp. 252-253). Mindful of the politics of care, we approach take-home naloxone as affording different capacities for, and subjects of, care. These all bear on when, how, why and in what ways the technology is distributed, taken up and applied.

Method

The analysis conducted for this article was approached using a case study method covering two of the 46 interviews conducted with people who consume opioids for the broader project (see, Research design p. 4). We work with Mol and Law's (2002) argument that cases are productive because they can offer 'partially translatable' insights that emerge from their ability to sensitise us to previously unrecognised events and situations (see Fraser & Seear, 2011). In this way, the forms of care and responsibility emerging through the analysis can also shed light on other health initiatives (Fraser & Seear, 2011). In choosing the two cases presented in this article we focused on those offering rich detail and nuanced ways of discussing the different sets of interpersonal relations implicated in events of administration. In this respect they were selected for their potential utility for in-depth analysis. Importantly, while this article focuses on these two cases, discussions of care practices were common in the interview data overall (see, Research design p. 4). Both cases emphasise the multiple affordances created by take-home naloxone initiatives, illuminate previously unexamined issues, and help us to rethink assumptions.

Analysis

Case study 1, Gabrielle: Caring, choice and intimacy

Our first case study comprises an account provided by Gabrielle (48, female, Vic, non-prescribed opioids) in which she describes giving naloxone to her partner, Jeremy. Jeremy is terminally ill with cancer. He also consumes heroin and, as she explains, his illness magnifies the intoxicating effects and risk of overdose, something of which Gabrielle is acutely aware. Gabrielle also says that Jeremy's health status makes him

ambivalent about revival from overdose. As Gabrielle goes on to explain:

> *I've got a living will from him, which he specifically states 'not to be brought back' [if he overdoses] [...] We've talked about it and made decisions, like a commitment to each other. So if he did [overdose], like if his heart stops and he has stopped breathing, I don't know if I could do it, but I'm not supposed to bring him back.*

Jeremy's living will, and Gabrielle's role in caring for him within their intimate relationship, directly shape how Gabrielle administers naloxone, why and to what ends.

> *I'm not using a full ampoule, because [...] he's using heroin to enjoy it and I don't want to completely reverse it [...] I just need to take the edge off it and straighten him up a bit. [Then] he goes back to a level of being stoned, but not quite as stoned as he was before. And then I can relax.*

Here Gabrielle articulates a very careful and caring process that requires a complex of elements including, among other things, an intimate relationship, specific living arrangements, and access to and particular use of take-home naloxone.

It seems take-home naloxone has afforded change in Gabrielle's ethical landscape and the conditions of possibility of care within her relationship. Understanding the relations between technology, subjectification and care through cases such as this one help us move closer towards understanding the complexities of why and how and under what conditions take-home naloxone might be taken up as a valid measure by people who consume drugs, and those in which it might not.

Case study 2, Dylan: Gentle naloxone administration

Dylan's (33, male, Vic, non-prescribed opioids) account offers our second case study demonstrating the co-production of take-home naloxone and care. Dylan was very supportive of take-home naloxone distribution, but according to him, paramedics responding to opioid overdoses often cause painful withdrawal sensations by administering too much naloxone too quickly. In contrast, Dylan draws on strategies he learnt in overdose response training conducted by a peer-run drug consumer organisation to revive 'gently':

> *I'm aware that ambulance officers give between five and six times the dose [of naloxone] that we're taught to give [in training], and a lot of the time it snaps people straight out of it, but it then sends them into instant withdrawal. They get really narky [angry and frustrated] [...] We're taught to try and do the gently-gently approach, and I wish somebody would notify Ambulance Victoria that there's a better way of reversing an opiate overdose than just jabbing people full of naloxone and sending them into withdrawal.*

For Dylan, while revival is the primary goal of naloxone administration, he makes a caring effort to achieve this without causing pain and discomfort. For Dylan, the frustration and distress that take-home naloxone administration can afford can be avoided, simply by administering naloxone with the right care.

The conditions of possibility of care

The differences between these accounts emphasise the importance of analysing the conditions of possibility of care. Gabrielle recounts an arrangement afforded by access to a private residence and long-term intimate relationship. This set of relations supports her capacity to become carefully attuned to another's embodied reactions and corporeality. For many targets of overdose, response training and take-home naloxone, this set of relations is not available. That said, Dylan's gentle administration approach emphasises that even within relations that may limit affordances, non-medically trained people, including those who consume opioids, can and are responding to overdose in a careful and sensitive manner.

Conclusion: Towards a politics of care

Drawing these cases together, we can see a politics of care in the accounts of our participants. The dynamics and affordances mapped in this article via this politics of care have at least three implications for policy, practice and service provision.

1. A politics of care approach to administration may not only improve individual experiences of revival but may advance naloxone's reputation and encourage uptake.
2. A politics of care approach emphasises social relations, which is especially important in a context in which those affected are heavily stigmatised and constituted as lacking meaningful relationships.
3. A politics of care approach demonstrates the importance of political issues of marginalisation, material resourcing and stigma to analyses of naloxone uptake and use.

PUBLICATION FOUR

Conflict and communication: Managing the multiple affordances of take-home naloxone administration events in Australia

Farrugia, A., Neale, J., Dwyer, R., Fomiatti, R., Fraser, S., Strang, J. & Dietze, P. (2020). Conflict and communication: Managing the multiple affordances of take-home naloxone administration events in Australia. *Addiction Research & Theory, 28*(1), 29-37.

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This article explores the conflict that can emerge during take-home naloxone administration, as well as more positive interactions and moments of appreciation. In doing so, it focuses on the strategies some use to reduce the potential for conflict and increase the likelihood of positive interactions. We argue that people administering naloxone actively manage the potential for conflict and, in moments of life-saving administration, enact this technology in particular ways. We conclude that efforts to increase uptake of take-home naloxone should highlight the capacity to administer this medication in ways that avoid conflict, and the efforts peer administrators already make in this area, and do more to recognise the life-saving actions of peer administrators.

Approach

The article uses Latour's (2002) notion of 'affordance' to conduct the analysis, a concept he uses to emphasise and characterise the mutually constitutive relationship between humans and technology. Latour argues that human-technology encounters produce particular capacities and possibilities, or affordances (Fraser, 2013). Here, affordances are not predetermined options between which the 'user' of a technology may choose, but non-determining possibilities and capacities that take shape in encounters between human and technological objects. Within this approach, naloxone can afford a number of possibilities if the right engagements arise and are enacted. Whether and how these emerge depends on the conditions of the administration event including, as we illustrate, specific administration and other practices.

Method

For this article we analysed data from 28 of the 46 semi-structured in-depth interviews conducted with people who consume opioids (see Research design p. 4). Of the 28 relevant interviews, 16 participants identified as male, 11 identified as female and one identified as a trans-woman. At the time of the interview, 19 of the participants were currently consuming opioids and 11 were not. The data were analysed using the inductive constant comparison method (Seale,1999). The first author conducted an initial analysis (which drew out the issue of conflict and pointed to different management techniques), presented the initial analysis to the research team for discussion, and subsequently conducted another round of analysis once the topic had been refined and clarified. As described (see Research design p. 4), the original dataset includes interviews with people who consumed illicit opioids such as heroin, and interviews with people who consumed prescribed opioids for health issues such as chronic pain (n = 18). As this article focusses on take-home administration, and none of the participants who consumed prescribed opioids only had experience with naloxone, their accounts were not analysed in this article.

Analysis

The possibility of conflict

Reflecting research on take-home naloxone conducted in Australia and internationally (Heavey et al., 2018, Neale & Strang, 2015, McAuley, Munro & Taylor 2018, Sondhi, Ryan & Day, 2016, Sporer & Kral 2007, Worthington, Piper, Galea & Rosenthal, 2006), participants in our study often spoke of the conflict that can arise when an opioid consumer has been revived with naloxone. Importantly, although revival events can be quite conflict-laden, and may even present danger to the person administering the naloxone, almost all of the participants in our research were very willing to respond to opioid overdose with naloxone. This is apparent in Andrew's (age 41, male, Vic, non-prescribed opioids) comments:

> *I've told them all, and any of my friends will tell you, I carry it [take-home naloxone] and I'm not scared of using it. Wake up and punch me in the mouth – at least you woke up. Yeah, you just cop it on the chin.*

While violence is a concern for Andrew, he remains committed to carrying and

administering take-home naloxone. For Andrew, it is the responsibility of others not to consume opioids in such a way as to require his intervention.

The potential for appreciation

Overdose can be a distressing event for the people present and those in their social networks. However, we found that take-home naloxone's capacity to reverse overdose also afforded positive interpersonal interactions. An example is found in Zippy's (age 59, male, Vic, non-prescribed opioids) description of a text message he received from a young woman whom he had revived:

> *Well, she couldn't thank me enough. I got this text on my phone and it took me a bloody five minutes to read it, she was going, 'I'm really grateful that you looked after me and thank you for helping me out [and] you are really kind and I'm ever so grateful that you helped me out'.*

Strategies to reduce conflict: Titrating the dose of naloxone

Aware of the conflict that can be afforded in naloxone administration events, participants in our research used different techniques to afford other outcomes. As noted but not explored in detail in other research (e.g. Lankenau et al., 2013), titrating the dose of naloxone is one such technique described in our data. For example, Lance (age 48, male, NSW, non-prescribed opioids) had used naloxone ampoules in the past and recognised that violence is a possibility after administration. He explains how he avoided conflict in a past overdose event by reducing the dose of naloxone he administered:

> *A lot of people, if you Narcan them, they sort of come up swinging [ready to punch you].*
>
> The times that you have done it, has that happened?
>
> *No. Because we didn't use the full quantity.*

As Lance explains, while he knows physical violence can occur during administration, he had not had such experiences because he actively employed a technique likely to avoid withdrawal sensations and related conflict.

Strategies to reduce conflict: Communication

Communication was a second strategy our research participants deployed as a means of contributing to particular naloxone affordances. For example, Gabrielle (age 48, female, Vic, non-prescribed opioids) emphasises the importance of communication during revival. She offers the following account of using naloxone ampoules to administer two doses to a man who had overdosed in her apartment block:

> *Within 30 seconds of the second one [naloxone dose], he gave a cough and a bit of spluttering and things were good. He started coming around slightly aggressive, but his girlfriend was with us and I had already asked her to start talking to him from before he was coming to [regaining full consciousness]. [This way] at least he could hear voices when he was coming around and wouldn't be so confused, because it's the confusion that makes people agitated and angry.*

Gabrielle's account emphasises the intimately social nature of overdose experiences and naloxone administration. For Gabrielle, the conflict that can emerge during revival does not stem solely from withdrawal sensations stimulated by naloxone, but inextricably from the confusion experienced by the person being revived. While the recipient of the naloxone may initially feel fearful, confused and agitated, hearing a familiar voice during revival can, according to Gabrielle, afford a less frightening experience. Calm revival may be much less likely where revival occurs with unfamiliar people in an unfamiliar place, such as may occur during revival by paramedics.

Conclusion

Peer administrators are already using naloxone to save lives without expectation of gratitude or recognition (see also Dwyer et al., 2018). It may be, however, that shedding light on this significant life-saving role, and encouraging community recognition for this work, can increase its appeal (Faulkner-Gurstein, 2017). Equally importantly, this life-saving work could be highlighted more actively in urgently needed efforts to tackle the stigma and discrimination faced by people who consume opioids.

Alongside providing information and training on recognising overdoses, calling an ambulance, resuscitation, the recovery position, take-home naloxone administration and after care, overdose response training programs that do not already communicate that painful withdrawal sensations are not an essential or unavoidable affordance of naloxone administration could begin to do so. Training that does not already introduce people to strategies that make negative interactions less likely, such as dose titration and sensitive communication, could begin to emphasise these possibilities. Together these strategies suggest that administration practices that reduce the likelihood of conflict are both possible and preferable.

PUBLICATION FIVE

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

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This article explores the ways stigma impacts on take-home naloxone uptake. 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). First, we focus on the ways stigma impedes professional information provision about take-home naloxone. Second, we explore the role of stigma in limiting the scale-up of programs and access points. From here we examine the ways stigma co-constitutes the politics of overdose and prevention, rendering take-home naloxone ill-suited to many social settings of overdose. While take-home naloxone is an excellent life-saving initiative, uncritically valorising it may divert attention from broader needs, such as the de-stigmatisation of drug consumption through decriminalisation, and other strategies to reduce overdose.

Approach

Drawing on Fraser et al.'s (2017) performative account of stigma, developed in the context of another qualitative research project on drug consumption, we show how addiction stigma shapes take-home naloxone uptake and limits its effectiveness as a technology for overdose prevention. Fraser et al. (2017) argue that addiction stigma serves an essential political purpose by reproducing normative conceptions of human reason, rationality and objectivity. In relation to take-home naloxone, much has been written about the 'intervention inertia' (Strang, Bird & Parmar, 2013; Strang, Neale, McDonald & Kalk, 2018) impairing its implementation and uptake. In this article, we understand this inertia not as a 'neutral' problem but as the effect of broader politics, including a social and cultural discomfort with drug use, that undermine overdose prevention efforts.

Method

For this article we analysed data from 46 semi-structured in-depth interviews conducted with people who consume opioids across the Australian states of New South Wales (NSW) and Victoria (Vic) (see, Research design p. 4). The dataset was made up of 28 people with experience of illicit opioid consumption and 18 who consume prescribed opioids primarily for health concerns such as chronic pain. Further details on the participants who consume non-prescribed opioids such as heroin is found in Research design (p. 4) and the methods section of Farrugia et al. (2020) (p. 11). Of the participants who had consumed prescribed opioids, eight identified as male, nine identified as female and one identified as gender-fluid. At the time of the interview, 14 of these participants were currently consuming opioids and four were not. All data were coded using the inductive constant comparison method (Seale, 1999).

Analysis

Impeding information provision

A key theme in this research project was concern about information provision about overdose prevention. Some participants reported, for example, that health professionals did not inform them about the availability of take-home naloxone. Simone (age 48, female Vic, non-prescribed opioids) explains that:

> *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.*

In contrast, 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. Readable from these examples is the way in which opioid and addiction stigma implicitly

impede information transfer (Bounthavong et al., 2019; Olsen et al., 2019; Paquette, Syvertsen & Pollini, 2018).

Other participants were reluctant to ask directly for information about take-home naloxone, fearing discrimination, especially from general practitioners. When Farez (age 43, male, NSW, prescribed opioids), 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.

Ordering access

This threat of discreditability can function 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 (age 34, male, Vic, prescribed opioids),

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.

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 perspective. A major obstacle to uptake is politico-legal in that the criminalisation of non-pharmaceutical opioids directly shapes the social settings of use, the production of overdose risk and the utility of take-home naloxone. Due to the stigmatisation of injecting drug use, for example, some participants consume opioids alone in private or secluded settings, without the safety of the presence of friends. Russell (age 50, male, Vic, non-prescribed opioids) 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.*

Following Fraser et al. (2017), we argue that 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 some consumption practices shameful and stigmatised and others normal.

Many of those interviewed who consumed prescribed opioids for chronic pain did not perceive themselves as vulnerable to overdose because the issue had not been raised by their medical practitioners. For them, risks were largely related to illicit drug use and 'addiction'. As Claudia (age 28, female, NSW, prescribed opioids) puts it, prescription opioid consumers resist seeing themselves as risking overdose because of its association with addiction:

> *[To 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 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 & Salmon, 2009).

Finally, addiction stigma also impedes access to take-home naloxone through the tropes of individual responsibility constituting overdose prevention. On this point, several participants commented that take-home naloxone was not publicly promoted like other forms of healthcare. As Fraser (age 43, male, NSW, prescribed opioids) 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 overdose prevention is more appropriately couched in terms of shared responsibility for the community rather than targeted at individual consumers of opioids.

Conclusion

This article demonstrates the ways stigma helps shape information distribution about take-home naloxone, limits scope for accessing take-home naloxone, and constructs particular patterns of responsibility for using take-home naloxone and saving the lives of others. In this context, structural conditions, such as the lack of a nationally coordinated framework for implementation, limited training for prescribing, and variable dispensing guidelines, urgently need scrutiny. Addiction stigma effectively renders the lives of people who consume drugs less important than the lives of others and even as objects of disgust. These meanings matter because they impact directly on a key avenue for increasing take-home naloxone uptake: the sharing of responsibility for responding to overdose among mainstream health services and the broader community.

PUBLICATION SIX

Passion, reason and the politics of intoxication: Ontopolitically oriented approaches to alcohol and other drug intoxication

Fraser, S., Moore, D., Farrugia, A. & Fomiatti, R. (In press).
'Passion, reason and the politics of intoxication: Ontopolitically oriented approaches to alcohol and other drug intoxication' in G. Hunt, T. Antin and V. Frank (Eds.), *Handbook on intoxicants and intoxication*, London and New York: Routledge.

Note: This chapter summary is not a complete work. Please access the complete published chapter if you have questions or wish to cite the research.

In this chapter we examine some of the political implications and effects of the notion of intoxication, using two large-scale qualitative Australian research projects as case studies. In one project, the place of intoxication is examined in accounts of accidental opioid overdose and the use of the opioid antagonist naloxone; in the other, it is examined in accounts of the use of performance and image-enhancing drugs (PIEDs). Our analysis draws on an approach that conceptualises intoxication not as a predictable effect of biochemistry, in which agency is inherently compromised, but as a variable effect of the relations between broader forces that shape drug consumption. As we argue, intoxication is a political designation reliant on a range of assumptions about drug-consuming subjects and practices.

Approach

In conducting our analysis, we adopt what has elsewhere been called an 'ontopolitically oriented' approach to research (Fraser, 2020). Based on science and technology studies and new materialism, this approach sees realities, including the realities of drug consumption, as emergent rather than predictable or guaranteed by biochemistry or prior states. As we will argue, this approach allows recognition of the ways in which different contexts and discourses of intoxication (including those operating in research itself) co-produce culturally and politically specific intoxication experiences and effects. In turn, we raise new questions about the conditions of intoxication, the assumptions made about drug effects, the meaning of intoxication and how best to respond to it.

Method

This chapter draws on two Australian qualitative research projects: 1) an investigation into the meanings and experiences of take-home naloxone for opioid consumers and health professionals, and 2) an exploration of PIED injecting among men, with a particular emphasis on hepatitis C transmission. The methods used for the research on take-home naloxone are addressed in other sections of this report (see, Research design p. 4). The PIEDs project conducted in-depth, qualitative interviews with 60 men in Australia who have experience of injecting PIEDs. Participants were recruited through a wide range of sites, including harm reduction services, primary health services, sexual health services, bars and clubs, supplement stores and sex on premises venues. The study was also advertised on social media platforms, and in Men's Health magazine. Participants reported using a PIED in the last 12 months, and were aged 19 to 72 years. Fifty-one men identified as heterosexual, eight as gay and one as bisexual. None disclosed that they were trans or had a trans history. Thirty-three participants reported that both they and their parents were born in Australia, 13 participants reported that they were born in Australia and one or both of their parents were born overseas, and 14 participants reported being born overseas. Curtin University's Human Research Ethics Committee approved the study (HRE2017-0372).

These projects both aimed to suspend pathologising narratives that tend to understand the complex phenomena of drug consumption in singular and narrow ways, for example, as issues of addiction, intemperance, disorder and pathological or absent agency. In analysing both projects together, we aimed to allow new insights about intoxication to emerge.

Analysis

Overdose, revival and intoxication

Conventional accounts of intoxication rely on binaries of sense and irrationality, and chaos and order. As we will see, such binaries are unable to effectively address the experiences and practices articulated by our participants. In our interviews we find reason to reconsider the pursuit and experience of intoxication, finding them not readily dismissible as excessive, chaotic and intemperate, as the effect of questionable individual agency or behaviour.

Valentina's (age 42, female, NSW, non-prescribed opioids) account of opioid overdose provides a useful example. As she explains:

> *We went just off to school one day, scored, had a shot in my car and we both passed out. She [Valentina's friend] woke up first and I was still out, and so she moved me over, got into the driver's seat and drove me to hospital, and I got a Narcan [naloxone] and I just came to.*

Valentina's story begins with a familiar series of events: drugs are bought illicitly, injected in a relatively isolated location, and overdose occurs, leading to unconsciousness. Here, intoxication is this loss of consciousness: the absence of conscious thought and rational action. However, immediately following these events, we are told, a series of other events occurs. Valentina's companion wakes up, identifies Valentina's overdose risk, moves her and then drives their vehicle to hospital. While this course of action could be criticised in that it may have involved driving while under the influence of a drug (the timeframe for the events is not available in the account), it is also a highly organised and decisive one. Not only does Valentina's account present a (young) companion possibly saving her life, the companion seems to show a significant amount of competence and resourcefulness. Here we see intoxication not as the opposite of sense, order, coherence and agency, but adjacent it, afforded by other elements such as the action of stigma in shaping injecting location, and the availability of a car for transportation purposes.

While Valentina and her companion did not have access to naloxone while injecting, the medication emerges in other accounts of overdose and revival. Some participants describe revival from overdose with naloxone in relatively benign terms in which a degree of intoxication is preserved, but Ghassan describes a significant wrench on revival, including cold shakes, diarrhea and vomiting. It was, he says, 'ugly':

> *So, I was locked up [in gaol] for a period of time and then I got out and I never knew about tolerance levels and stuff. So I went out and used the exact same amount that I was using prior to being locked up and I was at a friend's place luckily, and his sister was there and she was an addict too, yeah, so I've had it [naloxone], and then the next thing I know, I'm waking up in […] hospital throwing up all over, like the instant withdrawal and all that kind of stuff. […] It was ugly […] but it saved my life at the same time, so like I'm not the type to start jumping up and going, 'Oh yeah'. No, they did save my life [but] I didn't like it, it didn't feel good because of the instant, you know, like the vomiting and the cold shakes and the diarrhea and all that kind of stuff.*

Here, Ghassan wakes up in hospital – a relatively controlled environment – yet it seems the naloxone had been administered in such a way as to induce significant negative physical effects. While the symptoms induced by high doses of naloxone are rarely if ever labelled intoxication (it is usually labelled 'over-antagonism' in medical settings), it is difficult to avoid the conclusion that the sensations Ghassan describes are indeed ones of intoxication. In other words, rather than restoring order and coherence, the medically administered naloxone substitutes one kind of intoxication with another. The volume of naloxone used in producing such effects might, indeed, be considered excessive and even intemperate. Interestingly, the concept of over-antagonism medicalises the effects of naloxone, apparently precluding the designation of intoxication, an effect primarily attributed to non-medically sanctioned drug consumption. At the same time, as Ghassan woke, he says, he understood the use of naloxone and, despite new and unpleasant symptoms of intoxication, responded in a reasoned way.

Looked at closely Ghassan's account does much to disrupt standard understandings of intoxication, which tend to foreground poor consumer choices and conduct, the rationality of medicine, and the polarisation of intoxication and reason.

PIEDs and intoxication

In the project conducted on the consumption of PIEDs, the role ascribable to intoxication differs significantly from that in the opioid overdose project described above. Here we turn to the work of Helen Keane (2020), who argues for including within definitions of intoxication less intense effects and unfamiliar substances (her example is nicotine). Here we take up her advice because it allows us to see more clearly the politics of intoxication and its implications in our participants' accounts. As we will show, PIED consumption can be seen to trouble the binaries usually applied to intoxication discourse: impulse and reason, risky illicit consumption and safe, biomedical moderation.

For Grant, Nathan and Alex, life on PIEDs (steroids or human growth hormone) makes a great deal of sense, creating an enormous positive change in subjective experience of confidence, strength and power:

> *Your muscles look fuller, you look bigger. It's more of a … what's the best way to*

put it, you feel supernatural basically […] Like you can basically conquer the world. (Grant, age 25, male, NSW)

You know, you feel amazing, you feel confident, you feel like you can take on the world. You feel like nothing can hurt you, you know. (Nathan, age 26, male, Qld)

And just a phenomenal feeling in the body, like I just felt unstoppable, and I was training twice a day. I just felt really good because in general I suffer from pretty major anxiety and when I was on that stuff, I had no anxiety, no fear at all. (Alex, age 38, male, Qld)

These descriptions remind us of the ways in which intoxication, historically aligned with alcohol and with loss of consciousness, or at best compromised consciousness, may also be linked to heightened consciousness and awareness of changes in relations with the self. Here, intoxication, confidence and euphoria align with self-discipline, labour and self-improvement.

Elsewhere we have argued that PIED consumers indicate a strong desire to have informed, reasoned interactions with health professionals about their consumption and about ways of managing risks and avoiding ill-effects (Fraser, Fomiatti, Moore, Seear & Aitken, 2020). In these ways too, we can see the alignment of some kinds of intoxication, experienced in certain conditions and induced through particular practices, with their putative opposites: rationality, moderation, control and productivity.

Conclusion

Taken together, the two projects demonstrate that common assumptions about intoxication, how it happens, what it means and who is culpable, are thoroughly political. When conceived conventionally, intoxication sets up unhelpful binaries between reason and emotion, sense and irrationality, legitimacy and illegitimacy, chaos and order. As our analysis suggests, these distinctions do not hold up to scrutiny. Illicit drug consumers, possibly while still intoxicated themselves, can and do act decisively and save lives. The administration of naloxone can itself cause negative intoxication experiences, even in hospitals (Neale & Strang, 2015). In short, illicit drugs are as legible through notions of moderation as through notions of excess, and authorised drugs are as legible through excess as moderation. PIED consumers can feel angry or 'phenomenal', use legal and illegal drugs to do so, and incorporate labour, discipline, knowledge and care into their consumption. Contrary to widely held assumptions, drug consumers work hard to calibrate intoxication carefully. Responses that ignore or dismiss such work (perhaps because of lingering neo-liberal suspicions about intoxication) are likely to miss opportunities to support consumer health and wellbeing, or even actively impede them.

Recommendations

This report has summarised the key publications from a national ARC-funded project exploring the uptake of take-home naloxone undertaken between early 2017 and late 2019. The findings are drawn from interviews with 46 opioid consumers and 36 health professionals across the Australian states of New South Wales and Victoria. Interviews addressed perspectives on and experiences of opioid consumption and overdose, awareness of, and experience with, take-home naloxone, experience with, and opinions about, overdose response and take-home naloxone training, and preferred modes of take-home naloxone administration. Below we outline recommendations drawn from the findings of each publication as they relate to health services, overdose response training initiatives and broader relevant issues.

Recommendations for health services

1 Promote take-home naloxone both within and outside the alcohol and other drug health sector (Fomiatti et al., 2020)

Efforts to increase awareness of take-home naloxone should be expanded in specialist alcohol and other drug and primary healthcare settings. General practices and pharmacies are two settings that could especially benefit from increased uptake and promotion of take-home naloxone. Chronic pain specialists would also benefit from increased awareness of take-home naloxone. While the decision to offer naloxone to clients will remain the responsibility of health professionals, without increased awareness of the drug the potential relevance of it for each client may not emerge.

2 Expand support to implement take-home naloxone into health services (Fomiatti et al., 2020)

Support for improving knowledge about specific barriers to take-home naloxone initiatives in health services should be enhanced. Consultations with relevant health services are needed to develop insight into the specific implementation barriers for each setting. Once identified, health services

should be supported to implement or expand tailored take-home naloxone initiatives for their client base.

3 Review and revise emergency services naloxone dosing guidelines (Farrugia et al., 2019)

Emergency services should review their naloxone administration guidelines to ensure they are balancing the requirement for effective dosing while avoiding unnecessary distress.

Recommendations for overdose response training initiatives

4 Address training participants' care relations and broader social relationships (Farrugia et al., 2019)

In order to avoid individualising overdose, overdose response training should position overdose and take-home naloxone within care relationships and broader social ties. Key points to be covered could include the role of mastering take-home naloxone administration in protecting the broader community of people who consume drugs, the place of naloxone in caring for intimate partners and friends, and the availability of strategies to produce positive revival experiences.

5 Provide skills to negotiate emotional distress (Farrugia et al., 2020)

Overdose response training should include strategies that make negative interpersonal interactions less likely. Key points include the importance of appropriate dosing, and sensitive and reassuring communication strategies that may make revival less distressing.

Recommendations for naloxone regulation and access

6 Down-schedule naloxone further (Fomiatti et al., 2020)

Given its low risk profile, alternative medication scheduling regimes for naloxone should be explored. Community pharmacies are routinely identified as settings in which people who consume opioids encounter stigma (e.g. Paquette, Syvertsen &Pollini, 2018; Simmonds & Cooper, 2009). The need to speak with a pharmacist when accessing naloxone as a Schedule 3 drug compromises confidentiality and generates opportunities for discrimination, thereby acting as a barrier to access. However, any change to scheduling would need to consider the cost implications of the change ensuring that naloxone is available at minimal or no cost.

7 Expand cost-free access to take-home naloxone (Farrugia, Fraser & Dwyer, 2017)

While prescription naloxone can be considerably cheaper than over-the-counter naloxone, initiatives that make take-home naloxone available cost-free should be expanded. Cost-free naloxone should be made available in a wide range of settings such as alcohol and other drug-related health services, community pharmacies (especially those with significant pharmacotherapy and needle and syringe programs) and other community health settings, by expanding the federally-funded take-home naloxone pilot to all states and territories.

Recommendations for future overdose responses

8 Ensure future research does not reproduce unhelpful binaries (Fraser, Moore, Farrugia & Fomiatti, 2020)

Researchers must be cognisant of the ways research concepts can inadvertently reproduce limiting conceptual binaries. Future research approaches should be thoroughly interrogated to ensure they do not reproduce binaries of reason and emotion, sense and irrationality, legitimacy and illegitimacy, chaos and order that render people who consume drugs compromised subjects, and more generally can diminish the quality of analysis.

9 De-stigmatise overdose (Fraser, Farrugia & Dwyer, 2018)

Multipronged efforts to address the stigmatisation of people who consume alcohol and other drugs are urgently needed. Public campaigns and information resources such as the website this project produced (Overdoselifesavers.org) are one important strategy. The life-saving efforts of people who consume opioids could be used in other anti-stigma campaigns targeting health professionals and the broader community.

10 Address broader social, institutional and legislative contributors to overdose (Farrugia, Fraser & Dwyer, 2017)

While take-home naloxone is an important life-saving initiative, it should not become the sole focus of efforts to reduce overdose deaths. Opioid overdose is produced by the broader social, institutional and legislative environments in which opioids are consumed. While take-home naloxone saves lives at the moment of crisis, broader, more ambitious efforts are needed to reduce overdose events in the first place. Regulatory and legal conditions prohibiting access to, and safer usage of, all drugs – including opioids – need revision in that these are widely recognised as producing complex harms and stigma.

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