ACMD Evidence for a report on the implementation and provision of naloxone – WithYou response

October 2020

Points of interest to the ACMD

Prevalence and nature of naloxone provision, carriage and use	Our services have seen a significant increase in the prevalence, distribution, carriage and use of naloxone. At With You we have seen success when we take a proactive approach, reaching people in the spaces they already use. In Redcar and Cleveland, we were the first national treatment provider to run a pilot project of Peer to Peer naloxone. Focusing on using communities and going to where people are, not expecting them to come to us, has meant that we can better reach people who need our help, and help save lives. At the same time it empowers the peers and supports their own recovery journey. However, there are areas of concern. The provision of naloxone for people released from prison is a particular concern. The latest UK government statistics show that in 2018/19 only 17% of opioid dependent people leaving prison were given take-home naloxone.[1] In Scotland, a pilot study found that providing naloxone to people leaving prison reduced drug-related deaths by 36% in the weeks following their release.[2] The funding landscape for drug and alcohol treatment since 2012 has also limited the availability of treatment services to distribute naloxone. Funding for naloxone provision is not ring-fenced in local authority commissioning contracts and the reduction in the size of commissioned drug treatment contracts has ultimately limited the ability of treatment services to purchase the level of naloxone packs required to be distributed. Increasing drug and alcohol treatment budgets, and

[1] https://www.theyworkforyou.com/wrans/?id=2020-06-02.53402.h&s=drugs#g53404.q1
[2] https://onlinelibrary.wiley.com/doi/full/10.1111/add.13265

	mandating a specific spending requirement on naloxone per localised need, could be effective in increasing naloxone prevalence.
Evidence of effectiveness of naloxone	The clinical effectiveness of naloxone as an intervention to block the effects of opioids is well known. However, the effectiveness of naloxone in saving a person's life can be dependent on emergency services being immediately called to ensure appropriate medical interventions can be provided while the naloxone is in effect. People who use drugs can still be reluctant to call emergency services if they remain in possession of illegal substances due to a fear of arrest.[3] Further steps taken to ensure people who use drugs are not hesitant to call the emergency services could further enhance the effectiveness of naloxone as an intervention. However, naloxone isn't a panacea. Many of our services across the UK, particular in Scotland, are continuing to see an increase in poly-drug involving both opiates and benzodiazepines which presents an additional range of challenges in reversing the rising trend in overdose deaths. Therefore while naloxone remains a vital tool, it should be noted that it isn't a comprehensive solution and we'd encourage the ACMD to continue to look at the feasibility of flumazenil around countering benzodiazepine overdoses, and provide additional guidance where possible. Lastly, the effectiveness of naloxone is dependent on the quality of training which can vary greatly, and services must continue to strive and provide the highest quality of training to ensure naloxone is being used most effectively.
Evidence of who is administering naloxone (police, voluntary services, etc.)	The regulations that came into force in October 2015 allowing people who work in or for drug treatment services to supply naloxone to others was very effective in increasing the distribution of people carrying and administering naloxone in the community. However, these regulations could be relaxed further in order to allow the wholesale distribution of naloxone from drug services to organisations and services that work closely with opioid dependent people, such as in hostels. Allowing for a more wholesale model of naloxone distribution where possible, would significantly increase the supply and distribution among people at a high-risk of experiencing an overdose. Regulations in Scotland have recently been relaxed during the covid-19 pandemic allowing our services to provide bulk naloxone to multiple organisations.

[3] https://www.release.org.uk/sites/default/files/files/Naloxone%20Best%20Practice_v5%2007_11%20(003).pdf

	As noted in a case study below, we have been using a 'training the trainer' model, whereby people are trained and who can in turn, train their peers in the community. This has been very effective in ensuring access and distribution to people in the community most at-risk.
Barriers to uptake of naloxone (both intramuscular and intranasal naloxone)	There remain barriers to improving the uptake of naloxone, and several have been mentioned previously, including the fear of arrest, regulations around how naloxone can be distributed, and the funding landscape for drug treatment services from local authority commissioning. However, there are several additional barriers we'd like to raise. Provision remains extremely localised and often determined by the commissioner's demands/priorities, often aimed primarily at people who are injecting and people who are new into services. Unfortunately in some areas it's not possible to extend provision beyond these groups to family and friends, often because services just don't have the resources. Regulations that came into force in 2015 allowing people who work in or for drug treatment services to supply naloxone to others was very effective. Further relaxing regulations to allow a more wholesale distribution of naloxone model from drug services to organisations/services that work closely with opioid dependent people, would improve the uptake of naloxone to people that are at risk of having, or are likely to witness someone having an opioid-related overdose. Research has shown that intramuscular naloxone requiring an injection can be a barrier to its wider uptake, especially among people who do not inject drugs. There is a stigma attached to carrying needles and evidence has shown that people remain hesitant to carry and use them. Anecdotal evidence has also indicated that the size of packaging of naloxone can be a barrier, as packs can be inconvenient to carry and can often be larger than people's pockets. The training process required to distribute naloxone, though vital, can also act as a barrier to uptake. Our services in Cornwall increased the take-home naloxone acceptance rate by over 50% by shortening the training process, training people on the spot, making people opt-out rather than opt-in, and promoting naloxone in every interaction rather than waiting for people to come to us. Lastly, issues around supply and cost of intranasal naloxone remains a significant barrier to widening its uptake, especially to those who are

	hesitant to carry intramuscular naloxone. If this was more widely manufactured, it is likely that some of these issues around limited supply and its high cost in comparison to intramuscular naloxone would be less significant.
Evidence of collaborative approaches to provision	An example of effective collaborative approaches to providing naloxone is how we have worked with community pharmacies. Our services in Liverpool have been working in close collaboration with several community pharmacies to train and supply people released from prison naloxone when they pick up their OST script. While this partnership has worked well, the process is reliant on localised commissioning, and it would be beneficial if there was a clear national agreement on the specific role of community pharmacies in distributing naloxone to further promote collaborative partnership working in other parts of the UK.
Case studies of note	**Peer to Peer in Redcar and Cleveland** Involving people with lived experience of substance misuse has been a very effective way to distribute naloxone. With You in Redcar and Cleveland ran a successful Peer to Peer naloxone project, training people in the community as well as key organisations and businesses such as cafes, pubs, hostels, and a young person's housing charity. The peer to peer distribution model ensures we are able to access those most at-risk and who aren't engaged with services. We found that while our services in buildings might be able to distribute around ten naloxone packs in a day, the distribution volume by the peers was significantly greater. As a result of the pilot, 43 Naloxone kits were issued in Redcar and Cleveland in January 2020 alone. This was a 40% increase in packs given out when compared with an average month in the service, and 60% of people who received a naloxone pack were not known to With You, and 81% were introduced to naloxone for the first time. The project also had a very positive impact on the recovery and personal development of the peers themselves. **Working with housing organisations** Despite many overdoses taking place in people's homes and accomodation, many housing organisations still do not supply naloxone onsite. In order to address this issue, we developed strong relationships with multiple housing organisations, training staff and making sure they always have naloxone on-site in case of an emergency. We also make sure that a client's next of kin are always offered naloxone as they are

	often the first people who respond to an overdose. **HMP Lincoln** With You delivers the drug treatment service in HMP Lincoln and have improved the distribution of naloxone by utilising the role of 'naloxone champions'. In the weeks prior to a person's release, our recovery workers and peers who've been identified as 'naloxone champions' offer naloxone training. If this is at first refused, they are regularly reminded of its importance in order to encourage them to take the training. Nurses on reception are also trained to offer naloxone and are able to train people at the last moment before their release. Having a team of peers as 'naloxone champions' has been key to persuading increasing the number of people carrying naloxone once released and harnessing people's personal stories of using naloxone has been vital in improving the training uptake. **Opt-in distribution in Cornwall** In our services in Cornwall, we found that people were much more likely to reject carrying naloxone than accept it. To change people's behaviour, we put naloxone at the forefront of everything we do. Previously once seen as added extra to treatment, now anyone who's at risk of an opioid overdose, or knows someone who is, is given naloxone when they interact with us, rather than waiting for them to 'opt in'. Furthermore, we learned that you cannot wait for people to come to you. Cornwall is a huge geographical area and people often struggle to travel long distances to come to naloxone training events. We now promote naloxone in every interaction, both inside and outside of treatment. Our services in Cornwall now have the highest acceptance rates of receiving naloxone across any of our services.
If you have evidence and practice examples to share which don't fit into one of the categories above, please add detail here	