University of BRISTOL

Centre for Academic Primary Care

NIHR | School for Primary Care Research

Optimising take home naloxone intervention delivery in the community (retail) pharmacy setting

Jenny Scott

Senior Lecturer in Primary Care

[Acknowledgement: University of Bath, UK]

Mentor: Prof Sir John Strang, National Addiction Centre, Kings College, London, UK

www.bristol.ac.uk/capc

@capcbristol

Pharmacy Research UK

Conflicts of interest

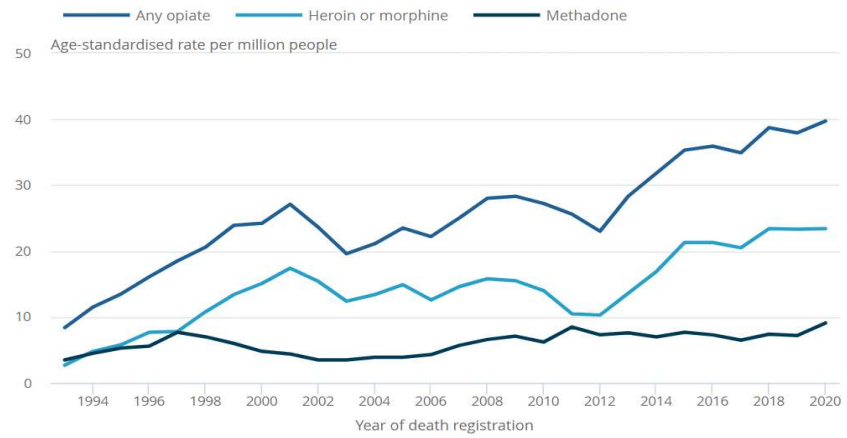
- I work clinically as a pharmacist prescriber with Turning Point, who are one of the organisations that supported recruitment and they are facilitating intervention piloting.

Background

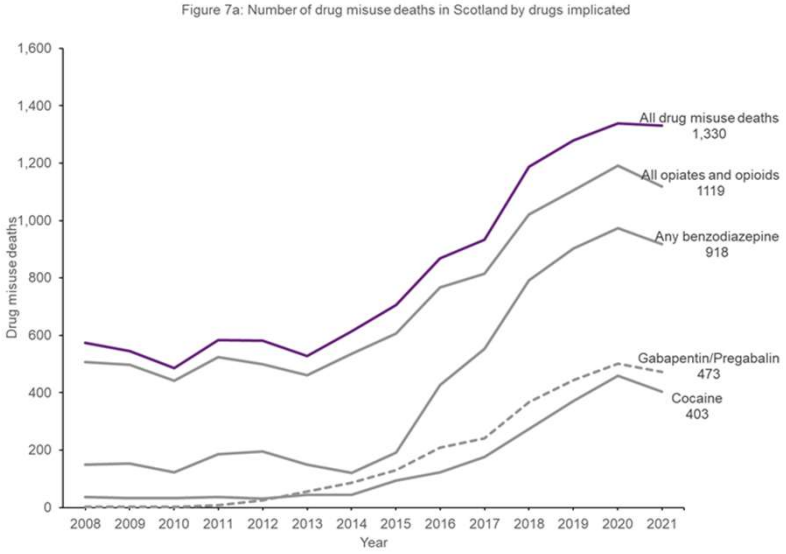
- The UK escalating drug related deaths is a crisis.

Figure 5: Rates of deaths involving opiates have increased in 2020

Age-standardised mortality rates for deaths by all opiates, heroin or morphine, and methadone, England and Wales, registered between 1993 and 2020



From: Deaths related to drug poisoning in England and Wales: 2020 registrations. Office for National Statistics, 2021.



From: Drug related deaths in Scotland in 2021. National Records of Scotland, 2022.

First aid for opioid overdose

Naloxone is a short-acting opioid antagonist, which if given early enough, can prevent an opioid overdose resulting in death or permanent damage.

UK 2015: **Take home** intramuscular naloxone supply was permitted without prescription by those engaged in drug treatment, including pharmacy staff. 2019 the intranasal formulation was added.

University of BRISTOL
Centre for Academic Primary Care

Background

- Majority of UK community pharmacies provide opioid substitution therapy (OST) and about 20% (England) engage in needle & syringe programmes (NSP).
- Pharmacies engage with people not in drug treatment e.g. through NSP provision.
- Increasingly pharmacies are contracting to provide National Health Service (NHS) services including public health interventions.
- Pharmacy supply of take-home naloxone (THN) has been introduced in some areas, but uptake is patchy, and supply levels vary.

Background

- Barriers and facilitators to community pharmacy naloxone have been reported in the international literature [1,2,3] although not all are relevant to UK context.

- There is very little in the literature about optimal ways to deliver pharmacy THN.

- Using relevant barriers and facilitators as a starting point, we wanted to explore the practice of THN supply from commissioned pharmacies – high level suppliers and low level suppliers, and the views of pharmacists experienced in OST and NSP provision who were keen to join a THN scheme.

Project overview of aims

- Define what makes a (UK) commissioned pharmacy THN service successful and what impedes success.
- Optimise a pharmacy THN intervention model, using findings, with the goal of maximising supply activity.
- Detail important operational factors to consider in future trial design
- Pilot and evaluate the intervention
- Test the intervention at scale

Project overview of aims

- Define what makes a (UK) commissioned pharmacy THN service successful and what impedes success.
- Optimise a pharmacy THN intervention model, using findings, with the goal of maximising supply activity.
- Detail important operational factors to consider in future trial design
- Pilot and evaluate the intervention model
- Test the intervention model at scale

Project overview of aims

- Define what make a (UK) commissioned pharmacy THN service successful and what impedes success.
- Optimise a pharmacy THN intervention model, using findings, with the goal of maximising supply activity.
- Detail important operational factors to consider in future trial design
- Pilot and evaluate the intervention model
- Test the intervention model at scale

Methods

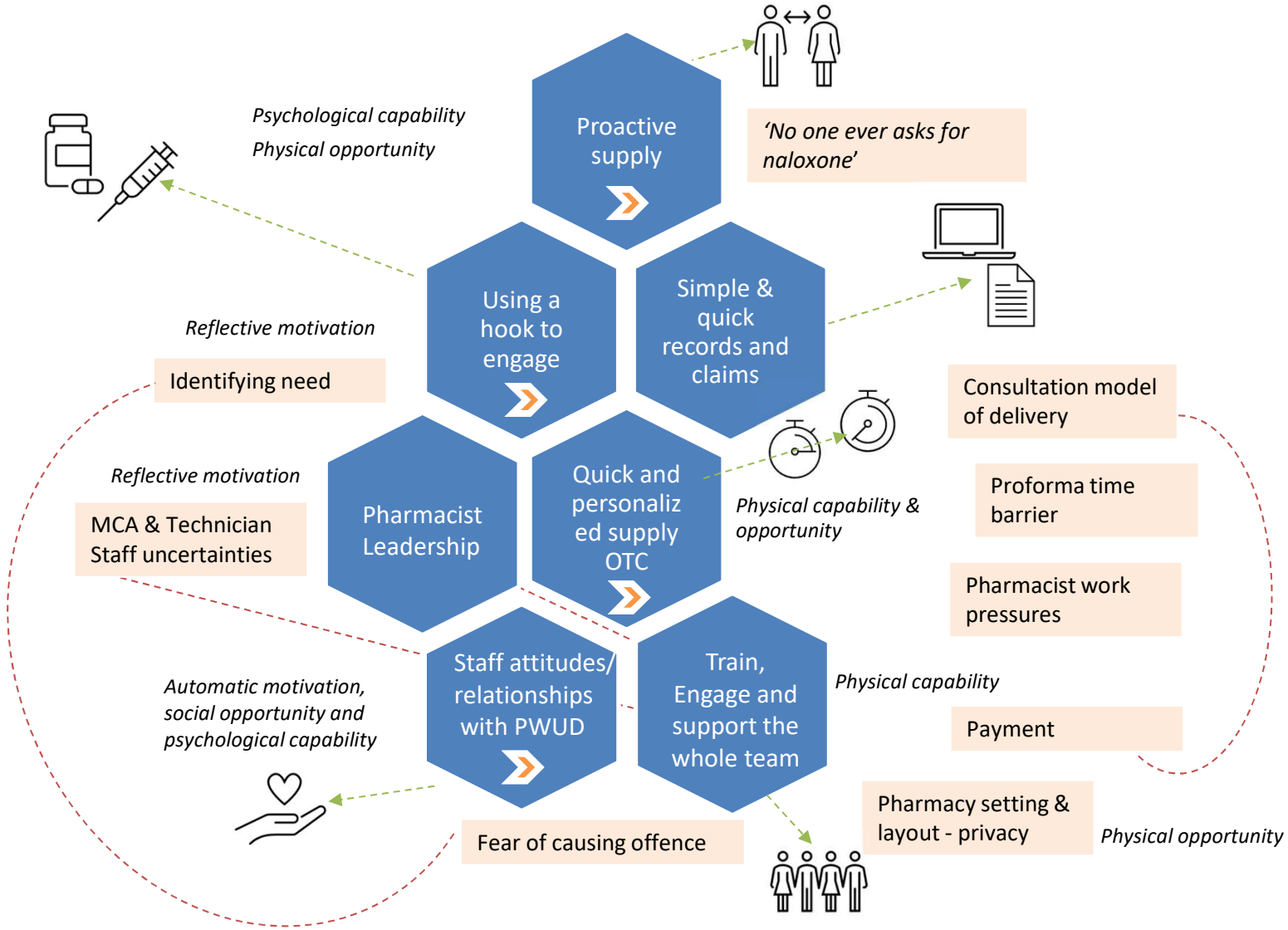
- Qualitative interviews with 21 community pharmacists, all providers of OST; 11 provide THN, of these, 7 also provide NSP; 10 *interested* to provide THN, all with NSP experience.
- 11 providers of THN: 7 at high level (10 to 25 per month); 4 low level (0 – 2 in 18 months).
- Recruited via gatekeepers from Local Pharmaceutical Committees and pharmacy naloxone scheme leads.
- 13 interviews face to face and 8 on the telephone, recorded and transcribed verbatim.
- Discussion group with 6 people with lived experience of using heroin, with further feedback as project progressed.

Methods

- Interview transcripts and discussion group notes analysed using deductive and inductive thematic analysis, managed with NVivo v11/12.
- Secondary deductive analysis of coded data using the Theoretical Domains Framework, mapped to COM-B to inform intervention development.
- Guided by 2008 Medical Research Council Complex Interventions Framework [4] and peers.
- The study was approved by REACH (Research Ethics Approval Committee for Health), University of Bath (EP 17/18 248).

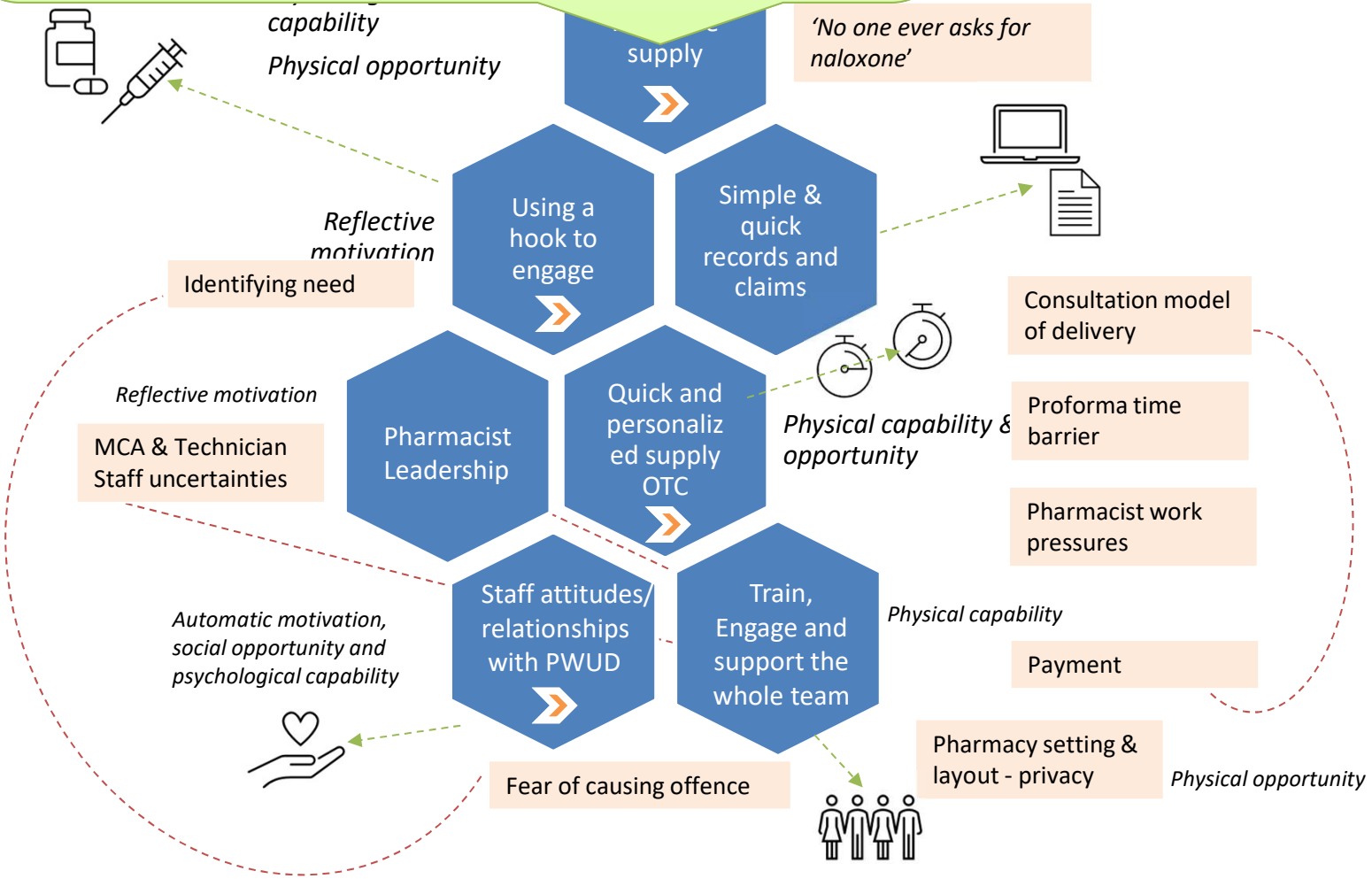
Findings

Components of Success & Barriers to Supply



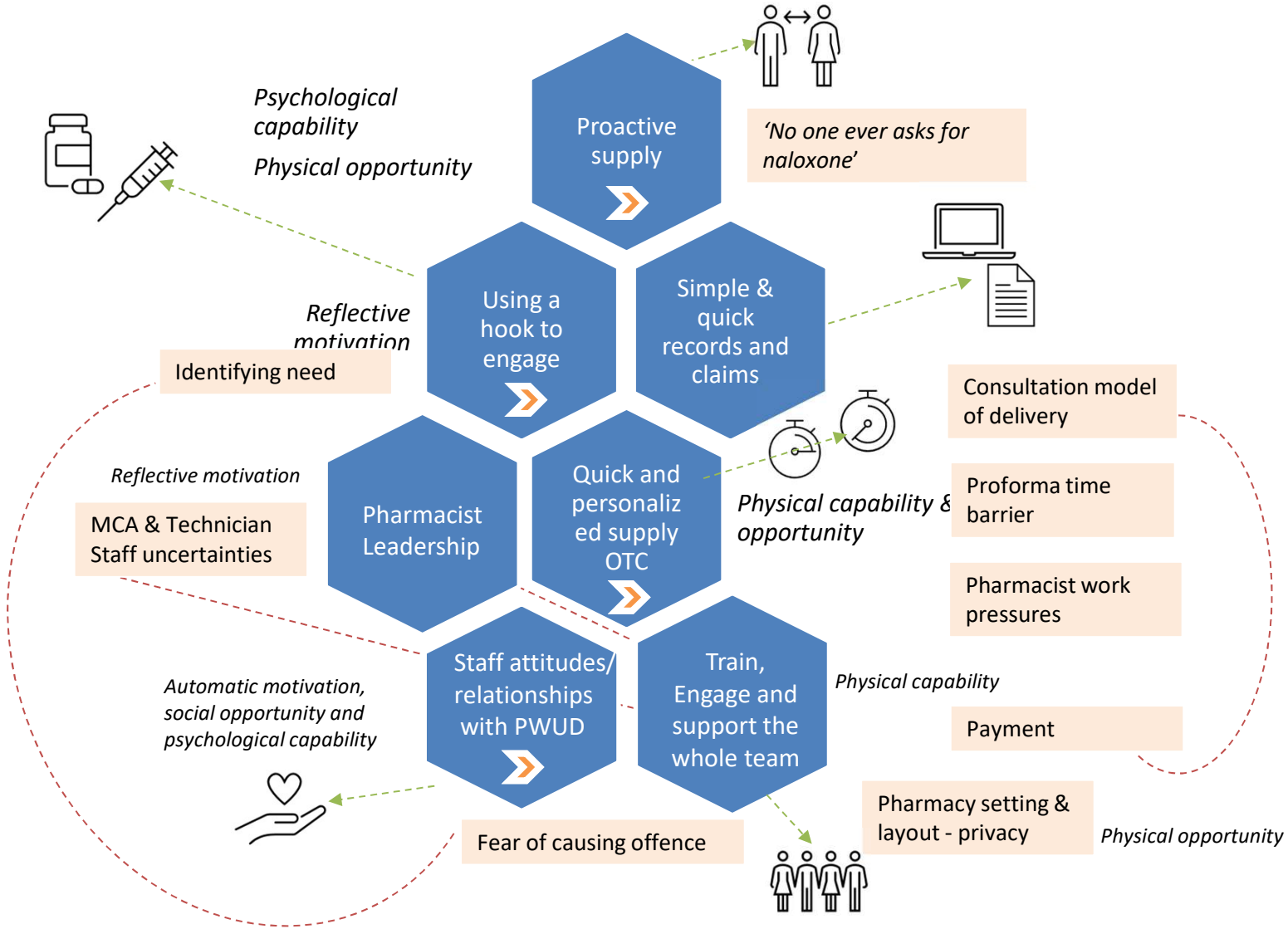
o Supply

We do have stickers up umm to say supplying naloxone here and sometimes people have had a recent overdose incident you know, from a family member, a friend, and they will ask the question, or they will come in and they will say 'have you got any of this stuff', but I would say kind of, eight out of ten times it is us that initiate it. [G07-29]



Findings

Components of Success & Barriers to Supply

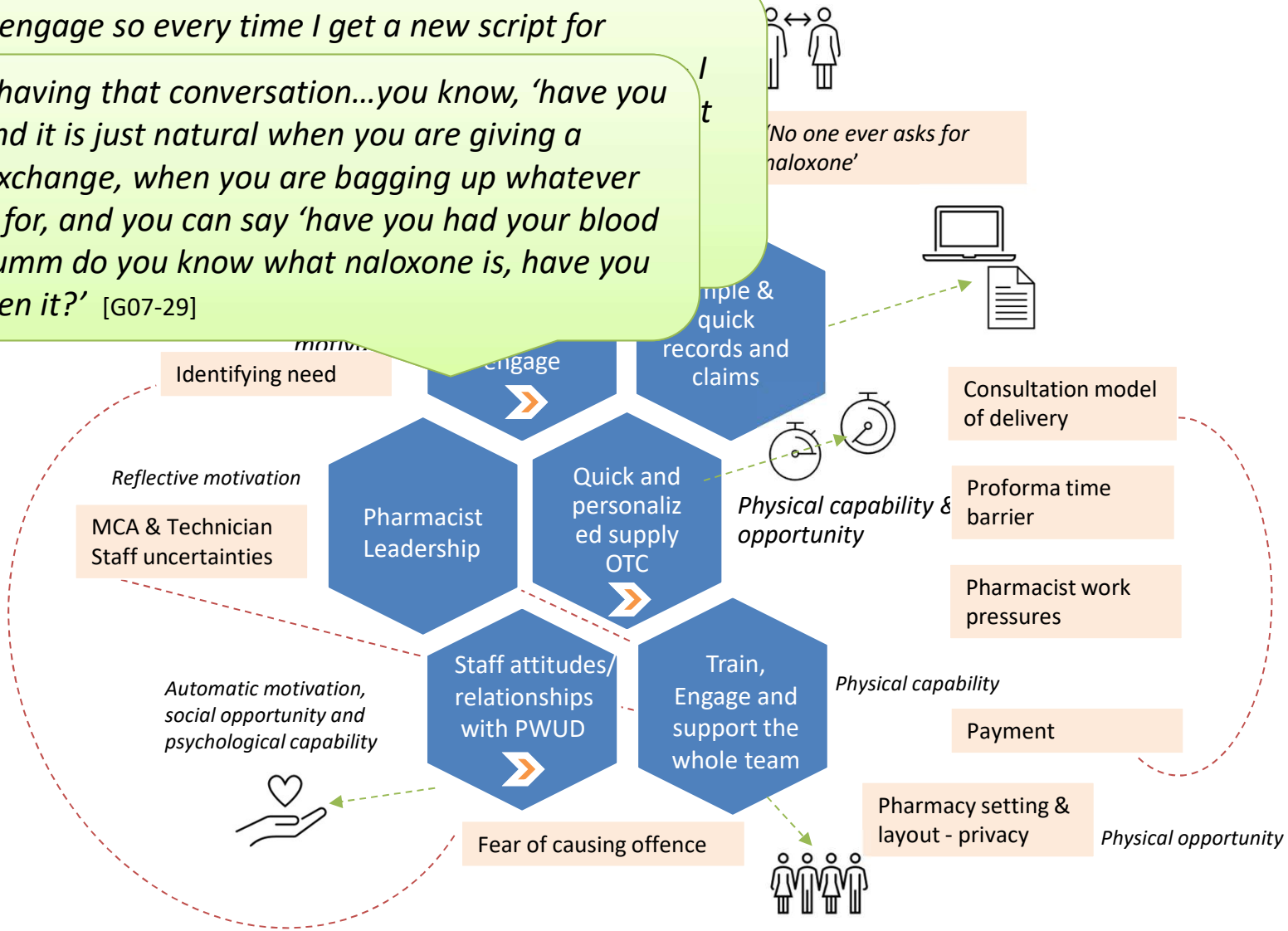


Findings

Components of Success & Barriers to Supply

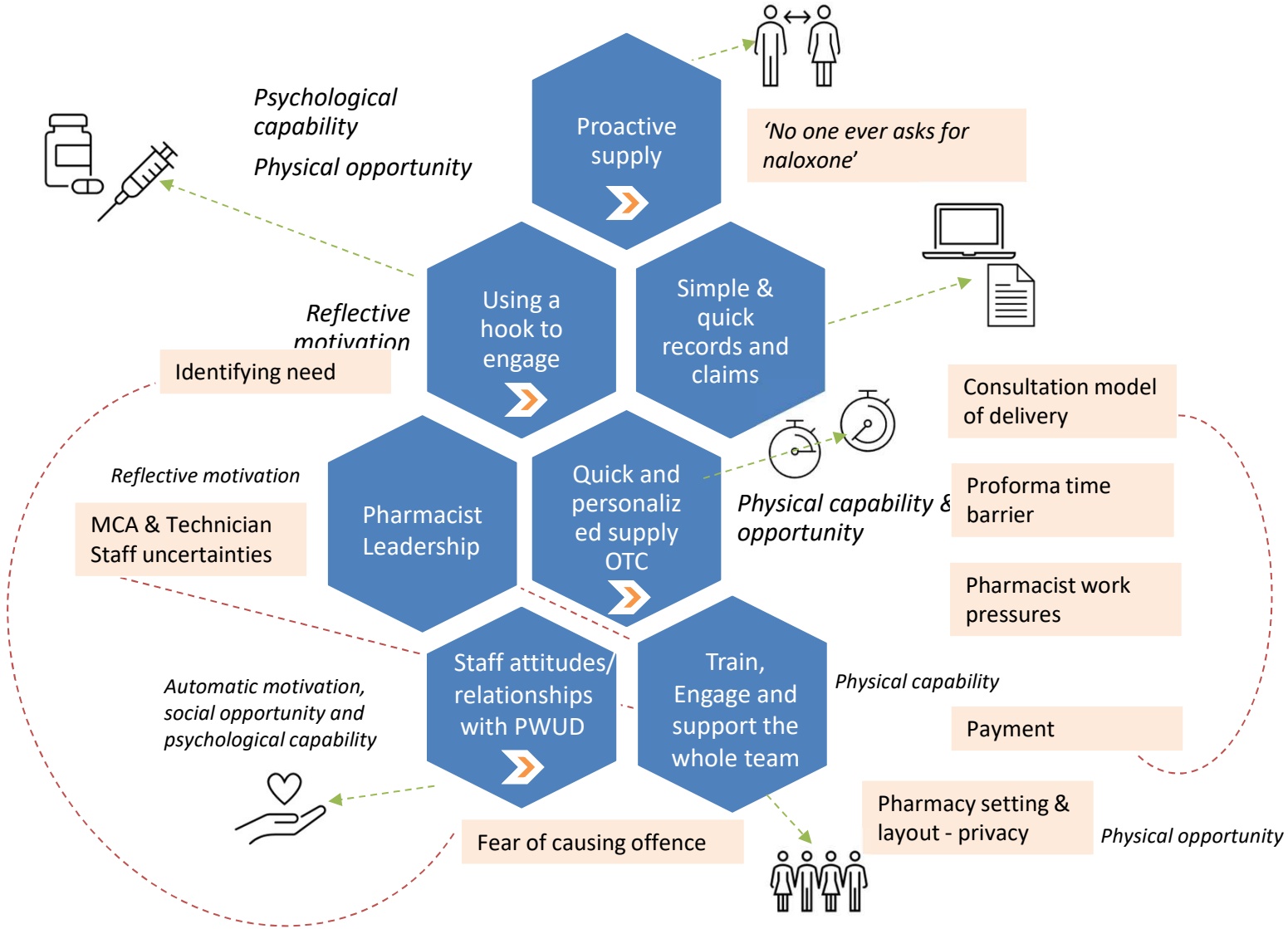
We engage so every time I get a new script for

It is just having that conversation…you know, 'have you had…' and it is just natural when you are giving a needle exchange, when you are bagging up whatever they ask for, and you can say 'have you had your blood tested? umm do you know what naloxone is, have you been given it?' [G07-29]



Findings

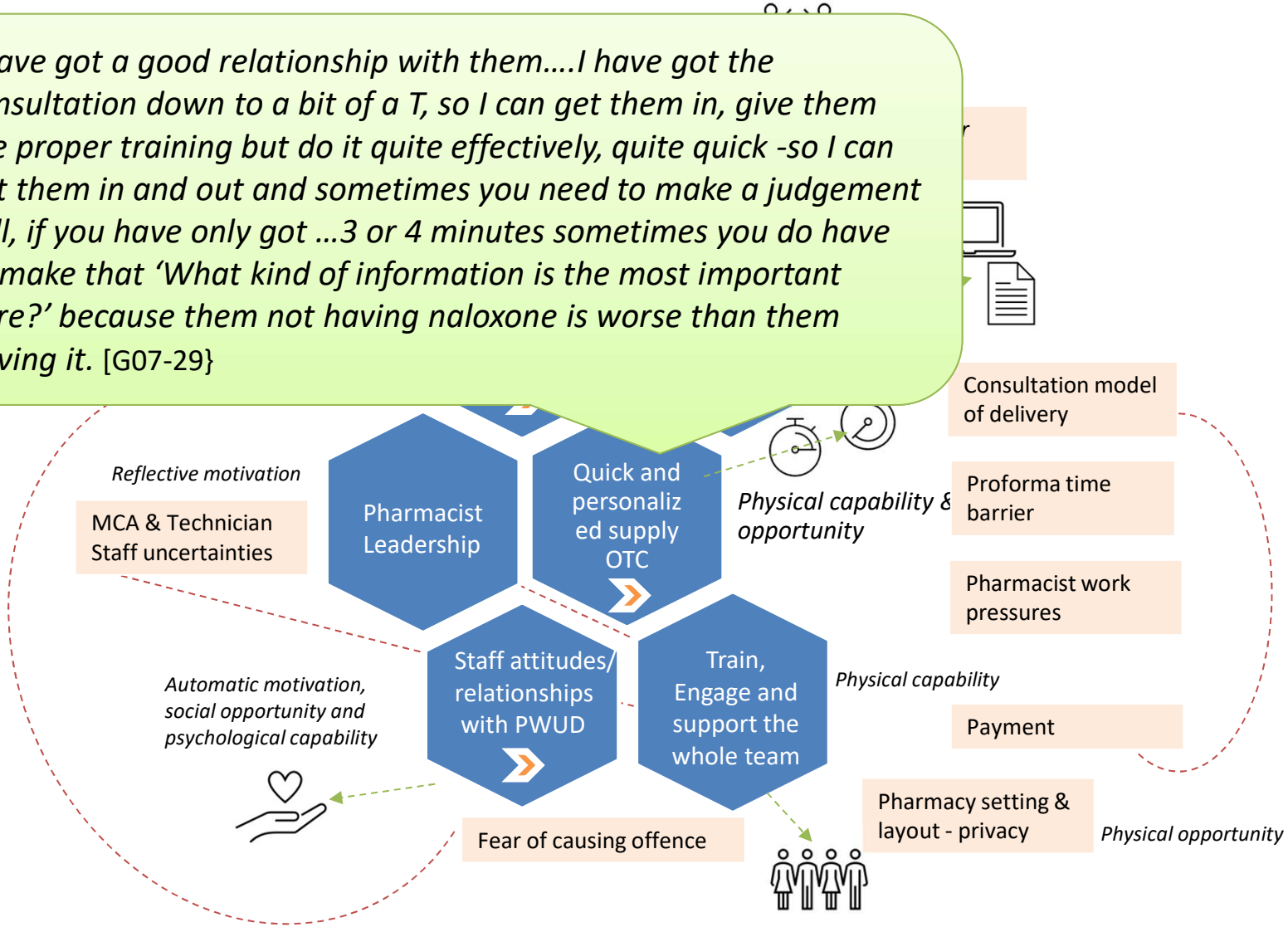
Components of Success & Barriers to Supply



Findings

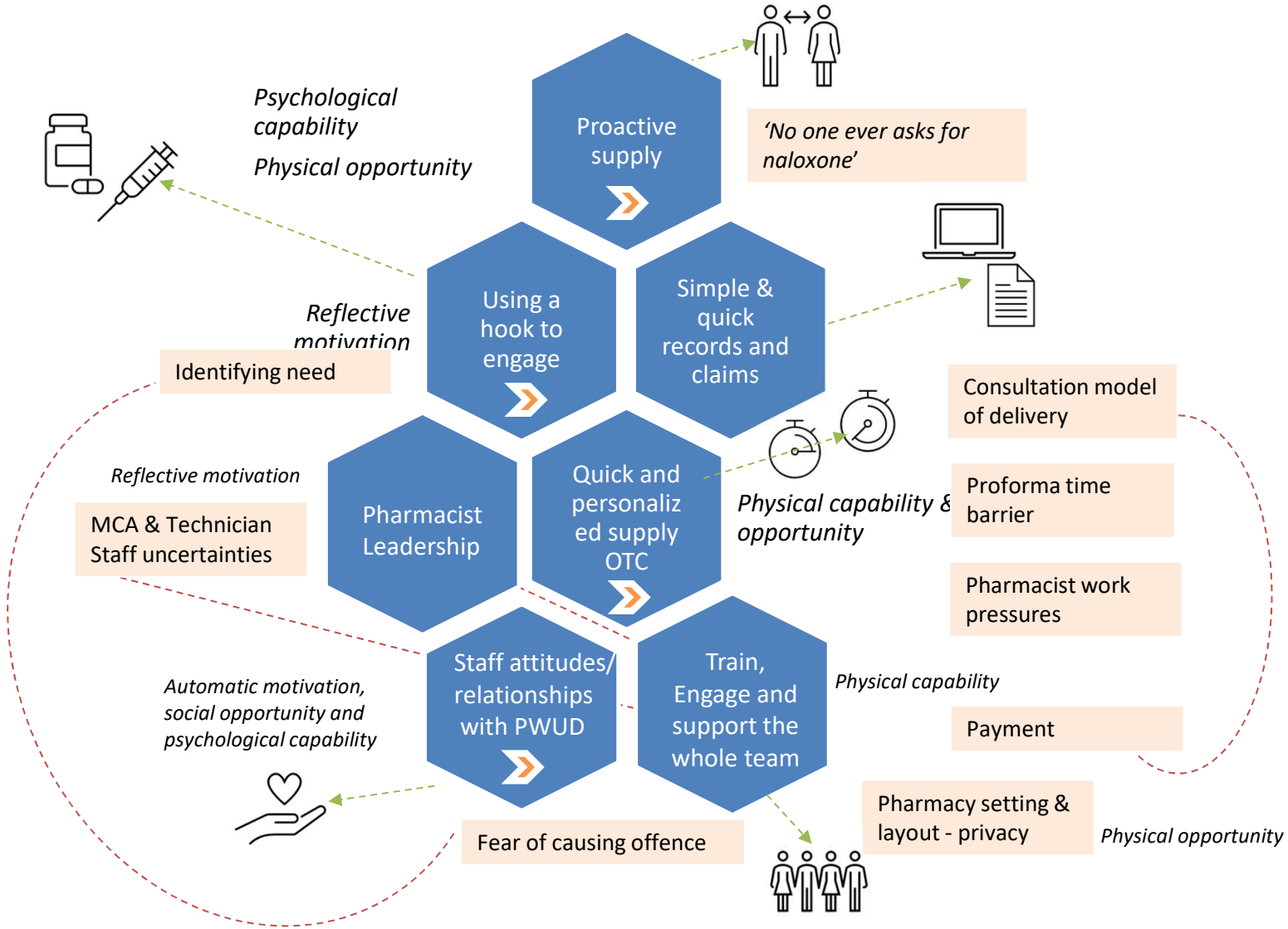
Components of Success & Barriers to Supply

I have got a good relationship with them….I have got the consultation down to a bit of a T, so I can get them in, give them the proper training but do it quite effectively, quite quick -so I can get them in and out and sometimes you need to make a judgement call, if you have only got …3 or 4 minutes sometimes you do have to make that 'What kind of information is the most important here?' because them not having naloxone is worse than them having it. [G07-29}



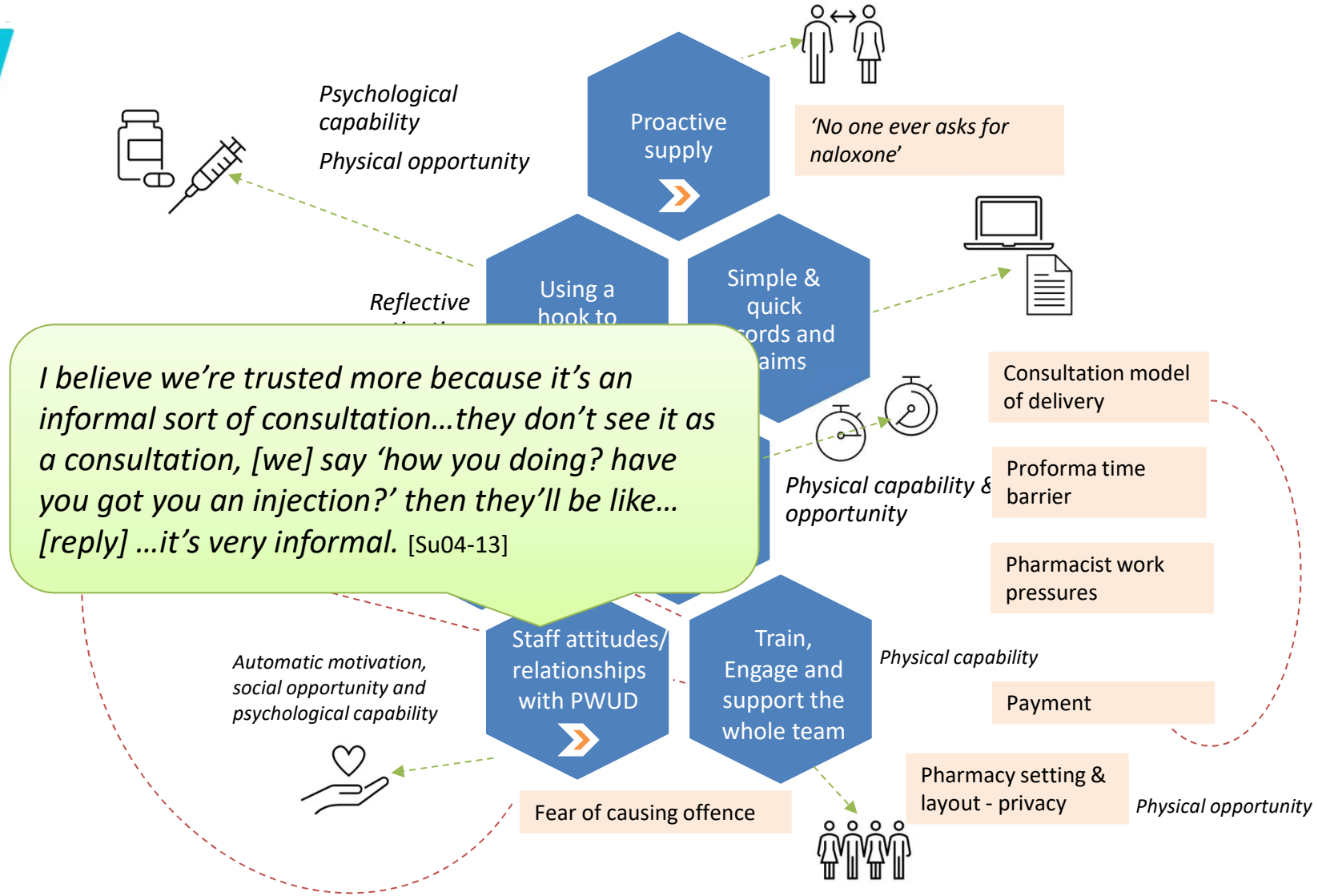
Findings

Components of Success & Barriers to Supply



Findings

Components of Success & Barriers to Supply



Intervention Components

Naloxone –Quick Intervention in Pharmacies (N-QIP)

Training (1 hour + 30 min discussion) for **all members of the Pharmacy Team (see You Tube)**

Proactive offer – do not wait for PWUD to ask for naloxone.

Hook onto an obvious service e.g. NSP or dispensing of OST.

Any member of the pharmacy team can deliver, avoid bottleneck when pharmacist is busy.

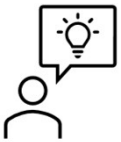
Think of it as an OTC supply

Quick 3-5 mins; cover signs of OD, how to give, call 999. Leaflet.

Priority is provision of naloxone into hands of those in need.

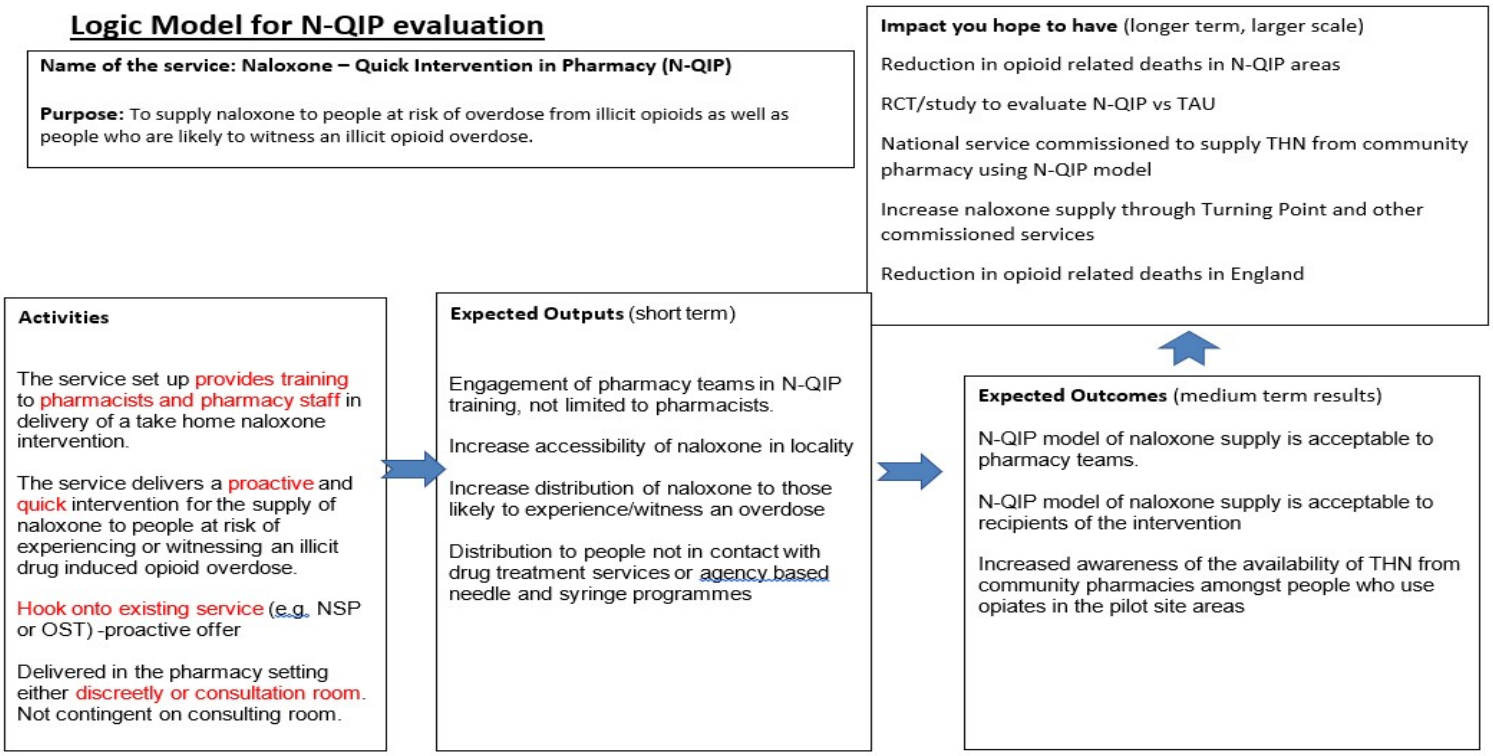
Emphasise it is a first aid response –*'call 999 if you have to give naloxone'.*

Resupply can be quicker



Fit the intervention to the individual, do not try to make the person fit the intervention

Logic model


Logic Model for N-QIP evaluation
Name of the service: Naloxone – Quick Intervention in Pharmacy (N-QIP)
Purpose: To supply naloxone to people at risk of overdose from illicit opioids as well as people who are likely to witness an illicit opioid overdose.
Impact you hope to have (longer term, larger scale)
Reduction in opioid related deaths in N-QIP areas
RCT/study to evaluate N-QIP vs TAU
National service commissioned to supply THN from community pharmacy using N-QIP model
Increase naloxone supply through Turning Point and other commissioned services
Reduction in opioid related deaths in England
Activities
The service set up provides training to pharmacists and pharmacy staff in delivery of a take home naloxone intervention.
The service delivers a proactive and quick intervention for the supply of naloxone to people at risk of experiencing or witnessing an illicit drug induced opioid overdose.
Hook onto existing service (e.g. NSP or OST) -proactive offer
Delivered in the pharmacy setting either discreetly or consultation room. Not contingent on consulting room.
Expected Outputs (short term)
Engagement of pharmacy teams in N-QIP training, not limited to pharmacists.
Increase accessibility of naloxone in locality
Increase distribution of naloxone to those likely to experience/witness an overdose
Distribution to people not in contact with drug treatment services or agency based needle and syringe programmes
Expected Outcomes (medium term results)
N-QIP model of naloxone supply is acceptable to pharmacy teams.
N-QIP model of naloxone supply is acceptable to recipients of the intervention
Increased awareness of the availability of THN from community pharmacies amongst people who use opiates in the pilot site areas

Conclusion

- The views of pharmacists interested in joining commissioned THN schemes and the experiences of pharmacists already in THN schemes were used to identify what can work and what can impede THN supply from pharmacies.
- Attention was paid to ‘high level suppliers’, their attitudes, experience and how they deliver their THN intervention.
- By mapping findings onto the Theoretical Domains Framework/COM-B model we were able to identify appropriate training and intervention components.
- We have piloted and evaluated the intervention (not reported today) - our next step we hope to take is a feasibility study.

References

1. Nielsen S, Van Hout MC. What is known about community pharmacy supply of naloxone? A scoping review. *Int J Drug Policy*. 2016 Jun;32:24-33.
2. Bakhireva LN, Bautista A, Cano S, Shrestha S, Bachyrycz AM, Cruz TH. Barriers and facilitators to dispensing of intranasal naloxone by pharmacists. *Subst Abus*. 2018;39(3):331-341.
3. Thakar T, Fray M, Tewning B. Pharmacist roles, training, and perceived barriers in naloxone dispensing: A systematic review. *JAPhA*., 2020. 60(1): 178-194.
4. Craig, P et al. Developing and evaluating complex interventions: the new Medical Research Council guidance. 2008; *BMJ*. 337: a1655.

Acknowledgements

- Community pharmacists who gave their time.
- People with lived experience who supported intervention development.
- Graham Parsons, former lead pharmacist, Turning Point
- Kevin Ratcliffe, CGL.
- Somerset, Wiltshire & Suffolk Local Pharmaceutic Committees.
- Pharmacy Research UK for funding.
- Prof Sir John Strang for mentorship.
- University of Bath, former employer.
- Dr Hannah Family, Research Fellow, Bristol Medical School, University of Bristol.
- The patients I see in my clinical work for their continued honest feedback.

University of BRISTOL
Centre for Academic Primary Care

Dedication

To M, for being such an advocate for naloxone, for saving others, but had no one on hand to give it when you needed it.

University of BRISTOL
Centre for Academic Primary Care