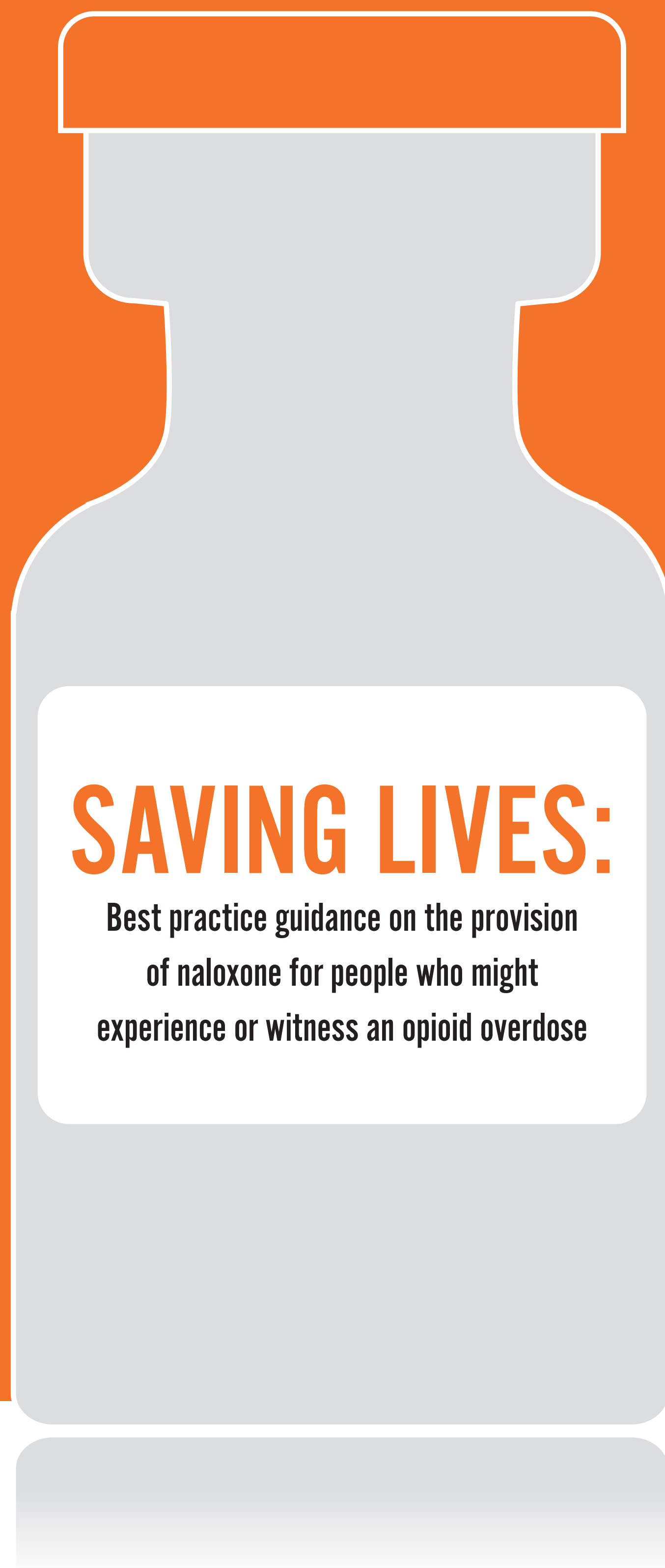

SAVING LIVES:

Best practice guidance on the provision of naloxone for people who might experience or witness an opioid overdose

Release
Drugs, the Law & Human Rights

Release

The national centre of expertise on drugs and drugs law - providing free and confidential specialist advice to the public and professionals. The organisation campaigns directly on issues that impact on our clients - it is their experiences that drive the policy work that Release does. Release believes in a just and fair society where drug policies should reduce the harms associated with drugs, and where those who use drugs are treated based on principles of human rights, dignity and equality.

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Members of the Naloxone Steering Group Organising Committee included: Niamh Eastwood, Kirstie Douse, Zoe Carre, Amal Ali, Prof. Sir John Strang, Basak Tas, Martin McCusker, Kirsten Horsburgh.

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Please see page 17 for the list of participants and affiliate organisations.

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Objectives

Building on the findings from Release's research on naloxone in England, Release hosted the Naloxone Steering Group 2019 in April 2019, in partnership with the National Addiction Centre at King's College London. The objective of the steering group was to get key stakeholders together for a day to discuss some of the main aspects of naloxone provision in the UK and to produce guidelines on the provision of naloxone for people who might experience or witness an opioid overdose.

Methodology

The steering group event was held in London on 1st April 2019, with 42 participants in attendance, from drug user activist networks, civil society, service providers, academia, pharmacy, housing, police, prison and governmental departments. Participants were invited to the steering group event to represent a range of backgrounds, expertise and UK regional perspectives. The Naloxone Steering Group Organising Committee selected participants to invite, agreed on topics to be discussed during the event and produced topic guides to inform discussions.
The process adopted to develop this guidance document was as follows:

- Experts on each topic delivered brief presentations to set the tone for discussion and summarise the main areas of interest;
- Participants discussed each topic in smaller break-out groups, using the topic guides to inform the discussion, with a rapporteur in each group moderating and taking notes;
- Rapporteurs from each group fed back discussion points orally to all participants, with one person taking notes to summarise discussion on the topic;
- The summary discussion notes were used to develop a draft framework document, which was then disseminated to all participants for feedback;
- The framework document was subsequently revised to incorporate participant feedback;
- The revised framework document was then used to develop a draft of this guidance document, which was then disseminated to all participants for feedback; and
- The guidance document was subsequently revised to incorporate participant feedback, with input from Naloxone Steering Group Organising Committee members to resolve any conflicting feedback.

Overarching principles

Drug-related deaths are on the rise in every devolved nation and "9 out of 10 overdose deaths (89 %) in the UK involved some form of opioid"[1]. Naloxone is a critical and life-saving intervention for those at risk of opioid drug poisoning. To mitigate the risk of fatal opioid overdose, we must foster an approach that is grounded in evidence and facilitates the enjoyment of human rights, with a goal of achieving the highest attainable standard of health for people who use drugs. To this end, the following overarching principles will need to be respected, if we are to achieve best practice in providing naloxone to those who might experience or witness an opioid overdose.

- Presumption to provide - decisions should be guided by a presumption in favour of providing naloxone.
- Duty to provide - naloxone should be part of the basic standard of care offered to people as part of harm reduction.
- There are no real external barriers - any barriers that exist in supplying naloxone are internal and can be addressed.
- Funding - there should be a clear and specific funding stream to protect funding and remove fragmentation in funding for naloxone.
- Change the narrative - naloxone saves lives. Stigmatising, harmful and damaging messages surrounding naloxone and people who use (or have used) drugs are dangerous and pervasive. It is important the narrative is renewed to one that emphasises the importance of preserving life.
- Naloxone is only part of the solution - naloxone should be part of a broader response to preventing drug-related deaths. The quality of drug treatment and harm reduction is also imperative to saving lives.

Providing naloxone to people in contact with drug services

People in contact with drug services, and in particular those people who use (or have used) opioids, might experience or witness an opioid overdose[i]. Naloxone is a prescription only medicine, however, since October 2015, "people working in or for drug treatment services" across the UK can supply naloxone without a prescription. Drug services that can supply naloxone without a prescription include mainstream drug services in community and prison settings, in-patient or residential drug treatment services, and community pharmacies delivering opioid substitution therapy (OST) and/or needle and syringe programmes (NSP). Despite the relative ease with which drug services can identify and supply naloxone to people in contact with their services, naloxone is still not widely available to this group, in part because of barriers to accessing the medication.[2]

Steps to best practice:

1. Ensure that *every drug service* in your local area[ii] is supplying naloxone and delivering training.
2. Supply naloxone and training on an opt-out basis to:
    - *Every person* on OST or attending NSP services, including via drug services, community pharmacies and GP shared care servcies;
    - *Every person* treated for an opioid related overdose; and
    - *Every person* [iii] at risk of/likely to witness an overdose on release from prison.
    - This means that every person should be offered and supplied with naloxone and training unless they explicitly opt-out from receiving this, and that every effort should be made to provide information about naloxone, encourage uptake and signpost to other pathways to access.
3. Involve everyone in the drug service - saving lives is everyone's job. Anyone "working in or for" drug services[iv] can *and should* supply naloxone without a prescription. Anyone can deliver training if they are taught how to. Responsibilities related to naloxone should consistently be included in job descriptions.

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i While Fentanyl overdoses are uncommon in the UK, experts supporting the development of this guidance suggest that standard advice on administering naloxone applies regardless of the opiate involved. 0.4mg every 2-3 minutes. If the person has not regained consciousness after 2 full kits, re-consider diagnosis of opiate related overdose.

ii This may include, but is not limited to: drug treatment services, harm reduction services, recovery and aftercare services, prison drug services, community pharmacies providing OST and NSP, shared care GPs providing OST, healthcare staff prescribing OST in prisons, specialist inpatient or residential drug services.

iii This includes the supply of naloxone to minors which the October 2015 regulations permits but should be dispensed on a case-by-case basis.

iv This can include, but is not limited to: receptionists, outreach workers, keyworkers, frontline workers, peers, apprentices, pharmacists, nurses, and other clinical staff.

4. Involve people who use (or have used) opioids and people who have experienced or witnessed overdose as much as possible. Please refer to the section below on involving people who use (or have used) opiods for best practice in this area.

5. Supply naloxone when and where the person asks for this – do not turn them away, expect them to pick it up somewhere else or to come back another time.

6. Always offer people a choice between intranasal (e.g. Nyxoid) and injectable (e.g. Prenoxad) formulations of naloxone.

7. Prioritise naloxone and training at the first point of contact and during an assessment appointment with the drug service.

8. Regularly check in with people at every stage of their treatment: Do they have naloxone? Are they carrying it? Do they need a training refresher? Do they need re-supply if their kit has been used or is about to expire? Have they experienced or witnessed overdose and do they need any support around this?

9. Offer and provide support – namely for bereavement and trauma – to people who have experienced or witnessed drug-related death or non-fatal overdose.

10. Have named naloxone leads, ideally people who use (or have used) opioids, in every drug service.

11. Ensure that every person due for release from prison is aware of all local pathways for accessing naloxone, including for re-supply, follow-up care and to support training of family members, partners and other loved ones who might witness an opioid overdose. This requires collaboration between prisons, drug services and other naloxone providers in the community.

12. Collect data[v] to monitor and regularly audit naloxone supply and training to people in contact with drug services. This can help to monitor performance and identify underserved groups, among other benefits.

v Drug services reporting to the National Drug Treatment Monitoring System (NDTMS) will normally collect data on naloxone and training to their clients. Drug services which do not report to the NDTMS are also encouraged to collect and monitor data on naloxone.

Providing naloxone to people not in contact with drug services & those who might witness an opioid overdose

There are a number of individuals who will not be in contact with drug treatment services but might either experience or witness an opioid overdose and should be carrying naloxone. Evidence suggests that there is an increased risk of premature opioid-induced mortality amongst those not in contact with treatment services[3]. Among this population there are specific vulnerabilities that increase this likelihood. Many of them are homeless and have coexisting drug and mental health problems.[4] Similar risks are also present amongst those who have recently been released from prison, where prolonged periods of abstinence in custody make "the administration of a dose [of an opioid] at previous levels deadly"[5]. In many cases overdoses are witnessed by family, friends or "someone whose work brings them into contact with people who use opioids"[6]; this includes staff working in primary care, housing services or people working in and around overdose hotspots. Increasing access to naloxone among people who might witness an overdose could significantly reduce the growing number of opioid related deaths. There are a number of ways to potentially reach these groups, such as through hostels or housing services, street outreach, healthcare services, police officers, people who use (or have used) opioids, soup kitchens, women's refuges, and family support groups.

Steps to best practice:

1. Ask people how and where they would like naloxone to be available and supplied.
2. Identify local areas to target by consulting with people who use (or have used) opioids and mapping out hotspots, for example, where naloxone is administered, where ambulance services are called out to respond to overdoses or where injecting equipment is discarded.
3. Ensure that naloxone is easily accessible in hotspots by:
    - Training and equipping staff working nearby to carry naloxone;
    - Having naloxone on-site, for example through vending machines, in telephone booths, or alongside defibrillators.

4. Investigate near-fatal overdoses and drug-related deaths locally to identify any missed opportunities to provide naloxone.

5. Raise awareness about naloxone through campaigns, for example, as seen in the U.S - the 'Be a hero' campaign or in the run-up to International Overdose Awareness Day[7], or by recruiting a high-profile individual to raise awareness.

6. Offer to supply naloxone and training to people accompanying someone treated by emergency services for an opioid overdose. This should be in addition to providing naloxone on an opt-out basis to every person treated for an opioid related overdose. Please refer to the section above on 'Providing naloxone to people in contact with drug services' for best practice on opt-out provision.

7. Encourage GPs to offer to supply naloxone and deliver training to patients that they have prescribed opioids to, and to the family members, friends and other loved ones of a person who might experience an opioid overdose.

8. Beyond ensuring that all persons released from prison have access to naloxone through an opt-out scheme, prisons should also have a pool of naloxone ready to supply to people who are likely to be released from prison on short notice. For example, those on remand, day or weekend release and those transferred to a lower category prison nearing the end of their custodial sentence.

9. Consider the needs of foreign nationals due for release from prison or Immigration Removal Centres, who are likely to be deported to their home country upon release. They should be signposted to services where they can access naloxone after release, either locally or in their home country where this is available. Harm reduction messages should also be encouraged through training and access to readily available information in a number of languages.

10. Aim to make naloxone available through as many services or individuals as possible, so that this is more accessible to people that are not in contact with drug services and those who might witness an opioid overdose. Please refer to the table below (on the next page), which is a non-exhaustive list of services or individuals that could either carry naloxone to administer, or supply naloxone.

	Carry to administer	Supply take-home [vi]
Drug workers	x	x
GPs (including those not providing shared care services)	x	x
Outreach workers	x	x
Peer workers (including family members)	x	x
Hostels, homeless ancillary services	x	x
Paramedics (including community first aiders, St Johns Ambulance)	x	x
Emergency departments treating opioid overdose	x	x
Allied professionals who provide voluntary work i.e. foot care	x	x
Refuges	x	x
First aid training	x	x
One stop shops	x	x
Sexual health clinics	x	x
Mental health teams, dual diagnosis, etc.	x	x
Student union welfare staff	x	
BME specialist services	x	x
Family, friends, partners, carers, etc.	x	
Prison and court staff	x	
Police officers, police in custody suites	x	
Practitioners working in police custody suites	x	x
Fire service	x	
People working in or around hotspots e.g. train stations, ferry ports, bus stations, toilets, parks	x	
Family support groups	x	
Night-time economy e.g. licensed venues, security staff, festivals	x	
Schools and colleges	x	
Soup kitchens, food banks	x	
Youth services e.g. YMCA, St. Basils, Centrepoint	x	
Libraries	x	
Job centres	x	
Day centres	x	
Religious groups (including religious outreach, street pastors, street angels)	x	
Park wardens	x	
Neighbourhood watch	x	
Private and local authority street cleansers	x	
Local council staff e.g. 'Antisocial Behaviour Officers' (in Belfast) or equivalents	x	

vi As long as the person providing naloxone at these sites is employed by drug treatment services provided by, or on behalf of an NHS body; a local authority; Public Health England; or Public Health Agency, this is permitted.

Involving people who use (or have used) opiods

Empowering people who use (or have used) opioids to supply, carry and administer naloxone can significantly improve access for those who might experience an opioid overdose, thereby saving lives. People who use (or have used) opioids are experts by experience; their use of anecdotal evidence in naloxone supply/training provides added credibility, authenticity and effectiveness whilst simultaneously debunking myths about overdoses. Involving people who use (or have used) opioids in naloxone programmes also has the added value of reaching those not in contact with treatment services, contributing local learning to benefit service provision, driving creativity and creating a dedicated workforce, with positive treatment effects.

A review of six naloxone programmes which involved people who use (or have used) opioids - or otherwise called 'Peer-to-Peer Naloxone distribution programmes' ('P2PN') – identified the following key lessons from these schemes:

- P2PN initiatives remain focused and committed so they drive forward the distribution of naloxone through specialist service settings, generic community-based venues, outreach delivery and the homes of peers.
- P2PN schemes can distribute naloxone as part of a one-hour training programme on opioid overdose prevention and management, including naloxone distribution or using a brief intervention (5 – 10 minutes) that guides peers to administer naloxone. Peer education has a key preventive effect that can reduce the number of opioid overdoses.
- P2PN schemes have also shown their ability to creatively train and distribute naloxone as part of the pre-release preparation of people in prison.[8]

CASE STUDY:

"EuroNPUD Naloxone Access and Advocacy Project (NAAP) tested access to take-home naloxone in three English cities with at least twice the national average of opioid overdose deaths and established take-home naloxone programmes. The peer focus groups and mystery shopper exercise in each area highlighted the successful role out of take-home naloxone through specialist drug services. However, NAAP identified ongoing barriers to accessing take-home naloxone or sign posting to specialist providers in general practice and community pharmacy settings. Further, momentum in specialist drug services also had a tendency to drop away after initial introduction with Prenoxad training kits being mislaid, practitioners not working through a training checklist to ensure the quality and comprehensive nature of the intervention, and other service priorities draw the attention of specialist staff from a systematic roll out of take-home naloxone."

Mat Southwell, EuroNPUD

Steps to best practice:

1. Recognise the added value that people who use (or have used) opioids bring by funding P2PN programmes, for example, by setting aside a specific budget for their work around naloxone or to prevent drug-related deaths.

2. Value the work that people who use (or have used) opioids do by paying them for their time and expertise[vii]. They are not free labour. Ideally, they should receive actual remuneration for their work (not just vouchers), and at the very least, they should receive travel and other expenses so they are not out of pocket.

3. Support people who use (or have used) opioids, just like any other workforce, through capacity building, coordination and other benefits.

4. Offer accredited training programmes for people who use (or have used) opioids involved in P2PN programmes.

5. Meaningfully involve people who use (or have used) opioids in auditing the quality of naloxone and training. Auditing could be done through anecdotal feedback, 'peer-to-peer' evaluation, mystery shoppers, looking at how many lives have been saved, and by revisiting training.

6. Educate professionals, including commissioners and senior management, about the added value that people who use (or have used) opioids bring.

7. Challenge stigmatising attitudes towards people who use (or have used) opioids among staff. Stigmatising attitudes are harmful and lead to people being treated paternalistically and subjected to controlling behaviour. For example, staff may perceive people who use (or have used) opioids delivering naloxone training to be unprofessional or to work in an unorthodox way, when actually it is completely congruent for the client group they are working with.

8. Consider the different groups of people who use (or have used) opioids, how they might interact with one another, and how their needs and experiences may differ. People who use (or have used) opioids are not a uniform group.

9. Commit to, and take steps towards, involving marginalised, disenfranchised and under-represented groups of people who use (or have used) opioids. This might include people who are currently using drugs, women, LGBTQIA+, people of colour, young people, people with a disability, sex workers, people experiencing homelessness, formerly and currently incarcerated people, and other heavily policed communities.

10. Recognise the traumatising effect of experiencing and witnessing overdose and offer appropriate support.

vii If people are receiving state benefits these might be affected by working and earning money. The rules are different for each benefit, so people should be encouraged and helped to check with the Department for Work and Pensions, so that this can be managed.

Removing barriers

There are currently barriers that exist, which hinder the effective provision of naloxone to those who might experience or witness an opioid overdose. Some of these barriers are based on misconceptions surrounding naloxone, for example, ideas that naloxone encourages risky behaviours or can be harmful. Another issue that exists is the provision of naloxone to families linked to fears of breaching confidentiality of the client to the service. Practical considerations also exist in relation to training, whether it is either too intensive, or conversely not thorough enough, or is a condition of access to naloxone. Other major practical barriers relate to the problem of people not carrying naloxone in circumstances where it may be needed or people hesitating to contact emergency assistance for overdose due to the fear of police presence and prosecution.

Steps to best practice:

1. Deliver training to relevant professionals, with the aim of de-stigmatising people with lived or living experience of opioid use, educating people about the benefits and importance of naloxone, and debunking misconceptions surrounding naloxone. This would be particularly beneficial for professionals working in criminal justice (namely police, prisons and probation) and health (namely doctors, GPs, pharmacists, paramedics, dentists and nurses working in community, inpatient and custodial settings).
2. Normalise naloxone in relevant services (please refer to the table above which lists services that could administer and/or supply naloxone) and encourage staff to adopt positive messaging around naloxone. Naloxone should be offered and discussed at every stage, so that service users know what it is, where they can access it, and when and how to use it. Training should also be offered at every stage and repeated.
3. Make naloxone more accessible to family members, friends and other loved ones who might witness an opioid overdose by:
    - Advertising availability of naloxone in places, such as family support groups, GP surgeries, pharmacies, and prison visit halls;
    - Encouraging people to bring someone along to naloxone training sessions;
    - Having a pathway to accessing naloxone and training, for family members, friends and other loved ones, which does not require disclosure or the consent of a service user;
    - Delivering "train the trainers" training to family support groups so that they can train other family members and feel more involved; and
    - Always offering a choice between intranasal (e.g. Nyxoid) and injectable (e.g. Prenoxad) formulations of naloxone.
4. Challenge any reluctance to administer naloxone in pregnancy. The reality is that pregnant people are at risk of death in the event of an overdose, naloxone has the potential to save their life, and it can be safely administered in pregnancy.
5. Tailor training to the individual and the context. Training can be delivered 1-2-1 or in group settings, opportunistically or at a set time, as a brief intervention or as a lengthier session. Ideally, everyone should receive a basic level of training, and should be offered more detailed training if they want it. However, this does not mean that someone should be denied naloxone because of a lack of training.

6. Work with key stakeholders - namely people with lived and living experience or manufacturers of naloxone products – to develop solutions for making naloxone easier to carry. Ask people if they are carrying naloxone and why they are not.

CASE STUDY:

"As we know very few drug users actually carry the naloxone kits with them, we started dispensing keyrings with ampoules of naloxone, in an attempt to get injecting drug users to carry at least 1 dose of naloxone on their person. We have found the keyrings extremely popular while they have increased the uptake of the Prenoxad kits. Just to be clear we would never advocate the keyrings instead or ahead of the Prenoxad kits, as they are our go to tool for reversing opiate ODs. While we dispense Prenoxad to everyone and anyone who may be around an opiate OD, we give the keyrings only to people who inject through our needle exchange at Lorraine Hewitt House. This way we are sure they have access to sterile works, as the keyring has no needle in it."

...

7. Police and prosecutors should implement a medical amnesty policy, which protects people who are seeking medical attention for drug-related injury or overdose from arrest and prosecution for related drug offences. Medical amnesty or 'Good Samaritan' policies have been widely implemented across the US and save lives by removing the fear of prosecution and hesitation during a life-threatening emergency. This could be achieved in the UK, at either a local or a national level, by developing prosecutorial guidelines with prosecutors and police.

Issues for further consideration:

To facilitate best practice, consideration should be given to:

1. Reviewing funding arrangements for naloxone to ensure sufficient funding and remove fragmentation.
2. Reviewing commissioning arrangements for naloxone to clearly allocate responsibility and remove fragmentation. For example, it is currently unclear where responsibility lies for commissioning and funding prison naloxone programmes in England, and this could be resolved by making NHS England responsible for commissioning such programmes.
3. Incorporating the overarching principle of a 'duty to provide' naloxone into NICE guidelines and CQC inspection criteria.
4. Taking concrete steps to ensure that people also have access to intranasal (e.g. Nyxoid) formulations of naloxone, for example in Northern Ireland where this is basically not available, and any other new formulations of naloxone as and when they become licensed.
5. Beyond drug treatment agencies providing naloxone, consideration should be given to making the medication available over the counter in pharmacies. This could potentially remove confusion around its current status as a prescription only medicine, which can be supplied without a prescription in certain circumstances. This also has the potential to make naloxone more readily available to those who might experience or witness an opioid overdose.
6. There is a lack of awareness among some police officers, with a number of areas reporting that this life-saving medication is being mistaken as drug paraphernalia, and as result, is being confiscated. Police officers should be trained to identify the medication to ensure it is not unnecessarily confiscated, nor that it results in the arrest of those carrying the medication.
7. The Police Federation of England and Wales should issue a position statement on the duty to protect life, including through the carriage, administration and supply of naloxone by officers who are often the first responders at the scene of an overdose and, therefore, have the potential to save lives.

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Resources

This page lists resources, including guidelines, reports and websites that may be of interest.

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Carre, Z & Ali, A. (2019) Finding a Needle in a Haystack: Take-Home Naloxone in England 2017/18, Release: https://www.release.org.uk/naloxone-2017-18

EuroNPUD, Naloxone Access and Advocacy Project: https://www.euronpud.net/naloxone

HIT, Drug and Alcohol Resources and Publications: https://www.hit.org.uk/index.php/publications

Improving Outcomes for the Treatment of Opioid Dependence (IOTOD), Take Home Naloxone Toolkit: https://iotodeducation.com/resources-and-tools/get-started/

Public Health England (2017) Take-home naloxone for opioid overdose in people who use drugs: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669475/phetake-homenaloxoneforopioidoverdoseaug2017.pdf

Public Health England (2018) Guidance – Fentanyl: Preparing for a future threat: https://www.gov.uk/government/publications/fentanyl-preparing-for-a-future-threat

Release, Naloxone Information Page: https://www.release.org.uk/drugs/naloxone

Scottish Drugs Forum, Scotland's Take-Home Naloxone Programme: http://www.sdf.org.uk/what-we-do/reducing-harm/take-home-naloxone/

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