Barriers to establishing take-home naloxone programmes

Sibella Breidahl[1], Dagmar Hedrich[2], Nicola Singleton[2], John Strang[1]

1. Kings College London, UK 2. European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Lisbon, Portugal

Background

The current EU drugs strategy identifies reducing drug related deaths (DRD) as a priority, correlating with Sustainable Development Goal 3 (health), which aims to reduce premature death by a third by 2030. In Europe, people who use opioids (PWUO) are the main group at risk of direct DRD; among the more than 9000 annual overdose deaths, 84% involve opioids. To support DRD prevention, the EMCDDA is developing new tools and materials to inform practice and policy, including a diagnostic tool to assess barriers and facilitators to establishing take-home naloxone (THN) programmes.

Methods

As part of the 'diagnostic tool', the EMCDDA contracted Kings College London to develop a checklist of barriers and facilitators to establishing THN programmes. The development of the checklist consisted of three steps: 1. Brainstorming session with EMCDDA on barriers; 2. Search of the literature; 3. Validation of identified barriers with stakeholders. A manual for a undertaking the diagnostic process through national or local stakeholder roundtables, including instructions on planning, preparation and conducting the roundtable discussion and on following up on action points will complement the checklist.

Results

THN programmes work by training people who use drugs and other likely first responders on how to recognise and respond to an overdose, and providing them with naloxone. A wide range of issues was identified which may represent barriers or facilitators for establishing such programmes. These were grouped into three levels: barriers or facilitators at the system-level, those affecting the potential organisers of THN programmes, and those that relating to the first responders, delivering naloxone.

System Level

Political and regulatory context

- Data on drug-related deaths inadequate for needs assessment
- No national strategy to reduce DRD in place or strategy excludes the setting up of THN programmes
- Low level of knowledge on evidence regarding THN programmes
- Lack of advocacy for THN programmes at national/regional level
- All existing naloxone products are 'prescription-only medications'
- Naloxone prescribing is limited to medical doctors/specific professions
- Nasal naloxone not available in the country
- Price of nasal naloxone too high
- No or unclear guidance regarding police attendance at emergencies

Society Level / Discrimination

- Attitude that research on and implementation of THN programmes are a waste of money
- Perception that THN encourages drug use
- Lack of awareness of THN among general population

Organisational factors

- No government funding available for THN programmes
- Naloxone not reimbursed by health insurances
- Naloxone dispensing limited to emergency services/hospitals
- Competence to deliver first aid training not available at drug services

Organiser Level

Internal Barriers

- Assumption by staff that THN programmes are too complicated
- Staff not familiar with new naloxone products/formulations and devices
- Belief that offering THN to people in drug treatment/detox may encourage drug use
- Not perceived as the area of responsibility of the staff in drug treatment services – medical intervention vs. social counselling
- People working in potential THN programme settings (prisons, GPs, pharmacists) unaware that programmes can be set up
- Other priorities / lack of time to offer THN training

External Barriers

- Community drug services are not allowed to dispense naloxone
- THN is not a priority for organisers of social/health services
- Insufficient staff available to offer training and provide take-home naloxone
- High fluctuation of staff in drugs services
- Lack of available funding and equipment to offer and perform THN trainings
- Lack of collaboration with emergency services for first aid training part of THN
- Lack of high quality training materials.

Deliverer Level

Knowledge and Concerns

- Not aware of THN programmes & availability of THN
- Misconceptions about effects of naloxone
- Missing knowledge about overdose risks, signs and response
- Lack of confidence in skills in naloxone use
- Peer reluctance to intervene in overdose because of need to wait for ambulance, concerns about police involvement
- Peers do not see themselves as potential deliverers of naloxone
- Peers are concerned regarding anger of person who overdosed following administration of naloxone
- Peers fear when carrying naloxone they will be targeted/searched for drugs by police

Access

- Non-medical responders not allowed to keep naloxone at hand
- THN training too far away (location) or physically inaccessible
- THN training not provided at sufficient number of services
- Opening times of services offering THN not suitable
- Competing demands on time & finances, such as childcare, health needs
- Length of training does not fit needs of peer providers
- Training not offered in relevant language/Language barrier
- Naloxone that the person received after training becomes out of date
- Re-fill procedure too demanding/complicated

* Peer: members of the target community, here: people who use drugs

Conclusion

Identifying and tackling regulatory and legal barriers to take-home naloxone programmes, misperceptions, knowledge gaps and training needs, as well as the impact of drug-related stigma among the general population, providers, and first responders are important steps to improving the availability of this response. Removal of some barriers may require changes to national regulatory or legal systems, while others can be solved by implementing simple agreements or changes in practice and by increasing knowledge among staff and clients. The list of barriers is not exhaustive and nor will all of them apply everywhere. However, they provide an important basis for discussion and identification of relevant issues to be tackled when considering establishing THN programmes.

DOI S. Hare Breidahl: current medical student at The University of Adelaide, and intern at the WHO – department of Mental Health and Substance Abuse. Previously research at KCL where she has worked to gather data on projects funded by MundiPharma.
DOI J. Strang: https://www.kcl.ac.uk/ioppn/depts/addictions/people/hod
D. Hedrich & N. Singleton declare no interests
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Contact: sibella.breidahl@kcl.ac.uk