Naloxone Key Facts

1. Take home naloxone reduces death due to opioid overdose

Fatal opioid overdose may result from the use of illicit drugs, such as heroin, or from the use of prescriptions opioids.¹ The 2015 EMCDDA systematic review of the effectiveness of take-home naloxone found “risk of opioid-related overdose fatalities was significantly lower in communities providing naloxone distribution and overdose management education than in communities without programme implementation.”² The study referred to was conducted over a seven year period and involved over 2,900 participants from cities and towns across Massachusetts.³

2. Issuing naloxone doesn’t encourage heroin use

Evidence from other countries has shown that fear of condoning or encouraging heroin use is unfounded. The idea that someone might decide to use more heroin because they’ve got the ‘back up’ of naloxone is difficult to support because naloxone brings on a withdrawal from opioids, is unpleasant and would in effect be a waste of the money spent on the extra heroin. A study by Wagner et al (2010)⁴ demonstrated that drug use went down at three month follow up after naloxone training and there was an increase in presentation for drug treatment.

3. Having naloxone and the relevant training encourages people to phone an ambulance

Without naloxone individuals may be reluctant to phone 999 for fear of potential consequences⁵. However, training individuals in the management of opioid overdose and issuing of naloxone equips them with the skills to intervene more effectively and aims to increase their confidence in managing these situations. One of the cornerstones of the training provided is the importance of phoning 999 and emphasising that naloxone has a short duration of action; therefore, training increases the understanding of the necessity of medical follow up.

4. Naloxone can be administered by the public while awaiting the arrival of professional assistance

Several studies have demonstrated that training drug users to appropriately recognise and respond to overdose is effective⁶–⁷–⁸. Green et al (2008)⁹ showed that opioid users were skilled at recognising the signs of opioid overdose and assessing the need for naloxone. Following an amendment to the Medicines Act in 2005¹⁰ it became legal for anyone to administer naloxone for the purpose of saving lives. We accept that some members of the public deliver CPR in other emergency situations, that defibrillators are placed in public areas for members of the public to use as needed and that people deliver first aid in many emergency situations¹¹ – so why is this viewed differently?
5. **Naloxone is unlikely to harm others even if used by mistake**

Naloxone is an opioid antagonist and has no pharmacological effect if opioids are not present⁴. If it was given in a situation where someone was deeply asleep, but not unconscious, no harm would be done, although if the person had an opioid dependency they would wake rather abruptly.

6. **Issuing naloxone to people who are no longer using opioids (for example, leaving rehab) is a protective action**

We know that individuals who achieve periods of abstinence from opioid use are at increased risk of overdose if they then use opioid drugs because they have lost their previous tolerance to the drug. Therefore the standard issuing of naloxone to these individuals (and their families/carers/friends with the individuals consent) offers a protective stance to all rather than making judgements about who may or may not lapse. Additionally, carrying naloxone can benefit peers who may still be using opioids.

7. **Risk of opioid overdose and what can be done to mitigate this risk is a matter of concern for anyone involved with the welfare of people who use opioids**

Clearly the welfare of those who use opioid drugs and protecting them from harm is the focus of drug and alcohol treatment services; therefore, training in the management of opioid overdose and issuing of naloxone needs to be standard practice within these services. However, this approach will generally only reach those individuals who are in drug treatment and therefore access to training and naloxone needs to be widened.

We know that deaths from heroin and morphine use have recently risen significantly in England and Wales¹¹. In 2014 the World Health Organisation produced guidelines on the community management of opioid overdose which recommend that all those at risk of opioid overdose should have access to training in the management of overdose and have naloxone available for use¹². This is a health issue. Both primary and secondary care services have a responsibility to deliver an intervention to their patients that decreases the risk of harm and death, as they would in numerous other circumstances, for example issuing patients with an Epipen if they are at risk of anaphylaxis. Therefore, ensuring patients are offered an intervention that has the potential to save their lives is the job of all those who work in the health system who come into contact with those at risk of opioid overdose.

8. **The training is quick and simple to deliver**

The training can be delivered in a 10 to 20 minute conversation. For those working in drug and alcohol treatment services this can easily be integrated into initial assessments or follow up appointments and doesn't require additional time to be identified. Primary and secondary care services can view such an intervention like many others they conduct in order to minimise harm to health. For example, offering dietary and exercise advice, making a brief alcohol intervention, offering advice around stopping smoking, teaching someone how to use an inhaler or training someone in how to use an Epipen.
The training delivered incorporates what puts people more at risk of opioid overdose and therefore has the potential to educate individuals in how they can reduce their risk. This might mean that emergency treatment might be required less and therefore be more time and cost efficient for the NHS. The training aims to give people the skills to effectively manage opioid overdose and introduce the earlier delivery of naloxone – it therefore has the potential to keep people alive who might otherwise die before an ambulance arrives and also to lower the risk of hypoxic brain damage in non-fatal overdose.

9. **The cost is minimal, especially when compared to the clear benefits**

A naloxone kit costs approximately £18. Unless used, the individual will carry this kit with them until its expiry date up to 3 years later. We should remember that many medications are far more costly when taken over a period of time.

We also need to ask what the cost of not issuing naloxone to people is: in the loss of life and subsequent impact on families and communities, loss of employability potential and in the cost to the NHS of caring for individuals following a non-fatal opioid overdose where a later intervention and more ‘damage’ has occurred. The risk of early death is many times higher amongst injecting drug users than the general population². The national agenda amongst drug and alcohol treatment services focuses on ‘recovery’, but if someone dies of an opioid overdose there can be no recovery. Therefore training and issuing of naloxone is a way of offering some protection so that individuals are able to stay alive to be able reach recovery in the future.

10. **This isn’t just a new, ‘trendy’ drug treatment intervention**

Naloxone isn’t a ‘new’ intervention. It’s a medication that has been used clinically for over 40 years. A report from the Centers for Disease Control and Prevention in 2012¹³ outlines how a survey conducted by the Harm Reduction Coalition of 188 opioid overdose prevention programmes in the US reported that between 1996 and 2010 over 53,000 people were issued with naloxone and reported more than 10,000 overdose reversals. The use of naloxone in this ‘take home’ form has been supported in the UK by the Advisory Council on the Misuse of Drugs since 2012¹⁴. It is available in this way in a number of European countries, in parts of the United States and in Australia. Both Scotland and Wales have their own national naloxone programmes. It is an evidence-based intervention which is now recommended by the World Health Organisation¹². Public Health England stated “In October 2015, legislation is expected to be enacted that will allow wider access to naloxone. But this should not delay the provision of take-home naloxone to at-risk individuals now, using existing provision for prescriptions and PGDs.”¹⁵

This is a health care responsibility which everyone who has contact with those at risk of opioid overdose needs to fulfil.
References:


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Access – Overdose Prevention – Family/Peers/first responders – Saving Lives