

Naloxone in homelessness services

Using naloxone as part of a wider harm reduction approach

Let's end homelessness together

Homeless Link, Minorities House, 2-5 Minorities, London EC3N 1BJ | 020 7840 4430

www.homeless.org.uk | Twitter: @Homelesslink | Facebook: www.facebook.com/homelesslink

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Introduction

This guidance aims to give managers in accommodation-based homelessness services (referred to as 'hostels' below) a framework to implement good practice around using naloxone as part of a wider harm reduction approach. We believe this will reduce the number of lives unnecessarily lost to heroin and other opioid overdose. This is especially relevant given that homelessness is understood to increase the risk of opioid use.¹

Opiates include a variety of drugs, ranging from legal drugs such as codeine and morphine, to illegal drugs such as heroin. The one thing they all have in common is the ability to depress or slow down the body's central nervous system, which can lead to an overdose situation.

Drug related deaths in England and Wales have been increasing each year, with two in five deaths of people while homeless related to drug poisoning, according to the Office for National Statistics (ONS).²

There have been continued reports of Fentanyl in relation to overdose deaths. Fentanyls are a family of drugs that have similar effects to heroin. There is limited information available about the effects of some fentanyls, but many are more toxic on a 'weight-for-weight' basis than heroin, some substantially so; as a result, even a small amount of a fentanyl in a heroin 'hit' can be enough to kill, especially without immediate naloxone (an opioid antidote) or medical attention.³

Provision of naloxone is an evidence-based intervention that can save lives by blocking or reversing the effects of a heroin or opioid overdose. Incorporating naloxone into homelessness services encourages drug users to engage with treatment services and helps to keep them alive until they are ready to address their drug using behaviour (should they wish to do so). It is important to remember that the intervention is not just about providing naloxone: training people to recognise the signs of overdose and how to respond appropriately are also key steps in reducing drug-related deaths.

Legislative regulations for naloxone were amended in February 2019 making nasal naloxone available (Nyxoid), in the same way as the previously licensed intra-muscular injectable product (Prenoxad) was. There is more information on both products within the guidance.

¹ High Risk of Overdose on Prison Release, Russell Webster, (2018) www.russellwebster.com/releaseod/

² ONS (2019): Deaths related to drug poisoning in England and Wales, 2018 registrations

www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2018registrations

³ Public Health England Guidance - Health Matters: Preventing Drug Misuse Deaths (2017)

www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths/health-matters-preventing-drug-misuse-deaths

Acquiring Naloxone

You can acquire a naloxone kit from your local drug treatment service provider (see guidance below on what can be done if naloxone is not currently provided in your area).

You should contact your local drug treatment service and discuss, with the support of commissioners, issues such as: how much naloxone your staff, residents, volunteers etc. may need, its safe storage and review, and suitable record keeping of any supply and use.⁴

When a replacement kit is required due to the current dose being used, lost, damaged, or out of date, you should ideally return to the drug treatment service from where the initial naloxone kit was provided. If the service provider has changed, then you should liaise with the current provider.

What is an overdose?

The signs and symptoms of an opioid overdose are:⁵

- Pinpoint pupils (indicates opioid use)
- Pale skin colour
- Bluish tinge to lips, tip of nose, eye bags, fingertips or nails
- No response to noise (where the helper 'shouts' at the casualty and gets no response)
- No response to touch (shoulder shake)
- Loss of consciousness i.e. the suspected overdose casualty cannot be woken
- Breathing problems
 - Slow/shallow or infrequent breaths
 - Snoring/rasping sounds
 - Not breathing at all

When someone has overdosed they can look and sound like they are asleep. Always check when you hear snoring that the person is actually asleep and not in an overdose situation. Snoring/rasping can be an indication of breathing difficulties. The time gap between a person taking (e.g. injecting) drugs and slipping into an overdose and can vary from a few minutes to several hours.

Staff or residents in homelessness services might find someone has overdosed in time to save their life. Even if you are not sure an opioid overdose has occurred, **if the person is not breathing or is unresponsive, give the naloxone injection right away** and then seek emergency medical care.

⁴ Department of Health & Social Care, Medicines & Healthcare Products Regulatory Service, Public Health England (2017):

⁵ Prenoxad Injection (2013): Training Manual www.prenoxadinjection.com/downloads/training_guide.pdf

Preventing Drug Related Deaths

People who misuse or are dependent on drugs – heroin and other opiates in particular – have mortality rates in the range of 1-2% per year, representing an excess mortality 10 to 20 times greater than expected.

The main cause of premature death among people who use drugs in the UK is drug overdose. The vast majority of these deaths are potentially avoidable. The other main causes of drug-related deaths are suicide, violence, accidents and physical health complications of drug misuse.

Opioids are present in the majority of overdose deaths. Heroin is most commonly implicated and other opioids are sometimes found (most commonly methadone but also tramadol, codeine and others). These deaths often occur in combination with other substances such as alcohol or benzodiazepines.

Increasingly, a wider range of other substances are identified as being present post mortem, including gabapentinoids and novel psychoactive substances. Even though certainty concerning causal attribution in the presence of multiple substances can be difficult, being able to provide clear general advice for those who use drugs of the added risks of combining different psychoactive substances is important. It is helpful for staff to keep abreast of new trends in the substances found in overdose deaths.

Approximately 90% of overdose deaths occur in those aged over 25 years, with the average age of such deaths rising, suggesting an ageing cohort of individuals with problem opioid use at particular risk.

There are marked local, city and regional variations in mortality rates, and local factors need to be considered by those advising people at risk and those developing local prevention plans, which may include intelligence on changing purity, levels of street homelessness, levels of injecting, changing markets and changes in substances used. Increases in overdose deaths in the UK pose a pressing challenge for clinicians and services working with individuals at risk. They need to try to optimise preventive interventions and to reflect on whether all reasonable actions are being taken organisationally and within individual care planning to reduce risk.

Engaging in drug treatment services and receiving opioid substitution treatment (OST) is associated with markedly reduced risk of overdose death. Drug services can improve the effectiveness of responses to opioid overdose by providing education and training to people who use drugs and to their families/carers, and others (such as hostel staff), on what increases the risks of overdose, and how to respond effectively to an overdose, including on the use of naloxone

Given the potential for reversing opioid overdoses to save lives, training in the use of naloxone should be widespread, particularly in first responders likely to be available to administer naloxone. **Legislation allows anyone to use naloxone available in an emergency to reverse a suspected opioid overdose.**⁶

⁶ Drug Misuse and Dependence: UK Guidelines on Clinical Management (2017)
www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

What is naloxone?

Naloxone is the emergency antidote for overdoses caused by heroin and other opiates/opioids (including synthetic variations), such as methadone and morphine (referred to as 'opioids' below). Naloxone temporarily reverses the main life-threatening effect of these drugs, which is the slowing and stopping of breathing, therefore providing more time for an ambulance to be called and treatment to be administered.

So why is naloxone so important?

Drug related deaths continue to be at the highest number since comparable statistics began in 1993. According to the Office for National Statistics (ONS), there were 4,359 drug poisoning deaths involving both legal and illegal drugs in England and Wales registered in 2018. This was the highest annual increase (16%) since the time series began in 1993.

The male drug poisoning rate has significantly increased from 89.6 per million males in 2017 to 105.4 in 2018. The female rate increased for the ninth consecutive year to 47.5 per million females in 2018, the latest increase was not statistically significant compared to 2017. Two-thirds (or 2,917) of drug-related deaths were related to drug misuse, accounting for 50.9 deaths per million people in 2018.

Between 2017 and 2018, there were increases in the number of deaths involving a wide range of substances, though opiates, such as heroin and morphine, continued to be the most frequently mentioned type of drug.

Deaths involving cocaine doubled between 2015 and 2018 to their highest ever level, while the numbers involving new psychoactive substances (NPS) returned to their previous levels after halving in 2017.⁷

Providing naloxone is not considered the solution to tackling drug related deaths. However, it is an important intervention, among a range of available treatment and support provided by drug services.⁸

Naloxone is safe, cost effective and, most importantly, it saves lives. There is a broad consensus among health and substance misuse professionals that naloxone should be freely available to all opioid users and those around them, in both in a personal and professional capacity, that may be first to the scene of an overdose. It is a recommendation of the World Health Organisation and is included on their Model List of Essential Medicines.⁹

In guidance that was updated in February 2019, the Department for Health and Social Care, the Medicines & Healthcare products Regulatory Agency and Public Health England all called for widening the availability of naloxone.¹⁰

'Take home' naloxone is where naloxone is issued by a prescriber or someone within a recognised drug treatment service (referred to 'drug services' below) in order to be used in an emergency situation. This

⁷ ONS (2019): Deaths related to drug poisoning in England and Wales, 2018 registrations
www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2018registrations

⁸ Scottish Care Inspectorate(2013): Health Guidance: National Naloxone Programme
www.careinspectorate.com/images/documents/1367/Naloxone%20guidance%20Aug%202013%20V2.pdf

⁹ World Health Organization (2015) Model List of Essential Medicines
www.who.int/selection_medicines/committees/expert/20/EML_2015_FINAL_amended_AUG2015.pdf?ua=1

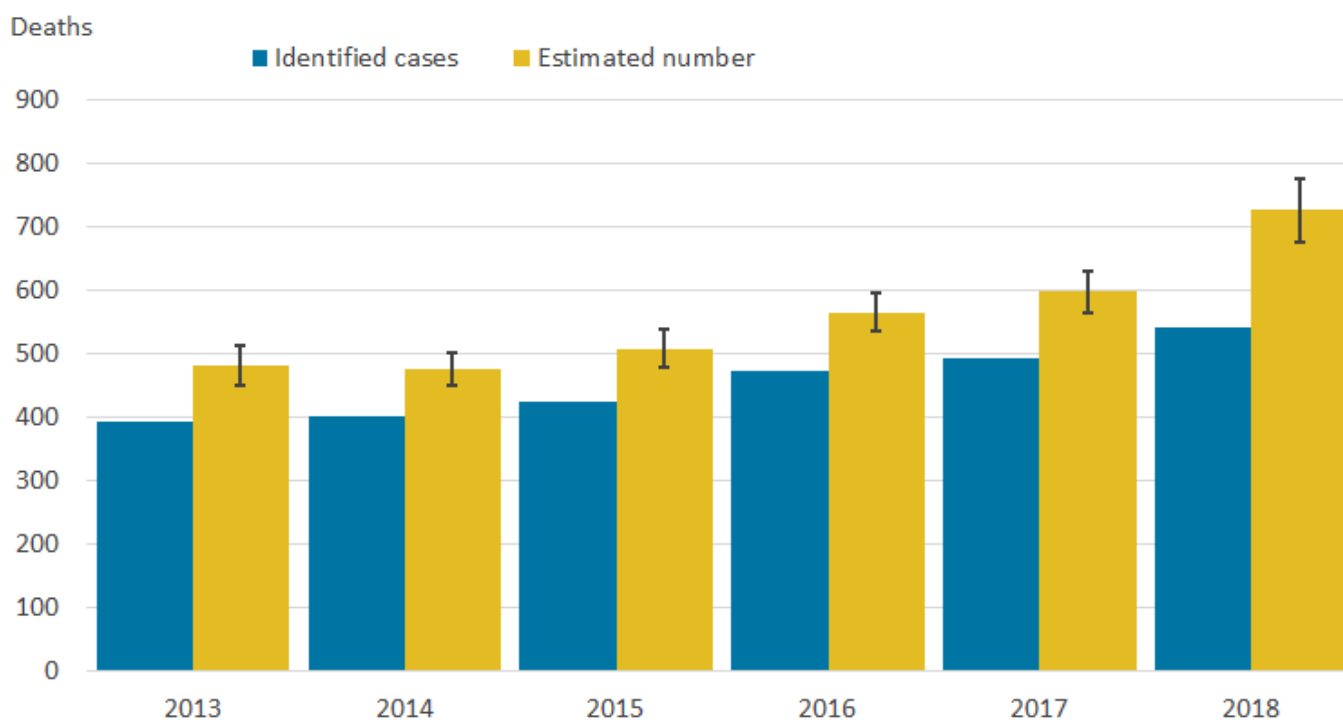
¹⁰ Public Health England (Updated February 2019) www.gov.uk/government/publications/widening-the-availability-of-naloxone/widening-the-availability-of-naloxone

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includes current or previous opioid users, as well as their support workers, family members, carers, peers and friends.

People particularly susceptible to opiate overdose include: those that have recently been through detoxification, those leaving prison¹¹ and those experiencing homelessness issues.

The estimated number of deaths among homeless people had increased by 51% between 2013 and 2018.¹²



Source: Office for National Statistics

As in the general population, homeless people die from a broad range of causes such as accidents, diseases of the liver, ischaemic heart diseases, cancers, and influenza and pneumonia. Most deaths among homeless people are captured in the National Statistics definitions of drug-related poisoning, suicide, and alcohol-specific deaths. 294 estimated deaths of homeless people in 2018 were related to drug poisoning, that is 40% of all estimated deaths.¹²

On 1st October 2015, regulations came into force which allowed for naloxone to be made more widely available. An amendment was made to the regulations in February 2019 to cover a nasal formulation.

¹¹ High Risk of Overdose on Prison Release, Russell Webster, (2018) www.russellwebster.com/releaseod/

¹² Deaths of homeless people in England and Wales: 2018

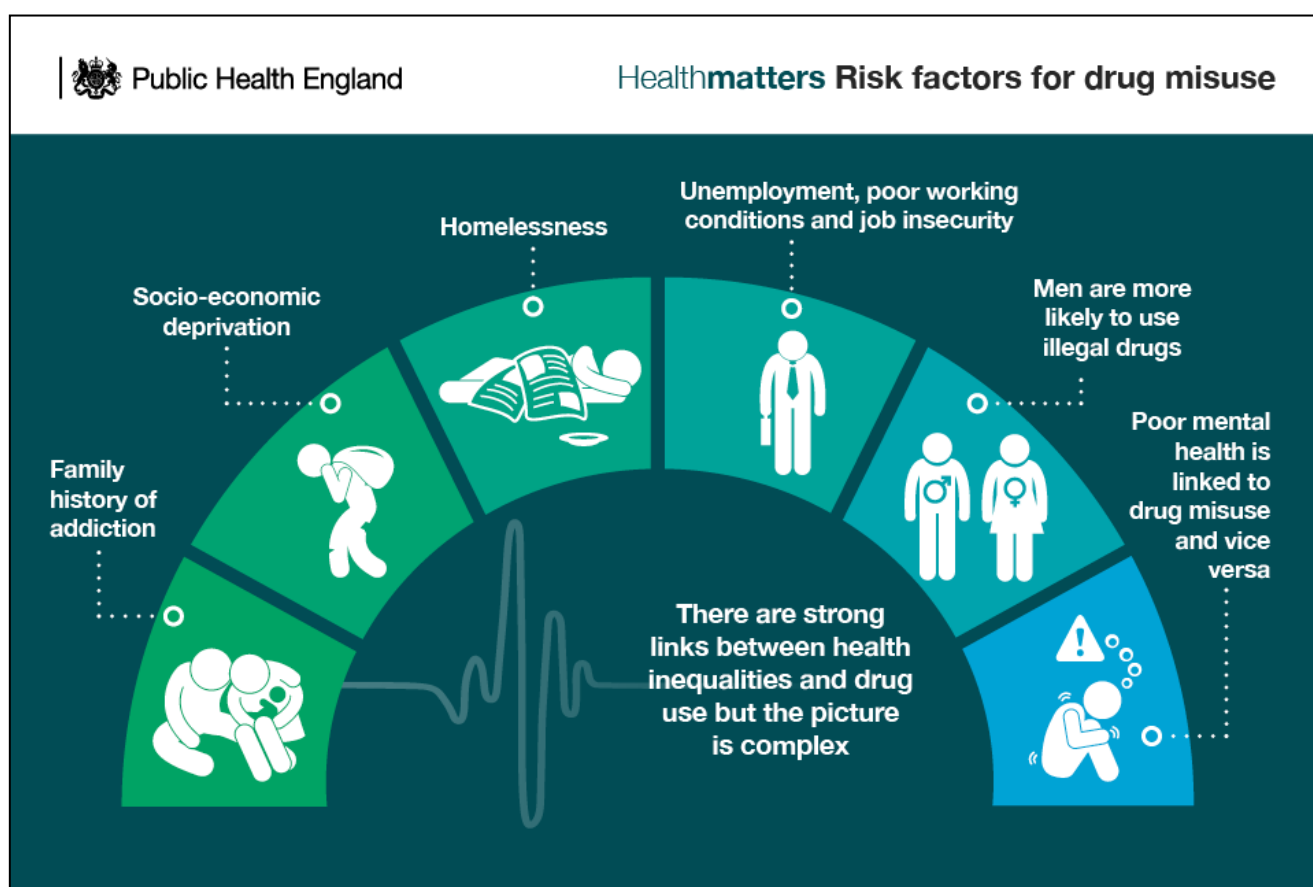
<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2018>

How can homelessness services use naloxone to save lives?

Risk factors are all negatively associated with health status and there is a complex and reciprocal association between social factors and illicit drug use.

Homelessness, for example, is a complex problem that occurs for many different reasons. Some individuals may later turn to addiction as a means to cope with their lack of a fixed home. However, it can be difficult to determine how much substance abuse leads to homelessness compared with the frequency by which homelessness leads to substance abuse.

Drug misuse can cause social disadvantage, and socio-economic disadvantage may lead to drug use and dependence.¹³



Before 1st October 2015, 'take-home naloxone' had been available in participating local authorities by prescription, usually from a drug service or a GP, or through other specific arrangements allowing supply from other healthcare professionals such as homeless healthcare teams. It had also been provided directly to family members, carers, peers and friends. In this guidance we refer to this as injectable or nasal naloxone.

¹³ Public Health England Guidance - Health Matters: Preventing Drug Misuse Deaths (2017)

www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths/health-matters-preventing-drug-misuse-deaths

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Identifying and supporting people that use drugs in the community is crucial in ensuring that they are made more aware of the risks associated with their situation and so that support can be offered in a timely manner.

People who use drugs, and who are accessing homelessness services, may be experiencing a number of different issues or problems, so accessing relevant services in a timely manner and offering naloxone will ensure that they are given opportunities to address the different aspects of their situation.

It is important to note that, in an emergency situation, anyone can use naloxone to save a life, whatever the source.

The initial legislation that came into force on 1st October 2015 brought about three key changes. The legislative regulations were amended in February 2019 to include nasal naloxone.¹⁴

1) Naloxone can be supplied by drug services without a prescription

Naloxone cannot be sold over the counter. It remains a prescription only medicine (POM) but one that is exempted from the POM requirements under specified circumstances i.e. when being supplied by a drug treatment service to an individual for the purpose of saving life in an emergency. This allows drug service workers to supply naloxone without a prescription.

2) Naloxone can be supplied to a wider group of people, including a named member of staff in hostel settings or any named individual working in an environment where opioid overdose is considered a risk. Naloxone would then be stored in different settings such as homelessness hostels in order to be used in an emergency.

What the regulations do not do is allow homelessness staff to dispense naloxone in the same way as treatment services i.e. to supply users, friends etc. to use in the event of an emergency. So, although hostel staff can use naloxone in an emergency situation, they cannot supply it to residents.

3) Naloxone can be supplied without the express permission of the person using opioids

Under the new regulations, where permission from the opioid user cannot be sought or obtained it is permitted to provide naloxone to a family member or friend without the express permission of the person who is using the heroin/opioid, as long as it is being supplied by the drug treatment service in order for the family member or friend to be able to use it to save life in an emergency.

¹⁴ The Human Medicines (Amendment) Regulations 2019, <http://www.legislation.gov.uk/uksi/2019/62/made>

Naloxone supply, storage and use

Obtaining Naloxone

Regulations do not limit supply to specific individuals, except to state that the “supply shall be for the purpose of saving life in an emergency.” Therefore, naloxone could be supplied, by drug services, to any of the following:

- an outreach worker
- a hostel manager
- a drug user at risk
- a carer, a friend, or a family member of a drug user at risk
- any individual working in an environment where it is considered there is a risk of overdose for which the naloxone may be useful

Although the regulations do not allow those individuals who have been supplied the naloxone by a lawful drug treatment service to supply it on to others for their possible future use at a later date, it remains the case that in an emergency situation anyone can use any available naloxone to save a life.¹⁵

Generally speaking, where naloxone is available it is funded locally from the substance misuse commissioning team as part of funding provided to drug services. Homelessness services will be supplied naloxone from a recognised local drug service. Some local authorities however do not currently fund naloxone.¹⁶

If you have naloxone provision in your region but it is not yet supplied to your service, your local drug service is a good place to start. Contact the local drug service to discuss arrangements for starting naloxone supply and accessing associated training for staff and residents. We recommend that drug service outreach workers hold regular sessions at the hostel to allow better access to drug treatment, especially for treatment naive/resistant residents, to allow a regular replenishment of naloxone and to deliver training and review incidents and practice.

Depending on local relationships and pre-existing arrangements, this might be an informal arrangement, or homelessness services could enter into a service level agreement with the local drug treatment service.

Residents engaging with a drug service providing naloxone should continue to receive a supply from their treatment key worker or prescriber. Engagement in wider drug treatment remains the utmost priority alongside naloxone availability. A wider recovery-based programme, which may include an opioid substitute, support groups and activities, is vital to help residents move away from dangerous opioid use.

For individuals not currently engaged with a drug service or whose engagement is infrequent, you may have access to a homeless healthcare provider that offers naloxone training and issues naloxone kits to those at risk.

¹⁵ Public Health England (Updated February 2019) www.gov.uk/government/publications/widening-the-availability-of-naloxone/widening-the-availability-of-naloxone

¹⁶ Release: Take Home Naloxone in England (2017) www.release.org.uk/blog/take-home-naloxone-england

The case for increased availability

Research from the US found that naloxone distribution was cost effective in all senses and it was cost-saving if it resulted in fewer overdoses or uses of emergency medical services. However, it is very difficult to carry out definitive research to prove that widening the availability of naloxone is cost effective, not least because of the scale of the studies that would be needed.¹⁷

However, there is an overwhelming consensus amongst Public Health England, the Advisory Council on the Misuse of Drugs (ACMD) and national drug service providers, to name but a few, that widening the availability of naloxone increases the potential impact for saving lives and in turn reducing drug-related deaths. Naloxone has the potential to reduce incidence of life-changing consequences of surviving opioid overdoses, such as neurological damage.

In 2019, England had 18,053 hospital admissions for drug poisoning by drug misuse.¹⁸ It should also be noted that there is a strong association between socio-economic position, social exclusion and substance-related harm, with greater harm recorded in people living in more deprived areas and with lower individual resources and socio-economic capital.¹⁹

In 2017, to map out and assess the provision of take-home naloxone in England, Release requested information from all local authority areas under the Freedom of Information Act 2000 through a self-completion questionnaire, as local authorities are responsible for commissioning drug treatment services (although this is not a mandatory requirement).

You can find the results, including an interactive map (which outlines coverage by local authority area) here: www.release.org.uk/blog/take-home-naloxone-england

Updated in 2019, the availability of take home naloxone in England had notably improved since the last report, as nine local authorities had since introduced take home naloxone programmes and it was available in almost every local authority in England. However, it also estimated that the level of coverage in England in 2017/18 was 16% amongst those that used opiates.

Read the Release report 'Finding a Needle in a Haystack', including recommendations here: www.release.org.uk/naloxone-2017-18

If you do not have naloxone availability in your area, contact your local drug service and work with them to see whether, with the support of commissioners, a naloxone programme can be started. If you are funded by the local authority you could also raise this with your commissioning team. There may already be a local strategic group looking at harm reduction or drug related deaths where you can raise the issue of naloxone availability.

¹⁷ Public Health England (2015, updated 2019): Take-home naloxone for opioid overdose in people who use drugs <https://www.gov.uk/government/publications/providing-take-home-naloxone-for-opioid-overdose>

¹⁸ NHS Digital: Statistics on Drug Misuse, England (2019) <https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-drug-misuse/2019>

¹⁹ ACMD: Vulnerability and Drug Use Report (2018)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/761123/Vulnerability_and_Drug_Use_Report_04_Dec_.pdf

Introducing take home Naloxone: A checklist for local areas

1. Identify local naloxone champions – this may be you.
2. Organise an initial ‘informing the managers’ or ‘train-the-trainer’ session.
3. Consider who will receive naloxone supplies, which product and how: users and carers, hostels and pharmacies etc.
4. Consider who will pay for naloxone supplies in different locations.
5. Agree how you will re-supply people when naloxone is used or expires. Will you have a system that flags approaching expiry dates to keyworkers, pharmacies, etc?
6. Hold regular meetings for local naloxone champions – including people who use drugs – to encourage progress, discuss any barriers or concerns, and learn from each other.
7. Explore the products and prices available, speaking to local pharmaceutical representative(s), and decide together with local service providers which to purchase.
8. Inform and liaise with the police, local coroners, ambulance service clinical lead, hostel managers and pharmacies.
9. Purchase the naloxone kits, and make the necessary arrangements for stocking and distributing them and for re-supply when naloxone held by an individual has been used or expires.
10. Provide training to all drug keyworkers, all opioid substitution treatment (OST) prescribers locally, dispensing pharmacists, and local service user groups – all of whom can contribute to the onward dissemination of information.
11. Arrange for training to be provided to people who use drugs, patients and clients, and their families and friends. Consider who is best positioned to deliver this training. Offer training to as many people as possible.
12. Consider whether and how you will record the numbers of kits dispensed and the reported number of times that naloxone has been used to reverse overdoses.²⁰

Storing naloxone

When naloxone is supplied by a drug service to an opioid user, the recipient should be encouraged to carry naloxone with them. In accommodation-based homelessness services (referred to as ‘hostels’ below), it is advised that residents keep another supply of naloxone in a specific and identifiable place in their room, helping them and others to find it in an emergency. This place could be standardised in all rooms, for example, pinned to a notice board in a plastic sleeve.

In terms of naloxone supplied to hostel staff, the decision on how many naloxone kits to hold should be discussed with the supplying drug service and based on factors such as the number of potential opioid using residents. The supply should be kept in an easily identifiable place, such as behind the reception desk. Some services keep it beside their first aid kit. In most cases it will not be necessary for staff to carry a naloxone supply on their person.

The injectable naloxone kit (Prenoxad) comes in a plastic container with tamper evident seals. These should not be broken except in an emergency.²¹

Two single dose nasal sprays (Nyxoid) are packaged in a single sealed blister pack.

²⁰ Public Health England (2017): Take-home naloxone from July 2017 www.gov.uk/government/publications/providing-take-home-naloxone-for-opioid-overdose

²¹ Scottish Care Inspectorate(2013): Health Guidance: National Naloxone Programme www.careinspectorate.com/images/documents/1367/Naloxone%20guidance%20Aug%202013%20V2.pdf

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The most important thing to note is **that they should not be locked away**. Every staff member should know where they are and have easy access to them in the event of an overdose.

Naloxone should be stored away from strong light in a cool dry place (although not refrigerated). The injection will have a shelf life and **should be replaced as it approaches its expiry date**. It should, of course, be kept out of reach of children.

Using naloxone

The Prenoxad naloxone product is administered via an intramuscular injection, usually into the outer thigh or upper arm muscle, through clothing if necessary.²² This type of injection should be clearly differentiated from intravenous injections, where a needle is inserted into a vein. The Nyxoid nasal naloxone spray requires a gentle insertion into one nostril and a plunger to be pressed until a 'click' sound is heard.

A number of products are licensed for use in reversing opioid overdose, although only two products, Prenoxad Injection and Nyxoid Nasal Spray, currently have a licence that specifies use in community settings, such as in homelessness services.

Prenoxad Injection comes in a pre-filled syringe containing five 400-microgram doses. Please find a link for its 'Instructions for Patient Administration' here: www.medicines.org.uk/emc/files/pil.3054.pdf

The Nyxoid single-dose nasal spray contains 1.8 mg of naloxone (as hydrochloride) in a 0.1 ml solution. Each pack contains two nasal sprays (2 single doses). A link for its 'Training Card for Patients and Carers' can be found here: www.nyxoid.com/assets/uk/pdfs/training-card-for-patients-and-carers.pdf

Nasal Naloxone

Naloxone hydrochloride single dose nasal spray is a formulation of the drug for the emergency treatment of opioid overdose that is given as an intranasal spray to adults and adolescents over 14 years. Naloxone hydrochloride nasal spray was licensed in September 2018 for use in the UK. It is a newer treatment option for patients with opioid overdose, and some may find it more convenient than previous treatments. Each pack contains two individual kits.



North Wales Police and Crime Commissioner Arfon Jones announced in February 2020, that officers would be carrying nasal naloxone to respond to emergency drug overdose situations, the second police force in England and Wales to do so. He is quoted as saying:

*"There's no difference between carrying a defibrillator and carrying Naloxone. It's a case of doing what's right. It makes sense they [officers] should be able to give the simple treatment that can make a life-saving difference."*²³

²² Prenoxad Injection (2013): Training Manual www.prenoxadinjection.com/downloads/training_guide.pdf

²³ BBC News, Spray for overdosed drug addicts trialled by North Wales Police www.bbc.co.uk/news/uk-wales-51462500

How does naloxone work?

Naloxone is a short acting medicine, and many of the opioid drugs often involved in overdoses last much longer in the body. This means that even following the administration of naloxone it is possible for the casualty to slip back into overdose. This is why it is essential to still seek medical help even if the casualty appears to be fully conscious/awake and breathing normally after naloxone administration.

Naloxone has no psychoactive properties itself, and it therefore has no intoxicating effects or potential for dependence.

Administering naloxone to someone who has overdosed may put them into instant withdrawal (otherwise known as 'acute withdrawal syndrome'). This is more likely if a large initial dose is given. This can have both unpleasant and potentially serious effects (see potential side effects below).

In these cases, as the effects of the opioid have been abruptly stopped this might annoy and disappoint the person using drugs. This can lead to seeking to use again, aggression and a refusal to accept further treatment (i.e. refusal to go in an ambulance or to stay in hospital). For these reasons, and to guard against the person slipping back into overdose, a person should not be left alone before the ambulance arrives.

Naloxone has no effect on other drugs taken, so if the person used another substance or has been drinking alcohol they will still feel the effects of it.

Take time to reassure all potential users of naloxone that if the casualty has not in fact overdosed on opioids (e.g. has had a heart attack, stroke or seizure), administering naloxone will likely do no harm.

Like other medicines, naloxone can cause side effects in some individuals. These should be discussed in the training.

Possible side effects may include: feeling or being sick, tremor, sweating, over-breathing (associated with an abrupt return to consciousness), fast heartbeat or disturbed heart rhythm, increased or decreased blood pressure, fluid on the lungs or fits.²⁴

However, as naloxone is given to an individual who is believed to be facing a potentially imminent fatal opiate overdose, such risks of side effects are largely irrelevant in the decision on whether to use it or not. Reducing unnecessary side effects and discomfort through careful, graduated, use of injectable naloxone according to the instructions for the particular product involved is likely to be a common element of advice and training provided. Such careful use may also have the benefit of limiting the unpleasant withdrawals the heroin/opioid user may feel as they come round.²⁵

An additional important, yet uncommon, side effect reported from naloxone use, particularly if high doses of naloxone are given rapidly, is the risk of triggering cardiac problems in susceptible people, which in some cases could be fatal. As noted above, given that the naloxone is intended be given to an individual already facing the risk of a fatal overdose, the small risk of triggering such a serious cardiac problem is not a reason to avoid its use. The advice on using injectable naloxone for overdose already addresses

²⁴ Public Health England (2017): Widening the availability of Naloxone

²⁵ NICE, National Institute for Health and Care Excellence: Naloxone Hydrochloride <https://bnf.nice.org.uk/drug/naloxone-hydrochloride.html>

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its careful use to try to mitigate such risks. It is recommended to start with a sufficient but relatively small dose of naloxone, providing further small doses as needed. Taking this graduated approach to giving the naloxone, in simple steps, will be a key element of any locally provided information materials and/or training.²⁶

Nasal naloxone is administered by holding the nasal spray with your thumb on the bottom of a plunger and your first and middle fingers on either side of a nozzle. There is no need to prime or test the nasal spray before use as it contains only one dose of naloxone and cannot be reused.

Does naloxone increase risk?

A study by Wagner et al (2010) demonstrated that drug use went down at three month follow-up after naloxone training and there was an increase in presentation for drug treatment.²⁷

Some people have expressed concerns that significantly increasing naloxone provision may encourage increased drug use or riskier drug use, with residents potentially viewing naloxone as a safety net. However, surveys of people who use opioids suggest that widening the availability of naloxone does not encourage overdose or risky behaviours. As naloxone can, in some cases, induce rapid and unpleasant withdrawal from opioid drugs, it is something that people using these drugs are likely to be keen to avoid.

When the ACMD reviewed the evidence, it made the following statements:

- Recent US evidence does not support the claim that naloxone provision could encourage increased or riskier drug use.
- There is a considerable body of published evidence, mostly from the UK and Australia, to suggest people would not use more heroin if naloxone was available.
- Participants in naloxone programmes have been found to have an “increase in self-efficacy and more insight in relation to personal safety and health”. Users would not wish to induce unpleasant withdrawal symptoms, and the availability of naloxone does not promote “a false sense of security” leading to an increase in heroin use.²⁸

Some people are concerned about the risk of the Prenoxad naloxone kit being used to inject illegal drugs. Injecting equipment is already freely and widely available from needle and syringe exchanges, primarily to prevent the spread of blood borne viruses, for which purpose the use of ‘clean’ needles and syringes is clearly recommended. It is recommended that anyone in need of such equipment should be directed to their local needle and syringe exchange so that they don’t try to use needles and syringes provided for naloxone that are less suitable and may cause health problems, such as damaging veins, if used repeatedly.

Some staff may feel uncomfortable about delivering a first aid intervention, such as naloxone. It is the responsibility of managers to ensure that staff have the appropriate level of information and training in order to feel confident in its use and an understanding of its importance. This is a discussion that would typically be raised in a supervisory setting. There should be at least one staff member trained to use naloxone on any given shift.

²⁶ www.gov.uk/government/publications/widening-the-availability-of-naloxone/widening-the-availability-of-naloxone

²⁷ Wagner et al Evaluation of an overdose prevention and response training programme for injection drug users in the Skid Row area of Los Angeles, CA. <https://www.ncbi.nlm.nih.gov/pubmed/19268564>

²⁸ ACMD (2012): Considerations of Naloxone
www.gov.uk/government/uploads/system/uploads/attachment_data/file/119120/consideration-of-naloxone.pdf

Training for staff and residents

The supply of naloxone alone is not sufficient to prevent drug-related deaths. Training residents, peers, volunteers and staff in how to recognise and respond appropriately to a suspected opioid overdose is just as important.

Training clarifies the causes of overdose and dispels myths about how to respond when someone overdoses, and leaves people more willing to intervene. There are four key aspects to the training:

1. Risk factors for opioid overdose
2. How to recognise the signs and symptoms of opioid overdose
3. How to respond on discovering a suspected opioid overdose (including practical instruction in the assembly of the injectable naloxone product or use of the nasal variation)
4. The recovery position

Injectable Naloxone (Prenoxad) training is often provided by the local drug service and takes approximately 30 minutes (although it can also be delivered in shorter period of time if necessary). It may take place in a one-to-one setting or be delivered to a group. Contact your local drug treatment provider to request training (including train-the-trainer), which should be provided free of charge.

Free nasal naloxone (Nyxoid) training is available via the film 'Responding to an opioid overdose using Nyxoid': www.nyxoid.com/uk where there are also a number of training materials available to view, download and print. Your local drug treatment service may also offer additional training as part of their supply procedure.

Local training will be aligned to your local arrangements and provision, with information specific to your local area. It's important that all staff working with opioid users know how to administer naloxone in the event of an emergency overdose situation.

You can ask the drug service to deliver an initial group session to the staff team. Some services invite residents to join staff for the session. This will help to lead into team discussions around implementation and reviewing practice within the specific setting. Following an initial session, new members of staff could receive group or 1-1 sessions as part of their induction or a refresher training for existing staff as part of their personal development plan.

Nominated staff could receive train-the-trainer training to be able to cascade information to others, including those not engaged with drug treatment. Again, this should be discussed with your local drug service.

If you have a local service user group or peer volunteers, consider getting them involved as peer trainers. This can be particularly effective in sharing information among residents and the wider community.

Basic first aid training should also be made available to all hostel residents and staff. This will complement the naloxone training and give the appropriate information needed to react in an emergency situation.

Pass the message on: Training is short, anyone can do it and you could save a life.

Introducing naloxone in homelessness services

Hostel culture

The culture in a hostel is shaped by organisational policies and procedures, management and staff, and other environmental factors. Developing a 'no blame' culture in hostels, with high tolerance policies towards on-and off-site drug use, will impact on engaging residents in harm reducing initiatives like naloxone.

Overdoses often take place behind closed doors, out of view of staff and volunteers. It may not be clear to those present if the person has overdosed or not, especially if other people are also intoxicated and/or have not completed the training. Those that use drugs, and others present, may not want to get into trouble or may be embarrassed about what has happened.

Conversations in one-to-one sessions with staff, group sessions, informal conversations, posters in the hostel, drug-tolerant policies and procedures, will all contribute to creating an open, harm reducing environment. It's important that residents feel comfortable and safe in alerting the appropriate person that someone may have overdosed, without fear of sanction.

In a 2017 Local Government Association survey, 99% of respondents who made naloxone available, provided it through drug treatment services, 25% did so through hostels and 25% using outreach workers.²⁹

Local Policies and Procedures

Local policies and procedures can provide a framework for creating a safe and open culture, supporting harm reduction and preventing drug related deaths. Policies and procedures such as drug use and evictions can be an important part of this: making clear that residents should feel comfortable talking to staff about their drug use and raising the alert if they have concerns that someone has overdosed, without the fear of punitive measures or putting their own or others' tenancies at risk.

Hostels should have procedures in place for the procurement, storage, administration and disposal of naloxone supplies. The service should ensure a needle stick injury policy is in place for injectable naloxone administration. In light of the regulation changes in 1st October 2015 allowing hostel staff to be supplied naloxone, policies relating to the wider storage and handling of medications may also need to be reviewed.³⁰

Local networks

If naloxone is already available in your area, your local drug treatment service should already be liaising with a wide local network in order to make them aware that people will be carrying naloxone, the reason why, and that people are trained to use it. The hostel manager should speak to the drug service manager to see if anyone needs to be informed about the hostel's intention to provide, or that you are providing naloxone.

This may include:

- The police
- Health services

²⁹ Local Government Association: Naloxone Survey (2017) Main Findings

³⁰ Homeless Link: www.homeless.org.uk/our-work/resources/managing-medication

Homeless Link

- Refugee and migrant services
- Other homelessness services
- Local authority
- Local ambulance service clinical lead
- Needle exchanges
- The local coroner (they may be interested in new efforts to prevent future deaths)
- Local hostel managers
- Other services in your organisation
- Friends, family, carers of residents (with the permission of the resident)

You may also want to enquire about participating in local strategic groups looking at harm reduction, recovery practice, drug related deaths and tackling homelessness.

Recording and reporting

Speak to your local drug service for guidance on local recording and reporting arrangements.

Where relevant to the individual, overdose prevention, management and use of naloxone should be a standard part of each resident's service introduction, initial assessment, support plan and review.

Keep up-to-date records of staff and residents who have completed naloxone training, are prescribed naloxone (with batch number and expiry date) and willing to be called in case of another resident's overdose. This could be kept on a secure central database and feature as part of individual resident's risk assessment and risk management strategies. You should record information on where individuals keep their naloxone, if not in a standardised place for each resident.

Where an incident involving an overdose has occurred, an incident form should be completed with a summary of the situation and outcome. The supplying drug service may also want to keep a record of this and review upon re-supply or other regular points. Incidents should be reviewed soon after by the manager and staff team to see what worked well and any learning to inform future practice.

Impact of Social Deprivation on Drug Related Harm

There is growing evidence on the impact of poor social and economic circumstances and harms related to the use of drugs. Social exclusion is one determinant of inequality that affects people who use substances and drug use can exacerbate social disadvantage. Therefore developing appropriate health and social responses are important in meeting the needs of homeless communities.

A 2019 report by the ACMD (Advisory Council on the Misuse of Drugs) entitled 'Drug-related harms in homeless populations and how they can be reduced', states that:

*"...there is increased risk of problematic drug use associated with people who experience homelessness. There is a higher rate of drug-related deaths, infections among people who inject drugs, and multiple morbidities. People who experience homelessness and use substances have particularly complex circumstances and additional risks which require intensive long-term support"*³¹

Therefore, when considering naloxone provision for your residents, the following areas of need should also be addressed:

- Reducing levels of debt
- Improving overall health and wellbeing
- Access and effective management of welfare (benefits)
- Increasing positive social networks
- Undertaking recreational activities
- Arranging volunteering placements and educational courses
- Regular health screening and checks
- Creating pathways for BBV (Blood Borne Virus) testing and treatment
- Supporting mental health related problems
- Providing advocacy and support

This means that, in order to meet the needs of those accessing homelessness services, joint working practices are vital. Arrangements should be made locally to address the complex needs of people that use drugs, across a range of services and to make best use of resources available locally.

These should include:

- Primary, secondary and specialist healthcare services (including drug and alcohol treatment)
- Financial services
- Community and voluntary sector organisations
- Education, training and employment service providers
- Benefits agencies
- Legal services
- Refugee and migrant services

³¹ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810284/Drug-related_harms_in_homeless_populations.pdf

Case studies – introducing naloxone in homelessness services

Case study: Increasing access to naloxone across Porchlight's services

"We had our first use of Naloxone a few weeks ago. If we hadn't changed the policy and trained workers, it would have been a life lost rather than a life saved."

Porchlight are a provider of homelessness support services in Kent, with projects including supported housing and outreach. Director of Development and Innovation, Aidan Gray, joined Porchlight from a background in drug and alcohol services. With staff in generic projects seeing a high level of dual diagnosis and increasing drug-related support needs, he saw an opportunity to change how the organisation works with substance use: strengthening use of harm reduction approaches, rolling out naloxone, and equipping staff with the training and skills to improve their practice.

Previously, Porchlight residents were prescribed naloxone to store in their room, whereas the new approach meant issuing naloxone to staff. The first challenge came from the insurance company, who were initially highly risk averse. It took time to explain the reasons for using naloxone more widely, educating the insurers about what naloxone is and the legislation governing its use, and sharing draft policies in order to get agreement for this change.

Aidan delivered the change management process throughout Porchlight management structures, as well as with the project teams. While there were some initial fears, he also found change champions among staff who welcomed the proposals as a way to save lives. Commissioners at Kent County Council and local treatment providers Forward Trust and CGL were supportive. The relationship with treatment providers is a key element for rolling out naloxone, as training and supply has budget implications for their services.

The changes meant updating organisational guidance in order to cover supply, storage, training, use and recording. Aidan developed existing policies to reflect extended provision, with reference to guidance from Homeless Link, government guidelines and learning from his experience in the drug and alcohol sector. Drafts of the revised policies – which included risk assessment and keyworking – were shared with the leadership, management and support teams for comment as part of moving the organisation towards new ways of working.

Naloxone is one element of skilling up the Porchlight staff team to work confidently with substance use. The drug and alcohol training programme is much wider than naloxone, so that teams see overdose prevention within the context of drug use and harm reduction. Training on harm reduction includes progression to methadone, using on top and relapse risk. Staff also attend training on how drug use and mental health may be interlinked (dual diagnosis) and how to manage risks between the two issues.

Key learning from Porchlight is to allow plenty of time – in total, it took about a year to take these changes from idea to implementation, with the negotiations with insurers taking up a significant chunk of time. Strong connections in local strategic leadership across homelessness and treatment services really helped to get buy-in, as there is a cost attached to naloxone supply and training. And time is needed to achieve any organisational culture change – communicating at all levels, updating paperwork, and learning from experience as the naloxone roll-out becomes embedded in practice.

Case study: the importance of reflective practice – naloxone at York Road Project

“There’s a whole mix of positive and negative emotions”

York Road Project in Woking has both a day centre and a night shelter. Chief Executive Cath Stamper introduced naloxone about three years ago, after night and day staff raised concerns about the lack of options to take action if someone was overdosing, or when staff weren’t sure if someone might be overdosing.

The teams received training from a local drug and alcohol service. Cath describes their policy as ‘pragmatic’ – all staff are trained to use naloxone, but it remains up to the individual whether to use it or not. Some York Road Project clients also hold their own naloxone kits, prescribed by their treatment provider independently of the organisation.

One naloxone kit is kept in the night shelter and one in the day centre, to be used as and when needed. In recent months, one kit was used to save a life in a Covid-19 emergency hotel. Overall, the kits are used 2-3 times a year. After each use, a RIDDOR serious incident form is completed, there is discussion and debrief at the next team meeting, and it forms part of the team’s reflective practice sessions.

Key learning from York Road Project is around the effect on the staff member administering naloxone, as giving an injection in an urgent situation can have a big impact on people, especially when the person overdosing comes round quickly and becomes aggressive. Cath emphasises the importance of helping the staff involved to process what has happened. There’s the shock of using a naloxone injection, the confusion they may feel if someone is angry at them, and also their pride at saving a life. There’s a whole mix of positive and negative emotions, and managers have to recognise that people might need some extra support to process what has happened.

As a PIE (Psychologically Informed Environment) organisation, staff have access to reflective practice. There is also an employee assistance scheme that staff can use for a whole range of support, including counselling, independent of the organisation.

Training is flexible and support changes depending on staff needs. For example, there is the knock-on effect on someone witnessing an overdose, even if they aren’t the one giving naloxone. Using naloxone can bring up feelings of guilt if staff find they have mixed feelings about needing to administer naloxone, for example experiencing a need to blame or resent the person who overdosed. These can be complex emotions that people need a safe space to work through. As most overdoses have happened at night, there is also a disproportionate impact on one part of the team.

Once a naloxone kit is used, staff contact their local substance use team who quickly replace it. There’s a procedure to ensure expiry dates are checked, and the practical side of storing naloxone is ‘low key and easy’.

Cath’s advice for smaller organisations is that introducing naloxone can be a light touch process. The key steps are: train people, check that staff understand how the policy applies to them, discuss using naloxone, and always make time to debrief after an overdose incident.

Case studies – individuals using naloxone to save lives

Names have been changed to protect the identity of the individuals involved.

Case 1 – public toilet

Michelle described how she had been injecting heroin with her partner, Rob, and their friend, John, in a public toilet one evening. She described how she and Rob injected heroin daily and how John only used heroin intermittently but was primarily alcohol dependent. Michelle reported that after they had all injected Rob turned round and noticed that John had turned blue and didn't appear to be breathing. Michelle described how she had her naloxone kit with her so got it out but was shaking so much that she couldn't open it, Rob took it from her and told her to go out and find a phone box and call an ambulance. Rob then administered the naloxone – giving a total of four doses at two minute intervals until the person came round. In the meantime, Michelle found a phone box and called 999, an ambulance attended some time later and John, who had already regained consciousness by this stage, was taken to hospital and survived.

Case 2 – subway

Craig related how he was walking through a subway one evening when he found someone unconscious, blue, not breathing and he believed they had had a heroin overdose. He did not know the person. He asked a passer-by to phone an ambulance whilst he commenced CPR. He described how he had given chest compressions for 7 minutes until the ambulance service attended. On attendance, ambulance personnel administered four doses of naloxone before the person came round – they were taken to hospital and survived. Craig described how until that point he had not always carried his naloxone with him when out and about but stated how he will never do that again and will always carry it with him wherever he goes. When asked if he had it with him now he opened his rucksack and there was his take home naloxone kit.

Case 3 – hostel

Jake reported how he had been trained in the use of naloxone in opiate overdose situations. He described how he had returned to his hostel the night he'd been trained and mentioned in passing to a couple of other residents that he had been trained that day and showed his naloxone kit to them. He reported how the very next day someone knocked on his room door and when he opened it they shouted that someone had overdosed in their room and he needed to bring 'that thing' he was given the day before. He described how he had run with his naloxone kit to the other resident's room and found someone in a heroin overdose situation. He gave naloxone whilst another resident ran to ask hostel staff to phone an ambulance. The person regained consciousness and was taken to hospital by ambulance and survived.

Case 4 – in someone's flat

Terry described how he had been in someone's flat where he and two of his friends were using heroin. One of these friends, Alan, had not used heroin for a couple of years and decided to inject. Terry reported how he noticed after a short while that Alan had stopped breathing and had turned blue. Terry used his naloxone kit and administered two doses to the person who came round minutes later and survived.

Further information

SMMGP (Free) e-Learning (Revised in 2018): Naloxone Saves Lives

www.smmgp-elearning.org.uk/

Public Health England (2017): Advice for Local Authorities and Local Partners on Widening the Availability of Naloxone to Reduce Overdose Deaths From Heroin and Other Drugs

www.gov.uk/government/uploads/sys1tem/uploads/attachment_data/file/669475/phetake-homenaloxoneforopioidoverdoseaug2017.pdf

Joint work between Collective Voice, the NHS and PHE to Improve Clinical Responses to Drug Related Deaths (2017)

www.collectivevoice.org.uk/news/joint-work-collective-voice-nhs-phe-improve-clinical-responses-drug-related-deaths/

EMCDDA: Preventing Opioid Overdose Deaths with Take Home Naloxone (2016)

www.emcdda.europa.eu/publications/insights/take-home-naloxone_en

International Overdose Awareness Day

www.overdoseday.com/

NHS National Services Scotland, National Naloxone Programme Scotland: Monitoring Report (2016)

www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2016-10-25/2016-10-25-Naloxone-Report.pdf

Naloxone Website (UK)

<https://naloxone.org.uk/>

Harm Reduction Coalition: Responding to Opioid Overdose - Administer Naloxone

<http://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/responding-to-opioid-overdose/administer-naloxone/>

Royal College of General Practitioners (RCGP): Naloxone Training in General Practice (2016)

www.rcgp.org.uk/clinical-and-research/resources/bright-ideas/naloxone-training-in-general-practice.aspx

Public Health England (Case Study) – Working with Accident and Emergency Units to Distribute Naloxone (2017)

www.gov.uk/government/case-studies/working-with-accident-and-emergency-units-to-distribute-naloxone

World Health Organisation (2015): Information Sheet on Opioid Overdose

www.who.int/substance_abuse/information-sheet/en/

Prenoxad Naloxone Kit Preparation Video (YouTube): Scottish Drugs Forum (2014)

www.youtube.com/watch?v=bNRZRYHJmEs

TEDx Talk (Video): Leana Wen – The One Medication That Will Save 25,000 Lives Each Year (2015)

www.youtube.com/watch?v=6E3fidGP8_Q

Public Health England, Alcohol and Drug Misuse Prevention and Treatment Guidance (2017)

www.gov.uk/government/collections/alcohol-and-drug-misuse-prevention-and-treatment-guidance



What we do

Homeless Link is the national membership charity for frontline homelessness services. We work to improve services through research, guidance and learning, and campaign for policy change that will ensure everyone has a place to call home and the support they need to keep it.

Let's end homelessness together

Homeless Link
Minorities House, 2-5 Minorities
London EC3N 1BJ

020 7840 4430

www.homeless.org.uk

Twitter: @Homelesslink

Facebook: www.facebook.com/homelesslink

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