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UNDERSTANDING WOMEN'S PERSPECTIVES ON TAKE-HOME NALOXONE TO SUPPORT EQUITABLE OVERDOSE PREVENTION EFFORTS

LA TROBE UNIVERSITY

DruGS

Australian Research Centre in Sex, Health and Society

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There is a special synergy between Bunjil and the La Trobe logo of an eagle. The symbolism and significance for both La Trobe and for Aboriginal people challenges us all to 'gamagoen yarrbat' – to soar.

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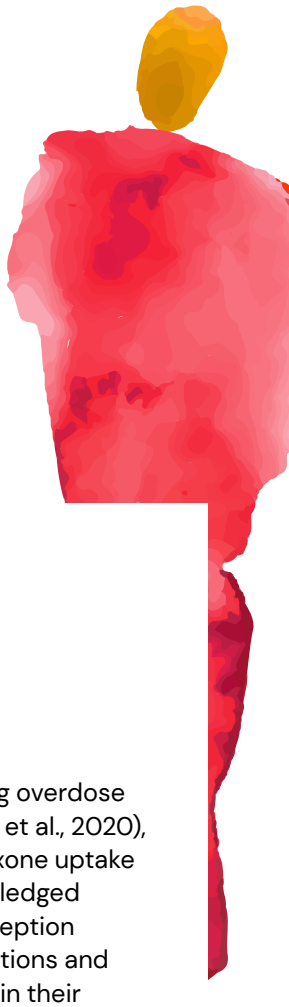


BACKGROUND AND AIMS

Since the late 1990s, Australia has experienced increasing number of opioid overdose hospital admissions and deaths (ABS, 2019). One response has been the implementation of take-home naloxone initiatives, which involve providing naloxone (a drug that reverses opioid overdose) products and training to those most likely to encounter overdose.

Despite its life-saving potential, the administration of naloxone can precipitate opioid withdrawal, an experience associated with a range of undesirable outcomes including nausea, body aches, shivering, confusion, irritability, anger, restlessness and headaches (Belz et al., 2006; Gaddis & Watson, 1992; Wermeling, 2015). Naloxone's potential for producing uncomfortable withdrawal symptoms has also been linked to distress, aggression and, occasionally, violence during revival from overdose (Bowles & Lankenau, 2019). Research suggests that concerns about withdrawal impact naloxone uptake (Bowles & Lankenau, 2019; Holloway et al., 2018; Worthington et al., 2006). While research on other overdose responses such as safe injecting facilities emphasises the need for gender sensitive approaches (Bardwell et al., 2021; Kolla et al., 2020) and other research suggests that women often feel obliged to take on caring roles during overdose events even when they felt unsafe (Kano et al., 2020), how gender may shape take-home naloxone uptake and use has only been fleetingly acknowledged (e.g. Ferguson et al., 2024). A notable exception examines how disproportionate expectations and burdens upon women to care for others in their social lives shapes their experiences with naloxone and overdose response (Austin et al., 2023). Similarly, research has documented women who inject drugs having to take on caretaker roles given men in their company are less concerned about the potential for overdose (Collins et al., 2022). Women in Hanson et al.'s (2020) study, for example, exercise greater caution about overdose than men, many of which relied on naloxone to reverse overdoses rather than aiming to prevent the overdose itself from occurring.

In order to bolster take-home naloxone uptake in ways that support the safety of women who consume opioids, this research examined the potential concerns about naloxone and overdose response that shape their engagement with the initiative. This broadsheet is based on research conducted as part of the project titled 'Investigating how gender shapes uptake and use of take-home naloxone: A qualitative pilot study'. Led by researchers at La Trobe University's school of Psychology and Public Health and the Australian Research Centre in Sex, Health and Society, this research aims to better understand barriers to take-home naloxone initiatives and how we can develop gender-sensitive overdose prevention.

METHOD

The findings presented in this broadsheet are drawn from an analysis of in-depth qualitative interviews conducted with 15 women[1] who were current consumers of opioids and had accessed take-home naloxone in the last 12 months. Participants were aged between 29-57 years old, with an average age of 43 years old. Most women identified as heterosexual (8) with the remainder identifying either as bisexual (5) lesbian (1) or asexual (1). Participants were recruited from harm reduction services such as needle and syringe programs and via snowball sampling. Interviews were semi-structured, lasted 28 to 60 minutes and explored participant perspectives of take-home naloxone and its effects; experiences of responding to, or witnessing, an overdose; and any concerns shaping the engagement with the initiative. Conducted in-person in private rooms at health services, cafés and libraries, the interviews were audio recorded, transcribed verbatim by a professional transcriber and then de-identified to protect the confidentially of the participants. All participants were reimbursed with a $50 Visa® card. Pseudonyms are used throughout this broadsheet when quoting participants.

1 While this pilot project only managed to interview cisgender women, these issues may also be relevant for trans people, non-binary people and other gender minorities. This is a potentially important area of study that requires further investigation (e.g. see Collins et al., 2022)

FINDINGS

This broadsheet explores women's concerns about and experiences of accessing, carrying and administering naloxone during overdose emergencies. In addition, it outlines participant suggestions to better support women to engage with overdose prevention efforts.

Accessing naloxone

The participants spoke of multiple barriers impacting their access to take-home naloxone. Nearly all argued that naloxone should be more widely available, preferably at services where it could be provided immediately and free of charge:

> *I got a prescription for [naloxone] from my doctor before, but I've still got the script. I've never cashed it 'cause of the price of it. (Kara, 50 yo)*

> *Anywhere where they give needles, I think they should definitely have naloxone […] I know you can go to the doctors and get a script, and then go to the chemist and get it and this and that […] But you want it quick if you want to use [drugs], and then it's not there and you have to go through all that hassle. (Lily, 37 yo)*

Participants such as Kara (50 yo), describe supply limitations impeding their access to take-home naloxone:

> *I've tried to ask many times at the chemist [and] even though there's a big sign on the methadone window saying, 'Ask here for the free naloxone', they've never had it.*

Opening hours of services and overdose prevention training times also impacted take-home naloxone access. Hariklia (38 yo), for example, became of aware of the availability of take-home naloxone a few years ago at her local alcohol and other drug service, but as she worked during the day, she was unable to attend training times. She explains:

> *I wanted [naloxone], because I think it's important to have, but you had to [do] some sit-down training, so it seemed like a bit of an effort to get it [and] so I never got around to being there at the right time.*

For others, like Lily (37 yo), acquiring take-home naloxone at the chemist was not preferable. Reflecting issues examined in other research, Lily expresses concern about her privacy and potentially encountering stigma and judgment from the pharmacist (Olsen et al., 2019; Paquette et al., 2018):

> *They wanted me to go to my same chemist as [where I get my methadone] and I kind of don't want that […] he will obviously know that I'm still using when [I ask for naloxone] and you try to keep that secret from your doctors and stuff.*

The accounts in this section suggest that take-home naloxone provision will be enhanced if it is consistently available in a range of services and free of charge. Importantly, provision of take-home naloxone must also account for practical issues such as afterhours availability and complex issues such as the impact of concerns about privacy and stigma in some settings such as chemists.

Carrying naloxone

Nearly all women in this research regularly carried naloxone, especially if they knew they were going to consume opioids with others. Many of those who carried naloxone also shared information about it with friends and other people who consumed drugs. For example, Belinda (57 yo) explains:

> *I've always got some in my bag. I've actually got one with a set of vials, one with a Prenoxad and one with the Nyxoid, just in case. There's two in one bag and one at home just in case, because I might encounter*

somebody who feels like they need some and I can just give one of those away to someone and replace it.

Participants in heterosexual relationships commonly discussed taking responsibility for carrying naloxone when consuming opioids with their intimate partners, indicating that gender, in this case masculinities, also shapes uptake in significant ways (Ferguson et al., 2024). Lauren (37 yo) and Belinda (57 yo), for example, discuss this dynamic in their relationships:

I don't feel like I can go out into society without having it on me in case he [my partner] does overdose [...] The only time I really feel comfortable without having it, is if he's in jail. (Lauren)

I know a lot of blokes that do carry naloxone, but in my relationship I'm the one with the naloxone in my bag, not him. His reaction would be, 'Oh, keep that shit away from me'. (Belinda)

Drawing on her experience as a peer worker distributing take-home naloxone, Margaret (58 yo) makes a connection between feelings of responsibility and gender. During street outreach, Margaret (58 yo) explains that women are more likely to be interested in take-home naloxone:

Maybe it's a motherly thing, or the caretaker role in a group, or something like that. When I see couples on the street, if I'm doing one-on-one [naloxone training] it's usually the female that will take it and put it in her bag. She's got a handbag, he hasn't, I don't know.

These data demonstrate a commitment to carrying naloxone in order to care for other people who consume opioids (Farrugia et al., 2019). Further, they suggest that gender can shape how and who takes on the responsibility to prepare for the possibility of overdose with women potentially required to take on a caring role with their partners and within the community more generally (Collins et al. 2022).

Administering naloxone

All women we interview expressed a strong commitment to attending to overdoses and, overall, state that administering naloxone was something that they would do if required. Mia (53 yo), for example, describes it as 'just something that you do' because she 'couldn't just sit back and not do anything' if she was present at an overdose. For many, this sense of duty was motivated by the loss of loved ones to overdose. Diana (50 yo) explains:

I've had friends left in stairwells, in various different places, or dumped in front of hospitals when they're already dead, stuff like that [...] It should be our duty to keep our friends and our loved ones alive.

While most women were aware of the potential for conflict following naloxone administration (Farrugia et al., 2020; Ferguson et al., 2024), they suggested that negative reactions like aggression from those who are revived were uncommon. Belinda (57 yo) suggests that very few people are aggressive:

I haven't experienced it, and I think it's an exception rather than a rule. I think only a really small percentage of people wake up aggressively or have an aggressive reaction.

I KNOW A LOT OF BLOKES THAT DO CARRY NALOXONE, BUT IN MY RELATIONSHIP I'M THE ONE WITH THE NALOXONE IN MY BAG, NOT HIM.
(BELINDA)

Importantly, while the women in this project were committed to using take-home naloxone to save lives, a third had some experience of managing an aggressive reaction after administering naloxone. For example, Melissa (39 yo) recalls a man reacting violently:

> *They were trying to punch me because they just woke up all confused and delusional.*

Similarly, Mia (53 yo) said people she revived often regained consciousness and were 'really pissed off.' She recalls the reaction of one woman in particular:

> *When she came around [regained consciousness], she started going off her head [acting aggressively] thinking everyone had stolen stuff off her, and stuff like that, and fucked up her buzz [high].*

Despite such reactions, the women in this research spoke of deescalating these situations and employed efforts to ensure the person revived did not risk another overdose by consuming more opioids (Farrugia et al., 2020; Ferguson et al., 2024). Furthermore, these types of reactions did not deter them from using naloxone, with participants such as Margaret (58 yo) explaining that they would continue to access take-home naloxone regardless of the potential risks:

> *At the end of the day, I'd rather cop a punch in the head than a dead friend.*

These data demonstrate a commitment to accessing and carrying take-home naloxone to save lives. However, as has been explored in other research, the reputation for conflict to occur during revival from overdose shapes uptake and use of take-home naloxone (Ferguson et al., 2024). Despite experiences of conflict, the women in this research articulated the use of naloxone as a duty.

The potential burden of responsibility

While the women in this research described using take-home naloxone as a duty, many also spoke of feeling exhausted by the burden of taking on caring roles such as administering naloxone and tending to people who have overdosed. Lauren (37 yo), who has administered her partner with naloxone around 18 times, for example, explains that tending to his overdoses is very upsetting. Furthermore, the obligation diminishes the pleasure of her own drug consumption. She says, 'I can't enjoy what I've had'.

Speaking about the challenges of being responsible for responding to overdoses while managing other family commitments, Diana (50 yo) speaks of her friend who 'constantly overdoses' because, according to her, he 'drinks too much alcohol' and 'takes too many other drugs'. She recalls a particular instance:

> *It was in the morning, and I'm trying to get my son ready for school, and [our friend] overdosed. I had to wake up my partner and get him to take my son away. I was pissed off with him, but I still breathed for him. I naloxoned him, he came around. I monitored him. I didn't call an ambulance but I was pretty sure that he was gonna be okay, I monitored him [...and] he was at our place for another three, four hours.*

Likewise, Mia (53 yo) described herself as the 'go-to person for all that stuff [responding to overdose with naloxone]', however, she explains that she wants other people to take on this responsibility too:

> *[I ask myself] 'Oh, why can't you'se do it [learn to administer naloxone]?' kind of thing. But still you've got to do what you've got to do, I guess. I'm not gonna leave someone to die.*

Similarly, Margaret (58 yo) explained that while it 'makes [her] feel angry' that other people do not know how to use naloxone, she feels a sense of pride from her role as lifesaver:

> *I guess at the end of the day, it makes me feel good because my social group looks up to me and feels okay knowing that they can do stuff when I'm around 'cause I'll make sure that they're still here at the end of the day.*

While the women who participated in this research readily take up the call to save lives with take-home naloxone, the accounts discussed in this section suggest that this responsibility can become burdensome. Gendered understandings of responsibility and care may be an important force in the inequitable distributions of responsibility for attending to potentially distressing overdose events.

Ideas to better support women in overdose prevention efforts

Participants offered insights on how take-home naloxone initiatives could be strengthened to better address their needs.

Improving training and emotional support

Participants suggested that training on how to safely administer naloxone could be improved. For example, Hariklia (38 yo) was first offered naloxone at the chemist whilst picking up her methadone but did not receive any training. She argues that instructions could be more informative:

> *Maybe even something like a little pamphlet, even an information pack, just to say the dos and don'ts or a little bit of information.*

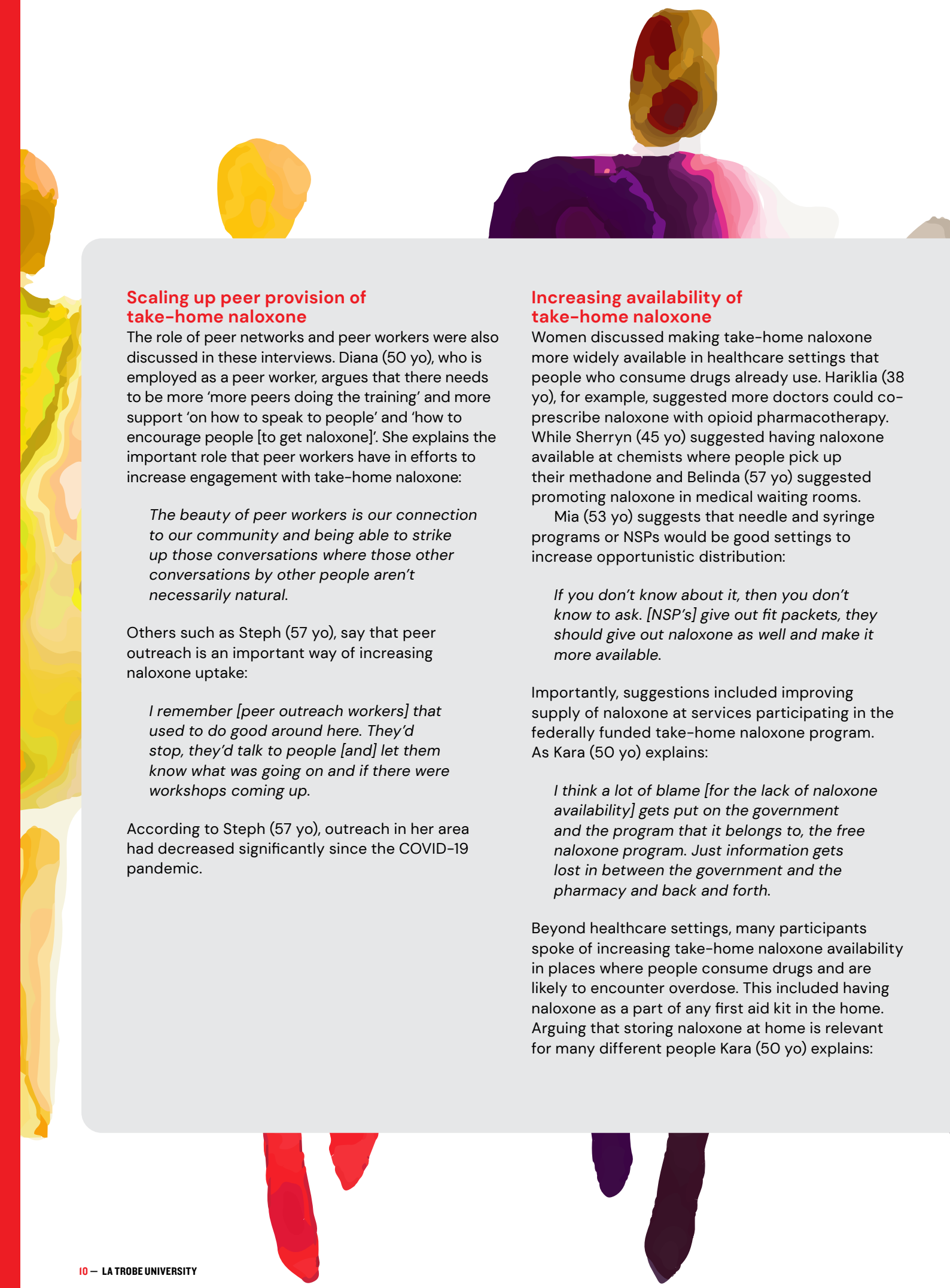
Similarly, Melissa (39 yo), who encountered multiple aggressive reactions reviving people with naloxone suggested that training could include more information on how to manage conflict or withdrawal including de-escalation techniques (see also, Ferguson et al., 2024).

Lauren (37 yo) suggests training could include strategies on how to manage the emotional toll of savings someone's life:

> *[Someone] could actually explain the feelings that [...you might] feel while saving someone's life compared to a nurse. A nurse and a doctor, they're trained to do that, and that's what they wanna do with their life where [... we aren't] really trained to save someone's life.*

Also speaking about emotions relating to take-home naloxone use, Melissa (39 yo) explained that an opportunity to debrief or receive counselling following reversing an overdose would be helpful in processing stressful experiences and sustaining overdose prevention efforts in the long run.

Overall, the accounts in this section suggest that take-home naloxone distribution efforts need to consistently include sufficient technical information about how to administer naloxone and could be improved by incorporating emotional support.



Scaling up peer provision of take-home naloxone

The role of peer networks and peer workers were also discussed in these interviews. Diana (50 yo), who is employed as a peer worker, argues that there needs to be more 'more peers doing the training' and more support 'on how to speak to people' and 'how to encourage people [to get naloxone]'. She explains the important role that peer workers have in efforts to increase engagement with take-home naloxone:

> *The beauty of peer workers is our connection to our community and being able to strike up those conversations where those other conversations by other people aren't necessarily natural.*

Others such as Steph (57 yo), say that peer outreach is an important way of increasing naloxone uptake:

> *I remember [peer outreach workers] that used to do good around here. They'd stop, they'd talk to people [and] let them know what was going on and if there were workshops coming up.*

According to Steph (57 yo), outreach in her area had decreased significantly since the COVID-19 pandemic.

Increasing availability of take-home naloxone

Women discussed making take-home naloxone more widely available in healthcare settings that people who consume drugs already use. Hariklia (38 yo), for example, suggested more doctors could co-prescribe naloxone with opioid pharmacotherapy. While Sherryn (45 yo) suggested having naloxone available at chemists where people pick up their methadone and Belinda (57 yo) suggested promoting naloxone in medical waiting rooms.

Mia (53 yo) suggests that needle and syringe programs or NSPs would be good settings to increase opportunistic distribution:

> *If you don't know about it, then you don't know to ask. [NSP's] give out fit packets, they should give out naloxone as well and make it more available.*

Importantly, suggestions included improving supply of naloxone at services participating in the federally funded take-home naloxone program. As Kara (50 yo) explains:

> *I think a lot of blame [for the lack of naloxone availability] gets put on the government and the program that it belongs to, the free naloxone program. Just information gets lost in between the government and the pharmacy and back and forth.*

Beyond healthcare settings, many participants spoke of increasing take-home naloxone availability in places where people consume drugs and are likely to encounter overdose. This included having naloxone as a part of any first aid kit in the home. Arguing that storing naloxone at home is relevant for many different people Kara (50 yo) explains:

It's the sort of thing you wanna have in a house, like an EpiPen because you can use it on kids, you can use it on your grandmother that's taking too much codeine or something, or morphine, or a cancer patient or somebody that's taking big painkillers and stuff.

Participants also proposed having naloxone available in public settings in much the same way that other emergency technologies such as defibrillators are available. Suggestions included having naloxone at train stations, bus stops, public toilets, public seating areas, libraries, drop-in centres or over the counter at supermarkets. The most common suggestion from participants was having naloxone available via vending machines. As Mia (53 yo) explains:

Just say in the middle of the night someone needed it, they have the syringe vending machines and you can pick what fits you want, so there should be a section [in the vending machine] to get naloxone just in case.

Alongside public awareness campaigns, some of the participants also supported increasing the size and scope of take-home naloxone initiatives targeting public housing or prisons.

For many of the participants in this research, increasing the availability of take-home naloxone was seen as urgent. Diversifying which services make take-home naloxone available, while also addressing issues related to privacy and stigma (see section Accessing naloxone), alongside targeted programs for specific populations, were all described as potentially important strategies to support uptake.

Broadening responsibility for attending to overdose

The women who participated in this research suggested broadening the responsibility of tending to overdose beyond people who consume drugs. For example, Kara (50 yo) argues, 'It's not just us [...] that fucking need to carry these things around'. She adds it would help if:

Just everybody [was] being responsible for each other. More so than a couple of people looking after everybody, but [instead] everybody looking after everybody kind of deal, including fucking strangers in the street.

In relation to the burden of care that women often experience, Belinda (57 yo), a peer worker, suggests increasing efforts to include more men in overdose prevention efforts:

Just include men. So, whenever we're doing community events, whether it's barbecues [...] I just think try and bring men into the fold, because I think it easy feeling isolated and not feel like you're part of anything. And once someone recognises that they do belong to a group, hopefully that means they want to be a part of that and wanna do activities related to that group.

The accounts in this section address a desire to broaden the purview of take-home naloxone programs. Pointing to an inequitable focus on people, especially women, who consume opioids for addressing overdose in the community, the participants in this research speak of the need to enrol other groups into overdose prevention efforts.

Gender inclusive services

Many participants argued that it was important to consider gender when designing harm reduction initiatives. Diana (50 yo) explained, for example, that if you want to engage women in overdose prevention efforts then 'making sure there's women peer workers in naloxone training and provision programs is really important'. She also suggested that consideration must be paid to training sessions times, so they did not exclude women with caring responsibilities: 'if you've got kids, you need to factor those things in'.

Similarly, Steph (57 yo) suggests that gender specific workshops could be useful to bolster attendance:

> *I was thinking [take-home naloxone] workshops are mixed [gender] workshops. Maybe some women don't feel comfortable going to mixed workshops. So maybe if they had like a women's only and then a male one.*

Diana (50 yo) also spoke to this issue:

> *I would love to see a female-specific harm reduction service [where only] female and non-binary [people], were allowed. And I just think it so makes sense, especially some women in our community have had really fucking horrible early lives [...] If there are spaces that are safe for women and [non-binary people] where they don't have to put up with the bullshit and inequity that goes on sometimes with drug use. I think that that'd be really important as well.*

Like Diana (50 yo), other participants argued that healthcare and harm reduction services could become more inclusive to diverse range of genders. For example, Liz (37 yo) proposed that services could make 'spaces more culturally safe for trans women and non-binary folks'. She added 'I think it's not something that heaps of services necessarily put a lot of effort into.' She suggests services could be improved by:

> *Making [... sure to employ diverse groups of] people and supporting them properly. The way we talk about peer workers in other org[anisations], we should be doing the same kind of thing for other identities as well.*

Belinda (57 yo) also reflects on how to make men more engaged at harm reduction services:

> *I think men feel unsafe just as women do, emotionally, I think, possibly even more than women do in community spaces because we frequent them [more than men do]. We're okay, we feel comfortable here [...] We need to work out ways to make men feel comfortable in these spaces, so that they want to be here.*

The women in this research offered several ideas for ensuring that take-home naloxone initiatives effectively attend to their needs. Some argued for gender-specific sessions and ensuring session times allow for participation from people with parenting responsibilities. Overall, they argued that take-home naloxone training and the services that often offer it could be improved by a great awareness of gender dynamics.

SUMMARY

Participants in this study demonstrated a commitment to accessing, carrying and administering naloxone to ensure they could adequately care for those around them who consume opioids. Despite experiences of conflict, the women in this research articulated the use of take-home naloxone as a duty. They indicated that this sense of duty was likely shaped by gendered understandings of responsibility, in particular the notion that women are inequitably called upon to take on caring roles within their relationships and within the community more generally. Importantly, participants indicate that tending to overdose could become burdensome and offered a range of suggestions on how to better support women and attend to gender more generally in order to enhance engagement with overdose prevention efforts. Several of the suggestions from the women in this research have the potential to enhance take-home naloxone engagement for men and other genders too. Practical issues such as increasing access and availability of take-home naloxone at a diversity services and locations, ensuring training session times are flexible and accommodate care and work commitments and increasing the role of peer workers in naloxone promotion, provision and training are all widely applicable issues. Additionally, many of the participants were strong advocates for making the initiative more attentive to the needs of a diverse range of genders, including and also beyond women. Overall, our research demonstrates that while concerns about and barriers to accessing and using take-home naloxone to save lives can be shaped by gender, women who consume opioids are often committed to caring for those around them and their community more generally. With many women already accessing take-home naloxone as form of duty, it is essential that efforts to expand and support naloxone uptake also strive to equitably distribute the responsibility for attending to potentially distressing overdose events and saving lives.

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