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Reluctant Saviors: Professional ambivalence, cultural imaginaries, and deservingness construction in naloxone provision

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ABSTRACT

Professions compete over jurisdictions by laying claim to specific tasks. Research shows that they enhance their professional status by siphoning off tasks and seizing control of social problems that belong to other professions. Not all tasks are equally desirable, though. Studies find that workers resist helping stigmatized groups or taking on "unsolvable" social problems. This raises a critical question for social scientists: How do professionals respond when opportunities for jurisdictional expansion are contingent on aiding a stigmatized population? Our study draws on research from the sociology of culture, professions, and stigma and empirical evidence about naloxone provision to develop a theory of professional ambivalence that explains how professionals respond to this fundamental tension.

In response to rising rates of overdose deaths in the U.S., many cities have adopted naloxone provision programs in which first responders—police, firefighters, and EMTs—carry and administer naloxone, an opioid overdose antidote. For police and firefighters, this task enables them to venture into medical territory, but for all three professionals, it requires working with the stigmatized population of people who use drugs. We use abductive analysis of qualitative interviews (n = 20) conducted in a Midwestern metropolitan area from 2018 to 2019 to explore professionals' attitudes about naloxone.

We find that professionals' willingness to take on new tasks is largely grounded in how they construct patients as deserving or undeserving of care. Deservingness construction is a constitutive process through which first responders draw on cultural imaginaries about addiction and treatment as well as their own experiences providing naloxone. This results in three mechanisms of deservingness construction—experiential, behavioral, and interactional—that reinforce cultural imaginaries and affect how they think about patients, naloxone, and addiction. Findings contribute to theory of professional ambivalence and offer policy implications to enhance the effectiveness of naloxone provision programs.

1. Introduction

In the system of professions, professionals vie for control over tasks and social problems and use these maneuvers to expand their jurisdictions and bolster their social status (Abbott, 1988). Meanwhile, on the frontlines of work, professionals who control valuable resources like welfare benefits and legal knowledge often avoid helping clients they deem undeserving (Maynard-Moody and Musheno, 2003; Van Cleve, 2016; Zacka, 2017). This documented tension between a desire to compete for occupational control and an unwillingness to provide resources to undeserving clients raises a critical question for social scientists: What happens when an opportunity to expand one's professional jurisdiction requires working with a stigmatized population? Will professionals seize the chance to claim a new scope of work, or will they resist helping those they consider undeserving?

Naloxone provision programs in the United States offer an ideal case to explore answers to this question. The United States is facing the biggest drug crisis the country has ever seen, one in which almost one million Americans have lost their lives to overdose (CDC, 2021), nearly half a million of which involved opioids (National Institute on Drug Abuse, 2021). In response, city and municipality leaders have begun to equip first responders—Emergency Medical Technicians (EMTs),

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firefighters, and police officers—with naloxone, an opioid overdose antidote best known by its brand name, Narcan®. Naloxone binds to receptors in the brain to reverse an overdose entirely, or stop it long enough to transport a person to the hospital (Gould, 2019). This capacity makes naloxone a powerful tool for fighting the overdose crisis's death toll.

Although police and public health initiatives nationwide place naloxone in the hands of first responders, not all first responders are enthusiastic about administering it. Past studies show that police officers, in particular, balk at the idea of providing medical treatment (Banta-Green et al., 2013; Beletsky et al., 2009; Burris et al., 2009). Their resistance largely stems from the fact that naloxone provision is not traditional police work and from the assumption that naloxone enables drug use by stripping the consequences away from an overdose (Green et al., 2013). Naloxone resistance is not limited to police officers for whom administering drugs is unfamiliar, however. In 2017, a town in Ohio made national news after a city council member proposed a "three-strikes rule" for EMTs responding to overdoses. Citing concerns over the city's budget, this policy would have limited an individual to two revivals, the cost of which they would pay back to the city with community service. Such a policy highlights deep ambivalence toward naloxone and the individuals who require it, an ambivalence that is reflected in the council member's statement: "John Smith obviously doesn't care much about his life, but he's expending a lot of resources and we can't afford it" (Siemaszko, 2017).

Sociological theory offers two predictions about how first responders will react to naloxone provision programs. One prediction that stems from the sociology of the professions suggests that police officers and firefighters will embrace the opportunity to provide naloxone because each occupation wants to claim the task of overdose reversal—and the social problem of addiction—to advance their professional project (Abbott, 1988; Larson, 1977). According to this line of thinking, EMTs would attempt to protect their jurisdiction by resisting other workers' attempts to siphon off tasks under their purview (Abbott, 1988).

A second prediction stems from theory about stigma, "dirty work," and the social construction of deservingness. It suggests that first responders will resist providing naloxone because they do not want to aid the heavily stigmatized population of people who use drugs (Emerson and Pollner, 1976; Hughes, 1962; Shaw, 2004; Tsai et al., 2019). Frontline workers such as police officers, teachers, nurses, social workers, and judges provide and withhold resources and punishment based on how they construct clients, patients, and citizens as deserving or undeserving of care (Lara-Millán, 2014; Maynard-Moody and Musheno, 2003; Van Cleve, 2016; Zacka, 2017). From this perspective, we would expect all three types of workers to feel negatively about providing naloxone in general, but we would expect them to be more willing to provide care to those they construct as "deserving."

Public health officials and politicians hope that distributing naloxone will save lives, but they need first responders' buy-in. If first responders embrace the opportunity to provide life-saving care, naloxone access will expand, but if they resist providing resources to stigmatized populations, naloxone access will remain inadequate. How do first responders react to programs that require them to provide naloxone to people who have overdosed? Are they enthusiastic to venture into new areas of work or do they balk at working with individuals who have been culturally constructed as undeserving? How do they determine who deserves what?

We sought to answer these questions by examining the dynamics of naloxone provision on the frontlines of the overdose crisis. We conducted twenty in-depth interviews with first responders in a mid-sized city in the Midwest to explore their opinions about and experiences with naloxone provision. We find that first responders' attitudes towards people who have overdosed reflect larger cultural imaginaries about addiction and treatment and that first responders draw on these imaginaries as they construct deservingness experientially, behaviorally, and interactionally. Based on these findings, we develop a theory of professional ambivalence that extends insights into sociological theories about jurisdictional control and the social construction of deservingness. We conclude with policy recommendations for those tasked with curbing the U.S. overdose crisis.

2. Professional power: expanding jurisdictions versus punishing the undeserving

Taken together, literature on the professions and literature on stigma and deservingness reveal a fundamental tension that arises when professionals face the possibility of taking on new tasks. Theories of professionalization and jurisdictional control suggest that professionals embrace new tasks—especially those that address social problems—as a means of expanding their jurisdictions (Abbott, 1988). At the same time, theories of stigma and deservingness suggest that frontline workers parse patients, clients, and citizens into categories of moral worth and provide fewer resources and more punishment to those they have constructed as undeserving (Lipsky, 1980; Maynard-Moody and Musheno, 2003; Van Cleve, 2016). We reconcile the tension between these theoretical perspectives by developing a theory of professional ambivalence that captures how uncertainty and cultural context shape frontline decision-making. We develop this theory using the empirical case of naloxone provision.

2.1. Jurisdictional control

Professional work exists in a system in which professions compete for control of tasks and social problems to expand their jurisdictions and enhance their status (Abbott, 1988). Each profession has a jurisdiction that contains bodies of knowledge and sets of tasks recognized by others as belonging primarily or exclusively to them (Abbott, 1988). Acquisition and maintenance of jurisdictions is a political process. Professions achieve "closure" by securing control over specific jurisdictions and warding off competitors (Weeden, 2002). Doing so helps to advance their "professional project," an effort to secure high social status and agency over one's area of work while remaining free from intrusion by others (Larson, 1977).

Securing a jurisdiction is essential for being recognized as a profession, but not all tasks within a jurisdiction are equally desirable. Professions pursue tasks that allow them to address a new social problem, while rejecting menial or low-stakes tasks, work that is labeled "scut work" (Becker et al., 1961). Workers also resist "dirty work," tasks they believe are "physically, socially, or morally" beneath them (Ashforth et al., 2007; Hughes, 1962). Another set of tasks that professionals shy away from are those that address "unsolvable social problems," because failing to effectively address the social problem they have claimed opens the profession up to scrutiny and infringement (Abbott, 1988). Any of these could be a reason for rejecting naloxone provision, but doing so constitutes a missed opportunity to expand one's jurisdiction.

2.2. The social construction of deservingness in frontline work

Another set of literature suggests that rejecting a set of tasks has less to do with the task itself and more to do with how workers construct clients as deserving or undeserving. Frontline workers—those located at the bottom of organizational hierarchies and who interact directly with clients—often work with highly stigmatized groups. They are gatekeepers who not only make choices about apportioning resources as wide-ranging as prescription drugs, welfare checks, health insurance, and education (Chiarello, 2015; Epp et al., 2014; Soss et al., 2011; Zacka, 2017) but also make decisions about punishment. Workers in the criminal legal system engage in punishment through arrest, prosecution, and sentencing, while workers in other domains engage in punishment by withholding resources (Lipsky, 1980; Maynard-Moody and Musheno, 2003; Van Cleve, 2016; Lara Millán and Van Cleve, 2017). Because their

workloads are too heavy and their time too limited to devote extensive attention and resources to each client, patient, or citizen they encounter (Lipsky, 1980), much of what frontline workers do comprises people processing (Prottas, 1979). They treat most people similarly, but single out specific people for particularly favorable and particularly unfavorable treatment (Maynard-Moody and Musheno, 2003; Van Cleve, 2016). Choices about who receives which resources and punishment depend on how workers construct the moral worth of those with whom they interact; that is, how they construct deservingness on the frontlines of work.

The process of deservingness construction is both interpersonal and cultural. Workers base their ideas of moral worth on social cues that they ascertain through interaction with clients (Maynard-Moody and Musheno, 2003; Pryma, 2017) and on broader cultural categories of deservingness woven into law, culture, and organizational policy (Katz, 1989; Kimport et al., 2016; Skocpol, 1995; Watkins-Hayes and Kovalsky, 2016). Gatekeeping processes result from both how workers construct their roles—as primarily medical, legal, fiscal, or moral in nature—and from how they create and act upon stories about clients that combine facts of clients' lives and workers' assumptions (Chiarello, 2013, 2015).

Clients are not just passive recipients of deservingness construction, however. They can behave in ways that signal that they are more or less deserving, at least to a degree. Clients attempt to prove themselves worthy by engaging in a "moral performance" that portrays them positively (Pryma, 2017; Radcliffe, 2011). When a client's moral performance matches the worker's beliefs about who should need resources and why, they are more likely to categorize that individual as deserving (Kimport et al., 2016).

This interaction between workers/gatekeepers and clients/moral performers affects how workers "stratify legitimacy" (Kimport et al., 2016), how they categorize needs as legitimate or illegitimate. Those most deserving are those who express their needs in culturally and personally acceptable ways. Examples from medicine and law are illustrative: in a culture that values motherhood, women who perform a desire to become a mother even as they seek an abortion are more legitimate in physicians' eyes than those who unilaterally reject the role of mother (Kimport et al., 2016). In a court system with insufficient resources, public defenders construct people who commit heinous crimes as more deserving of the court's time than those whose cases lie in a morally ambiguous gray area (Van Cleve, 2016).

Constructions of deservingness not only manifest on the frontlines of organizations, but are also woven into law and policy where they are codified and bound to resources and punishment. In this way, systems of categorization that parse the deserving from undeserving become enshrined in law in ways that influence, but do not wholly determine, what happens on the frontlines.

Research on the "deserving poor" demonstrates how deservingness becomes a matter of policy. Those deemed deserving are "entitled to economic, social, and political redistribution of public resources that would help them out of their hardships," whereas the undeserving are left empty-handed (Gans, 1995; Skocpol, 1995). For example, in the sweeping welfare reforms of 1996, policies that excluded children born while mothers received welfare betrayed a longstanding belief in the myth that poor women have children solely to receive more cash benefits from the government (Mink, 1998). This construction of undeservingness manifested in policy, which in turn, impacts decisions on the frontline. All of these elements—frontline gatekeeping, interactional spaces that invite moral performance, and legal codification of worth—are present in efforts to treat addiction and prevent overdose.

2.3. Deservingness and addiction

Policy, praxis, and cultural knowledge surrounding substance use disorders result in a multi-pronged construction of deservingness. Substance use disorders are both heavily moralized and vastly misunderstood, with addiction resting uncomfortably on the cusp of medicalization and criminalization (McKim, 2017; Tiger, 2012). Addiction is nominally framed as an illness, but often treated like a crime, poised between "sickness and badness" (Conrad and Schneider, 1992). This tension is reflected in cultural imaginaries that offer narrow and often inaccurate stories about addiction and treatment (Carroll, 2019), in laws and policies that restrict access to treatment (Hampton and Foster, 2018), and in the ways in which frontline workers construct the deservingness of people who use drugs (Rieder, 2019).

Our collective cultural knowledge about how to interact with people who have substance use disorders is predicated upon these myths: many believe that individuals won't seek help until they have a "wake up call" after hitting "rock bottom," so we must set strong boundaries and provide them with tough love. Similar myths surround treatment: that the best forms of treatment are self-help groups like Alcoholics Anonymous or 28-day treatment programs where patients detox, abstain from drug use, and undergo psychotherapy (Keane, 2002).

Extensive research pinpoints why these ideas are misguided (Tsai et al., 2019; Wakeman and Rich, 2018), yet narrow understandings of addiction and treatment saturate popular culture and form the basis of law, policy, and behavior (Szalavitz, 2021). Popular conceptualizations form what we can think of as the "addiction imaginary" and the "treatment imaginary." These imaginaries are cultural constructions of addiction and treatment created and reified through law, policy, and mass media that pervade social institutions, channel gatekeepers' discretion, and shape how people with substance use disorders are treated. Note that we use these terms differently than they have been used in past work, notably Jennifer Carroll's book *Narkomania* in which she describes the "addiction imaginary" as a political tool that shrinks the rights of people who use drugs to "serve the needs of the politically powerful" (Carroll, 2019: 16–22).

Addiction and treatment imaginaries constitute institutionalized misunderstandings of disease and treatment that persist despite contradictory evidence. For example, these imaginaries overlook research that suggests that addiction is a culturally-bound phenomenon (Keane, 2002), and that criminalization and the resulting societal marginalization can beget addiction as individuals are cut off from their families, jobs, and social support system (Acker, 2002; Dobkin et al., 2002; Duster, 1971; Farris and Fenaughty, 2002). They fail to see the role that structural inequality plays in creating conditions for addiction: loss of agency, poverty, generational trauma, and chronic stress (Lie et al., 2022; Victoria Smye et al., 2011; Case and Deaton, 2020).

These imaginaries also ignore the fact that relapse is common, so addiction usually requires more than one stint of treatment, and they fail to address trauma, mental health, and physical health conditions that frequently occur alongside substance use disorders (Garami et al., 2019). What results is an individualistic approach to addiction that assumes that people with substance use disorders are undeserving of empathy and compassion and that they will only seek help when they have an experience bad enough to "scare them straight." It also results in an overly optimistic perspective of the addiction treatment system that assumes that expensive, in-patient treatment is worth the cost, when evidence shows that these programs often do worse than fail by increasing rather than reducing the risk of overdose (Hampton and Foster, 2018).

Addiction and treatment imaginaries also link morality and race by depicting people who use prescription opioids as white and suburban, and therefore sympathetic patients in need of care, while depicting people who use heroin as Black, Latino, and urban, and therefore criminals in need of punishment (Netherland and Hansen, 2016). These disparate narratives impact both public policy and praxis: past studies on addiction treatment and drug courts find that the perceived "deservingness" of the person with a substance use disorder typically determines whether their addiction will be categorized as a medical issue or a criminal transgression (Gordon, 2018; O'Hear, 2009) as well as how severely they will be punished (Van Cleve, 2016).

This cultural construction of people with substance use disorders as

undeserving is reflected in restrictive policies that limit access to treatment. The U.S. addiction treatment system is inaccessible, fragmented, expensive, and unregulated with few facilities providing evidence-based care (Hampton and Foster, 2018; Szalavitz, 2016). Only 11% of the 23.5 million Americans with substance use disorder receive any form of treatment (Substance Abuse and Mental Health Services Administration, 2019). Even fewer access evidence-based treatments: medications for opioid use disorder (MOUD), such as buprenorphine and methadone. Research shows that people who receive buprenorphine and methadone experience lower rates of overdose and need for acute treatment than those who receive in-patient or out-patient behavioral health treatment (Wakeman et al., 2020). Yet methadone treatment is severely restricted, provided only in specialized clinics, not hospitals or pharmacies. Only 46,000 physicians have DATA waivers that permit them to prescribe buprenorphine (ASPE, 2021), while only 23% of publicly funded programs offer any form of MOUDs (Knudsen et al., 2010). Hospitals also fail to connect patients with substance use treatment plans: stigma about people who use drugs drives doctors and nurses to rush visits, delay medical care, downplay patients' pain, and avoid offering harm reduction services (Brener et al., 2010; Van Boekel et al., 2013). Racial disparities persist in in-patient treatment programs where staff and administrators are overwhelmingly white, and often do not address the needs and experiences of Black Americans, who are dying from opioid overdoses at a staggering rate. Black Americans are nearly four times less likely to receive buprenorphine than white Americans (Lagisetty et al., 2019). This failure is evidenced in the fact that although Black Americans are more likely to seek treatment, they are less likely to recover from drug use afterwards (Kaliszewski, 2020).

Harm reductionists have stepped into the breach formed by inadequate treatment. Harm reduction strategies aim to minimize the negative health and social impacts of drug use by "meeting people where they are at" and encouraging any change that renders drug use safer (Szalavitz, 2021). While the healthcare system is not yet equipped to treat substance use disorder on a large scale, harm reductionists argue that we can at least curb addiction's death toll. Enter naloxone. In 2015, the FDA approved Narcan, a formulation of the injectable opioid antidote that could be administered nasally. This new version of naloxone is easy to administer, even for people who lack training: One Massachusetts study found that untrained bystanders successfully administered naloxone 98% of the time (Coffin et al., 2016). If administered to someone who is not overdosing, naloxone has no effect. This technology, in conjunction with mounting pressure to address opioid-related deaths, has led to expanded access to naloxone.

Despite naloxone's life-saving potential and ease of use, many officials hesitate to make it widely available. Myths about naloxone abuse are widespread, including unfounded notions that people take naloxone while using drugs to enhance their high or host "Lazarus parties'' in which groups of people intentionally overdose together with the expectation of resuscitation (Crabtree and Masuda, 2019). Many allege that an antidote leads to risk compensation, or an individual acting more recklessly because they are aware of a safety net (Winograd et al., 2019).

As a result, public health advocates have sought to require first responders such as police officers, EMTs, or firefighters to carry naloxone, rather than entrust it to the general public. In 2018, the Surgeon General recommended all first responders carry naloxone, and the Office of National Drug Control Policy stated that naloxone "should be in the patrol cars of every law enforcement professional across the nation" (Chau, 2020). Currently, nineteen states allow any first responders to carry naloxone, while three states only permit paramedics to administer it (LAPPA, 2022). While paramedics, emergency responders with the most medical training, have been equipped with naloxone for years, they are far less numerous than police officers or EMTs, who have fewer hours of training. Taking into account that most cities require firefighters to undergo EMT training as well, there are three times as many EMTs as paramedics, and ten times as many police officers (US Department of Transportation Federal Interagency Committee on Emergency Medical Services). Furthermore, police and firefighters are often the first emergency personnel to arrive at the scene of an overdose, where mere minutes can determine whether an individual lives or dies (Davis and Carr, 2015). Putting naloxone in the hands of these first responders has the power to save many lives. The question is whether first responders are willing to provide it.

It is in this cultural, legal, and organizational context that frontline workers construct deservingness and make decisions about treatment and punishment. We sought to understand how first responders—some newly tasked with naloxone provision—made sense of this task and the people they were obligated to help.

3. Methods

3.1. Study setting

We conducted interviews with first responders in a mid-sized metro area in the Midwest from 2018 to 2019. Like many U.S. cities, the metro area is highly segregated racially and economically, with wealth concentrated in the west and south counties, leaving the city proper and north counties with limited resources. Neither city nor county is insulated from the overdose crisis, however. In 2018, the state experienced one of the highest increases in overdose deaths in the nation, concentrated in the metro area where three people died from opioid overdoses per day.

Starting in 2014, the state began to allow first responders to stock and carry naloxone and administer it in the case of an overdose. In this metro area, a suburban police department in a predominantly white affluent neighborhood became the first to carry naloxone in November of 2015. Three months later, other police departments in more racially diverse suburbs began carrying naloxone. Despite a similar or greater number of overdoses in the economically and racially diverse city proper, the city police department was the last to equip its officers with the drug. The city police chief explained why he originally refused to train his officers to use the drug: he claimed such tasks fall under the jurisdiction of Emergency Medical Services, not law enforcement. Following an executive order, the department announced in 2018 it would begin training officers to administer naloxone. A federally-funded nonprofit conducts most of the trainings and a federal grant offsets the cost of the naloxone. Each organization sets their own policies when it comes to naloxone provision: some wait for the police to arrive before approaching the site of the overdose; some impose limits on the amount of naloxone they will provide; some require an investigation post-revival.

3.2. Data collection procedures

This qualitative study was conducted using a semi-structured instrument focused on professional identity and experiences with naloxone, as well as perceptions of addiction and of people who use drugs. A student researcher conducted the interviews under the close supervision of a faculty advisor and we worked together along with another student to analyze data and develop the findings. For example, we asked first responders about their typical experience of Narcan provision to measure how they perceived the people they revive.

Using a combined purposive and snowball sampling strategy, we sampled participants from three professions: police, firefighters, and emergency medical technicians (EMTs). We chose these professions so that we could compare workers who had spent years with access to naloxone (EMTs) to workers who had gotten access only recently (police and fire). We purposively collected data from the three professions but selected individual participants using a snowball sampling technique. We attempted to contact participants in several different ways, but receiving a referral from a friend or co-worker was the most effective method.

We recruited participants from urban and suburban areas. Interview

participants were chosen based on their position and experience. We contacted potential participants using email addresses found on department websites and through private messages on professional networking sites, such as LinkedIn. Out of the thirty-two individuals contacted, seventeen first responders and three related professionals agreed to participate; the other twelve—contacted through professional networking sites—never responded. Four participants were police, five were EMTs, and eight were firefighters, including a high-level fire and EMT administrator. Though many firefighters are also certified as EMTs or paramedics, we use the term "firefighter" to refer to all who operate a fire engine rather than an ambulance. Similarly, we extend the term "EMT" to cover paramedics, emergency responders who have received more specialized medical training. In addition to interviews with these first responders, we conducted three interviews with the following individuals: 1) a representative of a national non-profit organization who oversees a federally-funded initiative to distribute naloxone to local police and fire departments in the state; 2) a representative of a grant-funded organization that trains first responders and the community on the use of naloxone; and 3) a former EMT who works as an ambulance dispatcher. We obtained informed consent verbally from all participants. In order to protect confidentiality and get the most accurate data, we use pseudonyms when referring to participants and do not disclose the state in which they work.

Participants ranged in age from 19 to their mid-60s. Sixteen identified as men and four as women. Ninety percent identified as white, 5% identified as Latino, and 5% preferred not to say. Law enforcement and firefighting are heavily male-dominated fields in this area, as in much of the country: nationally, only 4% of career firefighters (Evarts and Stein, 2020) and 12% of police are women (Duffin, 2020). The 20 interviews conducted ranged from 25 min to 117 min in length. Each interview was digitally recorded, professionally transcribed, and verified for completion and accuracy by the original interviewer. This project was approved by the Saint Louis University Institutional Review Board, IRB # 29521.

3.3. Analytic approach

We analyzed interviews using an abductive, iterative approach (Timmermans and Tavory, 2012). We approached the data equipped with "sensitizing theories" that put us in a position to find surprising results in the data. We began with a main question—how do first responders react to naloxone provision—and a variety of sub-questions. After each interview, the interviewer wrote memos recounting themes, posing questions, and highlighting surprising or contradictory data.

The flexibility of this interview structure enabled the interviewer to adapt and add questions as new ideas emerged from the data. At three stages during data collection, we open-coded transcripts for emerging themes, noting some that fell beyond the predicted scope of our research question. Rather than remain in "predefined conceptual boxes" this approach allowed us to investigate the outliers through data collection and theory formation (Timmermans and Tavory, 2012). When all transcripts were completed, we open-coded once again for emerging themes, then line-coded a small sample of transcripts to develop a comprehensive codebook. Using this codebook, we then coded all transcripts using Atlas.ti qualitative coding software. Coding data and writing memos along the way helped us familiarize ourselves with the data. We also engaged in a process of constant comparison so that we could spot variation in the data and consider alternative explanations. The quotes included in the article are those that represent the most common patterns that we discovered.

4. Findings

We anticipated that first responders' reactions to administering naloxone would stem from one of two sources: enthusiasm for expanding their jurisdiction or reluctance to work with a stigmatized population. What we discovered instead was significant professional ambivalence. There was some evidence of jurisdictional expansion—EMTs do in fact attempt to safeguard their jurisdiction from firefighters and police. However, firefighters and police do not so easily concede control over the task to EMTs. Instead, they consider administering naloxone part of their existing job or a new iteration of their old work.

A stronger force over whether first responders embrace naloxone provision is how they construct patients' deservingness. First responders construct deservingness behaviorally, experientially, and interactionally in ways that reveal their discomfort with these tasks and that reflect broader addiction and treatment imaginaries. Instead of resolving their discomfort by simply rejecting patients they deemed undeserving, professionals navigate this space by placing patients into archetypes that shape how enthusiastic they are about treating them.

Blame placed on the patient and naloxone instead of on the addiction treatment system results in at best, ambivalence, and at worst, open hostility towards naloxone and those who need it, particularly when first responders feel uncomfortable with what they perceive as their own role in enabling drug use. Many of the stories upon which first responders base their opinion of naloxone and people who overdose are not their own. Rather, these are stories that circulate through departments like urban legends that first responders often privilege over their own experiences. In this way, urban legends become part of the addiction imaginary and are used to justify perceptions of people with substance use disorders as undeserving.

4.1. Limited efforts at jurisdictional control

Across professions, first responders considered administering naloxone well within their professional purview already, so they did not see it as an opportunity to expand their jurisdiction. Every EMT believed that naloxone should fall under their purview—after all, they had been treating or managing overdoses in other, less effective ways prior to adopting naloxone (Bartlett, 2004). Chelsea, an EMT who works for a private ambulance company in the city, describes how administering naloxone fits within the parameters of her career.

> *"We're there when people make dumb decisions. We're the ones that help them live through it."*

For some first responders, such as firefighters, administering drugs is a familiar task. Narcan is fairly new, but medically-trained firefighters have been equipped with some version of overdose treatment for years. Mark, a middle-aged, medically-trained lieutenant in the fire department of a wealthy suburb, explains that public attention to naloxone has created a surge in interest. Mark notes,

> *"We've always carried it. They just didn't know we carried it before the opioid crisis."*

Police lack medical training, but still consider naloxone administration within their purview. Some, like Dave, a middle-aged police officer in a surrounding middle class suburb, used the new task to rearticulate their professional identity, fitting it within the old framework of their profession. Dave juxtaposes his experience saving lives with the rash of officer-involved shootings that occurred during the years prior to the interview. When administering naloxone, Dave feels his job more closely aligns with the reasons he joined the force: to practice "life-saving" tasks instead of the "life-taking" now commonly associated with officers.

Some EMTs dispute police officers' competence at administering naloxone. This indicates the presence of an interprofessional turf war, though it is one-sided. Jack, a young EMT at a private ambulance company in the city, describes a case in which police arrived first at a scene and administered four doses of naloxone. According to Jack, this created an unsafe environment for medics, as the individual came to consciousness and "assaulted the medics." Jack argues that police lack the specialization necessary to deliver the drug:

"I think if a [police department] wants to have it, they just need to get better trained."

EMTs may attempt to protect their jurisdiction from infringement; however, this jurisdictional contest does not explain the negativity that first responders, including EMTs, expressed about administering naloxone. Instead, the ways in which they constructed patients' deservingness explained much more.

4.2. Social construction of deservingness

First responders contend with ambivalence by drawing heavily from addiction and treatment imaginaries to make sense of people who overdose, as well as by constructing deservingness in three main ways—experientially, behaviorally, and interactionally. First responders develop a sense of futility through repeated experiences, so they sort real or perceived patient behavior into archetypes, and they respond to patients' moral performances during their interactions. They do so through the lens of addiction and treatment imaginaries, cultural narratives that coalesce into singular ways of understanding social problems.

When describing their resistance to naloxone, many first responders invoke popular ideas about addiction and recovery that saturate broader American culture. They think that "hitting rock bottom" is the only path to recovery and believe that people who use drugs need a "wake up call" such as an overdose scare to convince them to seek treatment. This places workers in a difficult position. In their view, if patients need these experiences to turn their lives around, naloxone might do more harm than good. Many first responders view naloxone as a safety net that catches an individual right before they hit rock bottom, thus eliminating the motivation to seek treatment.

Alongside the addiction imaginary, first responders invoke the treatment imaginary, culturally popular ideas about treatment. First responders believe that people who receive treatment through either the health care or criminal justice field should recover and should not overdose again. They either do not know or do not acknowledge that addiction is an ongoing condition and that the health care system and criminal justice system rarely link patients to viable, long-term treatment options (Blevins et al., 2018; Nunn et al., 2009). These cultural imaginaries form the lens through which first responders make sense of their interactions with patients and construct them as deserving or undeserving of care. They also inform how workers understand their own experiences.

4.2.1. Experiential construction of deservingness: futility

First responders' experiences with naloxone run counter to their expectations based on the addiction and treatment imaginaries: naloxone is not addiction treatment, nor is it usually a path to treatment, but first responders feel that it should be. This results in a feeling of futility—frustration that their attempts to help seem fruitless. Workers are employing limited tools in the context of a broken system, but direct their frustration at naloxone and the patient instead of the system.

First responders describe naloxone as a "Band-Aid" that prevents people with substance use disorders from seeking more effective treatment, while they maintain that reviving someone and taking them to the hospital should be enough to heal them. When it is not, they blame the patient for not wanting help. Many first responders such as Brian, a fire chief in a middle-class suburb, draw a clear connection between administering naloxone and perpetuating a cycle of harm.

[Narcan is] a Band-Aid … the issue hasn't been addressed … Somebody has overdosed more than one time in a day, and that's the problem with the naloxone being so readily available. They're not getting the help they need.

Jack, an EMT, described his sense of futility in similar terms, outlining his frustrations with patients who refuse to go to the hospital after their overdose:

To be able to do heroin, get brought back with Narcan, and then say 'Nah, I don't need anybody,' … It's basically giving someone a Band-Aid, and then they just rip it off and put on a new Band-Aid … You're not helping.

Like many first responders, William, a city EMT, channels his frustration about how few people recover from addiction into a critique of naloxone and the patient, individualizing a structural social problem. He describes feeling morally torn over his role in enabling drug use.

Sure, it's great to have [naloxone] as a backup, but why buy more bullets for the gun? You're supporting their horrifically poor life choices. Jesus, there are so many programs out there to help people, it's just that people don't want to help themselves. I've watched a lot of my regular overdoses just spiral and it's sad to watch … these were people that at one point had decent lives that now it's completely destroyed. A lot of them are dead already. You can only do this for so long before it kills you.

Because William incorrectly believes many effective treatment options exist, he displaces blame onto the patient for not accessing help. He consequently blames naloxone for acting as the safety net that allows the patient to avoid seeking help, even equating stocking naloxone to "buying more bullets for the gun." As he views people who overdose as unwilling to access treatment, he believes they are already gone, past the point of help, which, in his mind, makes administering naloxone even more futile.

Laden with a misunderstanding of addiction, an inflated belief in the availability of treatment, and a sense of moral ambiguity, first responders construct patients they encounter as undeserving of naloxone. In their minds, the patient may be deserving of treatment, but naloxone does nothing to get them there. Their experiences of futility get paid forward onto the patient instead of onto the system. While first responders use their own emotional responses to construct deservingness, they also look to the behavior of the patient.

4.2.2. Behavioral construction of deservingness: archetypes

As a general rule, first responders criticize those who overdose, whether affluent teens sent to posh treatment facilities or people who live without running water. Yet, even among the undeserving, there are some people whom first responders construct as more deserving of naloxone than others: those that adhere to the addiction imaginary. Those that contradict this imaginary are deemed less deserving of care, as evidenced through a set of five archetypes of undeservingness grounded in real or perceived patient behavior. There archetypes are: "frequent fliers"[1] nonchalant patients, combative patients, savvy patients, and nefarious dealers. Armed with the addiction imaginary and department-wide urban legends of naloxone revival, first responders employ these archetypes to decide who deserves life-saving care and who does not.

4.3. The frequent flier

When first responders revive the same person multiple times, they are more likely to consider that person undeserving, dubbing them "frequent fliers." However, instead of focusing on their own experience of futility, the first responder hones in on the reckless behavior of the person who has overdosed. Rather than being "scared straight" from the overdose as the addiction imaginary would suggest, the patient continues to use drugs. Worse still, they perceive the undeserving "frequent flier" as someone whose recklessness takes scarce resources away from other, more deserving patients.

Terry, a paramedic working on one of the city's few ambulances, sees some people overdose on a weekly basis. He describes how his

[1] This term is one that first responders themselves used. The others are terms that we developed to describe phenomena occurring in the data or adopted from previous studies.

interactions with them become routine:

> *I've had the patients who I've given naloxone to twice in one night. Wake them up and then they go shoot up again. And we got a couple frequent fliers and we know we're going to give Narcan to them at least once a week. "You OD'd again. You want to get help this time? No? Alright."*

Terry and others find that reviving someone with naloxone does not change their lives and encourage them to get help. Instead, it just puts them back on the street to overdose again. Far from an act of heroism, providing naloxone becomes a type of people processing (Prottas, 1979), a task that takes first responders away from their "real" work. Unlike people who experience "real" emergencies like heart attacks or car accidents, they reason that people who overdose are to blame for their affliction.

The nonchalant patient offers a similar scapegoat: rather than critiquing a system that does not fully medicalize addiction, focusing on the patient's attitude allows first responders to blame individuals for not seeking medical care.

4.4. The nonchalant patient

The addiction and treatment imaginaries suggest that people who overdose will experience consequences for their actions. Those who come back from the brink of death will be motivated to turn their lives around and those who engage in criminal activity will be punished. When this does not happen, first responders consider patients undeserving of care. First responders worry that people who overdose will suffer no consequences because of the ready availability of naloxone, the lack of legal ramifications for drug use and overdose, and the ease of administering naloxone. Patients' attitudes stoke these fears.

It is in this context that first responders encounter patients who seem to treat overdose casually, patients we call "nonchalant patients." These patients' attitudes frustrate first responders because they resist the "wake-up call" first responders believe is necessary to motivate change. Like frequent fliers, nonchalant patients often require multiple revivals, but they further frustrate first responders because they are explicit about the fact that naloxone can save them. First responders see this as proof that naloxone enables them to continue using drugs and prevents them from seeking treatment. Jason, an EMT, describes his experience:

> *We had one patient that knew us by our name. "Thanks for the Narcan. How many did you give me this time?" He would keep track of how much naloxone we gave him like it was a game to him.*

Although understanding how much naloxone is required may prove crucial to protecting one's life or the life of a friend, Jason views it as a sign that the patient is not taking his overdose seriously.

First responders are also concerned that nonchalant patients will avoid entanglement with the law due to "Good Samaritan" laws. Good Samaritan laws are designed to encourage bystanders to call 911 by ensuring that arrests for drug possession will not be issued at the scene (Rees et al., 2019). The metro area in this study passed a Good Samaritan Law in 2017. In reality, these laws do not always work as intended because police officers are unaware of the law, choose to confiscate drug paraphernalia, or still find reasons to arrest people at the scene of an overdose (though arrest is rare) (Banta-Green et al., 2013).

Some police officers in our study skirt the bounds of the law, like Melissa, who described following someone she had revived to a neighboring municipality with less protective laws to make an arrest. Yet, firefighters and EMTs who do not know about these loopholes believe that patients who overdose "face no legal consequences."

In conjunction, some first responders point out that patients no longer have to endure invasive medical procedures to be revived from an overdose. Until the early 2000s, first responders used what they called a "coma cocktail" to reverse an overdose, which included a combination of drugs to treat everything from alcohol withdrawals to diabetic hypoglycemia to opioid overdoses. This approach could have serious side effects, including seizures and heart attacks. As EMT William states,

> *"Holy shit! So we were killing people left and right with that. And we never understood why."*

By contrast, first responders can now revive someone with naloxone without even intubating them. Naloxone can be administered as a nasal spray, an intramuscular injection, or an IV drip. The individual can choose to go to the hospital or can go about their day. As a result, some first responders believe that the drug works too well. One captain of a city fire department, Rick, described what he perceives as a typical interaction with a person he revived with naloxone: "As soon as he wakes up, he'll be like, 'Man, that was awesome.'"

One story in particular highlights the belief that naloxone lowers the medical and legal stakes of drug use. Many first responders recalled the same story of a person who overdosed on the highway, was revived with naloxone, and continued driving. Jack details an iteration of this oft-cited account and states:

> *So, even if they still have the needle in their arm, and you have to bring them back [from unconsciousness] and they're driving a vehicle, if they say they don't want to go to the hospital, you can't force them to go.*

First responders find this story reprehensible: the person who overdosed is not held accountable in the legal system for driving under the influence and is likewise not processed in the health care system. Substance use disorder, therefore, exists in a void: to first responders, it is neither criminalized, nor medicalized, it is just a burden.

However, first responders rarely express this wider view of addiction and treatment. Instead, what could be conceived of as a critique of the healthcare system ends up as a critique of the patient. Because first responders believe that overdosing should be the "wake-up call" someone needs to seek treatment, when patients seem unconcerned about a near-death experience, they blame naloxone.

The archetype of the combative patient also allows first responders to direct their frustrations at the individual rather than the system.

4.5. The combative patient

In contrast to the nonchalant patient, the combative patient wakes up disoriented and violent, blaming the first responder for "killing their high." With very few exceptions, all first responders described a combative patient in these terms. This seems to highlight a belief that the person overdosing values their experience of intoxication over their own life, which raises an issue for first responders who are committed to saving lives. Jack, an EMT, describes his experience with patients who "come up swinging" noting that some of his coworkers have "administered naloxone and gotten popped in the eye at the same time."

Because naloxone blocks the opioid receptors in the brain, if administered quickly it ends intoxication and launches overdose survivors into immediate withdrawal: nausea, vomiting, abdominal cramps, hot and cold flashes, a racing heart rate, searing muscle pain, restlessness, and anxiety (Sharp, 2021). Naloxone also blocks the release of endorphins, leading to higher levels of pain and anxiety (Hargreaves et al., 1986). Coupled with the chaos of an overdose scene, this can cause confusion and disorientation. Still, while some first responders maintain that patients "come up swinging" every time, others describe this as an exceedingly rare occurrence. I asked Maya, an EMT, about her first experience administering naloxone. She described the dichotomy between what her coworkers tell her is the norm and what she experienced.

> *[The patient's] like, "oh, thank you so much for carrying naloxone. I really am grateful that you guys were here" … he was super nice. Wow, this is not what I was expecting because my coworkers [say] they usually get really mad because you took the high away and they're like "That was so much money I just wasted."*

While data regarding agitation in overdoses is scarce—after all,

many overdoses are treated in spaces that don't collect data—emerging studies suggest that how first responders choose to administer naloxone and their demeanor after revival greatly impacts patient behavior. If first responders push an appropriate amount slowly, studies show that those experiencing overdoses suffer fewer withdrawal symptoms and remain calm. If they treat patients with hostility, patients are more likely to become combative (Marino and Escajeda, 2019; Neale et al., 2020). First responder behavior, then, can create a self-fulfilling prophecy which, in turn, may motivate first responders to treat patients unsympathetically.

While first responders' actions may impact a patient's cooperation, they nonetheless construct the combative patient as undeserving, as someone who values their high over their life. Patients who take measures to preserve their own lives, however, also face rebuke.

4.6. The savvy patient

Savvy patients are those who overdose in areas where they can expect to be revived, a choice that indicates that they value their lives, but first responders do not see it that way. Savvy patients might carry naloxone on their person or inject drugs in the parking lot of a police department with the headlights on. Like other first responders, Mike, a fire service member, describes this as "gaming the system."

> *The word got around real quick, if you're going to do this, do it in a public place where people will see you. Because if you really don't want to kill yourself … they'll call 911, they'll wake you up and you can walk away as long as there's no paraphernalia.*

By using drugs where they can be found in the case of an overdose, these individuals are adhering to a principle of harm reduction—"never use alone" (National Harm Reduction Coalition, 2020). Still, first responders construct savvy patients as undeserving of care because, to them, their actions prove that naloxone *does* in fact enable addiction. If people who overdose plan to use drugs in locations where they will be able to access care in the case of an emergency, first responders reason that providing that care is encouraging the behavior.

While first responders rail against this harm reduction mindset, they reserve special vitriol for those they consider dealers.

4.7. The nefarious dealer

The "nefarious dealer" (El-Sabawi, 2019) constitutes another archetype of undeservingness, one that serves as a foil to the imagined deserving person experiencing an overdose. First responders typically create separate categories in their minds for the victims of overdose versus "drug dealers." They reconfigure their discussion of people who overdose when they talk about drug dealers: in comparison to people who deal drugs, people who overdose—those first responders generally consider undeserving—become "innocent victims." This allows them to treat the blameless overdose survivors while transferring all of the blame to the individual that supplied the drugs. Melissa and Luca, police officers in two departments outside the city, draw this line distinctly.

> *Our only hope is if one of those shitheads die, there might be hope for everyone in their circle. We celebrate every time one of them turns up dead. I'm not gonna* save *someone that is killing other innocent people with drugs.*
>
> -Melissa

> *The more of these guys that we can put in federal prison, the less innocent people will die.*
>
> -Luca

This attitude, while prevalent among police, emerges among other first responders as well. Maya, an EMT, relates how she believes many teenagers become addicted to drugs:

> *Sometimes they have people like drug dealers that will sneak into schools as kids and just hand them [drugs] out to kids and that's how kids get ahold of them. Just so they get their product out.*

First responders paint drug dealers with a broad brush, as people who prey on kids in schools, as "shitheads" who destroy "innocent" lives, and as businesspeople committed to moving their product no matter the cost. From the first responder's perspective, these imagined drug dealers deserve harm—whether in the form of prison or death—to prevent them from harming others.

These imagined perpetrators and victims reveal a fundamental misunderstanding of how drug markets work. In reality, the dichotomy between people who use drugs and people who sell drugs is not clear cut—they are often the same people (El-Sabawi, 2019). Some individuals sell drugs to support their own substance use and friends and family members sell or trade drugs amongst themselves. These complexities blur the line between victims and criminals.

For first responders, however, the nefarious dealer occupies the far end of the spectrum, garnering more blame than any of the other behavioral archetypes. Though first responders rarely construct a patient experiencing an overdose as wholly deserving of naloxone, the archetypes that they construct illuminate how they use behavior to parse degrees of deservingness. However, it is not patient behavior alone, but also the interaction between first responder and patient that results in deservingness construction.

4.7.1. Interactional construction of deservingness: moral performance

The interactional construction of deservingness serves to reinforce or undermine archetypical deservingness categorization frameworks. People who experience overdoses are not merely passive recipients of how first responders construct deservingness. They can help shape those constructions by engaging in moral performance that paints them in a more positive light (Pryma, 2017; Radcliffe, 2011).

People considered more deserving behave in ways that make first responders feel their effort is worthwhile: they show a desire to change their lives. Patients can perform deservingness by differentiating their overdose from others that first responders encounter. They explain that they fell in with the wrong crowd again, relapsed again after a long period of recovery, or took more of the drug than they intended. Those that show remorse for their actions set themselves apart from those who treat overdose as routine and therefore appear more deserving in the eyes of first responders. This results in "stratified legitimacy" (Kimport et al., 2016) in which moral performance affects how first responders construct deservingness. Maya, an EMT in a small township outside of the city, draws this distinction, noting some people who overdose will express remorse and either "be more careful or get clean," whereas others just say "whatever."

Others like Jack, an EMT, employ patients' moral performances to justify their belief that an overdose can serve as the "wake-up call" individuals need.

> *There's some that something happened or whatever, that they overdosed that one time and were brought back, and that completely changed them around.*

By signaling to first responders that their revival has made a difference, overdose survivors render themselves more deserving than those who are nonchalant or combative. Thus, deservingness is interactional—a survivor's deservingness is more closely linked to the first responders' sense of the benefits of their actions than to any patient characteristic.

5. Discussion

This research demonstrates that professionals' enthusiasm for new jurisdictions is dampened when new tasks require providing resources to stigmatized groups. These findings are surprising because they are out of

sync with existing theories of jurisdictional expansion. Based on Abbott's theory of jurisdictional control (Abbott, 1988), we expected police officers and firefighters to enthusiastically embrace naloxone provision, since doing so would enable them to expand their jurisdiction. We expected EMTs to negatively frame the work of these professionals out of fear of losing jurisdictional ground. Jurisdictional control, however, only partially explains our findings. A more important factor is deservingness construction.

5.1. Theorizing professional ambivalence

The key contribution of our research is that constructions of deservingness foster ambivalence, interrupt professional projects, and constrain the tasks in which workers are eager to participate. Many studies show the impact of deservingness construction in frontline work (Maynard-Moody and Musheno, 2003; Soss et al., 2011; Watkins-Hayes, 2009), but this study shows how deservingness construction affects jurisdictional boundaries.

The literature on jurisdictional control and deservingness construction suggest two directions that professionals might take. They could opt to expand their jurisdictional boundaries or they could refuse to do so when it requires working with a stigmatized population. We theorize that the tension between these options constitutes a kind of professional ambivalence that plays out on the frontlines of care. Unlike cases in which professionals eagerly adopt tasks, professionals who feel ambivalent about tasks adopt them hesitantly and incompletely. This ambivalence is evident in how workers construct clients experientially, behaviorally, and interactionally. Naloxone provision offers a useful empirical case that illuminates how professional ambivalence manifests in frontline work.

First responders experience a sense of futility when naloxone does not lead to recovery, which motivates them to blame the patient for failing to get well or to blame naloxone itself for providing a safety net. Though they generally consider people who overdose undeserving of naloxone, they categorize some people as more worthy by creating a set of archetypes of deservingness that inform how they treat patients. Meanwhile, it is through interactions at the scene of an overdose that patients engage in moral performances (Pryma, 2017; Radcliffe, 2011) that affirm addiction imaginaries and therefore push back on first responders' interpretations of them.

Findings from this study offer insights into the intersection of culture, stigma, and professional work. Cultural narratives such as the addiction and treatment imaginary serve as the backdrop against which professionals perform their work. These cultural touchstones inform the ways in which professionals understand patients and themselves and the reasons that they give for constructing some patients as more deserving than others. These imaginaries also create a set of expectations about addiction and treatment that fail to reflect lived realities. The disconnect between the imaginary and professionals' lived experience results in a profound feeling of futility—they are doing the same work over and over and are helping the same people, yet nothing seems to change. Instead of using their experiences to dismantle addiction and treatment imaginaries, professionals pay their frustration forward to the patient and naloxone itself while allowing the imaginaries to remain intact, resulting in less compassion for patients.

In light of these cultural imaginaries, first responders experience significant ambivalence about their role in stopping overdoses. They respond to this discomfort by constructing patient deservingness in ways that hinge not only on a patient's identity, but on how the patient makes the worker feel: the worker may feel ineffective, attacked, or used, or they may feel like they saved a life. Patients influence how workers construct their deservingness not only by constructing their need as legitimate or managing impressions (Goffman, 1959), but by helping workers to feel that their work is meaningful.

The constitutive relationship (Ewick and Silbey, 1998) by which macro-level cultural imaginaries weave their way into frontline work and by which frontline work, in turn, helps to reinforce cultural imaginaries and helps to explain how deservingness constructions undermine efforts to expand professional jurisdictions.

Scholars interested in understanding workers' willingness to take on tasks should consider the moral interpretation of the clientele. We show here that workers' enthusiasm to expand their jurisdiction is constrained when working with a stigmatized population. While past literature defines "dirty work" as engaging in morally dubious or unpleasant tasks (Hughes, 1962) and "scut work" as inconsequential tasks (Becker et al., 1961), providing resources to populations deemed undeserving comprises another form of undesirable task. While the task of naloxone provision offers an opportunity to combat a pressing social issue in an impactful way, first responders react negatively in some circumstances due to how they construct addiction, naloxone, and patients. Future empirical research should assess whether other types of workers cope with ambivalence in similar ways.

5.2. Policy implications

These findings are informative for policymakers and activists. As the overdose crisis rages on, first responders will play a growing role in curbing opioid deaths—but only if they embrace the task of naloxone provision. Hesitation, even momentary, can spell life or death in an overdose. Those interested in enlisting first responders should understand the role that deservingness construction plays in the process of providing care. Anti-stigma training is one option to confront this; however, in our study, first responders who had completed harm reduction and anti-stigma training still use individuals' harm reduction behavior as proof that they are undeserving. Futility, predicated upon the misunderstanding that those who overdose and are taken to the hospital will access resources to overcome substance use disorder, leads first responders to construct those who do not as undeserving. Naloxone training could incorporate an overview of the current treatment landscape and set realistic expectations for managing substance use disorder. Combating addiction and treatment imaginaries could help to reduce the gap between desired and actual outcomes and help first responders to see that although they are not curing substance use disorder, they are making a difference in people's lives.

Education is important, but improving outcomes requires changing key aspects of the treatment landscape. As participants noted, naloxone *is* a Band-Aid: it keeps people alive, but it does not fix the holes in the addiction treatment system. Expanding access to evidence-based addiction treatment is essential for reducing overdose rates and for reducing the burdens on first responders that culminate in futility.

One promising effort that some cities have mounted is initiating buprenorphine treatment in the hospital. Research shows that prescribing patients an effective, life-saving drug immediately after overdose increases the likelihood of receiving in-patient and out-patient treatment (Christian et al., 2021). First responders would feel far more effective if taking patients to the hospital resulted in access to care instead of remaining stuck in a revolving door of overdose and revival.

Another promising effort is expanding access to buprenorphine by allowing pharmacists and nurses to manage patients on the drug (Aronowitz et al., 2021; Chiarello and Rottnek, 2021). Currently, only 10% of physicians are licensed to prescribe buprenorphine (Rapoport, 2020). Studies with nurses and clinical and community pharmacists demonstrate that these professionals are prepared to step into the gap to expand access to care and that their participation has promising results in terms of treatment, overdose prevention, and cost containment (Tierney et al., 2015; Wu, 2021). If educating first responders about the shortcomings of the addiction treatment system helps reduce their experiences of futility, then developing a more robust addiction treatment system will do even more.

A third strategy is to bypass first responders entirely and place naloxone in the hands of the people who need it most—people who use drugs and their families and friends who are most likely to discover that

someone has overdosed and who must act fast. First responders are gatekeepers to a life-saving drug. When they rely on stereotypes about people who use drugs, the care they provide may be impacted. An individual should not have to posture as repentant and effusively grateful to receive compassionate care. If those with substance use disorder anticipate negative interactions with institutions such as the health care system, they may be less likely to seek treatment options (Tsai et al., 2019).

This is true not only for the kinds of deservingness construction we have demonstrated here, but also deservingness construction based on characteristics like race. State and county-level data show vast disparities in opioid deaths by race, with Black men dying at a rate seven times that of white women. Given perpetual tension between police and Black communities, Black people are less likely to call 911 in the case of overdose (Desmond et al. 2016). When Black and other racialized individuals do seek help in an emergency, they are too often subjected to arrest, assault, brutality, and extrajudicial murder. If Black and other racialized people must rely on the police to provide 'life saving' medications, they risk putting everyone at the scene of the overdose at risk. Furthermore, the bloated law enforcement presence and the police-for-profit systems in predominantly Black neighborhoods translate to higher rates of outstanding warrants, rendering the Good Samaritan Act obsolete and likely deterring witnesses from seeking help (Koester et al., 2017). Increasing police presence under the guise of naloxone provision may not only lead to more incarcerations, but may also encourage drug use in seclusion, ultimately causing more overdose deaths.

Equipping community members with naloxone instead of relying on first responders as gatekeepers could help to mitigate this problem. Systematic reviews of existing take-home naloxone programs show that they greatly reduce overdose deaths (McDonald and Strang, 2016). This has motivated some researchers support incorporating take-home naloxone programs into public health strategies (Katzman et al., 2020). Research also shows that strategies such as providing naloxone to trusted community leaders such as pastors' spouses can narrow the racial gap in overdose deaths (Chau, 2020). Today, naloxone is in short supply due to the COVID-19 pandemic, so putting it in the hands of those who will be most likely to use it to save lives is crucial (Godvin, 2021).

6. Study limitations/suggestions for future research

Insights from this study help to explain how professionals' jurisdictional pursuits are linked to the construction of client deservingness, but more research is necessary to explain how professionals construct deservingness and how doing so shapes their experience of work. First, this study relies on interviews with first responders, data that are necessarily one-sided. We can see the construction of deservingness from the professionals' perspectives, but we know little about the experiences of patients who interact with those providers. Ethnographic research and interviews with people who have overdosed are necessary to address patient experience and to analyze both sides of moral performance—the performer and the audience.

Second, because this study draws on interviews, it does not account for the gap between what people say and what they do (Pager and Quillian, 2005). Ethnographic methods are necessary to assess behavior. However, it would be reasonable to expect first responders' reports of how they treat patients to be a conservative measure of what they actually do in the field. Interview participants typically want to paint themselves in a positive light, so the negative behavior that interview participants describe is likely to be even worse in practice.

Third, the archetypes of deservingness that we uncovered were largely grounded in behavior rather than in identity like race, class, and gender. Alongside the addiction and treatment imaginaries exist a set of raced and classed imaginaries about who uses drugs and how drug use is connected to violence (Hansen and Netherland, 2016). Future research should explicitly consider how race factors into the construction of deservingness and how that impacts first responders' willingness to provide care. This should be considered not only in light of people who overdose, but also in light of the neighborhoods in which overdose occurs. Not only are Black and Latinx neighborhoods simultaneously over- and under-policed (Rios, 2011), but research shows that EMTs distance themselves from impoverished neighborhoods to avoid being called there (Prener, 2022) and that police, nurses, and EMTs shuffle around the "burden" of people who experience problems for which there is no clear legal or medical solution (Seim, 2020). Therefore, future research should address deservingness construction of patients as well as their neighborhoods.

Finally, future research should further explore the impact of futility on deservingness construction and jurisdictional expansion. Is it the case that working with stigmatized populations has different effects when the worker can see clear benefits from their work or when workers encounter different people instead of the same people over and over again? A more nuanced study could parse the roles of stigma and futility in ways that would indicate the effects of each on jurisdictional reluctance.

7. Conclusion

People who use drugs find themselves passed from first responders to hospitals or the criminal justice system without receiving evidence-based treatment. Their experiences contrast sharply with addiction and treatment imaginaries that suggest that the pathway to treatment is clear if a person can summon the will to seek help. First responders who provide life-saving care experience a powerful sense of futility when their experiences with patients contrast with cultural imaginaries. If reluctance to perform tasks is contingent upon deservingness construction, then it is time to rethink the addiction and treatment imaginaries to improve first responders' experiences and save the lives of people who use drugs.

Credit author statement

Madison Baumgart: Conceptualization, Investigation, Formal analysis, Writing – original draft, Writing – review & editing; **Elizabeth Chiarello**: Conceptualization, Formal analysis, Writing – original draft, Writing – review & editing, Supervision, Funding acquisition; **Tayla Slay**: Formal analysis, Writing – original draft

Data availability

Data will be made available on request.

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