Dismantling Addiction Services: Neoliberal, Biomedical and Degendered Constraints on Social Work Practice

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Abstract

Background This research was conducted in response to concerns reported by social work practitioners to a Canadian College of Social Work which indicated that their practice was constrained by ideological and system limitations in publicly funded mental health and addiction systems.

Method The dislocation theory of addiction which posits globalization and neoliberalism is linked to addiction rates worldwide, serves as an analytical frame to examine findings from fifty interviews, three focus groups and an online survey with one hundred and fifteen respondents.

Results Themes specific to social work practice in addiction services referred to neoliberalism, stigma, biomedicalization, trauma and addiction, elimination of women services, shrinking services and privatization.

Conclusion Social workers expressed a dissonance between their training rooted in relational approaches and biopsychosocial models of practice and system expectations. Our findings indicate concern about the erosion of core social work values within addiction services, the reduction of state funded programming and need for further research.

Keywords Dislocation theory of addiction · Social work practice · Neoliberalism · Biomedicalization · Trauma · Privatization

This article presents findings specific to addiction services from research initiated by a Canadian College of Social Work in response to social work providers who complained that their practice was constrained by ideological and structural system limitations within publicly funded mental health and addiction services. Their concerns included fears about the contraction of addiction services within state-sponsored healthcare that were related to increased limitations on their ability to practice a biopsychosocial, justice-based approach that is violence and trauma-informed (Healy, 2016; Levenson, 2017). These fears related to their perception of narrowed eligibility to qualify for treatment within public-funded healthcare, the erosion of services and ensuing increases in privatization. These services comprise approximately 6.3 per cent of the provincial healthcare authority budget which
falls short of the 10 per cent recommended by the World Health Organization (Currie, 2021). In Nova Scotia, nearly one-third of approximately 1000 mental health and addiction employees of the Health Authority are registered social workers (Connection, 2021).

Globally, the World Health Organization (2021) reports that the percentage of government health budgets allocated to mental health and addiction services is about 2 per cent, and as highlighted by Roberts (2021), this minuscule amount reflects the fundamental goals of neoliberal globalization to reduce public spending, taxation and state regulation. The doctrine of neoliberalism expressed in economic and political dimensions is allied with a state minimization response to social policies that dismisses the reality that broad social and systemic factors play a role in personal ‘success’ or ‘failure’ (Roberts, 2021). Each person is responsible for their wellbeing, and addiction is not viewed as a consequence of socio-structural factors or a coping response to trauma but rather as a problem within the individual who is viewed in society as deficient. For example, as neoliberalism accelerates, reliance on a market mentality increases the availability of potentially addictive substances and gaming opportunities while simultaneously promoting the concept of responsible consumption or gaming. Neoliberalism constitutes the ideal citizen as one able to perform in the marketplace, who consumes responsibly and does not admit harm, thereby generating further stigma of those who do and a subsequent reduction in policy to support treatment programs and research (Breitkreuz, 2005; Haydock, 2014; Mercille, 2016).

We chose the dislocation theory of addiction to frame our analysis of the findings because it is aligned with the foundational values of the profession of social work. This theory emerged from the social sciences and constructs a critical social, economic and political understanding of the origins of addiction. Developed by Bruce Alexander, it theorizes that the social and cultural environment is crucial in determining if an individual will develop a predisposition to substance abuse and/or addiction and thus moves away from individual responsibilization to examine societal explanations (Alexander, 2008; Mate, 2008). The dislocation theory states that ‘the loss of psychological, social and economic integration into family and culture [and] a sense of exclusion, isolation and powerlessness’ are precursors to addiction (Mate, 2008, p. 261). Adverse childhood experiences and trauma are factors which can contribute to a predisposition to substance abuse and/or addiction and frequently occur in stressed community environments and result in feelings of exclusion, isolation and powerlessness (Dube et. al, 2003; Ellis & Dietz, 2017; Hughes et. al. 2017). The first principle of this theory states ‘psychosocial integration is an essential part of human well-being, and that dislocation—the sustained absence of psychosocial integration—is excruciatingly painful’ (Alexander, 2008:86). The term psychosocial integration points to the essential satisfaction people can feel if they live in a society that meets their basic needs for four things: belonging, identity, meaning and purpose (Best et al., 2016; Chevalier, 2019). Alexander (2008) describes psychosocial integration as reconciling the need to belong with the equally vital need for autonomy and achievement. What is important to understand about psychosocial integration is that it only occurs when a person experiences social inclusion and a sense of belonging with access to the social determinants of health. The dislocation theory of addiction is a critical theory that points to the need for a more just society to encourage the likelihood that people will have opportunities for psychosocial integration which include opportunities to explore their potential and define and achieve a meaningful life.

In advancing the dislocation theory of addiction, both Alexander (2008) and Mate (2008) suggest that addiction in Canada, and elsewhere, can be linked to a growing sense of alienation and disconnection that is fuelled by neoliberalism, globalization and free market economies. A study that spanned six countries supports these claims by finding
experiences of dislocation, displacement as the result of conflict, breakdown of cultural ties and a perceived lack of community support as contributing factors to addiction (Ezard et al., 2011).

To lower rates of addiction, this theory prioritizes connection, social inclusion and a sense of belonging as essential to mental wellbeing and recovery from addiction. These values are aligned with the profession of social work and trauma and violence informed models of practice that define recovery as a relational social process of reconnection and healing (Alexander, 2008; Heather et al., 2018; Levenson, 2017; Najavits, 2002; Poole & Greaves, 2012). These tasks of recovery conflict with the vacuity of neoliberalism which relegate those individuals most vulnerable and unable to conform and perform as market citizens to an underclass in which those who can pay receive addiction treatment and those who cannot suffer and may die. The resulting crisis is value-laden and pits social work practitioners in these systems in opposition to their ethical and professional codes of practice.

The dislocation theory proposes the establishment of welcoming communities that provide opportunities for people to develop a sense of identity and purpose as the antidotes to addiction. This theory provides our analytical frame to examine findings from a provincial study that explored if social work providers were constrained in their practice by ideological and structural system limitations within publicly funded mental health and addiction services.

Method

This research which was conducted in 2020 was approved by the Dalhousie University Research Ethics Board. Our research included a literature review, an Opinio survey (n = 115, 166 contributed but did not fully complete the survey), 50 individual interviews and 3 focus groups (n = 15). All participants in the study completed a socio-demographic questionnaire. All participants resided in the province of Nova Scotia. These diverse methods of data collection provided consistent data and data saturation, resulting in data triangulation.

Survey

Survey recruitment criterion was membership in the provincial College of Social Work for service providers and supervisors, which is a requirement for their practice. An opportunity to participate in the survey was advertised and promoted by the provincial College of Social Work in their newsletter and on their website. The survey explored questions related to scope of practice and employment satisfaction with primarily closed-ended questions. The calculation of responses to these questions was conducted by the OPINIO software. The small number of open-ended questions in the survey was thematically analysed, and survey results informed the design of the semi-structured interview schedule.

Individual Interviews

In-depth, semi-structured narrative interviews were conducted with 50 adults in rural and urban settings. All participants were over the age of 18 years, and of those who participated in individual interviews of approximately 1 h, thirty were mental health and
addiction services social work providers, ten were social work supervisors and ten were service users in receipt of services from social workers. We hoped to interview 50 people, and our recruitment process resulted in this ratio of participants. In addition to the College of Social Work newsletter and word of mouth (snowball sampling), participants were recruited through posters distributed in the community and a service user Facebook site.

To allow for greater representation across the province, individual interviews were conducted either in person or by telephone. We offered a $50 honorarium to service users who were interviewed to compensate for childcare and/or transportation costs incurred.

**Focus Groups**

Focus groups took approximately 90 min each. We conducted three focus groups among service providers: one in an urban area (n=5), a second urban focus group 1 (n=6) and a rural focus group 2 (n=4). The focus groups were conducted in person by the research team, except for the last rural focus group which was conducted through Zoom due to provincial requirements of social distancing due to the COVID-19 pandemic. The use of an online focus group was a necessary innovation, that has been described in other published studies, as a measure to increase accessibility to those having a computer and access to the internet, particularly for rural participants (Dos Santos Marques et al., 2021). Participant interviews addressed perceived strengths and limitations of services and included questions related to resources, equity, access, dominant mental health discourses and the impact of marginalization discrimination on mental health and addiction service delivery.

**Data Analysis**

A summary of socio-demographic data is presented in the findings. Together with the qualitative survey results, the transcriptions from the audio recorded interviews and focus groups were integrated and thematically coded using a thematic analytic approach to identify themes (Braun & Clarke, 2006). This is a flexible method that included identifying, analysing and reporting patterns within data and is used with a variety of epistemologies (Braun & Clarke, 2006, 2013; Clandinin, & Connelly, 2000; Wells, 2011). A narrative discourse analysis was used because it emphasizes gathering in-depth information on participants’ account of ‘addiction’ and healthcare services and starts with the assumption that these stories emerge within a social context. This approach allowed us to contextualize the participant’s narratives within some of the dominant discourses of addiction services including an emphasis on biomedical professionalism and neoliberalism (Braun & Clarke, 2006; Clandinin, & Connelly, 2000; Wells, 2011).

**Findings**

The age categories representative of most participants were between the ages of 30 and 44 (n=51) and 45 and 59 (n=57). One hundred and nineteen identified as female, 22 as male, one as Male(cis)Two Spirit and one as gender diverse. Twenty-one participants identified as 2SLGBTQIA+. Most participants (n=109) identified as White, and other racial/ethnic identities included Indigenous, African Nova Scotian, African Canadian and Sinhalese. Ninety-three participants had a Masters’ Degree in Social Work, 42 participants had completed a Bachelor of Social Work degree and 3 had completed a PhD. Most participants...
were employed in the public sector and noted their individual income to be between $60,000 and $79,999.

The findings from the survey, interviews and focus groups were very consistent in their critique of the mental health and addiction service delivery model, the standardization of approaches, biomedical frameworks and devaluation of addiction-specific knowledge. A summary of survey results presented in Table 1 indicates that most participants believed that their scope of practice was constrained and that further resources are required to support the wellbeing of service users.

The following sections discuss six central themes that emerged from our data analysis specific to addiction services social work practice: (a) neoliberalism, addiction and stigma; (b) biomedicalization of addiction; (c) trauma and addiction; (d) degendered services; (e) the decline of addiction services; and (f) privatization.

**Neoliberalism: addiction and stigma**

As one service provider noted, substance use among youth is normalized, even by parents, despite its’ harms and the inability to name it as addiction speaks to the power of stigma.

So, it’s hard with addictions… Like since everything has been legalized, we seem to have an increase in our addiction referrals. So, is it that a lot of parents will call and say, “Oh, they’re just dabbling, I think that’s normal?” But then when you do the intake, it’s impacting their functioning in all their different areas. So, then you may not say to them, “Oh, this is addiction,” Sara, Service Provider

Fraser et al. (2017) re-poses stigma as ‘a biopolitical technology of the social: a performative process that operates in the service of normative social relations’ p. 195). Within the neoliberal context, addiction is understood as a failure that discredits the substance user as incapable of performing day to day responsibilities. Stigma understood as a process of social reproduction is a biopolitical technology of power that legitimizes certain subjects and not others (Fraser et al., 2017). As such it serves as a powerful silencing tool rendering addiction and those it affects as invisible. This mechanism affects both the person challenged with an addiction and service providers.

| Percentage of respondents | Perspective of mental health and addiction service provision |
|---------------------------|------------------------------------------------------------|
| 98%                       | There need to be changes made to the current provision of mental health services and addiction services |
| 97%                       | There are no adequate resources in the community to support the wellbeing of their clients (i.e. affordable daycare, affordable leisure, affordable housing) |
| 96%                       | Experienced barriers to providing services which included insufficient resources, a lack of control and restricted opportunities to implement change |
| 85%                       | There are no sufficient day programs or services available within the community, such as drop in programs, faith-based group activities or volunteer work support |
| 82%                       | Social work training and perspectives do not have enough recognition in the current service delivery system |
| 35%                       | Were satisfied with their current role |
So, stigma from people that are marginalized. And then stigma on the hospital side. So, remember I was talking about the no-shows and the problem of no-shows.... That’s because we’re expecting somebody to trust us to come in when those folks may have gone through the residential schools, the Sixties Scoop, racism in general, whatever, they may see in any hospital setting as a white government institution. So why would I come in? Charlie, Service Provider

Anticipation of stigma among individuals who are racialized functions as a barrier when deciding if to access healthcare settings where they may not see themselves represented among service providers and operates to preserve normative social relations by perpetuating colonial and culturally unsafe practice.

In general, stigma was noted to influence both the availability of services within healthcare settings and the experience of those who were able to access services.

The biggest problem for me recently is how people with substance use problems are being treated. I feel like they’re being given inadequate services, and they’re being not offered services because of that stigma. Jill, Service Provider

Scambler (2018) contends that capitalism’s class structure has led to a political skewing of social norms of shame and blame, which he refers to as the weaponizing of stigma, that results in blaming and punishing vulnerable people as deserving of their misery. In turn this allows for the state’s abandonment of people with substance abuse and/or addiction issues.

Biomedicalization of Addiction Services

The findings of our research were consistent in a shared critique of the biomedical model which constrained the ability to address social factors noted by our participants as central to understanding the development of a substance use and/or addiction and measures required to ‘recover’. For example, members of a peer-led drug user group (SNAP) diagnosed with opioid use disorder stated that the DSM-5 criteria failed to encompass their diverse experiences of opioid use or capture the complexities of their lived experience (Boyd, et al., 2020). They believed that the DSM-5 constructed an idea of these experiences and the addicted person based on a list of symptoms that often obscured their structural and cultural vulnerability by shifting the focus away from political and social issues.

… It’s a very simplistic way of looking at them – the medical model approach. … The idea being that you categorize people, and this is what you do with them. Well, that doesn’t work with addictions…. do addictions just become another two or three pages of the DSM? Because it’s a different world than just everything else in mental health. It is a world onto itself. Because people have to realize there’s a lot more social factors. Doug, Service Provider

As implied by the dislocation theory of addiction, neoliberal influences set in motion a business or industry model to healthcare that was noted by our participants to result in the standardization of approaches, limited numbers of sessions and limited opportunities to develop therapeutic relationships or network with community partners. These measures designed to increase efficiency and reduce costs result in dissatisfaction among practitioners who feel there are limited opportunities to address social and relational factors that are central to recovery from substance abuse and/or addiction.
So social justice issues are psychologized, invisibilized. The bigger social justice issues are actually constructed into being psychological distress... And so people feel more and more and more frustrated, frustrated, frustrated and helpless. I just mean do something proactive for clients in terms of social justice. I just think that nobody gets it. I mean the framework is so individualized, and it is a medical model. So, if that’s what your understanding is then my gosh. Service Provider, Karen

In lamenting the lack of a social justice framework, Karen describes the inadequacy of the medical model which she perceived as contributing to the frustration service users experience when their social needs are not met. This view was also framed by another service provider who discussed the limitations of medical approaches.

And I think it’s hard for them, particularly around mental health and addictions, because it does not fit a nurse model easily. You know, you just can’t give someone an injection or bed rest. It doesn’t work like that. Jess, Service Provider

This respondent is acknowledging the difficulty in moving beyond a one-size-fits all approach to address relational and social concerns. Members of the European Addiction Theory Network have challenged the brain disease model of addiction by agreeing that substance abuse cannot be separated from the social, psychological, cultural, political, legal and environmental contexts (Heather et al., 2018). They argue that the emergence of a recovery paradigm challenges biological-driven conceptions of addiction by pointing to recovery as a social experience occurring within social contexts. Recovery, often defined as a healing process involving a sense belonging, identity, meaning and purpose, is aligned with Alexander’s concept of psychosocial integration.

Disconnections: Trauma and Addiction

Several participants noted the association between prior experiences of violence, trauma and adversity with the development of an addiction.

I mean there’s a whole rich literature on feminist analysis of addictions and substance use. And then you add in the whole trauma piece, the understanding of trauma and how that can lead to substance use, you know, to calm the body, to forget about the pain, to block things out, not remember, shut down the feelings. So, you add that piece in terms of a feminist approach to working with trauma. Karen, Service Provider

Extensive literature conclusively confirms associations between trauma and subsequent substance abuse, particularly among cisgender, transgender and non-binary women (Boppre & Boyer, 2021; Brown, 2020; Covington, 2008; Najavits, 2002; Ross and Morrison, 2020). Connecting a prior history of adverse childhood experiences and/or trauma with addiction points to the need to provide healthcare that is responsive to these experiences while also, at the same time, addressing addiction challenges. Trauma is defined as an exposure to an extraordinary experience that presents a physical or psychological threat to oneself or others (American Psychiatric Association (2013)). These experiences can constitute a relational injury and when paired within a social context that may include marginalization, oppression and inequity, can result in extreme feelings of disconnection and dislocation. A focus on developing a strong therapeutic alliance is needed to adequately address this degree of distress and suffering. In contrast research participants described the provision of services as often based on an individualized approach that was too narrowly
focused and time limited to allow for the development of a strong therapeutic alliance. As one service provider expressed, a trauma history so often associated with substance abuse may not be addressed at all.

I think substance use is getting… And it’s ridiculous because I think it’s one of the more complex diagnoses usually because it’s concurrent usually, if not always. I think it’s getting pushed down. But it’s like you present with this, “Well, see if you can get better with like an NSCC counsellor. Like we’re not giving you to a like MSW [a Masters’ Degree trained Social Worker],” kind of thing. Jill, Service Provider

When clients present with substance use issues, the denial of their lived complexity occurs in a healthcare system that is often symptom driven and relegates the focus on social and relational factors as requiring less expertise as implied by this statement. However, harm reduction approaches, essential to both trauma and substance abuse/addiction, can be quite complex, frequently addressing concurrent mental health and addiction challenges.

Addressing the social determinants of health requires an equity lens and willingness to move beyond narrow symptom responses as noted below.

What I’ve learned over the years, is that trauma is also a significant factor for people who are living with addiction …So I don’t prescribe a one-size-fits-all approach. The ultimate goal is to keep people safe.... Not just in terms of the actual consumption of substances or addictive behaviours but what are the other kind of determinants of health and what do we have to do in terms of reducing harms across the spectrum. Jane, Service Provider

A focus on keeping people safe is a first principle of trauma-informed approaches and must acknowledge the need for safe housing and food security in addition to the provision of trauma-specific services (Poole & Greaves, 2012). Further principles include trustworthiness, peer support, collaboration and mutuality, empowerment, voice and choice and cultural, historical, and gender issues (Levenson, 2017). These are aligned with the goal of psychosocial integration which emphasizes the importance of belonging and obtaining a sense of purpose. The incorporation of an adverse childhood experiences and trauma-informed lens rests on the belief that what has happened to an individual matters (Hughes et. al. 2017). This acknowledgement provides a pathway to link individual experience to family and community opening the door to prevention work and political advocacy (Burke Harris, 2018). The complexity inherent in responding in ways that support the recovery of individuals, families and communities presents a significant challenge to healthcare systems to operationalize services that promote recovery and a sense of wellbeing.

**Degendered Services**

Nowhere is this complexity more apparent than in work specific to women. Woman, inclusive of cisgender, transgender and non-binary women, experience many concurrent challenges associated with substance abuse/addiction that can include childhood sexual abuse and other early life adversities, untreated mental health difficulties, parenting challenges, interpersonal violence and poverty (Andrews et al., 2019; Brown, 2008; Covington, 2008; Hanpatchaiyakul et al., 2017; Najavits, 2002; Poole & Greaves, 2012). One Canadian study of women who abused alcohol found that 90% of participants reported experiencing traumatic events, primarily childhood sexual abuse and using alcohol to self-medicate...
the painful feelings connected to these incidents (Brown, 2008). Research has also found women to be more likely to misuse substances following a traumatic experience(s) (Collins Reed & Evans, 2009; Kendler et al., 2000). The pathways to substance abuse/addiction, the associated harms and implications for a healthcare response are gendered (Ross et al., 2015). Regardless of what framework is used to understand substance use, Greaves (2020) claims that it needs to be viewed within a sex and gender lens to fully understand and respond most effectively. This approach requires an intersectional and critical feminist lens to inform a trauma-responsive paradigm as noted below.

I’ve done a number of programming for women that’s sort of out of the box and focusing on the larger social picture. We were able to do a little advocacy within the system around women’s gendered and racialized needs in the community. I did work with some of the other women service coordinators, and they brought a bigger perspective to their work. But I’d say that we were on the margins. I mean after all, we were eliminated. Karen, Service Provider

The Women Service Coordinator positions were initiated in the province of Nova Scotia in 2002 and were designed to be innovative by delegating 60% of the job description to address community development, policy and health promotion in addition to a 40% focus on clinical issues (Brown et al., 2021). These positions were trauma and violence-informed and as such were innovative within healthcare by furthering an analysis of the historical, embodied and daily experiences of sexism that impacted women’s mental health and addiction challenges (Ahmed, 2015). Responding to these issues within a symptom-driven medical model with narrowly prescribed treatment responses depoliticizes and de-genders girls’ and women’s experiences, dismissing what is crucial to a supportive response within these systems.

Subsuming Addiction Services

Our findings revealed a concern among participants about addiction services losing ground in the integration process with mental health. This process, which began in 2010, was described as more closely aligned with a biomedical model (Scotia and Dept. of Health Wellness., 2012).

And so when they merged…. they felt that Addictions was viewed as the poor cousin to Mental Health. So, they don’t feel that new people coming in are given adequate training around addictions. …. healthcare is largely dominated by nurses and nurse managers. Elaine, Manager

Nurses and nurse managers familiar with the structure of a medical model have limited training and understanding of the relational and psychosocial factors that are central to the provision of addiction services. A tiered framework to guide system design of mental health and addiction services in Nova Scotia was adapted from the national strategy (Canadian Centre on Substance Abuse, 2008). Tiers 3–5 comprise the core functions of the state mental health and addiction services system to provide services to those individuals and families experiencing the presence of severe mental health disorders and/or harmful substance use/gambling which results in moderate to severe functional impacts. Symptom-led reactive care has been characteristic of biomedical approaches to mental health (Morrow & Malcoe, 2017; Tseris, 2019). Individuals challenged by substance abuse and/or addiction issues who do not meet tier 3 criteria may be excluded from accessing services despite
having a traumatic history that deeply compromises their current quality of life and relationships with themselves, partners, families and community. Addressing these issues promotes mental wellness and recovery and was central to the treatment approaches of addiction services. As noted by the service provider below, this view of treatment was not shared by mental health.

When I was with Addictions before it merged. … the fear was that it would be swallowed up by Mental Health – which is what happened. Doug, Service Provider

**Privatization**

In Canada, as neoliberalism has increased, the role of the state as provider of social services has diminished. As governments promote market-based solutions to social problems, the private sector supplements or replaces services traditionally provided by the welfare state that cared for those most vulnerable (Dunlop, 2006). An initial google search of private addiction treatment programs in Nova Scotia revealed nine private treatment centres with one posting pricing of $500 for 1 day and $9800 for a 28-day treatment program (Crosbie House, 2017).

When you look at what’s happened with the system and the services in addiction for people that are addicted, they’ve crashed. Detox centres have been closed. Beds have been cut. Twenty-one, 28-day programs are a memory. And those were things that worked for a lot of people. And they’re inconvenient, they cost, they’re very difficult to work in. But if you have money, that’s the type of therapy you get. If you’re the run of the mill person, you don’t get in there. It’s $400 a day. Doug, Service Provider

This service provider clearly summarizes what he believes to be a financial rationale to cut programming and the inability of those with little income to access private options.

If you don’t have money to pay for private services, then you have to wait like quite a long time. So, like upwards of 3 months or more maybe just to see someone for an initial appointment. And that just doesn’t work for them. They just can’t wait. Sara, Service Provider

Waiting to access state services for addiction treatment for those who cannot afford private services is fraught with difficulties given a sense of urgency people can feel once they have decided to seek treatment and people’s lives often lay in the balance (Palad & Snyder, 2019).

**Discussion**

Taken together the themes discussed above create a consistent narrative depicting the enactment of neoliberal principles in healthcare that are clearly aligned with agendas that prioritize cost efficiency, standardized and degendered approaches and result in privatizing services assessed as not efficient and too costly for the state. This narrative is in stark contrast to the directives of critical social work practice and the dislocation theory of addiction which emphasize human-centred values, the need to define a purposeful life and establish meaningful relationships. The dissonance for social workers occurs when connections between private issues and public problems are severed, and individuals challenged with
substance misuse and mental health issues are viewed as inherently flawed, even blamed for the suffering and violence they have experienced (Giroux, 2014; Randall, 2013).

Within Canadian mental health settings, the integration of addiction services has accelerated a reduction of services specific to ‘addiction’ as expressed by research participants. Within the larger mental health discourses, the therapeutic work inherent in recovery models suggested by the European Addiction Theory Network is devalued because it does not rely on the Diagnostic Statistical Manual of Disorders and views substance misuse and/or addictive behaviours as coping mechanisms that can be addressed within harm reduction approaches (Heather et al., 2018).

Themes related to biomedicalization and degendered services point to a diminished focus on an intersectional analysis and a disregard for relational concerns. As alluded to in the findings related to stigma, individuals challenged by addiction can be portrayed as irresponsible ‘rejects’ and ‘recast as “abjects”’ who are then abandoned by the state (Scambler, 2018, p. 777). In turn this was seen to result in the dismantling of state-run addiction treatment and the subsequent increase in privately owned, and very expensive, addiction treatment services. Decisions to limit funding to support addiction research, policy development and treatment provision result in silencing of these issues and further alienation and dislocation of those most in need of support and unable to pay for private treatment.

Globally social work practitioners are guided by ethical principles that recognize the inherent dignity in humanity, promote social justice and access to equitable resources. This includes the responsibility to challenge unjust policies and practices. The inability to provide adequate services in the way social workers’ feel best meets the needs of service users results in distress that contributes a lack of satisfaction in their work.

The dislocation theory of addiction highlights the need for social inclusion and belonging and validates the role of social workers engaged in promoting social contexts that nurture mental wellbeing and equitable access to the social determinants of health. The need to belong and acquire a sense of meaning in our lives is universal and we argue, inseparable and essential to health and mental wellbeing.

**Limitations**

The information shared by participants in this study may not be representative of all views. While the authors consider the inclusion of holding focus groups in both urban and rural areas an overall strength of this research, the results may be impacted by a perceived lack of access to resources in rural areas that are more widely available in urban centres.

**Conclusion**

The pervasive influence of neoliberalism shapes our societal contexts and extends to decisions made by government officials and healthcare policy makers who determine the priorities of state healthcare provision. It results in one-size-fits all, standardized approaches with an emphasis on efficiency and biomedical approaches.

Moving beyond a reliance on brain science, the social workers we interviewed expressed their view that addiction treatment must encompass a critical social analysis and centre relationships. The dislocation theory of addiction defines addiction as aligned with the expansion of globalization and neoliberalism. It suggests that the vacuous values of the
marketplace purveyed by neoliberal mentalities of government erode a sense of belonging, identity, meaning and purpose that are essential to psychosocial integration and personal wellbeing. Obtaining a sense of belonging, exploring one’s personal identity and defining what gives life meaning and purpose is the work involved in recovery and is often definitive of helpful addiction treatment programs. This work, essential to healing from trauma and the promotion of psychosocial wellbeing, can take time and occurs within the context of relationships. Our research participants shared that such work has been devalued and along with it, core practice components of addiction services. Our findings indicate concern about neoliberal, degendered and biomedical constraints that contribute to dismantling services and the subsequent turn to privatization of services that needs to be resisted to better serve individuals challenged with substance abuse and addiction.

References

Ahmed, S. (2015). Introduction: Sexism - A problem with a name. New Formations: A Journal of Culture/ theory/politics, 86(1), 5–13.

Alexander, B. (2008). The globalization of addiction: A study in poverty of the spirit. Oxford University Press.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders DSM-5. (5th ed.). Arlington, VA: American Psychiatric Association

Andrews, N., Motz, M., Bondi, B. C., Leslie, M., & Pepler, D. J. (2019). Using a developmental-relational approach to understand the impact of interpersonal violence in women who struggle with substance use. International Journal of Environmental Research and Public Health, 16(23), 4861.

Best, D., Beckwith, M., Haslam, C., Haslam, A., Jetten, J., Mawson, E., & Lubman, D. (2016). Overcoming alcohol and other drug addiction as a process of social identity transition: The social identity model of recovery (SIMOR). Addiction Research & Theory, 24(2), 111–123. https://doi.org/10.3109/16066359.2015.1075980

Boppre, B., & Boyer, C. (2021). “The traps started during my childhood”: The role of substance abuse in women’s responses to adverse childhood experiences (ACEs). Journal of Aggression, Maltreatment & Trauma, 30(4), 429–449. https://doi.org/10.1080/10926771.2019.1651808

Boyd, S., Isvins, A., & Murray, D. (2020). Problematizing the DSM-5 criteria for opioid use disorder. A qualitative analysis. International Journal of Drug Policy, 78(102690), 1–10.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101.

Breitkreuz, R. (2005). Engendering citizenship? A critical feminist analysis of Canadian welfare-to-work policies and the employment experiences of lone mothers. Journal of Sociology and Social Welfare XXX, 11(2), 147–165.

Brown, C. (2008). It’s not cut and dry: Women’s experiences of alcohol use, depression, anxiety and trauma. Dalhousie University.

Brown, C. (2020). Feminist narrative therapy and complex trauma: Critical clinical work with women diagnosed as “borderline.” In C. Brown & J. McDonald (Eds.), Critical clinical social work: Counterstorying for social justice (pp. 82–109). Canadian Scholars’ Press.

Brown, C., Johnstone, M., & Ross, N. (2021) Repositioning social work practice in mental health in Nova Scotia, Report. Halifax: Nova Scotia College of Social Workers (pages 172). http://hdl.handle.net/10222/80244

Burke Harris, N. (2018). The deepest well: Healing the long-term effects of childhood adversity. Houghton Mifflin Harcourt.

Canadian Centre on Substance Abuse. (2008). A systems approach to substance use in Canada. Retrieved from: https://www.ccsa.ca/systems-approach-substance-use-canada-recommendations-national-treatment-strategy

Chevalier, J. (2019) Filling the void. Bruce K. Alexander On How Our Culture Is Making Us Addicted. The Sun Interview. https://www.thesunmagazine.org/issues/519/filling-the-void.

Clandinin, D. J., & Connelly, F. M. (2000). Narrative inquiry. Experience and story in qualitative research. Jossey-Bass.
Scotia, N., and Department of Health Wellness. (2012). Together we can: The plan to improve mental health and addictions care for Nova Scotians. Halifax, NS: Department of Health and Wellness.

Palad, V., & Snyder, J. (2019). “We don’t want him worrying about how he will pay to save his life”: Using medical crowdfunding to explore lived experiences with addiction services in Canada. The International Journal of Drug Policy, 65, 73–77.

Poole, N., & Greaves, L. (2012). Becoming trauma informed. Center for Addiction and Mental Health.

Randall, M. (2013). Restorative justice and gendered violence? From vaguely hostile skeptic to cautious convert: Why feminists should critically engage with restorative approaches to law. Western University.

Roberts, M. (2021). Globalization and neoliberalism: Structural determinants of global mental health? Humanity and Society, 45(4), 471–508.

Ross, N., Morrison, J., Cukier, S., & Smith, T. (2015). Consuming carcinogens: Women and alcohol. In D. Scott (Ed.), Our Chemical Selves: Gender, Toxics, and Environmental Health. pp 29–104, UBC Press.

Ross, N., & Morrison, J. (2020). Safety, belonging and voice: Critical clinical practice with girls and women struggling with substance use. In C. Brown & J. Macdonald (Eds.), Critical clinical social work. Counterstorying for social justice (pp. 171–194). Canadian Scholars’ Press.

Scambler, G. (2018). Heaping blame on shame: ‘Weaponising stigma’ for neoliberal times. The Sociological Review Monographs, 66(4), 766–782.

Schmidt, R., Poole, N., Greaves, L., & Hemsing, N. (2018). New terrain: Tools to integrate trauma and gender informed responses into substance use practice and policy. Vancouver, BC: Centre of Excellence for Women’s Health.

Tseris, E. (2019). Trauma, women’s mental health, and social justice: Pitfalls and possibilities. Routledge.

Wells, K. (2011). Narrative inquiry. Oxford University Press.

World Health Organization (2021). WHO report highlights global shortfall in investment in mental health. https://www.who.int/news/item/08-10-2021-who-report-highlights-global-shortfall-in-investment-in-mental-health

Braun, V., & Clarke, V. (2013). Successful qualitative research: A practical guide for beginners. SAGE

Healy, K. (2016). After the Biomedical Technology Revolution: Where to Now for a Bio-Psycho-Social Approach to Social Work? British Journal of Social Work, 46, 1446–1462.

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