Nurses Supporting Harm Reduction: How Take-Home Naloxone is Conceived in the Context of Neoliberalism

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Abstract

Individuals must be personally invested in their own recovery journey; however, the neoliberal perspective absolves the state of responsibility of this work and makes promotion of health merely an individual action. Naloxone distribution, as a harm reduction strategy, is presented herein as one practice engaged by nurses that demonstrates philosophical tension between neoliberalism and harm reduction. The research literature supporting the provision of take-home naloxone (THN), non-medically administered, is significant and broad. The problem with neoliberal discourses of constrained healthcare resources in this case is that without broad availability of naloxone, drug poisonings will continue unchecked. There is an ethical call to nurses to support broad distribution of naloxone regardless of the costs involved. THN is not only a best practice to reduce the harms of substance use, but it is also a political and philosophical act to hand over the control of public health resources to the public.

Keywords: neoliberalism, take-home-naloxone, nursing, harm reduction, discourse

Harm reduction is an evidenced-based practice, a paradigm, a social movement, and a non-judgemental approach to substance use. As harm reduction has garnered attention from various disciplines and scholars working definitions continue to evolve (Elliott, 2014; Harm Reduction International [HRI], 2022). However, encompassing several principles and strategies, the main goal of this movement is to reduce harm (biological, social, economic) associated with substance use without forcing cessation or reduction of consumption (HRI, 2022). Harm reduction first emerged as a social movement in the Netherlands as a result of increasing HIV infection among people who use substances (PWUSs), which pushed them to take action to minimize the consequences of use in the 1960s; broader international recognition of this movement did not occur as a public health approach until 1973 (Ball, 2007, p. 685). With the rapid spread of HIV/AIDS among PWUSs, especially those who use heroin and (base) cocaine in 1980s, harm reduction gained momentum (van der Gouwe et al., 2022;

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O'Hare, 2007). Beginning as low-threshold facilities, such as living rooms, harm reduction has evolved to encompass initiatives such as needle exchanges and methadone programs (van der Gouwe et al., 2022). As the popularity of substances like ecstasy increased, along with the rise of dance culture, harm reduction efforts expanded to include drug testing at festivals (van der Gouwe et al., 2022). Similarly, the UK grappled with a heroin surge, notably in Liverpool (O'Hare, 2007). Traditional detox treatments proved ineffective, prompting a shift to providing clean equipment, methadone prescriptions, and outreach (O'Hare, 2007). By the mid-1980s in New York City, half of injection drug users were HIV positive, leading to strong advocacy for harm reduction (Deren & Hagan, 2011). Concurrently, the 1980s also witnessed overdose crises, notably with the rise of crack cocaine (Fagan & Chin, 1991). This era marked a significant shift in drug policy and public perception, with increasing criminalization of drug use and the portrayal of drug users as deviant (Deren & Hagan, 2011; Selwyn, 1993).

In Canada, harm reduction, named as such, was introduced in the 1980s to prevent drug poisoning deaths and reduce HIV transmission among PWUSs (Elliott, 2014) as a social movement and a radical direct action by those directly affected by the consequences of drug use. The epicenter of the movement was the Downtown Eastside of Vancouver where there has been an overdose crisis and outbreaks of blood-borne diseases due to ineffective health and social policies (Wood et al., 2003; Smith, 2003). In response to this situation a group called the Vancouver Area Network of Drug Users (VANDU) emerged (Jozaghi, 2014). By supporting harm reduction initiatives and fostering collaborations between researchers and PWUSs, their actions have played a role in reducing the spread of blood borne infections and preventing overdose deaths (Jozaghi et al., 2018). Even though many of VANDU's members come from marginalized backgrounds, facing issues like poverty, social exclusion, homelessness, substance use disorders, and mental health challenges, they have been at the forefront of advocating for better health and

social outcomes for their community and have influenced the health policies pertinent to PWUS (Miller et al., 2002; Spittal et al., 2002; Wood & Kerr, 2006; Jozaghi et al., 2018). The history of harm reduction emphasizes its connection with the real-life experiences of PWUSs, which should be acknowledged when discussing its evolution and significance (Jozaghi et al., 2018). Distributing naloxone (for opioid poisonings), providing clean and free equipment, safe injection sites, drug checking services, and safer supply are all illustrations of harm reduction practices that focus on the dignity of the human being (Boyd et al., 2016). In this discussion article, we investigate naloxone distribution within the current context of neoliberalism in Canada in particular.

Harm reduction as a philosophy includes respect for human rights, and proponents note substance use as a public health issue rather than a criminal, biological, or moral problem (Boyd et al., 2016). Nevertheless, harm reduction has been a contentious issue for several reasons, and herein we investigate particularly its ties with neoliberalism. Neoliberalism is a form of liberalism which is premised on the tenets of free market capitalism such as "individual choice, competitiveness, consumerism, economic liberalization, efficiency, privatization, and profit maximization" (Viens, 2019, p. 148) as well as limited state intervention (Larner, 2000). Larner (2000) notes that while neoliberalism can be interpreted as "less government", it does not mean "less governance" (p. 12). Neoliberalism prioritizes individual agency, such as seeing health care users as consumers, i.e., clients, which can have the detrimental effect of reducing collective rights to public services (Sills, 2017). According to Elliott (2014), the impact of neoliberalism on the conceptualization of substance use originates from discussions around "regulation, apparatuses of government, and the management of citizens who are politically and economically marginal to the state" (p. 10). While there is no singular moment at which neoliberalism begins, generally in social critique of high-income nations, the right-ward shift seen in the 1980s under the governments of Thatcher, Reagan, and Mulroney is the key policy era. This is

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interesting in the Canadian context where you have harm reduction as a philosophy that recognizes the complex context of substance use arising simultaneously as self-responsibility narratives take hold across political realms (Gill, 2021). Since the 1980s, then, the hegemony of neoliberal ideology has been pervasive in the delivery and structuring of healthcare with a slow and subtle shift towards privatization in Canada and placing more of the burden of blame in the hands of the individual by emphasizing self-care (Elliott, 2014; Souleymanov & Allman, 2016; Gill, 2021; Crawford, 2021).

Neoliberal hegemony accentuates individualization and responsibilization (Souleymanov & Allman, 2016; Crawford, 2021). In the neoliberal perspective, PWUSs are also constructed as "rational decision-makers" who have a duty to improve their quality of life by measuring and avoiding risks through the provision of adequate knowledge and equipment (Moore & Fraser, 2006; Souleymanov & Allman, 2016; Sills, 2017). In this sense, harm reduction can be co-opted as a form of self-regulation as it imposes an idea of being a rational citizen who can act independent of public services. In this case, being "a responsible drug user" is encouraged through harm reduction (Souleymanov & Allman, 2016; Elliott, 2014; Sills 2017; p. 39). This perspective, which is rooted in moralistic stances, often fails to consider the underlying structural and societal factors contributing to drug use. The criminalization of drug use further perpetuated the stigmatization and marginalization of drug users thereby reinforcing the perception of drug use as deviant behavior (Motavalli et al., 2021). It is important to recognize that harm reduction at its core emerged as a response to these challenges by advocating for the rights and well-being of individuals who use drugs in the face of political and health difficulties (Selwyn, 1993). Through the exploration herein we hope to unpack how neoliberal perspectives can reduce services available to substance users even in the face of harm reduction, using take home naloxone as an example of a harm reduction practice that counters the constraints on public services advocated within neoliberalism.

Significance

The relationship between neoliberalism and discourses around drug use has been well explicated in literature to date (Gordon, 2006; Baker et al., 2020; Elliott, 2014; Souleymanov & Allman, 2016). Since substance use is culturally constructed in North America as a deviant action, it is assumed within the neoliberal lens that maintaining a healthy lifestyle and using drugs deemed illicit are not compatible (Souleymanov & Allman, 2016). Thus, individuals engaging in substance use are deemed to disrupt social norms until they make perceived rational decisions to "heal" themselves (Elliott, 2014). While it is known that individuals must be personally invested in their own recovery journey if they wish to reduce harms, the neoliberal perspective absolves the state of responsibility of this work and makes promotion of health an individual action by placing an undue burden on individuals. In the context of neoliberalism, drug use is often viewed as an individual choice, emphasizing personal responsibility. In this way we can understand why broader acceptance of harm reduction has not necessarily equated to a reduction in blaming individuals for their substance use related health challenges. The human rights dimensions of public health responses, especially during crises like the COVID-19 pandemic, further highlight the obligations of governments to protect their citizens, especially the most vulnerable populations. The state has a responsibility that goes beyond implementing policies. It also includes the duty to protect the rights and overall welfare of all individuals, including those who use drugs. With nurses often on the frontlines of supporting individuals through substance use journeys, these contested philosophical perspectives can be felt in the challenges nurses face to their practices, and in the ways nurses themselves conceptualize care. In particular, nurses and other health providers often become the unintended champions of neoliberalism, those assigned to constrain the use of public resources, the gatekeepers of the public purse.

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Harm Reduction Nursing

Today's healthcare, influenced by neoliberal views, stresses individual responsibility. Even though harm reduction principles, such as autonomy, align with the ethical values of nursing (Canadian Nurses Association, [CNA], 2018), this can shape how nurses see and treat PWUSs, potentially viewing addiction more as personal failure than a societal issue. Such views might hinder the adoption of harm reduction strategies, which view addiction within a broader socio-economic context. Hardill's (2019) study is a good illustration of how these neoliberal ideologies impact nursing care. The study shows that these influences have fostered an environment of stigma, discrimination, and inappropriate care for individuals using illicit opioids. Neoliberalism, emphasizing individual responsibility, combined with the punitive War on Drugs, has led to reluctance among nurses to provide compassionate care (Hardill, 2019). This reluctance is further exacerbated by societal biases that criminalize drug use (Hardill, 2019). The research highlights the need for a shift in nursing practice and suggests for policy changes like decriminalization, to prioritize patient well-being over prevailing political ideologies (Hardill, 2019). Similarly, Pauly et al. (2015) emphasize the need for a more culturally sensitive approach, recognizing the broader context of substance use and stressing the importance of cultural sensitivity in the context of nursing care for PWUSs. The study sheds light on the often-divergent perceptions between nurses and patients regarding illicit substance use within hospital environments (Pauly et al., 2015). By emphasizing the need for a culturally safe approach, Pauly et al. (2015) challenge the prevailing healthcare paradigms that might inadvertently marginalize or stigmatize PWUSs. Their findings suggest that fostering a deeper understanding and respect for the socio-cultural contexts of substance use can lead to more compassionate and effective care (Pauly et al., 2015). This perspective aligns with the broader call for harm reduction strategies that prioritize patient dignity and agency over punitive or judgmental approaches (Pauly et al., 2015).

There is far from ubiquitous acceptance of harm reduction within the profession.

Harm reduction services, such as supervised drug consumption sites (SCSs), are liberatory spaces for PWUSs, with staffing primarily comprising harm reduction workers and peers. While nurses and clinicians play a role, it is essential to recognize that they are not always the central figures in these environments. The literature emphasizes the importance of involving PWUSs and peer workers in the operation of SCSs (Taylor et al., 2019; Yoon et al., 2022; Ali et al., 2023). For example, in a qualitative systematic review, Yoon et al. (2022) note that the active engagement of PWUSs and those with lived experience significantly bolstered the implementation and sustainability of SCSs. Similarly, a study on Portugal's first mobile drug consumption room in Lisbon highlights the importance of a participatory and peer-led approach in shaping interventions (Taylor et al., 2019). Furthermore, Ali et al. (2023) note the necessity of integrating the insights and experiences of PWUSs in the development and operation of supervised drug consumption sites. Collectively, these studies accentuate the integral role of PWUSs and peer workers in the successful functioning of supervised drug consumption sites.

As social and political actors, nurses play an important role to respond to perceptions regarding substance use and harm reduction. Depending on how nurses themselves provide and perceive care, they can either contest or reify neoliberal discourses. Naloxone distribution is presented herein as one practice engaged in by nurses that demonstrates this philosophical tension. In particular, naloxone distribution counters the constraints on public services advocated within neoliberalism by handing resources over to the general public, beyond the direct management of health providers. In a way, this is an act in defiance of nurses' traditional function as limiting the use of public healthcare resources.

Naloxone Distribution

Naloxone is an opioid antagonist that can reverse the respiratory effects of opioids if

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administrated properly and in time (Weisser & Parkinson, 2008; Kim et al., 2019). The research literature supporting the provision of take-home naloxone (THN), non-medically administered, as a harm reduction strategy is significant and broad. Beyond its pharmacological action, the distribution and accessibility of naloxone have been pivotal in its effectiveness as a harm reduction tool (Weisser & Parkinson, 2008; Razaghizad et al., 2021)

Historically, the harm reduction community of PWUSs has been at the forefront of naloxone distribution, long before its widespread acceptance in clinical environments and among the general public (Strang et al., 1999). In British Columbia, for instance, the THN program was implemented as early as 2012, aiming to reduce opioid overdose deaths by providing naloxone kits and overdose recognition and response training (Moustaqim-Barrette et al., 2020). This grassroots distribution by individuals who were prescribed naloxone and subsequently distributed it to others in the community, even before it was legally sanctioned, is a testament to the community's resilience and commitment to harm reduction (Moustaqim-Barrette et al., 2020).

In Canada, naloxone was removed from the prescription drug list in 2016, allowing for broad distribution. This has led to much broader community distribution, attributed now to the reversal of thousands of drug poisonings (Canadian Community Epidemiology Network on Drug Use, 2016; Government of Canada, 2022). Generally, the concept behind naloxone distribution is to make it readily available throughout the community given the immediacy of administration required to successfully reverse a drug poisoning. This allows members of the general public or peers within the substance use community to support an individual's cardiorespiratory system in advance of support from emergency medical services (EMS). An example of the breadth of this distribution is seen in harm reduction advocates distributing naloxone kits freely to the general public throughout various summer festivals and concerts in large and mid-sized cities across Canada.

Effectiveness and Peer Administration

Broad reviews of naloxone have found it to be effective for reversing drug poisonings in communities. For example, a systematic review by McDonald & Strang (2016), who analysed the data of 22 studies from different countries including Canada, concluded that THN programs were effective, increasing the survival rates among program participants and decreasing opioid poisoning mortality rates in the community. Another benefit of THN is cost-effectiveness, which was demonstrated in a report published by the World Health Organization (2014) from different geographical settings such as Russia and Canada (Coffin & Sullivan, 2013; Leece et al., 2013). These studies found that naloxone distribution reduced overdose deaths significantly and saved lives cost effectively compared to emergency room care.

Regarding effectiveness, availability of naloxone products in different forms, such as auto-injector and nasal spray that can provide therapeutic doses in a single step, are ideal for lay responders (Strang, 2022). To better understand the uptake of new forms of naloxone, McDonald et al. (2022) conducted a cross-sectional study in five European countries (Denmark, England, Estonia, Norway, and Scotland) with PWUSs, family, and staff who work in addiction treatment, harm reduction, and recovery services. According to results of this study, while the concentrated naloxone nasal spray was usually preferred by family members and staff, syringes were also used, particularly among PWUSs. It is estimated that peer naloxone distribution in Canada saves an estimated one life out of 17 (Leece et al., 2013). Therefore, peer administration of naloxone has become a common practice in Canada, the UK, and the USA given the extensive research verifying its effectiveness, feasibility, and efficacy beyond emergency departments or EMS (Leece et al., 2013; Walley et al., 2013; Clark et al., 2014; Nielsen & Van Hout, 2016). It has been clearly demonstrated that peers of PWUSs are willing to intervene in poisoning situations and administer naloxone (Neale et al., 2019) as

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well as receive training to administer properly (Green et al., 2015). The studies presented thus far provide evidence that the provision of take-home naloxone effectively saves lives.

Medical Providers' Perspectives

Several studies have explored the discourses presented by healthcare/medical professionals about THN (Faulkner-Gurstein, 2017; Lacroix et al., 2018; Holland et al., 2019). In an ethnographic study of THN programs in New York (Faulkner-Gurstein, 2017), physicians explain their concerns about legal responsibility and accountability of the person who applies naloxone, such as lack of education, risky application, and neglecting calling emergency services. Herein you can feel the discomfort of health providers in releasing control of medication distribution and administration to members of the general public. The emphasis on education-before-naloxone has been the dominant discourse in the literature, such as in a study by Lacroix et al. (2018), who evaluated the views of 459 Canadian emergency physicians, and in a study by Holland et al. (2019), who analyzed the perspective of emergency department physicians and pharmacists. Interestingly, participants in the Holland et al. (2019) study expressed their concerns around encouraging risky drug use. These studies indicate significant skepticism of turning over control of drug administration to the general public and a concern that having survival methods in place might be a form of encouragement of opioid use. Health professionals noted that administering THN without education carries several risks for recipients, such as "nerve damage"; and for administrators, it carries the risk of possible contact with body fluids of the patient, as well as violence related to individuals who "wake up swinging" (Faulkner-Gurstein, 2017, p. 25). These studies show an undercurrent of skepticism towards harm reduction approaches that shift control from providers to the public and peers and a preference for administration being perfect over pragmatic. While less explicit quotes are available concerning the costs of such broad distribution, we conjecture that some of the discomfort is related to nurses, physicians, and pharmacists shifting from their usual role of limiting service access.

Take Home Naloxone and Neoliberalism

Prior to the work of Faulkner-Gurstein (2017), THN's situation in neoliberal health policy has not been notably considered. Associating naloxone administration that serves a "public health strategy" with neoliberal ideology (p. 25), Faulkner-Gurstein (2017) proposes that while peers become health providers in this scenario, undeniably, responsibility lies upon their shoulders. We would push this analysis further in noting that the shift in responsibility includes a shift in control of healthcare resources from health care professionals to the general public. The distribution is unconstrained, directly confronting the neoliberal perspective of a reduced public sector in favour of an increased private sector and personal responsibility. Faulkner-Gurstein (2017) notes that this practice modifies the relationships between stakeholders such as healthcare workers, law enforcement, and policymakers, because it makes substance users, their allies, and community members the arbitrators of healthcare services (p. 26). The free distribution of THN is beyond the reach of the state for monitoring purposes. Nurses can find this situation uncomfortable and continue in their role of constraining resources, warning of the risks, or can embrace harm reduction as resistance to neoliberalism, advocating for free and broad availability of THN.

Intersectionality, Prohibition, and Harm

Intersectionality provides a crucial perspective for understanding the complex harms of drug prohibition, the stigma associated with PWUSs and broader harm reduction strategies, including THN (Crenshaw, 1989). Historically, drug prohibition has disproportionately affected racial and ethnic minorities, exacerbating social, economic, and health disparities (Johnstone et al., 2022). This is further evident in the racial and social framing of substances like crack cocaine in countries

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such as the United States and France (Goulian et al., 2022).

The societal stigma against PWUSs is deeply entrenched, leading to their criminalization and pushing them further into societal margins (Myers et al., 2022). However, an intersectional perspective highlights that these stigmatized behaviors are not just outcomes of drug use (Ahern et al., 2007). They also mirror systemic oppressions like poverty, racial discrimination, and limited healthcare access (Smye et al., 2011). The term "waking up swinging" can be contextualized as a reflection of the trauma and systemic violence many PWUSs experience, leading to heightened alertness and defensiveness.

Criminalization, instead of addressing these foundational issues, only reinforces cycles of disadvantage, and marginalized communities bear the brunt of criminalization (Hughes & Stevens, 2010). For instance, incarcerating individuals for drug possession has shown limited effectiveness in reducing drug use and often leads to further harms, especially among Black and Indigenous communities (Johnstone et al., 2022; Volkow, 2021). While harm reduction strategies, including THN, are pivotal in addressing immediate drug use risks, their success is contingent upon addressing systemic barriers, including stigma, criminalization, and broader social determinants of health (Rhodes, 2009; Smye et al., 2011).

In conclusion, an intersectional approach underlines the need for holistic, systemic solutions that tackle the root causes of substance use and its associated harms. While harm reduction is vital, its effectiveness is intertwined with broader social justice initiatives that challenge and dismantle oppressive systems (Smye et al., 2011).

Discussion

In addressing the profound socio-emotional implications of THN for PWUSs, it is crucial to recognize the immense burden of grief, trauma, and loss they bear, especially when repeatedly tasked with the resuscitation of close friends and loved ones. While feelings of heroism and pride may arise from successful overdose interventions, the overwhelming feelings of stress, fear, and burden are intrinsically tied to the overdose events themselves (Kenny et al., 2022; Wagner et al., 2014). According to Kenny et al. (2022), repeated exposure to traumatic events, such as resuscitation attempts, can lead to severe psychological outcomes, including post-traumatic stress disorder, anxiety, depression, and complicated grief (Kenny et al., 2022). For PWUS, this trauma is deeply personal, and it is rooted in bonds of kinship, friendship, and love, which magnifies emotional toll (Wagner et al., 2014). The societal prejudices faced by PWUSs further exacerbate these challenges. From witnessing frequent overdoses to confronting their own mortality and feelings of guilt, these individuals grapple with compounded traumas. The lack of public forums/platforms to share their grief, combined with societal mistrust, legal repercussions, and negative public perceptions about drug use, intensifies their feelings of isolation and distress (Kenny et al., 2022). The pressing responsibility of life-preservation, juxtaposed with a pervasive sense of systemic abandonment, highlights the psychosocial complexities of using THN. While THN is undeniably lifesaving, it operates within a broader context where the hazardous unregulated toxic drug supply remains alarmingly unaddressed (Fairbairn et al., 2017). This situation underscores systemic failures to treat the opioid crisis as the dire public health emergency it is. Delegating the duty of saving lives to the community can be understood within the framework of neoliberal health policies that emphasize individual initiatives over comprehensive, collective measures. Such approaches may exacerbate inequalities and have profound psychological consequences for the most affected communities (Peacock et al., 2018).

Harm reduction as a philosophy has often stood as a form of counter-culture, confronting the hegemony of individualism and responsibilization that impact our healthcare systems. Harm reduction takes a pragmatic perspective and calls on the public sector to provide the resources needed to reduce harms of substance use rather than allowing individuals to

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suffer and die unsupported. The finances of harm reduction services are often what enters the public discourse as conflict, such as concerns about "tax dollars" going towards needles, pipes, or safe supply. The general concern is why the state should support individuals deemed to be making individual unhealthy choices. Harm reduction conversely suggests that the state is equally responsible for creating a context for people to be as healthy as possible, even while providing arguments more palatable to a neoliberal audience, such as arguing that harm reduction equates to reduced downstream costs or reduces use of other expensive public services. We note herein that in terms of finances of healthcare, nurses are often the ones dealing directly with the public/patients and are expected (or required) to manage the costs of the system. Broad distribution of THN is an opportunity for nurses to disrupt this model.

We would argue that the tension within the literature related to the quality of peer administered naloxone is a means of healthcare providers finding a rationale to meet the goals of a constrained public system. Stigma surrounding drug use is still prevalent in healthcare, as is evident in the discourses that counter the pragmatism of any administration of naloxone being better than none at all. PWUSs are aware of the importance of training on naloxone administration, and there is good uptake on training when available (Neale et al., 2019; McDonald et al., 2022); however, even if training was not broadly taken up, the implications of not providing naloxone are dire. Additionally, the broader availability of nasal naloxone may make the training a moot point. This argument seems to be a means to achieve the system outcome of constraint, yet in-and-of itself is insufficient to prevent THN distribution.

Ultimately, the problem with neoliberal discourses of constrained healthcare resources in this case is that without broad availability of THN, drug poisonings will continue unchecked. While the reduction and privatization of healthcare access can be determined to be sub-optimal for the health of populations in complex models, in the case of access to THN, the link between lack of access to THN and fatalities is unequivocal. Because of this, there is an ethical

call to nurses to support broad distribution of THN regardless of the costs involved. Nurses are responsible for ethical care that embraces harm reduction principles. Continued efforts are needed to make naloxone more accessible to PWUSs.

Conclusion

In conclusion, naloxone distribution as a harm reduction strategy confronts the public sector constraints that nurses might otherwise enact within a neoliberal environment. Nurses can both act in the face of stigma towards PWUS and subsequently, stigma towards harm reduction, and act in the face of calls to be the gatekeepers of health services. In this way, THN is not only a best practice to reduce the harms of substance use, but it is also a political and philosophical act to hand over the control of public health resources to the public.

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