PEER-TO-PEER DISTRIBUTION OF NALOXONE (P2PN)

TECHNICAL BRIEFING

EuroNPUD
European Network of People who Use Drugs

2019

EUROPEAN NETWORK OF PEOPLE WHO USE DRUGS

CONTENTS

EXECUTIVE SUMMARY

This Technical Briefing provides a description of **Peer-to-Peer Distribution of Naloxone (P2PN)**. This is based on six case studies of pioneers of P2PN; three from the UK and three international examples that inform the guidance in this Technical Briefing. This document will inform and be extended following a pilot of P2PN in four sites in England in 2019. These will be supported by small grants from EuroNPUD. The learning from this pilot will help test the model and peer education approach promoted in this briefing.

6 CASE STUDIES

3 from UK

3 international

A PILOT OF P2PN

4 sites (UK)

+ SMALL GRANTS

from EuroNPUD

DAN BIGG (1959 - 2018)

Executive Director Chicago Recovery Alliance

DEDICATION

The Chicago Recovery Alliance has been a global pioneer of take-home naloxone. A number of the peer leaders interviewed for this technical briefing cited CRA and its Executive Director Dan Bigg as an inspiration or even a direct advisor to their projects. The late great Dan Bigg is known in the sector as the 'Godfather of Naloxone' for his pioneering role championing take-home naloxone. It is sadly timely that this project acknowledges the passing and contribution of Dan by dedicating this project in his memory.

INTRODUCTION TO NALOXONE

Naloxone is an opioid antagonist which by displacing opioids from receptors sites in the brain. Naloxone can reverse the effects of overdose if administered within a short period following an opioid overdose. When administered intramuscularly the onset of action is between 2-4 minutes. The duration of the naloxone is up to 45 minutes. When someone accidentally overdoses and opioid drugs are involved, their breathing can be compromised and this can lead to their death.

Naloxone is available in prefilled syringes with 5 x 0.4mg doses of naloxone **(PRENOXAD)** and the nasal form of naloxone now also has a European license **(NYXOID).**

Naloxone can help restore the breathing of the opioid (or opioid-related) overdose casualty, ideally 'buying time' before an ambulance arrives.

In many contexts around the world, naloxone is available in a 0.4mg GLASS AMPOULE. A 2ml barrel and a needle intramuscular administration (usually 23 gauge 1 1⁄4 inch blue fitting) will be provided alongside the naloxone to support take-home distribution. Normally two amps and sets of injecting equipment will be distributed as sometimes it can take more the one dose of 0.4MG of naloxone to reverse the effects of opioid related overdose.

THREE FORMS OF NALAXONE:

PRENOXAD	NYXOID	GLASS AMPOULE
		

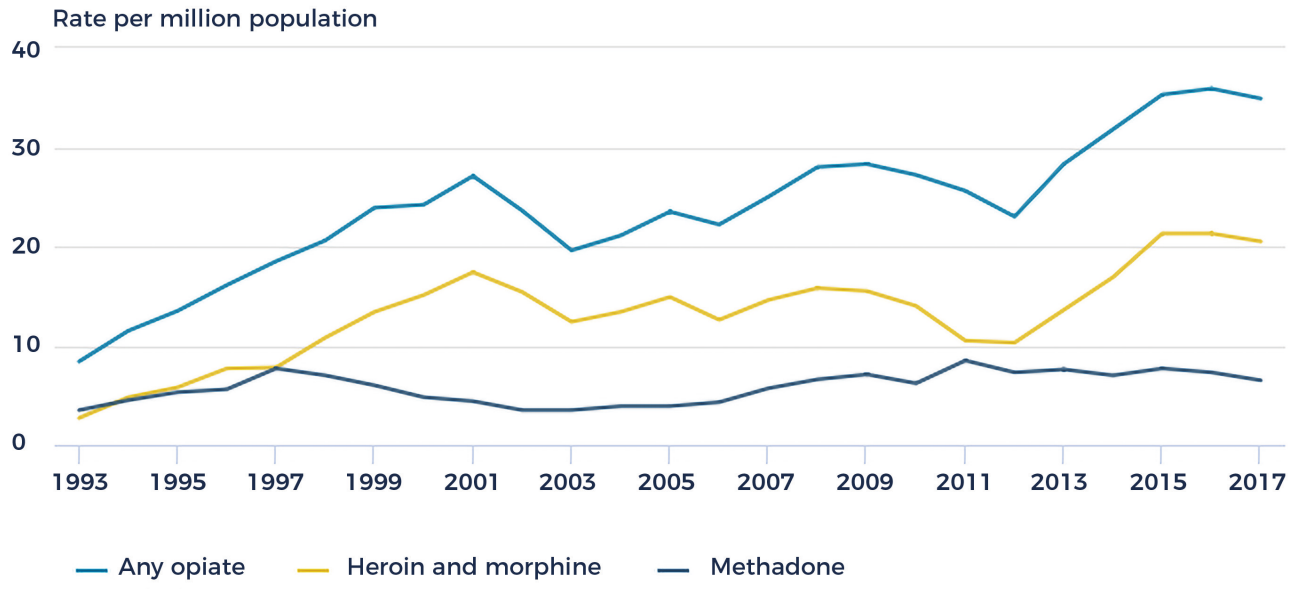
Drug user activists favour the prefilled injectable form as it allows their peers to be brought back in stages from an opioid overdose reducing the chances of triggering deeper and more uncomfortable withdrawal symptoms. However, it is always better to administer naloxone, whatever the form, when someone has overdosed on opioids and has stopped breathing or is having difficulty breathing. The period of discomfort will only last for about twenty minutes while death is forever.

THE CONTEXT FOR PEER-TO-PEER NALOXONE

Overdose is the leading cause of preventable death among people who use opioids in the UK. Accidental opioid overdose related deaths are at all-time high in the UK. We have not achieved the required saturation levels with naloxone within peer networks despite the best efforts of professional services.

About half of opioid-related-related deaths occur among those who have never or have not been in drug treatment for several years.[1] Barriers to treatment access and retention have arguably increased since the introduction of of national strategies striving for abstinence based recovery and the pressure on providers and practitioners to achieve drug-free outcomes. People in treatment for opiates made up the largest proportion of the total numbers in treatment (53% or 141,189). This is a fall of 4% since the previous year.[2] Collated data shows that 2017 is now the year with the highest number of registered drug-related deaths since records began. Opioid-related deaths have saw a slight fall in 2017, which is to be welcomed, but the numbers still remain concerningly high.[3]

FIGURE 1: AGE-STANDARDISED MORTALITY RATES FOR DEATHS BY ALL OPIATES, HEROIN AND MORPHINE, AND METHADONE, REGISTERED 1993 TO 2017[3] (ENGLAND AND WALES)



The key argument for P2PN is that it is highly effective at driving the distribution of take-home naloxone through the multiple entry points needed to reach both the treatment and non-treatment populations. As the case studies in this technical briefing will show, peer educators and drug user groups bring a momentum and commitment to the roll out of take-home naloxone that supports the strategic objective of saturating peer networks with naloxone and the supporting knowledge to manage opioid overdose.

DEATHS RELATED TO DRUG POISONING IN ENGLAND AND WALES

2017 REGISTRATIONS OFFICE OF NATIONAL STATISTICS

3.756 DEATHS IN 2017

There were 3,756 deaths relating to drug poisoning in England and Wales in 2017, a rate of 66.1 deaths per 1 million population, and similar to levels seen in 2016.

Two-thirds of drug-related deaths were related to drug misuse, accounting for 43.7 deaths per 1 million in 2017.

Males' mortality rate decreased from 91.4 deaths per 1 million population in 2016 to 89.6 in 2017, while the female rate increased for the eighth consecutive year to 42.9 deaths per 1 million population; neither changes were significant.

The North East had a significantly higher rate of deaths relating to drug-misuse than all other English regions; London had a significantly lower rate.

Deaths involving cocaine and fentanyl continued to rise while deaths related to new psychoactive substances halved in 2017.[5]

INTRODUCTION TO THE EUROPEAN NETWORK OF PEOPLE WHO USE DRUGS (EURONPUD)

DESCRIPTION

EuroNPUD was planned at a meeting held alongside the International Harm Reduction Conference in Liverpool in 2010. The network took time to gather resources, engage country activists and find the best operating model. In 2017 EuroNPUD switched to a project management model, which supports a highly participative, dynamic and consensus-based network. A Project Manager and Project Administrator sit at the centre of the organisation consulting, mobilising and drawing on the skills of a broad-based Steering Committee with representatives and alternates from across the European Union and its neighbourhood.

VISION STATEMENT

A Europe that respects the rights of PWUD and supports drug users' health with science-based and rights compliant harm reduction, drug treatment and healthcare services both domestically and around the world.

MISSION STATEMENT

Promoting the health and defending the rights of people who use drugs in Europe.

EuroNPUD's operational work is framed as technical bundles that normally range from 3 – 10 days' work, which is offered first to Steering Committee members in acknowledgement of their voluntary contributions. A Communications Coordinator and voluntary Communications Working Group maintain and develop EuroNPUD's virtual office and outward facing communication platforms. Our representatives sit on the Boards of partner organisations and our advocates sit on civil society partnership mechanisms at the EU and UN.

DONORS

Robert Carr Network Fund

ViiV Positive Action

INTRODUCTION TO EURONPUD NALOXONE ACCESS AND ADVOCACY PROJECT

The EuroNPUD Naloxone Access and Advocacy Project (NAAP) was funded with an unrestricted educational grant from Martindale Pharma an Ethypharm Group company in support of activities leading up to International Overdose Awareness Day (IOAD) – 30 August 2018.

The project started with the selection of three areas with at least twice the national average of opioid overdose – Burnley, Blackpool and Liverpool. These areas were chosen as illustrations of the situation in England. It is notable that all were in the North of England, which continues to face higher rates of opioid overdose than the South of England and particularly London. We believe the resulting lessons can inform the planning and provision of services for people using opioids across England and to a greater extent across the UK.

6

Preparing for International Overdose Awareness Day

Tuesday 28th August
Henfry Seminar Room, Blackburne House, Blackburne Place, Liverpool L8 7PE

A half-day event bringing together service users and professional partners in Liverpool organised by drug users in Liverpool in partnership with the European Network of People who Use Drugs (EuroNPUD).

Liverpool is experiencing one of the highest overdose rates in Britain despite the distribution of Naloxone. What are the barriers? How can we prevent more unnecessary deaths?

The project assessed access to naloxone and peer knowledge about the use of naloxone and opioid overdose management based on a peer focus group and a peer-led mystery shopper activity. The results of the peer audit were fed back to a multi-disciplinary meeting of the peers involved in the peer audit and professional partners involved in the planning and provision of services for people who use opioids. The meetings reviewed the findings and developed strategies for overcoming barriers to access to naloxone. In the final stage of the project, EuroNPUD is supporting local drug user groups to develop peer-to-peer naloxone distribution (P2PN) pilots in the three audited areas and also the pilot site of Bath.

METHODOLOGY FOR DEVELOPING THE TECHNICAL BRIEFING ON PEER-TO-PEER NALOXONE DISTRIBUTION

EuroNPUD's Project Manager Mat Southwell interviewed in person or through video conference key drug user organisers involved in the development and delivery of the six case studies that form the basis of this technical briefing. A working draft of the report was shared with these drug user organisers, some of their professional partners and the EuroNPUD UK NAAP Project Team. The briefing was worked up through this interaction. The limited available publications on P2PN were reviewed as were media stories, blog posts, and policies and procedures relating to the different case studies.

LEGAL ENVIRONMENT IN UK

In 1995 England and Germany became the first countries to distribute naloxone to people who use opioids. In 2005 the UK Medicines Act was amended to made it lawful for anyone to administer naloxone. UK pilot projects were established and these demonstrated the practical application and value of take-home naloxone but did not create the required momentum to achieve a comprehensive roll out.

Scotland introduced a National Patient Group Directive in August 2010 to ease the development of take-home naloxone programmes and to support its national naloxone programme, which was announced in the same year.

Patient Group Directives (PGD) allow naloxone to be prescribed by appropriately qualified nurses and pharmacists. In 2015, the Human Medicines (Amendment) (No. 3) Regulations 2015 (2015/1503) was enacted in the UK.

This allows naloxone to be supplied by "Persons employed or engaged in the provision of drug treatment services provided by, on behalf of or under arrangements made by one of the following bodies:

(A) AN NHS BODY

(B) A LOCAL AUTHORITY

(C) PUBLIC HEALTH ENGLAND

(D) PUBLIC HEALTH AGENCY

It can be supplied to anyone in the course of lawful drug treatment services and only where required for the purpose of saving life in an emergency."[7]

Critically this created the conditions required for the peer-to-peer distribution of naloxone. Peer educators could be registered as volunteers of local drug services, empowering them to cascade

out the distribution of P2PN by providing training and/or brief interventions before distributing naloxone to their peers. Arguably the regulations could also include drug user groups being sub-contracted to provide peer-to-peer distribution of naloxone as part of a consortium model for commissioning drug services.

DEFINITION AND MODELS

Drug users can be engaged by drug service providers in the distribution of naloxone in two different ways:

1. Engaged as volunteer peer workers attached to a harm reduction or recovery agency to extend the reach and lower the threshold of services.

2. Contracted as a drug user group to distribute naloxone and support the community management of opioid overdose.

P2PN is underpinned by drug users' privileged access. Peer educators are able to enter and interact in drug using venues and they naturally interact with the local drug supply system. Even where there are not formal drug user groups, PWUD naturally cooperate together in informal mutual aid networks.

Importantly, when peer educators are active drug users, they have access to the drug scene at times when drugs are being bought and used. Peer educators who are active drug users, on OST or ex-drug users / in recovery can all draw on their trusted status with those currently actively using drugs based on their shared lived experienced and access to friendship and supply networks. Internationally drug user groups have also worked autonomously to distribute naloxone and deliver peer education through peer networks when politicians have been too slow to act. Official take-home naloxone schemes in some US States have shared naloxone with smaller satellite programmes in other US States.

Whereas prohibitionist drug policies seek to isolate drug users from the spaces and cultures of drug use, harm reduction strategies like P2PN treat the social contexts of drug use as crucial resources for intervention. Such programmes make use of the expertise, experience, and social connections gained by users in their careers as users. In revaluing the experience of drug users, naloxone facilitates a number of harm reduction goals.[8] It also supports a sense of community and individual and collective self-worth founded in defending the most fundamental of human rights principles – the right to life.

CASE STUDIES

WILTSHIRE USERS FORUM UK

Wiltshire is a rural area in the West of England including the famous prehistoric monument Stonehenge. The Wiltshire Scheme was initiated in 2006 by Mick Webb who was the Service User Coordinator leading the Wiltshire Users Forum. Mick was an employee of the local service provider BADAS but he was managed by the local commissioner.

In many ways, the Wiltshire Scheme applied a traditional approach to take-home naloxone. Once the peer-led training had been completed, the prescriber would give the course graduates naloxone to take home. However, on other occasions, the doctor filled out prescriptions retrospectively with the personal information of the course graduates who were provided with take-home naloxone on an outreach basis. The training was often delivered opportunistically to individual or small groups of opioid users. By necessity the training was restricted to a brief intervention as active drug users were often busy raising funds for or buying or using drugs. The outreach worker used his discretion to match the length and content of the training to the capacity and availability of the drug user.

The Wiltshire Scheme benefited from the expert advice and backing of a highly committed local GP Dr Gordon Morse who was the specialist prescriber and key partner with Mick. Dr Jenny Scott an academic pharmacist with a specialist interest in drugs from Bath University also advised

the project. Mick described the importance of the advice and backing of these two experts and also the policy support of the Joint Commissioning Group. This gave the partners the confidence to stretch the legislation to allow for P2PN before it was strictly enabled by the legislation. The partners carefully thought about the risks they were taking and considered whether the police or their professional bodies would sanction them for their liberal interpretation of the rules.

They considered the ethical imperative to save lives and the resulting need for a flexible interpretation of the rules and assessed that the police or professional bodies would not see any public interest in sanctioning the scheme and particularly the prescribing GP. The embedded status of the WUF within the local joint commissioning and provider system also allowed for a strategic dialogue with both the police and ambulance service who supported the scheme.

The scheme was finally taken over by the local provider Developing Health and Independence (DHI) and Mick became an employee. WUF's initial low-cost pilot only cost £247, which was the cut price negotiated for the initial box of 50 units of naloxone. Data from the project is no longer available but Mick remembered 3 reversals being achieved in the first 3 months of the scheme highlighting the reach of P2PN even in a rural area.[9]

GLASGOW SCOTLAND UK

Scotland has the highest rate of opioid-related deaths in the UK and the most developed take-home naloxone scheme. Announced in 2010 and launched in 2011, the take-home naloxone (THN) programme was introduced by the Scottish Government following successful small-scale take-home naloxone pilots in Glasgow, Lanarkshire and Inverness. Over several years, Scottish Drugs Forum (SDF) had been advocating for take-home naloxone and was subsequently commissioned to coordinate the programme and to train the workforce. Staff working in community drug services and the Scottish Prison Service were the primary focus of a 'training for trainers' model across the country.[10]

The 2015 regulations allowed for volunteers of drug services to distribute naloxone and this created the enabling legal environment for P2PN. Steven Kerr and Jason Wallace were interviewed in Glasgow about the P2PN programme. Both were volunteers in their local recovery group and they were trained, registered as volunteers and equipped through the national health service. The P2PN scheme was delivered as part of the recovery group's community support to those still actively using opioids. PWUD were offered access to take-home naloxone after taking part in a one-hour training course or after receiving a brief intervention to guide them in the administration of naloxone. Training was delivered through a variety of community outlets, specialist drug and alcohol services, criminal justice services including prisoners being prepared for release, recovery cafes and self-help groups, and private homes of PWUD. The recovery group ensured the dynamic promotion of opioid overdose management and take-home naloxone. Under ten peer educators distributed over 1300 units of naloxone in the North-East district of Glasgow in the first 11 months of the scheme; this was more naloxone than every professional gave out across the whole of Glasgow in the preceding year. This highlights the ability of peer educators to saturate drug using networks with naloxone and the peer expertise to manage opioid overdoses. The Glasgow Scheme was the first formal P2PN initiative to be launched to response to the regulation reform in 2015.[11]

One of the peer educators from the scheme highlighted the personal value of being a volunteer in terms of learning and applying specialist skills, building a sense of self-worth, and gathering transferable employment skills. The volunteer also stressed the importance of working in a supported and supervised environment, which avoided putting undue pressure and demands on a volunteer still engaged in their own personal change journey.[12]

LAMBETH LONDON UK

LAMBETH IS IN THE SOUTH OF LONDON AND INCLUDES THE VIBRANT AND CULTURALLY DIVERSE BOROUGH OF BRIXTON.

Lambeth Service Users Forum is a service user initiative funded through Lambeth's drug and alcohol service provider consortium, which is led from SLAM part of the National Addictions Unit at the Maudsley Hospital. LSUF have been one of the best funded service user initiatives in England and despite cuts in the last few years, LSUF remains a key part of the local consortium service provision model. As such, LSUF operates as a comprehensive service user group interacting with a health service led harm reduction, drug treatment and recovery service.

LSUF is led by an Executive that draws representatives from the various peer-based initiatives including recovery and self-help groups, OST consumer advocacy, community watchdog or peer audit, drug user representation, and peer-led harm reduction initiatives. Cuca McCusker leads LSUF peer education and community harm reduction initiatives. This has included delivering training sessions in support of take-home naloxone, benefiting from Professor John Strang's academic and policy leadership on naloxone in the UK through the National Addictions Unit.

Cuca went through an 18-month process to become registered as an NHS volunteer. Becoming an NHS volunteer was a challenging and demanding process that was necessary for Cuca to be validated by the NHS and thereby empowered to distribute naloxone under the 2015 regulations. A more streamlined process will be considered to roll out P2PN and interim arrangements were necessary while this registration was being sought.

However, delivering this scheme through the NHS ensured a systematic approach with template documentation and reporting requirements described in a supporting protocol.[13] In addition, competencies were defined for the P2PN volunteers setting out the skills and abilities that they would need to demonstrate in order to perform their role. Volunteers are required to retrain and be re-registered every 3 years. The protocol also sets out clear standards for safe storage which is an important issue particularly if naloxone is stored in a hot or cold car.

COMPETENCIES FOR PEER TRAINERS AND DISTRIBUTORS OF NALOXONE

Volunteers should be able to recognise signs of an opioid overdose and be able to prepare and administer naloxone.

Volunteers should be able to open and/or prepare the naloxone for administration and be able to administer the naloxone.

Volunteers should understand how to book out naloxone for a training session and how to document peer distribution.

Volunteers should understand how to report an incident if a problem situation arises.[14]

MINNESOTA USA[15]

Lee Hertel's one-person grassroots harm reduction service is called Lee's Rig Hub. It is based in Minneapolis, Minnesota in the United States of America. Lee has trusted privileged-access as a member of the drug using community even if he is not an opioid enthusiast personally. Lee delivers harm reduction commodities through local drug using and supply networks.

He rides along with local peers as they sell, deliver and buy drugs and interact with using friends. Lee's trusted status allows him to equip his peers with new injecting equipment and to provide them with harm reduction advice. Lee works as a volunteer distributing harm reduction materials that have been donated to him by larger harm reduction providers and purchased through small grant awards from public and private entities as well as by his own personal funds. Lee's naloxone distribution initiative is made possible by in-kind donations from a big-hearted secret donor. Over a six-year period the participants of Lee's Rig Hub flooded the state of Minnesota with more than 60 litres of naloxone. In 2014 the number of fatal opioid overdoses in the state of Minnesota dropped more than 22% from the previous year. That was also the year the state of Minnesota passed an expanded naloxone access and Good Samaritan law. This law mandated all emergency first-responders to carry naloxone and allowed any state resident to administer it regardless of medical training or licensure. However, that law did not go into effect until 1 August 2014. Although Lee's Rig Hub's accomplishment has never been officially acknowledged, the consistent peer feedback confirms the life saving impact of P2PN distribution among PWUD in Minneapolis.

Lee is not limited by the normal requirements of prescribing or dispensing a controlled medicine or managing official reporting requirements for drug related deaths or harm reduction programmes. This allows for an incredibly low threshold service where naloxone amps are distributed with the same ease as condoms, needles or injectable water ampules. Lee described how he will put a handful of naloxone amps in with the client's other harm reduction materials. Lee is motivated by his community commitment and passionate belief in the principles and practices of harm reduction. Lee's Rig Hub does not keep formal data but the appreciation and acknowledgement that Lee receives from the local drug community is a key motivating factor.

THE KACHIN REGION OF MYANMAR

The Kachin Region of Myanmar faces the dual challenges of being a major producer country for opium and methamphetamine and being in the midst of a longstanding conflict between the national army and insurgents from the northern regions of the country where different ethnic groups are seeking independence. Myanmar's HIV epidemic among PWUD is running out of control with prevalence levels exceeding 50%. Opioid overdose deaths were extremely common linked to the high quality of number 4 heroin (China white), poly-drug use, and very low knowledge levels among PWUD. Their vulnerability is amplified by the actions of a Christian community anti-drugs group, who round up PWUD, beat them and coerce them into 3 months of forced, non-medically assisted detoxification.

Coact were invited by Médecins du Monde (MdM) to support the introduction of community mobilisation through 3 technical support mission delivered in Kachin in 2017. Naloxone was arriving in the country through the Global Fund to Fight HIV, TB and Malaria but through this pilot phase Coact had 20 units to use to reinforce the peer training.

Coact supported the piloting and introduction of four different peer-based harm reduction interventions, including P2PN. Peers were paid to attend training courses delivered though drop in centres, cafes or peers' homes with the support of different local drug user groups. Drug user groups were then equipped with sets of 5 units of naloxone. These were held in a central location ready for use in the community. Two drug user organisers from Flying Bird drug user group in Mitychina saved the lives of three peers in the 3 month period between two mission after receiving training and a stock of naloxone.

A working relationship was established between different drug user groups and the outreach workers from MdM's prevention teams. This allowed peer educators to be re-supplied if they used or lost their naloxone. The training targeted the drug user organisers and activists in the local drug user groups providing them with a one-hour training course and take-home naloxone that would be held centrally by the drug user group. In time, it was hoped that all the trained peers would be equipped with take-home naloxone. The future maintenance of the programme was based on two models:

1. The drug user group could host a training session on opioid overdose management and MDM's trainer would attend to deliver the course and distribute naloxone.

2. With the Pure Balanced Mind Group in Hopin, Coact trained the drug user organisers (leaders) in the group so they could deliver the training to their peers who could then access naloxone through their partnership with MDM.

Knowledge sharing was key given the very low knowledge levels about the risk factors for opioid overdose. Investing in training drug user organisers was a first step in shifting cultural norms and community understanding about the prevention and management of opioid overdose. MDM's community mobilisation teams have since integrated and rolled out the P2PN programme in partnership with the National Drug-user Network Myanmar (Kachin Region).

CANBERA AUSTRALIA[16]

Canberra is the capital of Australia and the Government and administrative centre of the country. The Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) is the state drug user group in Australian Capital Territory (ACT). The development of Australia's first take-home naloxone program in the ACT has been an 'ice-breaker' for development of other Australian programmes. As such the Canberra Scheme was the pioneer of take-home naloxone in Australia and a catalyst for the other state programmes which have learned from this example.

Geoff Ward from CAMHA highlighted the pivotal role of then Chief Minister of the ACT, Katy Gallagher of ACT. During the 2012 election campaign, Katy championed prison-based needle and syringe programmes so she arrived with a mandate to respond progressively to drug use. However, the prison officers association were a barrier to the roll out of prison-based NSP, so the Chief Minister decided to re-direct her focus to the roll out of take-home naloxone.

CAHMA WAS FUNDED TO RUN A TRIAL OF PEER-BASED NALOXONE TRAINING WITH 200 OPIOID USERS. A MULTI-DISCIPLINARY TEAM OF STAKEHOLDERS WERE INVOLVED IN THE ESTABLISHMENT OF THE TRIAL. 57 OVERDOSE REVERSALS WERE ACHIEVED, AND THE TRIAL WAS EVALUATED POSITIVELY.[17]

As a result of the success of the trial, CAHMA received new funding for a three-year contract to develop and maintain the roll out of take-home naloxone.

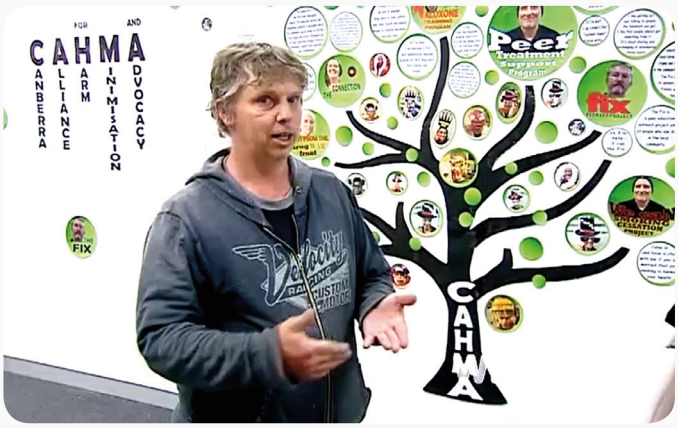
With political backing and guaranteed resources, CAHMA were able to work consistently to roll out naloxone and engage other key stakeholders. Significantly the scheme delivered peer training and distribution through drug services, community settings, and peers' homes and paid peers $AUS30 for completing the training. A supportive doctor, who works with CAHMA, comes at the end of the training and writes prescriptions for naloxone for participants. Kits are given out that contain harm reduction information and five 0.4 mg IM doses of naloxone. As naloxone is now dual listed and can be bought over-the-counter at pharmacies a supply of naloxone is on hand to give out to people following brief interventions, which is essentially a very short version of the training. This allows CAHMA to give out naloxone kits as part of brief intervention engagement of active drug users.

CAHMA was also responsible for training practitioners in specialist drugs and related health and social care services in the management of opioid overdose before distributing naloxone to these frontline staff. The CAHMA model uses a drug user group to maintain the focus and momentum on opioid overdose management, which might not be sustained in services with multiple tasks and targets. Rather than P2PN being a bolt on to traditional harm reduction services, P2PN was at the heart of the Canberra Scheme and CAHMA ensured roll out through their peers, through practitioners and even to people being prepared for release from prison.

FEATURES OF PEER-TO-PEER-NALOXONE

P2PN can take a number of forms from a full comprehensive system run by a drug user group as illustrated by the Canberra scheme through to P2PN being an extension to the local needle and syringe programme (NSP) as illustrated by the Myanmar case study. It is unsurprising to find drug groups pioneering harm reduction responses to new drug trends. While Wiltshire and Glasgow may contest the title of the first P2PN programme in the UK, it is notable that both of these pioneer programmes were led by drug user groups.

A P2PN distribution model can look very similar to a professionally run take-home naloxone programme. A one-hour training programme is delivered by a peer trainer. At the end of the training course a professional dispenser such as a doctor or authorised pharmacist or nurse joins the course to dispense naloxone kits to graduates.



The P2PN also allows these one-hour training courses to be delivered on an outreach basis through satellite locations such as recovery groups or cafes, offender services, youth centres, community centres and peers' homes . The option of approved peer workers being authorised to distribute naloxone on an outreach basis ensures that graduates of the one-hour training are able to receive take home naloxone at the end of the course without the direct participation of an approved prescriber. The peer educator keeps a record of the peers trained and distributes naloxone to them; the peer educator records the dispensing on returning to the office.

FEATURES OF PEER EDUCATION TRAINING SESSION ON OPIOID OVERDOSE MANAGEMENT

- CAUSES OF AN OVERDOSE
- RISK FACTORS:

o Mixing drugs/poly drug use (for example the risk of taking benzodiazepines to 'boost' a shot)

o Reduced Tolerance (especially post incarceration, detoxification or residential rehabilitation)

o Using Alone (the obvious inability to administer naloxone to yourself if you have lost consciousness)

- COMMON MYTHS
- NALOXONE SIDE EFFECTS, DOSAGE, STORAGE, ACCESS TO NEEDLE AND SYRINGE FOR AMPOULE
- OVERDOSE AND DEATH PREVENTION STRATEGIES (eg: go low-go slow, risks of polydrug use and trying to use one drug at a time if possible, fix with someone nearby who can help you if needed)
- IDENTIFICATION OF SIGNS AND SYMPTOMS
- ASSESSMENT OF CASUALTY
- CALLING AMBULANCE
- MANAGING A CASUALTY WHO IS UNCONSCIOUS AND BREATHING
- APPROPRIATE BASIC LIFE SUPPORT INCLUDING RECOVERY POSITION
- MANAGING A CASUALTY WHO IS UNCONSCIOUS AND NOT BREATHING
- NALOXONE ADMINISTRATION
- RESCUE BREATHS
- MANAGING THE CASUALTY AS THEY COME ROUND AND OCCASIONAL RISKS OF AGGRESSION
- LEGAL CONTEXT – MANAGING THE POLICE IF CAUGHT CARRYING AND/OR USING NALOXONE

The outreach delivery of P2PN is a low threshold version of take-home naloxone distribution. In this case, peer workers engage PWUD in street setting or using venues. They offer to provide access to naloxone in exchange for 5 – 10 minutes of training. In this case the focus of the brief intervention training is on recognising an opioid overdose and administering naloxone. Reports from the US indicate a growing focus on the use of a brief intervention to drive the distribution of take-home naloxone. This reflects the need to low the threshold to naloxone for those living busy and pressured lives while managing active dependency on opioids, particularly without the support of OST. In gorilla programmes naloxone is distributed as easily as amps of water or syringes being seen as a routine part of the safer injecting toolkit.

FEATURES OF BRIEF INTERVENTION TRAINING BEFORE OUTREACH DISTRIBUTION OF NALOXONE

- IDENTIFICATION OF SIGNS AND SYMPTOMS
- ASSESSMENT OF CASUALTY
- CALLING AMBULANCE
- APPROPRIATE BASIC LIFE SUPPORT INCLUDING RECOVERY POSITION
- NALOXONE ADMINISTRATION
- LEGAL CONTEXT – MANAGING THE POLICE IF CAUGHT CARRYING AND/OR USING NALOXONE
- RISK FACTORS AND PREVENTION STRATEGIES (IF TIME WITH PEER ALLOWS)

The challenge for most naloxone programmes is the ability to distribute naloxone to those facing the high-risk situation of being released from prison. Both the Canberra and Glasgow schemes successfully negotiated with the prison service so they could deliver peer education training to appropriate prisoners as part of their preparation for release. The challenge is how to distribute the naloxone to the prisoner after they have been trained, as they cannot be given the naloxone kit until the moment of release. Prison Officers cannot open prisoners' property until the prisoner is present to witness the unsealing of their property bag, which normally happens as one of the final steps prior to release.

The Glasgow Scheme overcame this barrier by prison staff stapling the naloxone kit to the prisoners' property after they have graduated from the training. This ensures that the naloxone is available at the point of release without the need to unseal the prisoner's property. The alternative was to provide graduates of the peer training course with a voucher for naloxone that can be redeemed from their local drug service on release from prison. The challenge is that many prisoners will celebrate their release with substances before they reach their harm reduction provider with the resulting risk of overdose.

The Canberra Take-Home Naloxone Programme was commissioned through the state drug user group. The drug user group delivered P2PN training sessions in a variety of settings from professional agencies, to community settings, to the homes of peers. The DUG also trained the professional frontline staff to be professional first responders. As such the drug user activists became the key agents of change in the promotion of take-home naloxone. The value of using peers and drug user groups to sustain the intensity of the response to rolling out naloxone was highlighted by a number of the peer projects alongside the benefits of privileged access.

CONCLUSION

Drug user groups are often involved in harm reduction innovation because issues like opioid overdose affects our lives and the lives of our friends and community.

P2PN provides an effective, affordable, and efficient method of putting the life-saving opioid overdose reversal drug naloxone into the hands of those most likely to be present when a drug user overdoses on opioids.

P2PN contributes to ensuring that enough naloxone is available in the drug using community to achieve the saturation levels required to deliver consistent reversals.

Drug user groups and peer projects innovate and pioneer when others are too slow to act.

Drug user groups and peer projects can form dynamic partnerships with harm reduction organisations and policy makers in combatting opioid overdose.

It is welcome that the UK Government have created the legal environment to allow for P2PN.

This technical briefing highlights why P2PN should be widely adopted and tailored to local contexts in partnership with local drug users and their groups.

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REFERENCES

1 https://publichealthmatters.blog.gov.uk/2018/08/08/drug-misuse-deaths-fall-but-still-remain-too-high/

2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/752993/AdultSubstanceMisuseStatisticsfromNDTMS2017-18.pdf

3 https://publichealthmatters.blog.gov.uk/2018/08/08/drug-misuse-deaths-fall-but-still-remain-too-high/

4 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2017registrations

5 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2017registrations

6 https://www.overdoseday.com

7 https://www.hey.nhs.uk/wp/wp-content/uploads/2017/07/Naloxone-for-Opioid-Overdose.pdf

8 Faulkner-Gurstein, R. (2017) The social logic of naloxone: Peer administration, harm reduction, and the transformation of social policy. Social Science and Medicine 180, pp. 20-27

9 https://www.wiltshiretimes.co.uk/news/1326012.revolutionary-help-for-addicts/

10 http://www.sdf.org.uk/what-we-do/reducing-harm/take-home-naloxone/

11 http://www.sdf.org.uk/news_peer_naloxone_training_supply/

12 https://www.nhsggc.org.uk/working-with-us/volunteering/volunteer-testimonies/naloxone-peer-educator/

13 NAC Protocol P2PN

14 Addictions CAG standard procedure for issuing naloxone without a prescription

15 https://www.mprnews.org/story/2016/04/18/opioid-profiles-lee-hertel?fbclid=IwAR2DsoN1lS1LNAyVIxovnT-JqBK3GOf4gozM1rv7FeX3vuK-y5_4C7DRuqKQ

16 Lenton, S et al (2015) Working together: Expanding the availability of naloxone for peer administration to prevent opioid overdose deaths in the Australian Capital Territory and beyond. Drug and Alcohol Review, 34(4), pp. 404-41118

17 http://www.atoda.org.au/wp-content/uploads/Naloxone-Evaluation-Report-FINAL_August-2015_BI.pdf

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To access the Naloxone Advocacy and Awareness Project's range of downloadable and free resources, visit EuroNPUD's website:

www.euronpud.net/naloxone

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