Release and Harm Reduction International's response to the Department of Health and Social Care (DHSC)'s Consultation: 'Expanding Access to Naloxone'

September, 2021

Release is the national centre of expertise on drugs and drugs law in the UK. The organisation, founded in 1967, is an independent and registered charity. Release provides free non-judgmental, specialist advice and information to the public and professionals on issues related to drug use and to drug laws. The organisation campaigns directly on issues that impact its clients - it is their experiences that drive the policy work that Release does and why Release advocates for evidence-based drug policies that are founded on principles of public health rather than a criminal justice approach. 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.

Harm Reduction International (HRI) is a leading NGO dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. We promote the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies.

Release and **HRI** are both NGOs in Special Consultative Status with the Economic and Social Council of the United Nations.

The present report is submitted in response to the Department of Health and Social Care (DHSC)'s Consultation on expanding access to naloxone.

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 or 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.

Whilst regulations were introduced permitting naloxone to be supplied without a prescription in October 2015, with the aim of making naloxone more widely available across the UK, the change in legislation only permitted supply without prescription to people 'employed or engaged in the provision of drug treatment services', or where arrangements have been made with a prescribed authority. Release and Harm Reduction International therefore welcome the ambition to expand access to naloxone.

Whilst Scotland, Northern Ireland and Wales all have national naloxone programmes and report on Take Home Naloxone (THN) provision, in England the responsibility to provide THN is devolved to local authorities and there is no requirement to report on THN provision at the national level. Release's 2019 policy paper 'Finding a Needle in a Haystack' produced a map of THN coverage in England by local authority area for 2017/18. Since this report's publication, availability of THN in England has notably improved, with THN now available in almost every local authority in England, and with peer to peer naloxone initiatives increasing during the coronavirus (COVID-19) pandemic (discussed further in response to Question 4). However, there is still ample room to improve THN provision *throughout* the UK, and amendments to the current regulations around naloxone supply could assist in the following areas:

(a) expanding the list of services/individuals

Legislation for the distribution of naloxone is a national one – UK wide – as naloxone is prescription-only but can be legally supplied without a prescription by 'drug treatment services'. Whilst a small number of services beyond drug treatment services are able to supply THN, this is currently dependent on the person providing naloxone at these sites being employed or engaged by drug treatment services provided by, or on behalf of an NHS body; a local authority; Public Health England; or Public Health Agency, usually through a service level agreement. For those supplying outside of drug treatment services, establishing systems and agreements can be burdensome and can create significant barriers to adopting the provision of naloxone within their services. Widening the number of settings and professions that can lawfully supply naloxone will reduce the barriers to supply, and will also actively promote the involvement of agencies who work with those at risk of overdose.

Examples that Release has either experienced or heard about in relation to barriers to naloxone provision include the homeless services having to enter into tri-partite agreements with Commissioners and pharmacies to include naloxone provision in their own outreach work. The

complexity in trying to establish these agreements can have the effect of deterring services from even considering naloxone access as part of their outreach strategy, and this is vital considering the high levels of drug-related deaths amongst this population. We have heard repeatedly of missed opportunities to supply naloxone, on exit from A&E, on release from custody at a police station, and in hostels where there is a high level of drug dependency amongst the residents. One of the most egregious examples is where pharmacies are providing needle exchange but not naloxone. This is why any change in legislation must be coupled with a national naloxone campaign.

In April 2019, Release hosted a 'Naloxone Steering Group' in partnership with the National Addiction Centre at King's College London. The objective of the steering group was to bring key stakeholders together 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. Forty-two participants were involved, ranging from drug user activist networks, civil society, service providers, academia, pharmacy, housing, police, prison and governmental departments. The findings of the steering group were published in Release's 2019 policy paper 'Saving Lives'. Included within a set of overarching principles to achieve best practice in naloxone provision, were the following two principles (Saving Lives 2019, p.4):

- "**Presumption to provide** - decisions should be guided by a presumption in favour of providing naloxone"; *and*
- "**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".

So, whilst we welcome the proposed expansion of the regulations to include a range of groups, we would ask that consideration is given to widening the definition to allow the supply of naloxone in circumstances where it can be shown the person supplied was at risk of overdose or was likely to witness an overdose.

Some international examples from Harm Reduction International's 'Global State of Harm Reduction' report may be helpful to the Department of Health as part of this consultation. Italy, for example, explicitly exempts naloxone from the regulations around antidotes, meaning it is available over-the-counter in pharmacies without prescription, with pharmacies under an obligation to ensure they have supplies of naloxone (IDPC 2017). Puerto Rico this year passed the Law to Prevent Death by Opioid Overdose in Puerto Rico which establishes an Opioid Overdose Prevention Programme to authorise medical and non-medical NGOs to distribute naloxone to people likely to experience or witness an overdose (this explicitly includes NGOs providing NSP, homelessness services and 'community organisations') [Article 5(d)(1)(iv)]. The law also requires that distributing organisations train naloxone recipients in the first instance [Article 6(a)].

> *(b) consider reclassification of naloxone from a prescription-only (PO) medicine to a pharmacy (P) medicine*

In Release's (2019, p.14) report 'Saving Lives', the expansion of naloxone provision via a change in the medicine's classification is discussed: "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 (POM), 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". We would encourage the Department to explore reclassification of naloxone to a pharmacy medicine (P) as part of this consultation.

Question 2. To what extent do you agree or disagree 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 or 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 or disagree
- disagree
- strongly disagree

Police officers

- **Strongly agree**
- agree
- neither agree or disagree
- disagree
- strongly disagree

Drug treatment workers commissioned by Police and Crime Commissioners (PCCs) to work in police custody suites

- **Strongly agree**
- agree
- neither agree or disagree
- disagree
- strongly disagree

Prison officers (orderly officers and duty governors)

- **Strongly agree**
- agree
- neither agree or disagree
- disagree
- strongly disagree

Probation officers

- Strongly disagree
- Disagree
- Neither agree or disagree
- Agree
- **Strongly agree**

Registered midwives

- **Strongly agree**
- agree
- neither agree or disagree
- disagree
- strongly disagree

Registered nurses

- **Strongly agree**
- agree
- neither agree or disagree
- disagree
- strongly disagree

Registered paramedics

- **Strongly agree**
- agree
- neither agree or disagree
- disagree
- strongly disagree

Pharmacists

- Strongly disagree
- Disagree
- Neither agree or disagree
- Agree
- **Strongly agree**

Please provide a reason for your answers with reference to any, some or all of the above settings and any supporting evidence.

There is a wealth of evidence to support that the individuals/organisations listed in Question 2 should be able to supply THN without prescription, as well as the merits of expanding naloxone's accessibility.

The EMCDDA (2016) report on 'preventing opioid overdose deaths with take-home naloxone' observes that THN was originally developed in response to the rising rates of heroin overdose deaths in Europe. Expanding THN provision in the UK, including via the expansion of services/individuals who can prescribe THN without prescription, is *essential* given that drug-poisoning deaths are at their **highest** rates since records began across the UK; with deaths involving **opiates** (such as heroin and morphine) making up a significant proportion of such deaths. Of the 4,561 deaths related to drug poisoning registered in England and Wales in 2020, for example, 2,263 of those deaths involved opiates. This is 4.8% higher than the opiate-related deaths registered in 2019 (2,160 deaths) and 48.2% higher than the opiate-related deaths registered in 2010 (1,527 deaths).

In many local authorities, THN is only available to the above (listed) groups through the main drug treatment provider, as evidenced by Release's 2019 policy paper 'Finding a Needle in a Haystack' – which produced a map of THN coverage in England by local authority area. THN is therefore arguably

more accessible to people in contact with drug treatment services and is less accessible to people accessing low-threshold services. This is cause for concern, mainly because opiate-related death rates are higher among people **not** in contact with drug treatment services, as highlighted by the Advisory Council on the Misuse of Drugs (ACMD). It is crucial then that THN is made available to people that are *not* in direct contact with drug treatment services, and the easing of restrictions around who can supply THN was recommended by the ACMD in 2012 (ibid).

In Release's 2019 report 'Saving Lives' (p.7), the importance of providing naloxone to people not in contact with drug services, and those who might witness an opioid overdose, was emphasised by the expert panel:

> "Among this population there are specific vulnerabilities that increase this likelihood. Many of them are homeless and have coexisting drug and mental health problems. 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'. In many cases overdoses are witnessed by family, friends or 'someone whose work brings them into contact with people who use opioids'; 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"

Release's Saving Lives report (p.14) also outlined 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. The panel also recommended that "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".

The prison release population have been identified as a particularly high-risk group (Strang et al. 2019), as well as those discharging from hospital or abstinence-based residential rehabilitation (Merrall et al. 2013). Within the National (UK) guidelines on clinical management of drug misuse and dependence (known as the 'Orange guidelines') the benefits of prison staff supplying THN are recognised:

> "Programmes for the provision of take-home naloxone may help save lives after release. Commissioners should agree with prison health and community providers how best to ensure provision of naloxone… All [prison] staff, including non-healthcare staff and operational/security staff, should have training in recognising and responding to opiate overdose, including using available naloxone" (2017, p.156).

In an unpublished survey conducted by Release in 2020, evidence shows that homeless outreach and accommodation services being allowed to distribute naloxone would reduce the time lag between someone needing a dose of naloxone, and its being available to administer.

One issue that will significantly limit the effectiveness of the proposal to expand the regulations to include a wider range of groups, unless addressed, is that of supply of naloxone from the manufacturers if they do not have a wholesale dealer's licence (WDL). Many of the proposed setting or individuals will not meet this requirement, and cannot meet this requirement - we would therefore suggest that consideration is given to making naloxone *exempt* from WDL conditions. Our colleagues at DrugScience have written about this issue in more depth in their submission, which we endorse.

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?

We do not directly represent any of the listed services/individuals.

Question 4. Are there any settings not explicitly cited in the above questions that you would <u>support</u> being able to obtain or supply naloxone? Please provide a reason for your answer with reference to any supporting evidence.

(a) Clarification regarding the listed settings/individuals at Question 2

Release strongly agrees that all listed settings/individuals (named in Question 2) should be able to supply THN without a prescription. We would like to add that 'pharmacists' should *include* pharmacy technicians, and that 'registered paramedics' should include first responders who volunteer for ambulance services. It is also essential that hospitals are included settings.

(b) Broaden the groups/individuals able to supply THN to those who provide services to people at increased risk of drug dependency

In 2018, Release submitted Freedom of Information (FOI) requests to each of the 152 local authorities in England about THN in their area. The findings, which can be found in Release's 2019 policy paper 'Finding a Needle in a Haystack', demonstrated that in some local authorities, innovative approaches to THN provision were being developed. Local authorities were given the opportunity to highlight **'Other'** groups that were given THN in their area, which included: Religious groups or street pastors, soup kitchens, food banks or recovery cafes, domestic violence services or women's refuges, women-only support groups, mental health services or mental health admission wards, street wardens or local park guards, sex workers' services, Social services or social workers, employment services, and family support services.

As discussed in our response to Questions 1 and 2, the 'test' for services/individuals being able to supply THN should be anyone involved in providing services to those at increased risk of drug dependency, or those likely to witness an overdose, as opposed to a prescriptive list of the groups/individuals that can be involved in THN supply.

(c) Expand peer to peer naloxone provision

Release's (2019, p.10) report 'Saving Lives' encourages the empowerment of people who use (or have used) opioids to supply, carry and administer naloxone. The report states that "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". It continues that "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".

Whilst peer to peer naloxone provision (also known as P2PN schemes) have been piloted and evaluated prior to the emergence of the coronavirus (COVID-19) pandemic, P2PN schemes

were seen to *increase* in the UK during the coronavirus pandemic, in part due to the restricted reach of traditional drug treatment services during national lockdown(s).

George Charlton, a UK expert in Naloxone provision and training, stated in Release's 2021 UK submission to Correlation's European Harm Reduction Network (CEHRN's) annual survey that despite the increases in P2PN during the coronavirus pandemic, peer to peer naloxone provision is an area that remains under-utilised and under-funded, "owing to providers not recognising the potential of working in partnership and co-producing peer led projects with people with lived and living experiences of addiction". He adds that in addition to improved funding and support, an essential change required for peer to peer initiatives is the "removal of the discriminatory approach of stating that people have to be six months drug-free in order to volunteer as Naloxone Peers. This approach "shuts the door to experts by experience/current drug users becoming Naloxone Champions". Peers must be involved in service design and delivery, and must be properly remunerated.

(d) Support naloxone provision/supply via vending machines

With increasing naloxone accessibility as the goal, the provision of THN via vending machines should be explored. In October 2020, in Chicago (Illinois, USA), the 'Chicago Recovery Alliance' – an organisation cited by the EMCDDA as being the *first* globally to provide THN - acquired a number of such machines and are planning to stock them with naloxone for the purposes of expanding availability.

This follows a similar scheme currently operating in Las Vegas (Nevada, USA) whereby harm reduction equipment - including safe injecting equipment and safe sex kits (but excluding naloxone) - are dispensed via vending machines.

(e) Explore the benefits of naloxone provision within overdose-prevention settings

It is important to recognise that other setting(s) in which naloxone can be administered, and has been proven to save lives, are within overdose prevention sites (or drug consumption rooms 'DCRs') (Dietze et al. 2019; Harm Reduction International 2018). The emergence of DCRs across Europe - and the increased opportunities to disseminate health advice and encourage entry into treatment that they present - are highlighted in the National (UK) guidelines on clinical management of drug misuse and dependence (p.176-177):

> "Drug consumption rooms have emerged in several European cities when circumstances have supported a new or additional response. These circumstances have included persistent public injecting, often in a city centre, acute public awareness of such injecting, risks from discarded injecting paraphernalia, and increased overdoses or transmission of infections. The response is to reduce the dangerousness of the continuing behaviour, to reduce risk to the public, and to address public nuisance and fear. Such facilities may be solely for people who inject drugs or they may allow users of any drug to attend and use their drug in a safer environment. Users will often be given health advice, monitored during their drug use, and encouraged to contact treatment services".

In order to reverse the trend of record-breaking drug related deaths across every country in the UK – which has been the case for the last nine years - the Department of Health should, in partnership, support the legal establishment of DCRs.

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 or 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?

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

- **Strongly agree**
- agree
- neither agree or disagree
- disagree
- strongly disagree

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

- **Strongly agree**
- agree
- neither agree or disagree
- disagree
- strongly disagree

3. Police officers:

- **Strongly agree**
- agree
- neither agree or disagree
- disagree
- strongly disagree

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

- **Strongly agree**
- agree
- neither agree or disagree
- disagree
- strongly disagree

5. Prison officers (orderly officers and duty governors):

- **Strongly agree**
- agree
- neither agree or disagree
- disagree
- strongly disagree

6. Probation officers:

- **Strongly agree**
- agree
- neither agree or disagree
- disagree
- strongly disagree

7. Registered nurses:

- **Strongly agree**
- agree
- neither agree or disagree
- disagree
- strongly disagree

8. Registered paramedics:

- **Strongly agree**
- agree
- neither agree or disagree
- disagree
- strongly disagree

9. Registered midwives:

- **Strongly agree**
- agree
- neither agree or disagree
- disagree
- strongly disagree

10. Pharmacists:

- **Strongly agree**
- agree
- neither agree or 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.

Please see our response to **Question 2**.

Question 7. To what extent do you agree or disagree that there are risks associated with the administration of naloxone in either nasal or injectable form?

Nasal naloxone

- Strongly agree
- agree
- neither agree or disagree
- disagree
- **strongly disagree**

Injectable naloxone

- Strongly agree
- agree
- neither agree or 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.

In 2012 (p.2), the Advisory Council on the Misuse of Drugs (ACMD) stated that:

> **"**The efficacy of naloxone is not in dispute. Naloxone is a WHO-recommended medicine, and efficacy has been proven in several published studies and pilots. Naloxone is a safe, effective drug, with no dependence-forming potential. Its only action is to reverse the effects of opioid overdoses".

Any potential risk associated with the administration of naloxone is greatly outweighed by its potential to reverse opioid overdose and prevent fatalities. There are some risks associated with administering **inappropriate doses** of naloxone and these are highlighted in the National (UK) guidelines on clinical management of drug misuse and dependence (the 'Orange Guidelines'). These include:

- **p.180** *(derived from an NHS England Patient Safety Alert in November 2014):* "Naloxone must be given with great caution to patients who have received longer term opioid/opiate treatment for pain control or who are physically dependent on opioids/opiates. Use of naloxone in patients where it is not indicated, or in larger than recommended doses, can cause a rapid reversal of the physiological effects for pain control, leading to intense pain and distress, and an increase in sympathetic nervous stimulation and cytokine release precipitating an acute withdrawal syndrome. Hypertension, cardiac arrhythmias, pulmonary oedema and cardiac arrest may result from inappropriate doses of naloxone being used for these types of patients".
- **p. 180** *(derived from a UK Medicines Information (UKMi) Q&A document on naloxone):* "When presented with an individual who has used sufficient opioid to reduce their rate of respiration to life-threatening levels, prompt administration of naloxone can reverse these effects and restore adequate levels of oxygen in the bloodstream. However, the risks of giving too much naloxone when it is not required are well documented. Acute withdrawal syndrome from opioids can have both unpleasant

and potentially serious effects. Physical effects such as vomiting, agitation, shivering, sweating, tremor and tachycardia are unpleasant, and may lead to aggression and a refusal to accept further treatment (i.e. refusal to go in ambulance or to stay in hospital). Furthermore, life threatening withdrawal reactions may also occur in as many as 1% of cases of naloxone administration, with the potential to cause a sympathetic excess and resultant pulmonary oedema and ventricular arrhythmia."

However, the Orange Guidelines also provide guidance to *mitigate* the above risk(s), including:

- **p. 217** "In dependent patients, it is worth being aware that using **stepped** doses of naloxone, as recommended, titrated carefully against response, may limit the severity of rebound withdrawals that themselves can lead to a problem of marked agitation (and possible attempts to leave the hospital). The recommended approach may also avoid unnecessary cardiac stress (in a population of patients who are anyway at risk of premature cardiovascular disease). In emergency departments and in other situations where the patient may leave the hospital suddenly because of the precipitated withdrawal that naloxone has created, attempts should be made to make clear to patients that they are at risk of re-emergence of life-threatening sedation when the naloxone wears off, typically in around 30-60 minutes. Engaging friends or family in this discussion is also important if the patient wishes to leave prematurely and the support from loved ones may go further towards reassuring the patient and preventing early discharge".

The provision of **take-home** naloxone (THN) has seen the introduction of new naloxone products, including pre-filled syringes and auto-injectors, for intramuscular (**IM**) use, and concentrated nasal sprays for intranasal (**IN**) use with speed of onset comparable to intramuscular naloxone and relative bioavailability of approximately 40–50% according to research by Strang and colleagues (2019).

In terms of efficacy in reversing an opioid overdose, research by Dietze and colleagues (2019), which involved a randomised clinical trial in Sydney, Australia, showed that intranasally (IN) administered naloxone in a supervised injecting facility can reverse opioid overdose but not as efficiently as intramuscularly (IM) administered naloxone can. These results suggest that determining the optimal dose and concentration of intranasal naloxone to respond to opioid overdose in real-world conditions is an international priority.

Strang and colleagues (2019) observe that IM formulations can require product assembly and training in their administration and can be accompanied by risks of needle-stick injury. Injectable medications may also be more intimidating for laypersons to use according to Beletsky, Rich and Walley (2012). Non-injectable (IN) naloxone formulations are therefore considered to have several implementation advantages for THN programmes, including that they may be more likely to overcome regulatory obstacles (e.g. prescription-only status for injectable medications) and be provided to a wider workforce (Strang et al. 2019). They may be easier for lay persons to administer and have less risk of failed delivery and accidental needle stick injuries with consequent exposure to blood borne pathogens (also see Dunn et al. 2018; Weaver et al. 2018).

There is evidence to suggest that intranasal formulations are preferred by people who use opioids, including an Australian study whereby nearly three out of four (74%) people who were experienced in using opioids reported preferring naloxone nasal spray to injectable devices (Kerr et al. 2008). Neale et al. (2021, p.1) conclude that "THN programs should offer **choice** of device when possible and nasal naloxone if resources permit. Asking people which devices they prefer and why and treating them as valued consumers of naloxone products can generate insights that improve future naloxone technology and increase THN uptake and usage".

In Release's (2019, p.12) report 'Saving Lives' - which details the findings of an expert panel regarding best practice in THN provision - it is also made clear that people should be offered a **choice** between intranasal and injectable formulations of naloxone. Another key principle highlighted by the expert panel is that the **narrative** around naloxone must be changed: "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" (Saving Lives 2019, p.4).

Question 8. What safeguards do you think should be required in the settings from which naloxone is supplied?

Training should be required in naloxone's administration, as well as recognising the signs of opioid overdose, so as to *avoid* inappropriate administration when it is not necessary, which is one of the (only) risks identified in response to Question 7.

In Release's (2019, p.6) report 'Saving Lives' the expert naloxone panel state that naloxone provision and training should be prioritised at "the first point of contact" and during an assessment appointment with the service.

Question 9. If your organisation distributes naloxone, have you received training on how to use it?

- Yes
- No
- **Not applicable to me**

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.

As mentioned in response to Question 7, one of the key principles highlighted by Release's expert panel in terms of best-practice THN provision is that the *narrative* around naloxone must be changed: "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" (Saving Lives 2019, p.4). It is therefore also necessary to **publicise** the benefits of naloxone to both people who use opioids (PWUO) and people who do not.

One example of a campaign to increase public awareness of the benefits of naloxone is the April, 2021 National Overdose Awareness and Naloxone poster campaign. This campaign highlighted the importance of carrying naloxone to prevent fatal opioid overdose. The posters feature images of people who themselves have all been personally affected by overdose, and who have been trained in overdose prevention and now carry naloxone. A full list of where the posters can be found is available here. In September 2021, as part of the 'Stop the Deaths' campaign, a TV advertisement has been launched in Scotland, supported by the Scottish Government, which brings awareness to the opioid overdose crisis in Scotland and the role of naloxone in tackling this crisis. There should be a larger

roll-out of campaigns such as this *across* the UK, and there should be Government funding made available to support such efforts. Additionally, unhelpful and unevidenced narratives around increased 'risky behaviours' linked to the provision of naloxone must be challenged.

Release's expert panel also emphasise the importance of having a clear and specific **funding stream** to protect funding and remove fragmentation in funding for naloxone ('Saving Lives' 2019, p.4). In particular, it should be a mandatory requirement in every tendering process which commissions local services that are at increased likelihood of supporting people at risk of overdose.

An additional consideration for the Department of Health, and their colleagues at the Home Office, is the consideration of establishing a Good Samaritan law. Release has received calls on our national helpline of people who have been prosecuted after calling the emergency services to respond to an overdose: this practice can make people reluctant to seek lifesaving support. In Canada, they introduced the Good Samaritan Drug Overdose Act 2017 which protects people that call emergency services in cases of overdose (meaning they can call an ambulance equipped with naloxone without fear of prosecution for simple possession).

Finally, George Charlton - a UK expert in Naloxone provision and training - stated in Release's 2021 UK submission to Correlation's European Harm Reduction Network (CEHRN's) annual survey that "we need easier access for family members and the general public to access Naloxone via **postal** services and **online** training".

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.

Widening the groups that are able to supply THN without a prescription/written instruction will widen the reach to people who use opioids (PWUO), and will in turn, reduce the likelihood of impacting PWUO *differently*.

Drug treatment services do not always equally meet the needs of people with protected characteristics. For example, the EMCDDA's 2017 report on Women who use Drugs cites evidence that suggests women face additional barriers to traditional drug treatment service-attendance, including associated stigma (Grella, 2015[1]; Smith and Marshall, 2007) – and only 31% of people in substance treatment in England in 2019/20 were women.

Permitting specialised services, which are tailored to meet the needs of different protected groups, for example, women's groups and refuges, to supply THN without prescription/written instruction will ensure that THN provision to all PWUO is more readily available. Please also see further examples at Question 4 *"Broaden the groups/individuals able to supply THN to those who provide services to people at increased risk of drug dependency".*

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[1] *In* O'Neil, A. L., & Lucas, J. (2013). DAWN drugs and alcohol women network: Promoting a gender responsive approach to addiction. *Turin, Italy: United Nations Interregional Crime and Justice Research Initiative (UNICRI) Publication*.