Expanding access to naloxone consultation - WithYou response

Sept 2021

Question 1

To what extent do you agree that the current regulations mean naloxone is difficult to access in the event of an overdose?

- **strongly agree**
- **agree**
- **neither agree nor disagree**
- **disagree**
- **strongly disagree**

Please provide a reason for your answer and any evidence to support it, including any experiences you or your organisations have had trying to access naloxone (max 1,000 words).

The amendment to the regulations 2015 allowing naloxone to be distributed without a prescription by people who work in drug treatment services had a significant effect in expanding the availability and access to naloxone. As a result of this change our services have seen a significant increase in the supply, distribution, carriage and use of naloxone.

In light of the rising number of drug-related deaths, we believe these regulations can go one step further and allow a more wholesale distribution model of naloxone from drug services to organisations and services that work closely with opioid dependent people/people most at-risk of an overdose. We believe this would have a significant impact on improving the accessibility of naloxone by people at-risk of an opioid-related overdose, and those who are likely to witness an opioid-related overdose.

The critical issue we face is around third-party supply aspects of the regulations. For example, our staff can distribute naloxone in a hostel but we are unable to leave the

required level of stock for them to distribute as they see fit unless we set up a service level agreement with them. The same barriers are faced by pharmacies who need to be specifically commissioned to supply naloxone or require a prescription. Pharmacies should be able to supply naloxone without requiring a service level agreement or prescription, and that it would be beneficial for there to be a clear national agreement on the specific role of community pharmacies in distributing naloxone.

There are also areas where the availability and distribution of naloxone remains a major concern and additional actions need to be taken. UK government statistics from 2018/19 show only 17% of opioid dependent people who leave prison were given take-home naloxone,[1] despite the risk of a drug-related death being 7.5 times higher for UK prisoners in the first fortnight following their release.[2] It is essential that steps are taken to address this distribution issue. 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.[3] We know prison settings can be hesitant to supply injection based Prenoxad, so the scaling up availability and distribution in naloxone can be improved by focusing supply on Nyxoid, the nasal-based version, which may be seen as more appropriate in these settings.

The current regulatory approach is not the only factor limiting access to naloxone.

Scotland, Northern Ireland and Wales all have national naloxone programmes and report on take-home naloxone provision. In England the responsibility is devolved to local authorities and there is no requirement to report on take-home naloxone provision at the national level. In England, access is made more difficult by the localised nature of provision, often determined by the commissioner's demands or priorities which is often aimed primarily at people who are injecting and people new into services. In some areas, a lack of resources means it's not possible to extend provision beyond these groups to family and friends. Funding for naloxone provision is not ring-fenced in local authority commissioning contracts and the long-term trend which has seen a reduction in the size of commissioned drug treatment contracts has limited the capacity of services to purchase the supply of naloxone they require. Increasing funding for the treatment sector at the level recommended in the recent Black Review, alongside mandating a specific spending requirement on naloxone (per-localised need) would be effective in increasing the overall availability.

Lastly, people who are not in treatment are most at-risk of overdose, and it is vital that structural barriers preventing drug treatment providers from distributing naloxone to a wider range of environments are removed. Innovative approaches that focus on

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

community penetration, engagement and naloxone dispersal need to be prioritised, alongside any regulatory changes.

Question 2

To what extent do you agree that the following settings or individuals should be able to supply take-home naloxone without a prescription?

Outreach and day services for people who experience homelessness or rough sleeping:

- **strongly agree**
- **agree**
- **neither agree nor disagree**
- **disagree**
- **strongly disagree**

Temporary or supported accommodation services for people with substance

use disorders or people who experience homelessness or rough sleeping:

- **strongly agree**
- **agree**
- **neither agree nor disagree**
- **disagree**
- **strongly disagree**

Police officers:

- **strongly agree**
- **agree**
- **neither agree nor disagree**
- **disagree**
- **strongly disagree**

Drug treatment workers commissioned by PCCs to work in police custody suites:

- **strongly agree**
- **agree**
- **neither agree nor disagree**
- **disagree**
- **strongly disagree**

Prison officers (orderly officers and duty governors):

- **strongly agree**

- agree
- neither agree nor disagree
- disagree
- strongly disagree

Probation officers:

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

Registered nurses:

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

Registered paramedics:

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

Registered midwives:

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

Pharmacists:

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

Please provide a reason for your answers with reference to any, some or all of the above settings and any supporting evidence (max 1,000 words).

All of the above professions should be able to provide take-home naloxone without a prescription. A take-home supply of naloxone should be available to any person requesting it, particularly groups that are most at-risk of having an overdose or are likely to witness one.

Alongside drug services, take-home naloxone should be distributed and training provided to primary care services, hospitals, hostels and police services at the very minimum. This is vital to ensure that people who use drugs (and who may not be engaged with drug services) can access a take-home supply which can be used at a later date.

All community pharmacies commissioned to provide supervised consumption should also be able to supply naloxone as these people are most at-risk whilst titrating. The same rules should those that prescribe prison releases. Hospital pharmacies should also be able provide naloxone to people on discharge, as they are also at a significant risk

Ensuring prison officers are able to distribute naloxone to those leaving prison is also essential. Medical staff may not be present during a prisoner's release to provide naloxone, and so it is vital that prison officers are able to take on this role.

Question 3

If you represent any of the following services or individuals, do you think it is likely that they would keep a stock of and supply naloxone if the regulations were changed such that they were eligible to do so?

Outreach and day services for people who experience homelessness or rough sleeping:

- **highly likely**
- **somewhat likely**
- **somewhat unlikely**
- **highly unlikely**
- **I do not represent these individuals**

Temporary or supported accommodation services for people with substance use disorders or people who experience homelessness or rough sleeping:

- **highly likely**
- **somewhat likely**
- **somewhat unlikely**

- highly unlikely
- I do not represent these individuals

Police officers:

- highly likely
- somewhat likely
- somewhat unlikely
- highly unlikely
- I do not represent these individuals

Drug treatment workers commissioned by PCCs to work in police custody suites:

- highly likely
- somewhat likely
- somewhat unlikely
- highly unlikely
- I do not represent these individuals

Prison officers (orderly officers and duty governors):

- highly likely
- somewhat likely
- somewhat unlikely
- highly unlikely
- I do not represent these individuals

Probation officers:

- highly likely
- somewhat likely
- somewhat unlikely
- highly unlikely
- I do not represent these individuals

Registered nurses:

- highly likely
- somewhat likely
- somewhat unlikely
- highly unlikely
- I do not represent these individuals

Registered paramedics:

- **highly likely**
- **somewhat likely**
- **somewhat unlikely**
- **highly unlikely**
- **I do not represent these individuals**

Registered midwives:

- **highly likely**
- **somewhat likely**
- **somewhat unlikely**
- **highly unlikely**
- **I do not represent these individuals**

Pharmacists:

- **highly likely**
- **somewhat likely**
- **somewhat unlikely**
- **highly unlikely**
- **I do not represent these individuals**

Please provide a reason for your answers (max 1,000 words).

While the services/individuals mentioned above are likely to keep a supply of naloxone, it's important to note that stigma around carrying naloxone, especially injection based Prenoxad, plays a large role in reducing the carriage of naloxone among certain professions. A lack of awareness or ingrained stigma towards people who use drugs in agencies and institutions where naloxone could usefully be supplied needs to be addressed. Improving public health messaging and training to remove any fears and concerns around naloxone's administration would help increase and normalise its uptake and carriage among relevant professions.

Question 4

Are there any settings not explicitly cited in the above questions that you would support being able to obtain or supply naloxone? Please provide a reason for your answer with reference to any supporting evidence (max 1,000 words).

Given the relatively low risks associated with naloxone use, all settings and services frequented by people who use drugs should be able to obtain and supply naloxone. This includes:

- Peer mentors, and peer mentor groups

- Soup kitchens, food banks or recovery cafes;
- Domestic violence services or women's refuges;
- Women-only support group;
- Mental health services or mental health admission wards;
- Street wardens or local park guards;
- Sex workers' services;
- Social services or social workers;
- GPs and other primary care settings;
- Street outreach services;
- Located with defibrillator packs;

Question 5

To what extent do you agree that the labelling requirements on prescription-only medicines, such as the name of the individual to whom the medicine is being supplied, should be disapplied when naloxone is given out by services without a prescription?

- **strongly agree**
- **agree**
- **neither agree nor disagree**
- **disagree**
- **strongly disagree**

Question 6

To what extent do you agree that allowing the below settings or individuals to supply take-home naloxone without a prescription would help to reduce the incidence of opioid overdose and drug-related deaths?

Outreach and day services for people who experience homelessness or rough sleeping:

- **strongly agree**
- **agree**
- **neither agree nor disagree**
- **disagree**

- strongly disagree

Temporary or supported accommodation services for people with substance use disorders or people who experience homelessness or rough sleeping:

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

Police officers:

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

Drug treatment workers commissioned by PCCs to work in police custody suites:

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

Prison officers (orderly officers and duty governors):

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

Probation officers:

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

Registered nurses:

- **strongly agree**
- **agree**
- **neither agree nor disagree**
- **disagree**
- **strongly disagree**

Registered paramedics:

- **strongly agree**
- **agree**
- **neither agree nor disagree**
- **disagree**
- **strongly disagree**

Registered midwives:

- **strongly agree**
- **agree**
- **neither agree nor disagree**
- **disagree**
- **strongly disagree**

Pharmacists:

- **strongly agree**
- **agree**
- **neither agree nor disagree**
- **disagree**
- **strongly disagree**

Please provide a reason for your answers with reference to any, some or all of the above settings and any supporting evidence (max 1,000 words).

The clinical effectiveness of naloxone as an intervention to block the effects of opioids is well known and is a key preventative measure in reducing drug-related deaths. 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.

However, though greater prevalence and easier availability among most at-risk groups and those likely to witness an overdose will certainly reduce the number of potentially fatal overdoses, it is only a measure of last resort.

The effectiveness of naloxone in saving a person's life can be dependent on emergency services being called immediately to ensure appropriate medical interventions can be provided while the naloxone is in effect. However, many people who use drugs remain reluctant to call emergency services due to the fear of arrest.[4] Additional steps could be explored to ensure people who use drugs are not hesitant to call emergency services, such as a guarantee of non-arrest in specific circumstances.

Many of our services across the UK are continuing to see a significant increase in poly-drug use involving both opiates and benzodiazepines presenting additional challenges in tackling overdose deaths. While naloxone remains a vital tool, it isn't a comprehensive solution. To address the rise in benzodiazepine-related deaths, we recommend the government and relevant authorities examine the feasibility of flumazenil as a tool in countering benzodiazepine overdose, and provide additional guidance.

Question 7

To what extent do you agree that there are risks associated with the administration of naloxone in either nasal or injectable form?

Nasal naloxone:

- strongly agree
- **agree**
- neither agree nor disagree
- disagree
- strongly disagree

Injectable naloxone:

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

Please provide a reason for your answer and any evidence to support it, making sure to be clear which form of naloxone you are referring to (max 1,000 words).

There is negligible risk around administration of naloxone and this is something we have to ensure we emphasise during training.

Research has shown that intramuscular naloxone requiring an injection can be a barrier

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

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. For example, we have seen that people that smoke heroin often do not wish to be associated with an injecting item and there is a common view that a person cannot overdose from smoking heroin. 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.

There is an issue around supply and cost of intranasal naloxone which is a significant barrier to widening its uptake, especially to those who are hesitant to carry intramuscular naloxone. If it 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.

Question 8

What safeguards do you think should be required in the settings from which naloxone is supplied? (max 1,000 words).

The training process required to distribute naloxone can 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. The training must be clear and simple and remove any fears and concerns people may have around naloxone's administration.

Trainers should provide proper CPR training alongside naloxone training and encourage naloxone to be promoted in every interaction with those most at-risk, or likely to be in contact with someone at-risk, rather than waiting for people to come forward and request a supply.

Question 9

If your organisation distributes naloxone, have you received training on how to use it?

- **yes**
- **no**
- **not applicable to me**

If 'yes', do you believe said training is sufficient? (max 1,000 words).

How easy do you think it would be to expand this training to additional settings? Please provide a reason for your answer and any evidence to support it, making sure to be clear if referring only to nasal or injectable naloxone (max 1,000 words).

We have trained hostel staff, approved premises, peer mentors, police , paramedics and pharmacies on how to use it in both forms. It would be easy for us to further expand the training we provide to other settings.

Question 10

Is there anything else you would like to share on the risks and benefits of naloxone which you have not provided in answers above? If so, please provide further information and include any evidence and research you may have to support your response (max 1,000 words).

One of the most successful approaches we have found to improving the effectiveness of our naloxone distribution is through taking 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. We trained a team 'peers' with lived experience to supply naloxone to people at risk of dying in the community, as well as local businesses and charities. This significantly increased the number of packs given out, accessed many more people who were not known to treatment services, and over 80% were introduced to naloxone for the first time. Focusing on using communities and going to where people are, not expecting them to come to us, means we can better reach people who need our help. At the same time it empowers the peers and supports their own recovery journey. We are now rolling out this model in other parts of the UK.

Question 11

Do you think the proposals risk impacting people differently, or could impact adversely on any of the protected characteristics covered by the Public Sector Equality Duty set out in section 149 of the Equality Act 2010 or by section 75 of the Northern Ireland Act 1998? If so, please provide details (max 1,000 words).