



**Service Review:**  
**Take Home Naloxone programme in NI**

**Consultation with service users and service  
providers**

**February 2016**

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1. EXECUTIVE SUMMARY .....	6
Introduction.....	6
Context.....	6
Findings: Is training for staff sufficient and effective? .....	7
Is service user training sufficient? What was the experience in accessing, using or replacing the kits? .....	7
Challenges to the uptake and use of THN kits .....	8
Successes and challenges of the programme.....	8
Points for consideration .....	9
2. INTRODUCTION .....	12
Aims and objectives for the research .....	13
Methodology.....	13
Limitations of the methodology.....	16
Structure of the report .....	17
3. EVALUATION OF THE NALOXONE TRAINING PROGRAMMES FOR STAFF .....	18
Train the Trainer courses (TTT) .....	18
Opioid Overdose Response courses (OORT) .....	23
Summary of TTT evaluations .....	24
Recommendations for TTT provision .....	25
Summary of OORT evaluations.....	25
4. EVALUATION OF THE TAKE HOME NALOXONE (THN) INITIATIVE FOR SERVICE USERS .....	26
Resupply or replacement kits .....	26
Training programmes for naloxone.....	27
Experience of using the naloxone kits .....	28
Benefits of naloxone.....	29
Suggestions for improvement to the THN scheme .....	30
Barriers to accessing the THN scheme .....	31
Summary .....	33
Recommendations .....	34
5. CHALLENGES AND SUCCESSSES FOR THE TAKE HOME NALOXONE (THN) INITIATIVE IN NORTHERN IRELAND .....	36
Successes highlighted by hostel staff.....	36
Challenges identified by hostel staff or which refer to the hostel setting .....	37
Successes identified by addiction staff .....	41
Challenges identified by addiction staff .....	43
Successes identified by the Northern Ireland Ambulance Service (NIAS).....	49
Challenges identified by NIAS .....	50

Successes identified by staff working in the prison setting .....	51
Challenges identified by staff working in the prison setting .....	52
6. OVERALL EVALUATION OF THE THN SCHEME: SUMMARY AND POINTS FOR CONSIDERATION.....	54
Is training for staff sufficient and effective?.....	54
Is service user training sufficient? What was the experience in accessing, using or replacing the kits? .....	55
Challenges to the uptake and use of naloxone kits .....	56
Successes and challenges of the programme .....	56
Points for consideration .....	57
Appendix 1: Interview schedule for service users.....	60
Appendix 2: Interview schedule/discussion guide for hostel staff .....	63
Appendix 3: Interview schedule/discussion guide for addiction staff .....	65
Appendix 4: Interview schedule/discussion guide for Northern Ireland Ambulance Service representative.....	67
Appendix 5: Interview schedule/discussion guide for prison or ADEPT staff.....	68

## GLOSSARY

ADEPT	Alcohol and Drugs: Empowering People through Therapy: Start 360's drug and alcohol treatment service for adults based in Northern Ireland's prisons
CAT	Community Addiction Team
CHNI	Council for the Homeless Northern Ireland
CPR	Cardiopulmonary Resuscitation
DHSSPS	Department of Health, Social Services, and Public Safety
GP	General Practitioner
HSC	Health and Social Care
HSCB	Health and Social Care Board
NIAS	Northern Ireland Ambulance Service
NIPS	Northern Ireland Prison Service
NSD	New Strategic Direction for Alcohol and Drugs: the strategy document for Alcohol and Drugs in Northern Ireland now in Phase 2 (2011-2016).
NSG	Naloxone Steering Group
OORT	Opioid Overdose Response Training
OST	Opioid Substitution Team
PGD	Patient Group Direction
PHA	Public Health Agency
PSNI	Police Service Northern Ireland
THN	Take Home Naloxone
TTT	Train the Trainer

# 1. Executive Summary

## Introduction

- 1.1. The aim of this evaluation was to establish whether the current model of naloxone provision and training across all Health and Social Care (HSC) Trusts in Northern Ireland is sufficient and to identify areas for development.
- 1.2. The research objectives were:
  - To establish whether training for community addiction and homeless shelter/hostel staff is sufficient and identify gaps or other training needs.
  - To establish whether opiate users feel they are appropriately trained in the use of naloxone and to ascertain their experience in accessing, using or replacing the kits.
  - To explore challenges and barriers to the uptake of naloxone kits and possible ways of expanding naloxone provision to those not registered with community addiction teams.
- 1.3. The research was undertaken between December 2014 and March 2015 and included qualitative interviews (N=44) with a range of key stakeholders including addiction staff (n=12), hostel staff (n=9), ambulance staff (n=1), prison staff (n=3), and service users (n=18).

## Context

- 1.4. In 2011, concerns about increased opioid related deaths in Northern Ireland Communities prompted the Public Health Agency (PHA), the HSC Board, and the HSC Trusts to commence a pilot of a "Take Home Naloxone" (THN) initiative. In July 2012, Community Addiction Teams (CAT) and the Northern Ireland Prison Service (NIPS) began to give THN kits to those at risk of opioid overdose.
- 1.5. Naloxone is an opioid antagonist that blocks the action of opioids such as diamorphine (heroin), morphine, codeine, pethidine, fentanyl, and methadone. All those who obtain and hold a THN kit are trained in the prevention of overdose, identification of an overdose event, first aid including cardiopulmonary resuscitation (CPR), and how to administer naloxone in an emergency.
- 1.6. The Council for the Homeless Northern Ireland (CHNI) were the primary training providers. The two courses have been Train the Trainer (TTT) or Opioid Overdose Response Training (OORT). A Patient Group Direction (PGD) regulates the supply of

naloxone and only those named in the PGD can prescribe it. Training and supply has been primarily through treatment or outreach services in Northern Ireland such as Opioid Substitution Teams (OST), Community Addiction Teams (CAT), or other treatment settings.

### **Findings: Is training for staff sufficient and effective?**

- 1.7. The evaluation of training was universally positive for both TTT and OORT courses. Advantages identified by those interviewed included the provision of important information including overdose prevention and harm reduction, development of important life skills including relevant first aid, and building the confidence required to train others in how to administer naloxone when it might be required.
- 1.8. Suggestions to improve the training provision for staff included widening access of TTT courses to peer trainers and hostel staff. Hostel staff in particular stressed their interest in TTT courses. Peer and hostel staff trainers could engage those not presently in active treatment in naloxone administration, signs of overdose, and first aid. However, hostel staff and peer trainers would be unable to supply naloxone kits directly; routes to access a kit following training would need to be outlined for each of the services.
- 1.9. Some staff were unsure about how to refresh their training, particularly those working in the prison setting. Some staff would benefit from some guidance on how to, and how often to access the retraining sessions. Staff and line managers in their respective organisations hold responsibility for training or retraining.

### **Is service user training sufficient? What was the experience in accessing, using or replacing the kits?**

- 1.10. The training was highly praised. All clients indicated they would be very confident of their ability to use the THN kit and to apply CPR in an emergency. Some service users were interested in a refresher course but were unsure of where to go as they were no longer engaged with treatment services.
- 1.11. Service users found it easy to access kits if engaged with keyworkers in treatment settings across Northern Ireland. Keyworkers were also important in reminding clients about resupply and expired kits.
- 1.12. Of the three overdose situations described, only one had used naloxone (others did not have their THN pack on their person, or it was broken, but used CPR from their training).

1.13. Service users reported a range of successes. The scheme was credited as developing a sense of empowerment, building or strengthening therapeutic relationships, successfully reaching and engaging those who need it, saving lives, and providing useful education to lower overdose risk. The programme was viewed positively and increased individual self-worth. The training embeds important life skills, for example reducing overdose risks and other harm reduction practices, and practical skills like CPR which may be useful in communities beyond the administration of naloxone in an emergency situation.

### **Challenges to the uptake and use of THN kits**

1.14. Barriers identified by service users to both the uptake of the THN scheme and use of naloxone were:

a) limited access to the scheme (i.e. through treatment services) may not reach those not in treatment;

b) concerns about repercussions from Police Service Northern Ireland (PSNI) or probation services if they carry naloxone or engage with the THN scheme;

c) the client no longer uses opioids or associates with users of opioids, so the THN kit is perceived as no longer needed/useful;

d) concerns that asking for THN implies that the individual is a substance user and this could have repercussions from social services for clients with children;

e) lack of knowledge about scheme, particularly among young people or rural communities; and

f) not carrying it on their person so it is unavailable during an overdose event. There were also barriers identified in relation to resupply (whether the kit had been used or the expiry date had passed), particularly since most of those service users interviewed were no longer users, or in treatment.

1.15. The main recommendation was to expand access to the THN scheme through pharmacies and the facilitation of peer training schemes. New routes to obtain naloxone or the training should be communicated to communities who would benefit.

### **Successes and challenges of the programme**

1.16. The main successes were improving relationships between clients and staff, passing on life skills, empowering service users to save lives, responding to a need in the community to reduce opioid related fatalities, and building partnerships.



- 1.17. The main challenges arise from interagency working and communication, fear of legal consequences (from police and/or probation services), reaching those not engaged in treatment but who would benefit, dispelling myths about who is at risk, identification of an overdose situation to Northern Ireland Ambulance Staff (NIAS), and legislation which prevents hostel staff and community healthcare professionals from being supplied THN.
- 1.18. The THN scheme is and should be viewed as a community asset; it facilitates saving lives and empowers the members of the community where it is located.

### **Points for consideration**

Based on the findings and suggestions from the interviewees, key implications include:

*Expand the role of hostel staff, health professionals in outreach positions, peers, and pharmacies in the Take Home Naloxone initiative*

- A need for a Letter of Comfort which would facilitate hostel and outreach community healthcare professionals to hold a Take Home Naloxone (THN) kit for use on an as yet, unnamed person<sup>1</sup>.
- Encourage more hostel staff and peers to become involved in TTT training. They are more likely to interact with people at risk of opioid overdose. To be effective, routes to obtain a naloxone kit from someone named in the PGD need to be identified (as hostels and peers would be unable to prescribe or supply naloxone).
- To consider a greater role for pharmacies and general practice to widen the access to the THN scheme.

*Promoting the THN scheme*

- To improve education and awareness of the scheme through peer knowledge or relevant advertising including in GP surgeries, pharmacies, hostels, prisons, and other relevant locations. In particular, consider advertising to young people and rural communities.
- Consider placing a naloxone section on the PHA website, or other appropriate online resource. As the scheme expands to include other providers, this would help maintain

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<sup>1</sup> After this research was completed, the Public Health Minister wrote to Professor Les Iversen, the Chair of the Advisory Council on the Misuse of Drugs (ACMD), to inform him that the new regulations allowing supply of Take Home Naloxone to those who have contact with people at risk would come into effect on the Common Commencement Date of 1st October 2015

quality and best practice, and smooth the expansion of the scheme with existing provision. This could host information on the following:

- For **potential clients** – information on why the scheme is important, how to access THN kits and training in each of the trust areas (with particular focus on young people and rural communities), pathways and reasons for resupply/reissue, the U-turn app, or any other information required. Flowcharts may be helpful to simplify routes to training and supply.
- For **all staff** – information about training and retraining opportunities in their area, the mentoring scheme, their responsibilities in the programme, protocols/PGD, best practice for resupply, and routes to obtain kits.
- Explore Continuing Professional Development accreditation for the OORT and TTT courses if not already available.

#### *Strengthen the processes of the THN scheme*

- Ensure those trained in TTT are aware of a route to obtain a THN kit for their client from someone named in the PGD, particularly hostel staff.
- Reconsider routes to resupply naloxone and refresh training among service users. Whilst keyworkers are important in successful resupply, there are issues when individuals are no longer engaged with services. Resupply and retraining should also be included in any plans to expand the scheme (for example, if the scheme expands to include pharmacies or general practice).
- The training was universally praised; both the quality and the credibility of the trainers were highlighted in staff and service user interviews. The continued success of the THN scheme to reduce opioid related deaths depends on maintaining the high quality training provision.

#### *Build strong interagency partnerships*

- Continued liaison with the PSNI and Probation Services to improve the understanding of what naloxone is, and its importance among serving officers. This partnership working should help to reduce the barriers to accessing or carrying naloxone among opioid users through fear of harassment, or of legal consequences, and in particular, that naloxone will be used as grounds to stop and search an individual.
- To work with the Prison Service to consider how collaborative working can help prevent delays in getting naloxone on release from prison. Increase partnership working between the Addictions Teams in prison settings and ADEPT training providers at identifying and training those at risk of overdose on release.

- To support staff with service specific needs (e.g. translation services) where it is feasible to do so.
- To continue to stress the importance of the scheme to all stakeholders as a community asset, which improves access to naloxone, and provides valuable harm reduction advice to save lives.

#### *Monitoring the scheme*

- Service users should be encouraged to report adverse experiences (with dates and times) to relevant organisations or to their service user representatives to prevent reoccurrence.
- To consider recording cases where THN is used. This may be similar to those in place to record use of adrenalin for example. To consider if the use of naloxone could be added to the International Academy of Dispatch protocols and software used by Ambulance control.
  - If there are any adverse incidents noted in an emergency situation (for example with PSNI or NIAS) to encourage those involved to report these to the relevant body for review.
- Consider continued monitoring of the scheme to ensure the value to the community (not just service users) is documented.

All individuals interviewed regarded the naloxone programme positively. The programme is and should be viewed as a community asset, developing skills and providing equipment to save lives. The issues identified in the above list should help to increase the impact of this programme in reducing opioid deaths in Northern Ireland.

## 2. Introduction

- 2.1. The New Strategic Direction for Alcohol and Drugs Phase 2 2011-16 (NSD Phase 2; Department of Health, Social Services and Public Safety, 2011) aims to reduce the number of drug related fatalities. NSD Phase 2 required the Public Health Agency (PHA) to pilot and evaluate a scheme for distributed naloxone. This report forms part of this evaluation, and in particular, describes the consultation with service users and service providers as a part of the wider service review.
- 2.2. The pilot of a Take Home Naloxone initiative (THN) comprises a partnership between the PHA, Health and Social Care Board (HSCB), and the Health and Social Care (HSC) Trusts in Northern Ireland. The Community Addiction Teams (CAT) and the Northern Ireland Prison Service (NIPS) began to distribute THN kits from July 2012. The scheme is co-ordinated by a naloxone steering group comprised of a range of stakeholders from the PHA, HSC Board, HSC Trusts' addiction teams, NIPS, homeless services, service user representatives, and the Northern Ireland Ambulance Service (NIAS).
- 2.3. Naloxone is an opioid antagonist which temporarily reverses the effects of an opioid overdose. It blocks the action of opioids such as diamorphine (heroin), morphine, codeine, pethidine, fentanyl, and methadone. When administered to a patient who is experiencing an overdose, it allows more time for the emergency services to arrive and save the life of the patient. Naloxone distribution is regulated by a Patient Group Direction (PGD) in which "take-home" kits are provided to those who may be at risk. By law, kits can only be supplied to a named person at risk. With the named person's consent kits can also be supplied to their representative (e.g. family member, friend, or care giver). Kits are only issued following training in identifying the symptoms of opioid overdose and respiratory arrest, harm reduction techniques, relevant first aid, cardiopulmonary resuscitation (CPR) and how to administer naloxone in an emergency.
- 2.4. The PHA has funded two types of training which are the focus of this evaluation. The first of these, *Opioid Overdose Response Training (OORT)* is aimed at those who come into contact with at-risk individuals and need to know how to administer naloxone (primarily hostel staff). It comprises of CPR and instructions on how to administer naloxone. The second type is *Train the Trainer (TTT)* and it provides the same background in CPR and naloxone administration but also allows relevant individuals to provide the OORT training to at-risk individuals or those who meet at-risk individuals. Staff from CAT, outreach services, NIPS, Alcohol and Drugs: Empowering People through Therapy (ADEPT), and some hostel staff have availed of this training. *Mentoring* support was offered to those who were going on to train others.

## **Aims and objectives for the research**

- 2.5. The aim of this evaluation was to establish whether the current model of naloxone provision across all HSC Trusts in Northern Ireland, including the training of staff and opioid users, is sufficient and what may need to be improved.
- 2.6. The research objectives were:
- To establish whether training for community addiction and homeless shelter/hostel staff is sufficient and identify gaps or other training needs.
  - To establish whether opiate users feel they are appropriately trained in the use of naloxone and to ascertain their experience in accessing, using or replacing the kits
  - To explore challenges and barriers to the uptake of naloxone kits and possible ways of expanding naloxone provision to those not registered with community addiction teams.

## **Methodology**

- 2.7. Brief semi-structured interviews were conducted by Tim Bingham, via Skype, to the interviewees' telephone or mobile phone number. This resulted in 44 completed interviews. A range of stakeholders were targeted including HSC addiction and community outreach staff, hostel workers, NIPS staff, service users, and a NIAS representative. Relevant approvals were granted from HSC Trust research governance offices and service directors to undertake this service review prior to evaluation start.
- 2.8. The research aimed to get the views of staff and service users across all areas of Northern Ireland to explore any differences between HSC Trust areas.

### *Service users*

- 2.9. THN packs have been distributed since July 2012. Consent forms asking service users if they agreed to be contacted to participate in the evaluation had been completed since September 2012. In one area, the majority of packs supplied were distributed prior to the introduction of evaluation consent forms, so most service users in those areas could not be contacted. In all areas, the majority of packs were given out early on in the project. Although service users should ideally have been contacted six months after initial supply, a delay in commissioning the evaluation meant that the time to eventual contact was over two years in some cases. Consequently, a number of the contact details were no longer in use.

2.10. By the end of August 2014, 362 opioid users at risk of overdose had been supplied with THN packs (when this evaluation was initiated, records were available for only 338). Of these, 56 people received two packs at training. While data collected indicates that of the 362 people supplied, 24 were getting a resupply, anecdotal reports suggest this figure may be higher. The initial supply is broken down in Table 1. Note, two interviewed clients had their naloxone training in the Northern Ireland Prison Service; one received their naloxone on discharge, and one through contacts in their Trust area. One individual interviewed did not want their address or location to be disclosed and this is respected in the table below.

*Table 1: Take Home Naloxone kits supplied (up to end of August 2014), and the proposed and actual breakdown of clients approached and interviewed.*

<b>Trust or setting where training (and supply) were provided</b>	<b>Number of clients supplied (% in each Trust area) as per brief<sup>1</sup></b>	<b>Number of clients supplied (%) final total<sup>1</sup></b>	<b>Target clients in each area (based on % in each Trust area)</b>	<b>Clients interviewed (% in each Trust area)<sup>2</sup></b>
Belfast	97 (29%)	106 (29%)	11	8 (44%)
Northern	98 (29%)	103 (28%)	12	4 (22%)
South Eastern	16 (5%)	16 (4%)	2	3 (17%)
Southern	44 (13%)	46 (13%)	5	1 (6%)
Western	49 (14%)	54 (15%)	6	1 (6%)
NI Prison service	34 (10%)	35 (10%)	4	2 (-)
Confidential location	-	-	-	1 (6%)
No Trust area given	-	2 (0%)	-	-
<b>Total clients</b>	<b>338 (100%)</b>	<b>362 (100%)</b>	<b>40</b>	<b>18</b>

<sup>1</sup>At time of issuing the commissioning brief for this evaluation (23 Oct 2014), not all supply records up to the end of August 2014 had been returned to PHA which explains the difference to final total figures as checked in June 2015. Figures in the brief formed the basis for recruiting clients for the evaluation. <sup>2</sup>Two clients were trained by ADEPT in the prison setting, but received their kits in the Southern and Belfast Trust areas. They are counted in both locations and the percentage reflects where kits were supplied.

2.11. The targets outlined in Table 1 allowed for at least one female and at least one male to be interviewed in each area, and the research aimed to be broadly representative of the age range of individuals supplied. Unfortunately, there were difficulties in reaching targets outlined (see Section 2.21 for an explanation and implications).

2.12. At the time of this research, 264 clients had consented to be followed up. The breakdown of those interviewed compared with those who consented to be approached are broken down in Table 2. Information on age and sex was not available for all those who had consented to contact. Those interviewed were broadly similar to the database in terms of sex, however, the percentage of those interviewed from the 25-34 years age group was lower than those who consented to be approached.

Table 2: A comparison of those who supplied their details to take part of a review of the Take Home Naloxone programme and those who were interviewed by sex and age

Trust or area	Characteristics of those who consented to be contacted <sup>1</sup> Number (%)	Characteristics of those interviewed <sup>2</sup> Number (%)
Sex:		
Male	191 (75%)	11 (61%)
Female	64 (25%)	7 (39%)
Age range		
16-24 years	20 (9%)	2 (13%)
25-34 years	95 (43%)	4 (25%)
35-40 years	58 (26%)	5 (31%)
41+ years	48 (22%)	5 (31%)

<sup>1</sup> Information available for 255 individuals on sex and 221 individuals on age

<sup>2</sup> Information available for 18 individuals on sex, and 16 on age.

2.13. The interview schedule for service users is Appendix 1. Those interviewed were given a voucher worth £20 as a token of appreciation for their time.

#### *Hostel staff*

2.14. At the time this research was commissioned, overall 157 hostel staff had been trained, the majority of whom were trained in the OORT course. Based on the PGD that was current in Northern Ireland at the time of the evaluation, non-medically trained hostel staff were unable to independently obtain naloxone for use on as yet unidentified individuals.

2.15. Nine individuals were interviewed (see Appendix 2 for interview schedule) to represent the views of hostel staff in Northern Ireland. These represented all areas of Northern Ireland; four served the Belfast Trust, two Western Trust, two Northern Trust, two Southern Trust, and one South Eastern Trust (note some individuals served more than one HSC Trust area).

2.16. These staff ranged from project managers covering more than one hostel to harm reduction workers providing support directly to clients in a single location. Services differed in their acceptance of substance use on the premises from an abstinence-based approach to beds specifically allocated to substance using clients.

2.17. The likelihood of substance use on the premises varied by location, however, all staff were conscious of substance use risks and understood some individuals may hide a particular substance used to avail of the services.

#### *Addiction staff*

2.18. Twelve addiction staff were interviewed across all Trust areas. The number by each Trust area was Belfast (4), South Eastern (1), Southern (1), Western (3), and

Northern (3). These addiction staff were health professionals from a range of disciplines (including nursing, psychiatry, psychology, social work, general practice), and often represented team leaders or co-ordinators. They were from a variety of settings including primary care, addiction departments with and without inpatient facilities, and community settings including drug and homeless outreach. All would have received TTT training. The interview schedule is Appendix 3.

#### *Northern Ireland Ambulance Service staff*

2.19. A representative of the Northern Ireland Ambulance Service (NIAS) was interviewed to understand the ambulance service perspective when dealing with clients around naloxone. This included the support given as part of the telephone service, or as an Emergency Medical Technician at the scene of an overdose. The interview schedule for the NIAS representative is included in Appendix 4.

#### *Prison service staff*

2.20. Three staff members were interviewed to give their views on the THN scheme. One of these worked as part of the ADEPT team, an organisation that provides the OORT course in the prison setting. The other two members were health professionals in the Clinical Addictions Team. The interview schedule is included in Appendix 5.

### **Limitations of the methodology**

2.21. In preparation for this evaluation, service users who had obtained a THN kit were asked if they would be willing to be contacted about their views on the scheme. Those who were happy to do so provided their phone number, first name or initials, and, in some instances, key worker contact details to the PHA for the purpose of this evaluation. Only those who had their supply for six months or more were contacted from this list. Of the 264 who gave their name to the list, the majority were not contactable via this route. Consent forms were collected since September 2012; the evaluation work started in December 2014. This time lapse may have contributed to difficulties in contacting people; in many cases, individuals had changed their contact details over this period. It would be advantageous to explore different methods of record keeping of those who have been trained and issued with a kit to facilitate retraining or resupply, and to ensure the continued success and impact of the scheme can be documented. A number of individuals refused to take part as substance use was no longer a feature of their lives, or they did not wish to discuss their participation in the scheme.

2.22. This reduced the pool of individuals with whom we could discuss the THN programme. However, we are grateful for the 18 individuals who agreed to be interviewed about their experiences. Those who agreed to be interviewed were broadly no longer drug users, and consequently their views may represent former



rather than current substance users. Though fewer in number than preferred, these 18 did represent views across all HSC Trust areas. Two of these individuals received the training in naloxone administration and CPR whilst in the prison setting.

2.23. The sample was broadly representative in terms of sex and age of those in the database for whom information was available (see Table 2 above).

### **Structure of the report**

2.24. The report is set out as follows

- Chapter 3 examines whether naloxone training schemes were sufficient for addiction, hostel, and prison staff.
- Chapter 4 examines whether service users found the THN training and access sufficient.
- Chapter 5 discusses the challenges and barriers from narratives provided from all stakeholders including perspectives from the Northern Ireland Ambulance Service.
- Chapter 6 provides a summary and points for consideration.

### 3. Evaluation of the naloxone training programmes for staff

- 3.1. In this chapter the effectiveness of the training provided to addiction and hostel staff will be considered. Evidence in this chapter is drawn from the interviews with addiction, hostel, and prison staff.

#### Train the Trainer courses (TTT)

- 3.2. Trainers from the Council for the Homeless Northern Ireland (CHNI) delivered the TTT courses. Typically, training was delivered over two days. All addiction and prison staff and three of the nine hostel staff members interviewed attended a TTT course.

#### *Views of the TTT course*

- 3.3. The overall views of the TTT course were positive. The only critique was a request for more tailoring within certain groups to ensure information was not duplicated, for example doctors/nurses should be already trained in Cardiopulmonary Resuscitation (CPR) techniques in their role
- 3.4. Hostel staff who had received the TTT training were complimentary about the thorough nature of the training and how it met their needs:

*“Well I found the training was great for recognising signs and symptoms whenever you are in the hostel. I felt that really struck a chord with me... We witnessed an overdose in the hostel and it ended up fatal unfortunately, so I really wanted to for personal reasons, and of course professional reasons to expand my knowledge around this. If the event arose again I wanted to be prepared.” Hostel Worker 7- Southern/South Eastern Trust*

- 3.5. The practical elements of the training were also praised; one staff member stated

*“It also focused on muscle memory, so it was very active, and hands on, and people got the chance to use the dummy naloxone packs.” Addiction Staff 3, Belfast Trust*

- 3.6. Addiction, hostel, and prison staff were universally positive about the quality of the training. The training course was praised as comprehensive and representing individual needs for information with engaging materials, useful protocols, and information on the Patient Group Direction (PGD). A continued commitment to improving the course following end of course evaluations will ensure long-term quality control. A selection of comments from addiction staff are below:

*“I did enjoy the two days training. The PGD and the protocols were very good”- Addiction Staff 4, Western Trust*

*“The training materials were very useful, the U turn app has proved to be very useful for the training. We have also been training the inpatient staff in order to recognise opiate overdose and how to use the naloxone, they have had to use it on the ward a couple of times since then.” –Addiction Staff 7, South Eastern Trust*

*“The training was perfect in regards to delivering it to ourselves as well as the peer support people, it gave us everything we needed.”- Addiction Staff 1, Belfast Trust*

### *Applying the training: using TTT to train others*

- 3.7. Addiction staff reported they would train either one to one or in a group depending on the circumstances. Staff reported the need to be adaptable and pragmatic:

*“What we do is opportunistic training, it needs to be as pragmatic as possible”- Addiction Staff 6, Belfast Trust*

Both approaches to training (either in groups or one to one) were regarded positively, but worked best when tailored to the service user requirements. One staff member noted:

*“I have done the training both in one to one and in three different groups as well and both of them were equally well received. [They] definitely learn things that they didn't know before and when they have reflected about it afterwards they have sometimes become a lot more aware, and reduced their risk taking behaviours, and will pass that knowledge on”- Addiction Staff 10, Southern Trust*

- 3.8. Group training approaches facilitated wider service user discussion, and made it easier to demonstrate the recovery position. It also facilitated better family communication for some.

### *Discussing issues together*

*“There is a lot of reflection between the group but it can be a good thing because it sparks off recollections of overdose. I like the dynamics between people but it can take a lot longer because the group can drift off into other areas, its often the difficulty of getting people together at one time” – Addiction Staff 6, Belfast Trust*

*“In a group there is a bit more group learning, more issues will come up.”- Addiction Staff 10, Southern Trust*

### *Training in family groups*

*“maybe a few times the clients have had family members with them... the family members have been more than happy, clients see being trained as part of their treatment”- Addiction Staff 5, Northern Trust*

*“Some of the clients come in and we train a family member or a friend as well so we get more naloxone kits out that way as much as I can I train a family member as well.”- Addiction Staff 3, Belfast Trust*

### *Demonstrating the recovery position*

*“It’s easier to show someone how to do the CPR. If you have a few people, to be able to demonstrate that, and to be able to demonstrate to someone how to go into the recovery position, it’s very hard on a one to one basis”- Addiction Staff 1, Belfast Trust*

- 3.9. There was a preference for some to be trained on a one-to-one basis; some clients may feel uncomfortable being trained in the presence of others in the group approach. Where possible, staff facilitated one-to-one training.

*“some people prefer to do one to ones as some people would feel intimidated about doing the CPR in front of their friends”- Addiction Staff 9, Belfast Trust*

- 3.10. Training in the prison setting was first offered to those on substitution programmes but has since been expanded to anyone at risk. Group training in groups of 8-10 was the prevailing method of delivery. Prison staff reported this method to be broadly successful, but there was evidence of non-attendance at the training among those who signed up to attend. Whilst the reasons for this were not revealed, it is worth offering one to one training if the non-attendance relates to a preference for a more private approach to training.

### *Retraining requirements*

- 3.11. Hostel staff were highly committed to keeping their training up to date. Nearly all indicated they were either seeking or obtaining retraining within one year.

- 3.12. Addiction staff varied in their preference for future training. Three indicated they would like regular (yearly) updates of the training, some indicated they hold regular training meetings to keep themselves up to date within their organisation, and others indicated no further training was required. This is due to the nature of the service and the frequency to which information is needed; however, staff appeared committed to receiving new information updates and there was an appetite for refresher training.

*“I always find the updated training good to be honest. Because we would be frequently using it you would remember but it’s always good to know if something new comes along and a new way we should do things”- Addiction Staff 8, Belfast Trust*

*“The training was comprehensive, there are always updates for the training and I went on and did the CPR training, life support training; a few of us did that. We have regular updates, I think they are good”- Addiction Staff 5, Northern Trust*

*“I haven’t done the train the trainers for a while. I would like a refresher to be honest.”- Addiction Staff 6, Belfast Trust*

- 3.13. Addiction staff did express concerns about the commissioning of training agencies. They particularly highlighted the strength of the current provider (CHNI) and voiced

concerns about reduced effectiveness and impact of the scheme if the supplier changed.

*“We received refresher training last year, but we need more and it’s going to be an issue we don’t know where the commissioning of it will come from. The PHA are looking at retendering all of its contracts, so we have to look at what’s happening with naloxone. My feeling is that we need to receive yearly renewal for most of the services, its best practice to maintain the quality and to make sure we do re runs... We really noticed when Chris left he is such a powerful practitioner in terms of serving our service users, and is very driven by the harm reduction message. When Chris left it really made us wake up to the fact that we don’t have that resource any more, each big trust should have somebody who is key to delivering the training.”- Addiction Staff 6, Belfast Trust*

- 3.14. The current training provider also advised staff about the U-turn app. This is designed to support and refresh training on how to use naloxone in an emergency, and is available on both android and IOS mobile systems (see <http://www.u-turntraining.com/apps/>). The U-turn app was specifically credited as highly useful for both hostel and addiction staff to keep skills fresh between formal training sessions. For example, one hostel worker stated:

*“I would try and refresh myself every week by looking through the App, it’s easy to forget and it gives you more confidence if you’re aware of the steps”- Hostel Worker 8, Belfast Trust*

- 3.15. The Naloxone Steering Group (NSG) was important in the success of the scheme; however, some staff members expressed concern about communication pathways between those on the NSG and staff on the ground. On occasion messages from staff were not reaching the agenda of the NSG, or messages from the NSG were not reaching staff on the ground.
- 3.16. Staff in prisons indicated they were unaware if there were refresher courses available.

#### *The mentoring scheme*

- 3.17. Although the mentoring scheme was available to all those receiving TTT, among those interviewed there was limited knowledge of this initiative. Those aware were contacted directly about the scheme, and those who attended mentoring sessions found it useful.

#### *Widening access to hostel staff on TTT courses*

- 3.18. Three hostel staff who had attended train the trainer courses indicated this had been a progression from the single day Opioid Overdose Response Training (OORT). The TTT course was taken in direct response to a need in their centre:

*“I have just done the Train the Trainers course. We would update our naloxone training every year as we have had to use naloxone before. [What was your view on this training?] It was brilliant, it was very good, the train the trainer training was more in depth” -Hostel Worker 5, Belfast Trust*

- 3.19. A number of those who had just received OORT were interested in TTT courses as this training may help relieve pressure on their organisation. Staff unable to attend a one or two-day external training course due to work commitments may be able to receive in-house training from those who attended TTT sessions. In addition, another benefit would be the ability to train new staff as they join hostel staff teams:

*“I think it would be good to have in house training for all the staff .... A lot of the staff cannot go because of other commitments, even those that I work with that have naloxone, they would be interested in co-facilitating even if we could train them up so that they could be a trainer, something like that would be good I think” – Hostel Worker 8, Belfast Trust*

*“... because all of our staff are trained to administer naloxone as well as CPR, there may be scope for us as we have done train the trainer training to train new staff as they come in as well, because at the moment all of that training is being accessed through Council for the Homeless.” -Hostel Worker 6, Belfast Trust*

- 3.20. Another hostel worker outlined the advantages of TTT course provision to hostel staff. They were keen to provide a role in the access of naloxone by service users, highlighting their unique role:

*“I have just last week completed the train the trainer. I think we need to work out our governance in terms of where we will be in a position to train other new residents as they come in, which for me would be ideal. Time wise people are here and we would be able to do that with them.” - Hostel Worker 6, Belfast Trust*

- 3.21. If there are more opportunities for hostel staff to take up TTT courses, they would need additional support to set up processes for clients to access naloxone from someone named on the PGD as one worker describes below:

*“Because none of us are medically trained we need to work out how we would access naloxone for somebody, so we are looking at some options.” - Hostel Worker 6, Belfast Trust*

#### *Widening access of TTT to peers*

- 3.22. Some addiction staff suggested developing more TTT events for service user peers. They may help with expanding the scheme to those who are not engaged in active treatment at present.

*“I would look at developing more train the trainer events for service users”- Addiction Staff 7, South Eastern Trust*

An ADEPT trainer in the prison service supported this suggestion. A service user in prison who had received training was able to help with group training in the prison setting.

*“One of the guys in the custody setting at the minute had done train the trainer. So when he came in, he helped facilitate the groups with us, and that was very useful. Having peer trainers makes a massive difference, there is more reality, they can take it on board more.”- ADEPT staff, NI Prison Service*

## **Opioid Overdose Response courses (OORT)**

### *Views of the OORT course*

- 3.23. Hostel staff all reported that they felt very confident being able to administer naloxone should the need arise.

*“From my point of view and my team we left the training that if it needed to be administered we would feel comfortable doing it.”- Hostel Worker 9, Southern/South Eastern Trust*

- 3.24. The course content was praised. In particular, staff trained in OORT highlighted the following components as important information: knowledge about the need for naloxone, the history behind it, how it works, the risks before and after use, and how to prevent or reduce the chance of overdose.

- 3.25. One hostel worker noted the training highlighted the importance of risk management after naloxone administration. In particular, they highlighted the issue of using after an overdose episode:

*“...if they come around and go and use a bit more to try and get high again, because once the naloxone wears off people can find themselves in as bad or worse situation.” Hostel Worker 9, Southern/South Eastern Trust*

- 3.26. There were also unexpected benefits from attending the course. One hostel worker noted that the training helped break down barriers in relation to stigma and build strong partnerships between keyworkers and clients.

*“We have a responsibility of changing the culture because sometimes that sense of apprehension about opening up for the fear of losing your bed. It wasn't so long ago where injecting drug users would have been asked to leave, thankfully that was a while ago. Some hostel staff would have a negative attitude towards injectors; the training has gone some way to break that down.” - Hostel Worker 2, Western Trust*

- 3.27. Another unexpected benefit was highlighting the risk of some substance use practices, particularly in relation to polydrug use. As such, those who had trained

became ambassadors for the scheme, spreading the messages of the training in their communities to prevent overdose. For example:

*“If anything yes they get their naloxone but they also get a lot of training in and around mixing drugs, which they find probably more useful. Nearly all of them would have reduced the risk taking behaviour, you get some of them saying I told my friends not to be on the blue at the weekend when they are using.” - Hostel Worker 5, Western Trust*

- 3.28. These unexpected benefits may be difficult to measure and quantify, however, are important evidence of naloxone as a community asset in both preventing overdoses through minimising risk, or effective intervention in an overdose situation.

### **Summary of TTT evaluations**

- 3.29. TTT provision was highly praised. Strengths of the training provided by CHNI were the practical elements, the comprehensive nature of the training, good materials including U-turn app, and information about the PGD and related protocols. Expanding this training method to more hostel staff or peers was suggested and it was considered that some reworking of the training and identification of routes to obtaining a kit may be needed.
- 3.30. Addiction staff used group or one-to-one training as required. There were no real advantages or disadvantages to either option, aside from meeting client requirements. Training in prisons was exclusively group format. Given the success of other services in offering both delivery modes, they may wish to consider one-to-one training options to ensure the training reaches those who would most benefit. Some of those trained in the prison setting may feel uncomfortable discussing matters in a group setting, and the option for one-to-one training may help widen engagement with the THN initiative in this important client set.
- 3.31. Hostel staff were typically motivated to retrain within one year. For addiction staff retraining requirements depended on service needs. Prison staff were unaware of retraining opportunities. The high quality of refresher training was also noted.
- 3.32. Two issues arose in relation to training provision. The first concerns changes in service provider. The quality and credibility of the trainers at present is very high; the programme has the best chance of remaining effective if standards are maintained. Future decisions about training supply should be mindful of this. The second refers to widening TTT access to capable hostel staff and peer trainers, being mindful of the need to develop protocols to obtain a THN kit from someone named on the PGD.



## **Recommendations for TTT provision**

1. Consider widening access to TTT courses to Hostel staff and Peer Trainers and develop the training materials and protocols (e.g accessing naloxone) as appropriate.
2. Cascade information from the steering group to the services about retraining and mentoring possibilities and ensure this information reaches the staff on the ground. Consider the use of the PHA website to disseminate information.
3. Emphasise other supporting materials with TTT provision such as the U-turn App, and the wider benefits to the community of THN kits.
4. Continue to evaluate the course for training quality, and particularly if the provider changes.

## **Summary of OORT evaluations**

5. Again there was a strong positive evaluation of the OORT training provision with key information being communicated about signs and risks of overdose, and what to do in an emergency situation.
6. The most important issues raised in training included the recommendation not to use again following an overdose situation, risks associated with polydrug use, and the practical skills.
7. The training also had the unexpected benefit of reducing barriers around stigma and building strong relationships between keyworkers and clients.
8. There were no recommendations to improve OORT provision; however, the course should continue to be monitored for quality.

## 4. Evaluation of the Take Home Naloxone (THN) initiative for service users

- 4.1. This chapter considers the views of service users on the THN scheme. It describes whether service users felt appropriately trained in the use of naloxone. It also seeks to determine the experience in accessing, using, or replacing the THN kits.

### Accessing naloxone kits

- 4.2. Service users highlight the importance of the relationships with their keyworkers in obtaining naloxone. All of those interviewed (100%) obtained their naloxone through their keyworker and all indicated it was easy to get naloxone through this route if engaged with treatment services.
- 4.3. There were varying accounts of the time taken to obtain the THN kits when discharged from prison. Of the two experiences given below, the first describes a delay of two weeks, and the second describes getting their kit upon discharge. Minimising the delay between release dates and obtaining kits will maximise the effectiveness of the scheme.

*“I got the naloxone from my key worker when I came out of prison. I got it when I got my appointment which was within two weeks of coming out of prison. I was clean when I came out of prison”- Service user 5, Male, Southern Trust*

*“I got training in prison through ADEPT and got the kit when I was discharged”- Service user 9, Male, Belfast Trust*

### Resupply or replacement kits

- 4.4. The uptake of resupply depended on various factors: pro-activeness of and relationship with keyworker; uncertainty where to get it after leaving treatment services; and service user's understanding of their recovery progress, including change of peer network that might not benefit from THN. The link between treatment services and THN supply may prevent those not engaged in treatment (because they are either no longer receiving treatment or not wishing to be treated) from accessing the programme.

*“The kit expires, it's out of date, the other one I don't know where it is. I was offered one by my key worker and I refused it, as I said I am not using anything and I am not around anyone who is using anything so not in the company of anyone that is using. I am working every day, when I get home, the last thing I am thinking about is using”- Service user 7, Male, Northern Trust*

*“I never went back to get a new one as I was never asked”- Service user 2, Male, South Eastern Trust*

*"I wouldn't know where to go for a re-supply, I am not in the service anymore"-  
Service user 1, Male, Belfast Trust*

- 4.5. Around 50% of our respondents knew when their kits expired; 39% did not know when it expired, and 11% no longer had their kit. This supports the good practice of services contacting individuals to discuss resupply, but has consequences for staff resourcing and support.

### **Training programmes for naloxone**

- 4.6. The overarching impression of the Opioid Overdose Response Training (OORT) for naloxone use was positive. All 18 individuals felt 'very confident' they could use naloxone in an emergency. None of those interviewed had any concerns about using the kit or the use of Cardiopulmonary Resuscitation (CPR) that would suggest the training is highly effective in achieving its aims.

- 4.7. Benefits outlined included the training in CPR.

*"I got the training in prison, we learnt how to push the chest"- Service user 5, Male,  
Southern Trust*

- 4.8. Other positive aspects include feeling confident they could use the training when they needed to, one client commented:

*"If I had to use it I wouldn't hesitate. When I was issued [with it], I had stopped using, my daughter was born. The training is always handy to have, as you never know, when you would need something like that, it is a good idea for people to be issued with it because there is a lot of people who are going over and don't know what to do. I know what to do. I was using for 14 years so I was always aware of it" – Service user 13, Female, Belfast Trust*

- 4.9. However, some indicated they would like a refresher course to help remind them of the skills gained.

*"I would like a refresher course, I would have to look at the leaflet to remind me"-  
Service user 7, Male, Northern Trust*

*"I would like refresher training for CPR"- Service user 12, Male, Belfast Trust*

Given the role of keyworkers as previously stated, those trained should be reminded that retraining (and resupply) may be obtained via this route. Any expansion of the scheme to other organisations might wish to consider pathways to retraining and communicate this to individuals.

## Experience of using the naloxone kits

- 4.10. Three of the service users interviewed reported being in a situation where naloxone was required. Their accounts are as follows.
- 4.11. One client described a situation where their partner's friend overdosed. They used CPR on the person who had overdosed, however, were unable to use their naloxone directly because the syringe had smashed. Instead, they were able to move the individual into a lift in the building and down to a waiting ambulance. The person survived. They did not seek a resupply.

*"I never went back to get a new one because I was never asked"- Service user 2, Male, South Eastern Trust*

- 4.12. The second client described how they had used naloxone issued to and carried by the person experiencing the overdose. They also reported that the Police Service Northern Ireland (PSNI) attended the overdose event but the primary reason was independent to the use of naloxone in an emergency. They indicated they were able to use their training to put the patient in the recovery position and administer the kit.

*"...while they were going over I was able to put them in the recovery position and administer naloxone and waited until the ambulance was called. The PSNI did attend as they wanted to question the person who she was with" – Service user 14, Female, Belfast Trust*

- 4.13. One other individual described how they had been in a situation where naloxone was required but not available. They indicated they had given their kit back.

*"For example a few weeks ago someone required it and there was none in the house where I was so we had to call an ambulance and they administered it. There was no one there with the kit. I haven't had a kit on me since last summer because I have stopped, I only smoke now and I gave mine back last summer."- Service user 10, Male, Belfast Trust*

- 4.14. In two of these situations, the individuals we interviewed did not carry naloxone on their person. This may limit the effectiveness of the scheme. All 18 individuals were asked if they carried it on their person. Most did not because a) they were no longer users or associated with users, b) they were concerned about stigma, or c) they were concerned about harassment or legal consequences if found with naloxone on their person. The following narratives were provided:

*"...it would be too much hassle carrying it, and if the PSNI caught you with it"- Service user 6, Male, Northern Trust*

*"[Do you carry it on your person?] Not all the time, but sometimes I would"- Service user 5, Male, Southern Trust*

*“I never carry it with me, it’s always in the house, I don’t use needles anymore and I don’t hang around with people”- Service user 8, Female, Northern Trust*

*“I keep it in my first aid but don’t hang around with users anymore, if my social scene changed, I would carry it” – Service user 15, Female, Northern Trust*

*“I keep it in the house”- Service user 11, Male, Belfast Trust*

*“If I went anywhere where I thought I would need it I would take it with me. I keep it in my flat”- Service user 12, Male, Belfast Trust*

*“I don’t carry mine around with me for obvious reasons if I thought that if I was stopped by the police, that they wouldn’t ask me if I was a user, I would have mine at all times”- Service user 7, Male, Northern Trust*

*“I keep it in the boot of my car”- Service user 9, Male, Belfast Trust*

*“It’s in my medical box at home”- Service user 13, Female, Belfast Trust*

*“It’s in my medicine cabinet at home I am not using at the moment”- Service user 3, Male, South Eastern Trust*

## **Benefits of naloxone**

- 4.15. Service users believe the scheme to be a community asset; they reported feeling empowered to hold a naloxone kit and proud to state they had it.

*“I have let people know I have it because I have felt empowered to have it.”- Service user 11, Male, Belfast Trust*

- 4.16. Some clients state it is positive to have naloxone around in case it is needed. One person described that the THN scheme has reached everyone who might benefit in their network.

*“No I haven’t I haven’t been really using anything, I have always got it around just in case.”- Service user 7, Male, Northern Trust*

*“Everyone I know has it on them, but I don’t really ask people” – Service user 8, Female, Northern Trust*

- 4.17. The THN scheme was praised as saving lives. In one account, a client highlighted the partnership with the outreach team in facilitating access. The importance of peer information, ie from opioid user to opioid user, was noted:

*“Having the outreach team out there is saving lives. A lot of the peers are pushing it as well, they are listening to the peers” - Service user 10, Male, Belfast Trust*

- 4.18. Service users were asked how many individuals might benefit from them holding a naloxone kit. All stated between none to ten known individuals would benefit, but most of those we interviewed were no longer using themselves, or associating with individuals using relevant substances in a way they may have in the past. This may also be a function of the question asked, perhaps individuals may know those using but do not consider them to be at risk of overdose.

### **Suggestions for improvement to the THN scheme**

- 4.19. The main recommendation from the clients to improve the scheme is to expand the distribution beyond treatment providers, in particular to work with community needle exchange pharmacies:

*“I think if they put it into the needle exchange pack, apart from anything else it’s in a bright yellow box, and it’s written on it what it is. If the chemist gave the information that was in there for that reason I think it would be the best way to get it out and about and then everyone would have one. Some people will have it in their house, if they had it in the pack at least they would have it when they were using”- Service user 7, Male, Northern Trust*

- 4.20. The benefits of expanding beyond the Community Addiction Team (CAT) and other healthcare services included the anonymity afforded by roll out to community needle exchange pharmacies.

*“There are still quite a lot of people, who aren’t with Doctors, and who aren’t with outreach programmes for various reasons; they have children and some also work. If there was some place it could be done anonymously, somewhere they don’t have to give details”- Service user 10, Male, Belfast Trust*

*“See if the naloxone was freely given out there [needle exchange pharmacies]. Some people won’t go to the Community Addiction Team because they have children”- Service user 3, Male, South Eastern Trust*

*“To get it from a needle exchange, it does put people off having to go to the nurse” – Service user 12, Male, Belfast Trust*

*“To be able to walk into a pharmacy and make it more available”- Service user 9, Male, Belfast Trust*

- 4.21. There was some discussion about whether opioid users were fully aware of the THN initiative. One client stated that all those within their network had been supplied, suggesting some success with the existing provision. However, many more were less sure all who needed it were aware of the scheme.

*“More advertising, what to do and how to get it” – Service user 5, Male, Southern Trust*

*“More advertising, a lot of young people don’t know about it and make it available through the needle exchange”- Service user 13, Female, Belfast Trust*

## **Barriers to accessing the THN scheme**

4.22. The 18 interviewed service users identified five main barriers. Given under-recruitment and the predominance of former users rather than current users of opioids, there may be others not revealed.

### *Not being in treatment or actively accessing health services*

4.23. Service users noted there is a perception that naloxone is only available to those engaged with drug treatment services. If someone is not interested in accessing treatment, this will restrict their options to obtain training and a kit. When asked if they knew of others who would benefit but were not engaged with the scheme, two of the service users responded:

*“... there are people who don’t engage with Community Addiction Team” – Service user 3, Male, South Eastern Trust*

*“I do know people, but they have no interest in getting help”- Service user 6, Male, Northern Trust*

### *Fear of legal consequences*

4.24. The most common concern related to a fear of legal consequences. Clients indicated the perceived legal risks outweighed the benefits of obtaining naloxone and carrying it on their person. The effectiveness of the scheme depends on individuals having it on their person or in a place where needed. The concerns were two-fold: the hassle of being stopped by the police and having to justify the kit, and any subsequent legal consequences arising from being stopped.

*“...it would be too much hassle carrying it, and if the PSNI caught you with it”- Service user 6, Male, Northern Trust*

*“I don’t carry it around with me in the car for obvious reasons. If I thought I wouldn’t be stopped by the police and they wouldn’t ask me if I was a user, then I would have it with me at all times because if you’re stopped with it then you’re automatically stigmatised. That’s why I don’t carry mine around with me all the time, it’s in the house”- Service user 7, Male, Northern Trust*

4.25. Another individual was concerned the police would tear it open if they found it on their person.

*“...if the police stopped me they would tear it open even though it has a seal on it”- Service user 11, Male, Belfast Trust*

- 4.26. One service user interviewed illustrated the consequences of not carrying it on their person. As most of the service users interviewed were no longer opioid users, their kits were predominantly kept in their house rather than being carried on the person.

*“The only disadvantage of it is that you need someone else there to administer it. This has been a problem not for myself but with other people. For example, a few weeks ago someone required it and there was none in the house where I was so we had to call an ambulance and they administered it. There was no one there with the kit.”- Service user 10, Male, Belfast Trust*

#### *Don't think they need it*

- 4.27. There is an issue about perceived risk of overdose among those interviewed or their peers. The importance of THN may need to be re-emphasised regularly, and particularly, that all opioids convey risk. Given one of the narratives about when naloxone was needed but not available, it is helpful to keep naloxone on the person if there is even the slightest chance it could be needed (for either the person carrying it, or their associates).

*“Yes I don't think they think they require it”- Service user 1, Male, Belfast Trust*

*“People think they will never need it and it's sort of forgotten about, I am aware of it.”- Service user 7, Male, Northern Trust*

- 4.28. Some of the clients themselves stated they no longer required naloxone because they neither use, nor associate with substance users anymore. If their social scene changed, they would be happy to carry it on their person again.

*“I keep it in my first aid but don't hang around with users anymore. If my social scene changed, I would carry it”- Service user 15, Female, Northern Trust*

- 4.29. It is important to emphasise the scheme has two components, the training and obtaining the kit itself. Should the individual no longer be using or associating with users, there are still wider benefits around their training. For example, their community could benefit through their knowledge of reducing harm from opioid use, or they may be able to apply the first aid training in other circumstances.

#### *Concerns among service users with children about social services involvement*

- 4.30. Some of those who would benefit did not seek training or a THN kit as they had children and were concerned about perceptions. As outlined above, access through community needle exchange pharmacies might overcome this barrier.

*“Yes they have children and they don't want social services to know that they are back using again” – Service user 11, Male, Belfast Trust*



### *Lack of wider knowledge about the scheme*

- 4.31. Some respondents were concerned the THN scheme was not reaching everyone who might benefit. One service user commented this might be a particular issue for young people and for those in rural areas; however, no particular suggestions were made as to which advertising option may be more effective.

*“...there are young people dropping like flies here I don’t know if they know about the naloxone”- Service user 14, Female, Belfast Trust*

*“More needle exchange places, easier access to it, and for people to admit they might need it. A lot of people I have trained have never heard of it. More advertising in rural areas and [information about] where to collect it from”- Service user 4, Female, South Eastern Trust*

### *The need for widespread naloxone distribution among opioid using communities*

- 4.32. Concerns were raised around limitations of not having naloxone on the person. The concerns were two-fold: a) if you required naloxone in an emergency, a person would need to know you had naloxone on your person, and you would need someone to use your kit on you; and b) you may be in a situation where someone else needed the kit you carry. A wide distribution of THN kits in communities where there are high risks of opioid overdose or high levels of opioid use would reduce opioid related fatalities, but only if naloxone is available at the point of overdose.

## **Summary**

- 4.33. Clients found it easy to obtain THN kits through their treatment provider/keyworkers regardless of location in Northern Ireland.
- 4.34. There were no issues identified by service users with the resupply of naloxone, however, keyworkers have a key role to play in reminding clients. Many were unaware of when their kits expired.
- 4.35. The OORT training was highly regarded by clients; all indicated they felt confident in either using the kit or conducting CPR. There is an appetite for retraining for some, but not all clients.
- 4.36. Three of the service users described a situation in which naloxone was required. All survived, but only one effectively used naloxone in this situation. In the other two incidents, the individual was not carrying their naloxone on the person.
- 4.37. The advantages of the THN scheme were identified as empowering service users, it is positive to have it around, it saves lives, it is partially reaching those who need it,

and that the outreach team and peer distribution networks are particularly key to the success.

- 4.38. The primary recommendation from service users was to expand access routes to include community needle exchange pharmacies and improve advertising (particularly to young opioid users and rural communities).
- 4.39. Service users identified five barriers to success for the THN programme. These included the following:
- a) Primary access to the scheme via CAT excludes those not in treatment or who have discontinued relationships with keyworkers for whatever reason. Those not in treatment may still be at risk.
  - b) Concerns about the police, probation, or other legal consequences stop individuals from either obtaining a THN kit or carrying it on their person.
  - c) There was a perceived lack of need for naloxone among those who stopped using opioids and/or ceased socialising with opioid users. Though some acknowledged they would carry it if circumstances changed.
  - d) Concerns about the consequences of being a service user with children discourage individuals from approaching treatment providers to obtain a THN kit for themselves or others. There are fears about stigma or judgement about their ability to parent.
  - e) Lack of knowledge about the scheme and a need for advertising to ensure those at risk are aware of the THN scheme and where to obtain training and a kit.
- 4.40. In training service users, the THN scheme has wider community value through better knowledge of risks around use and knowing how to apply CPR. As such, service users and other stakeholders (including the PSNI, Probation Services, and others) should view the scheme as a community asset.

## **Recommendations**

- 4.41. Review the process for THN kit issue following discharge from prison to ensure that if a kit cannot be given on discharge, the time to obtain a kit is as short as possible. The Prison Service should continue to monitor incidents where supply was not as expected and continue to address this (in partnership with other agencies if required).
- 4.42. Assist treatment providers (or expanded partners) with developing systems to contact clients about resupply (and potentially offers of retraining). Use online resources to help signpost clients.

- 4.43. Work to reduce barriers about carrying naloxone on the person. Emphasise in service user training the efforts to reduce the legal fears being realised, and the value of training even if no longer using opioids. Efforts to address the above barriers will increase the availability in an overdose situation; this is crucial to ensure the scheme continues to save lives, prevents future opioid related fatalities, and meets goals outlined in NSD Phase 2.
- 4.44. Explore a role for pharmacies in the expanded THN programme to overcome many of the barriers to obtaining and getting trained in naloxone, and facilitating easier resupply (when kits are either used, lost or expired).
- 4.45. Consider some advertising about the scheme, and in particular address some of the myths (for example those about legal consequences of carrying naloxone on the person). An online resource may help, as may advertisements in GP surgeries, pharmacies, hostels, prisons, or other relevant locations.
- 4.46. Work in partnership with the PSNI and probation services to develop some shared protocols and understanding about naloxone as a community asset.
- 4.47. It may be worth revisiting record keeping in relation to naloxone training and supply, particularly if the scheme is expanded.

## 5. Challenges and successes for the Take Home Naloxone (THN) initiative in Northern Ireland

- 5.1. This section discusses the successes of the THN programme as identified by hostel, addiction, ambulance, and prison staff. It also contains some suggestions for improvement from these interviewed groups with each considered in turn.

### Successes highlighted by hostel staff

*The THN programme builds confidence that hostel staff can save lives*

- 5.2. As part of the current Patient Group Direction (PGD), hostel staff are able to hold naloxone on behalf of named clients. This has given hostel staff confidence they can intervene in the event of an emergency.

*“Having it in the hostel gives the staff the confidence as there are things we can do.”-  
Hostel Worker 4, Northern/Western Trusts*

*The THN programme builds partnerships between clients and staff*

- 5.3. After naloxone was used on one client, the hostel staff member noted how the experience built trusting relationships not just with that client but with other clients in their centre.

*“I am still working with that client [who experienced overdose] ..... For the clients it breaks down the stigma, that judgement, it says we are here to support you, not to judge you, that in itself is powerful”- Hostel Worker 4, Northern/Western Trusts*

*The THN programme fulfils an important community need*

- 5.4. The scheme addresses a real need in the community to prevent opioid related fatalities and it is saving clients' lives through the use of the kit, and through discussions about substance use. The knowledge of the programme has increased since the launch in 2012.

*“I think it's amazing, one of the other centres who have the naloxone they would have someone overdose nearly every week. They have used it and its definitely saved lives; it would be good if we could get more in the centre so staff could have more access to them. It gives people the opportunity to open up and talk about things the fact that this saves lives is amazing”- Hostel Worker 8, Belfast Trust*

*“...it is an excellent tool to have in a situation when somebody is clearly heading on to an opiate overdose because the consequences of not having it are much graver than the consequences of having it.”- Hostel Worker 9, Southern/South Eastern Trusts*

### *Good practice and processes for naloxone storage or use*

- 5.5. Packs are kept in locked cabinets with protocols identified for their usage. All staff that had naloxone on the premises were confident they could access it in an emergency situation.
- 5.6. All staff interviewed, without exception, stated they could access personal protective equipment such as face masks or gloves to help on occasions where naloxone would be needed. These were kept either with the kits, on their person, or at eye level in offices.
- 5.7. Hostel staff were comfortable with keeping it on their premises or to hand. One staff member particularly noted the low level of risks associated with having naloxone on site.

*“...there is no real risk associated with it in terms of storage within a staff area you know it’s not a psychoactive substance people are not going to go after it for their own entertainment from a risk management point of view it presents a low risk on site.”- Hostel Worker 9, Southern/South Eastern Trusts*

### *Confidence in using naloxone and effective engagement with others*

- 5.8. In addition, hostel staff have noted once an overdose situation has been identified, they have been guided by emergency services advice on how to, or whether to use naloxone. This demonstrates a commitment to following procedures, and an effective working partnership with Northern Ireland Ambulance Service telephone staff. Hostel staff are prepared to use naloxone in an overdose situation.

*“... if it was available as easy as that, it would be so much better for our clients. I wish one day we would be able to reach over to the cupboard and get naloxone we needed in an emergency and everybody knows where it is” – Hostel Worker 1, Southern/South Eastern Trusts*

## **Challenges identified by hostel staff or which refer to the hostel setting**

### *Getting naloxone on the premises*

- 5.9. Most staff in hostels where substance use is permitted will hold a second pack at the hostel on behalf of a named client. Where it is less likely that clients use substances, experiences vary on whether THN kits are kept on the premises. Most hostel staff stated they felt they would benefit from having an in date pack in the hostel at all times. Despite having training, processes, and working partnerships in place (see points 5.5 to 5.8), hostel staff were restricted by the inability of accessing naloxone.

5.10. Addiction staff highlighted the important and unique role of the hostel staff. They stressed the PGD only facilitates access as a client representative. However, it would be easier and less time consuming if naloxone could be directly issued for use on an as yet unknown resident of the hostel. Addiction staff recognise the important role hostel staff can play in saving lives and have stated:

*“With the hostels what we have done is that they might have a resident there, who might not want necessarily to be trained themselves. So we will train the hostel staff member, we will put the residents name on it [the naloxone kit], and they will keep it in their cupboard, knowing it may not be that person that uses it. It’s a way around it but we have no choice than to do it that way.”- Addiction Staff 10, Southern Trust*

*“It just needs to be as wide spread as possible. The more you have around, the better. The problem is when people don’t have it on them and they are in an environment where the naloxone isn’t actually there, that can be a challenge, getting it into establishments like probation hostels or the other hostels where we know substance users live there are staff available. The more wide spread it is, the more likely it will be used. Hostels need to be enabled to have a supply there without having to give it on a named patient basis”- Addiction Staff 8, Western Trust*

Other addiction staff working with individuals who are homeless echoed this.

*“There have been a few near fatalities in the hostels where two guys have maybe been using together and obviously they weren’t in a fit state to give naloxone. So that’s why we have been encouraging the hostel staff to do the training and the named person can be a staff member in the hostel as long as they are trained”- Addiction Staff 9, Belfast Trust*

5.11. Hostel workers agreed the requirement to be a named client representative is problematic. They highlighted an immediate risk of overdose for some clients as they move into the hostel. Disclosure about substance use (and knowledge about the risk) may come later after relationships are built between hostel workers and residents; this delay puts lives at risk.

*“I mean we could have people in the building now that could have it that we don’t know about and are engaging with the community addiction team for example who may not have lived with us long and we have not got to that point of disclosure.”- Hostel Worker 9, Southern/South Eastern Trusts*

An addiction staff member who works with homeless and vulnerably housed individuals restated this. They note there are difficulties for clients in carrying naloxone around between places.

*“I think the problem is where they can carry it, how many other things do they have to carry about with them. If they are in a facility they will ask them to hold it for them because they don’t all carry it with them. Some of it is due to their lifestyle; for males*

*it would be in their pockets, and females it would be in their bags.”- Addiction staff 9, Belfast Trust*

- 5.12. Hostel staff take steps to reduce the risk of hidden substance use and hidden risks by setting up structures that facilitate the building of a good rapport with clients, but note that even with this in place there are still risks.

*“Well it is part of our work that we have high tolerance to the individuals and it is also part of our work and ethos that we encourage open and honest communication between client and staff members, and we understand that secretive use is a risk.”- Hostel Worker 1 Southern/South Eastern Trusts*

#### *Delays in obtaining naloxone and interagency partnerships*

- 5.13. A key issue identified was a delay in being able to access naloxone. A hostel worker trained through Train the Trainer stated that even though they could train on site they could not issue naloxone kits in line with the current PGD.

*“When someone has moved in and they are not engaged with services and they are still using heroin, sometimes it can be a good while before they can get trained. So that’s why 2 of the staff have just done the training as the hope is as soon as the client moves in, we are able to complete the training with the client and then have the naloxone administered so it can be done on the day”- Hostel Worker 5, Belfast Trust.*

- 5.14. One hostel worker who described a death because of delays highlighted the importance of swift access to naloxone following release from prison.

*“We had one guy now he was a resident living here. He ended up going to Maghaberry Prison, and then was released from Maghaberry and we had no bed for him at the time. He was released on the Friday and he wasn’t released from Maghaberry with naloxone and died on the Saturday.”- Hostel Worker 5, Belfast Trust.*

This was also a concern for addiction staff as a naloxone kit may not be issued in the prison setting (although the training can be provided there).

*“One of the difficulties has been in the prison. Obviously, prisoners in the prison do not have naloxone. What happens is that the training is carried out by ADEPT and then on the point of somebody being released, they get the naloxone but because it’s a PGD then it has to be a nurse that delivers that to them and they are not always in a position to do that.”- Addiction Staff 1, Belfast Trust.*

*“I know that a number of my guys have been in prison and they are a captive audience in there so they have actually had, maybe a full day of training in there and they come out quite enthused about it.”- Addiction Staff 4, Belfast Trust*

- 5.15. The use of third party organisations might be problematic because of issues with supply of naloxone to these services. One staff member stated:

*“That’s definitely a barrier where we have to go to a third party agency to get naloxone when we have identified that someone is potentially at risk. They aren’t linked in with the local community addiction team or it could be an oversight that they haven’t got the naloxone, or it needs to be replenished, we would go through the community addiction service to access the naloxone on behalf of the client”- Hostel Worker 3, Northern Trust*

- 5.16. Interagency partnerships have been initiated and utilised to facilitate easy access to the THN kits for those not named in the PGD. For one organisation, Railway Street were particularly helpful and an example of good communication and interagency working.

*“We have a really good relationship with Railway Street and that would be our most frequent area, they organise that as quickly as they can.” – Hostel Worker 3, Northern Trust*

#### *Reaching beyond current provision: GPs and pharmacies*

- 5.17. Other suggestions to improve access included widening access from General Practitioners (GPs) or pharmacists to opioid users or friends/relatives of opioid users.

#### *Reaching beyond current provision: hostels may be the only service attended*

- 5.18. The problems and consequences of stigma and social exclusion were raised throughout many of the narratives. A hostel worker noted the hostel may be the only service that an opioid user attends, and they may not wish to, or be in a position to access treatment. There is a vital role for hostels to widen participation in the THN programme and to save lives of individuals who are homeless.

*“A lot of our clients are hard to reach because they are not engaged in community addictions, you know they are transient, they are in the homeless population. They are going from hostel to hostel; they are in and out of surgery. They fall through the net to be honest, so they will be the most hard to reach.”- Hostel Worker 1 Southern/South Eastern Trusts*

*“I think there are always unique opportunities in hostels. Residents are sharing information with staff that they may never have shared with anyone else before, and there is a unique chance to be linking them in. Not everybody is linked into the addiction service or drug outreach and sometimes the first step is when they come through the door here.” - Hostel Worker 6, Belfast Trust*

- 5.19. The importance of the scheme in saving lives was highlighted throughout; one individual stated:

*“Overdose is more likely to come from heroin than alcohol because a bottle of vodka is always going to have the same amount of vodka, whereas a bag of heroin may have twice the purity of the one you bought last week” - Hostel Worker 9, Southern/South Eastern Trust.*



## Successes identified by addiction staff

- 5.20. Staff members who trained clients in how to administer naloxone identified a wide range of benefits. These were building trust amongst clients and staff, identifying and reducing risky substance use practices, including at a family level. The examples below illustrate them.

### *Building trust between clients and staff*

*“Most of the patients are very grateful and very keen, they do feel an amount of trust because you have given them something that contains a needle and syringe.”- Addiction Staff 2, Western Trust.*

### *Reducing opioid use risks*

*“Training people with a family member present particularly those using a codeine based product and the family member is not aware of it. Suddenly there is a realisation of how much danger they are putting themselves in you can see that light bulb moment for both of them.”- Addiction Staff 2, Western Trust.*

### *Building family relationships*

*“It would have to be the client bringing in the family member, and train them both and to be honest they learn so much they are always really appreciative, we would then give 2 kits away, 1 kit for the family member and the other for the client. Some clients wouldn’t want their families to know they are even using or else they have disrupted their families lives so much that they are not in contact with them. I would have trained about 12 family members. They feel that they have to learn so much to be able to identify somebody in an overdose position that’s the thing, that’s a big thing. The blue lips and the pale skin and the not breathing, it’s very empowering for them they feel like if their child was dying they could possibly save them, and it also demonstrates that services care about their child because we are actually providing something that would help save them. So all in all it’s empowering and the clients are appreciative of it as well”- Addiction Staff 3, Belfast Trust.*

### *It is saving lives*

*“I thought it was a good idea to get it introduced because the drug does save lives and we have seen quite a few deaths within our area and I am sure in other places in Northern Ireland.” – Addiction Staff 11, Northern Trust.*

*“People have used it and it has been effective, it has saved lives, I definitely think it’s a good thing” – Addiction Staff 5, Northern Trust.*

*“We need to make sure its high on our agenda and across the province it has begun to take off quite well” – Addiction Staff 7, South Eastern Trust.*

*“Across Northern Ireland there have been stories where it has been used and it’s been enough to keep people safe until the Ambulance arrives” - Addiction Staff 8, Western Trust.*

- 5.21. The scheme plays a key role in dispelling myths about overdose in the training sessions. For example, there is a myth that someone in respiratory arrest can be aroused through shaking or having water thrown over them.

*“One of the difficulties we would have had is trying to convince people if somebody is overdosing and you smack them around the face, throw them in a cold shower, they won’t come round. They will say well it does happen, and they did come round, but we are trying to say yes, but they would have come round anyway, they clearly weren’t in respiratory arrest”- Addiction Staff 1, Belfast Trust.*

#### *Best practice in THN kit resupply*

- 5.22. There is some evidence clients are getting their kits resupplied. Two elements of good practice described are below.

#### *Good practice in record keeping*

*“I think it’s working well for us, we keep it simple for the patients and we have a database with details of refresher training and expiry dates.”- Addiction Staff 2, Western Trust.*

#### *Promoting it to every client as routine best practice*

*“I think it’s working really well, it’s become embedded into our work so when people are assessed it is one of the treatment options, so it’s automatically in there. The uptake of it is pretty good. The ones that we think are more at risk we will promote it with them and the ones that have already have it will come back and look for it again and look for a repeat kit.” - Addiction Staff 10, Northern Trust.*

*“Everybody knows about it, our two site based pharmacy based exchanges, they promote it to individuals, and clients can phone my number, we agreed that with the PHA. We have an open gateway we are responsive, it could always be better but I think it works well.”- Addiction Staff 6, Belfast Trust.*

- 5.23. However, not all clients find resupply easy. The pathways to resupply may not be clear (particularly if no longer in treatment or engaged with an existing service), or particular subgroups within the opioid using population may have very complex or diverse needs. One staff member called for identifiable pathways to help:

*“I think there needs to be a proper pathway. So when I train you, if I am in that hostel and you have used your naloxone you come back to me for a re-issue. If I have probably trained you and that’s fine, what worries me sometimes is people use it and don’t seek a re issue. There needs to be some governance that the people we have trained if they are still about, that we go back to them within a certain period and say*

*do you still have your naloxone, have you used it? Do you need further training? And I do think that I know we train them once when I do a re-issue, I always go back over the training with them again. There needs to be more of that. We have known a few people to have used naloxone and not come back for a re issue and also the instructions are if you get naloxone, we should get you to A&E. A lot of the guys would administer naloxone and not go anywhere, we have a very chaotic group of people, they could be using heroin, legal highs and using all sorts of stuff they are very diverse and complex with their needs.”- Addiction Staff 9, Belfast Trust.*

## **Challenges identified by addiction staff**

### *Police and legal matters*

- 5.24. Staff stated service users were concerned about being stopped by the police and the wider legal implications of being in possession of naloxone. Service user representatives on the Naloxone Steering Group indicated that Martindale (a pharmaceutical company who make the drug) are working to create a stop and search card outlining clients’ rights in such a situation.

*“We have people who are worried about calling an ambulance and the police being called, even though we give reassurances that you will not be prosecuted, you find that some people don’t always believe that.”- Addiction Staff 1, Belfast Trust.*

- 5.25. There were a number of suggestions on how to overcome this challenge. Staff members were clear about the importance of partnership working and helping educate police officers about THN and what it is used for. In some cases, the police have engaged with service providers to facilitate this understanding, and, although there have been positive experiences, care must be taken to avoid negative experiences that would reduce the future success of the THN initiative.

*“Some people are concerned about being stopped by the police, but the police know what it is and know we are giving it out, there should be no question about them being prosecuted. On the back of that, we did have a call from the police a few weeks ago. A patient of ours had been stopped and he had the naloxone on board, when they told them it was a prescription only drug, they weren’t aware that we were giving it out, but they should have been aware, so that gave us the opportunity to raise that with the local police service who took that on board. I am still telling patients that it is legal, there is no need to worry about being prosecuted.”- Addiction Staff 2, Western Trust.*

*“There have been some concerns about what if we are caught with this by the police; we have done some information and education work with the local police explaining what naloxone is”- Addiction Staff 8, Western Trust.*

- 5.26. The importance of peers was emphasised in perpetuating myths about legal consequences (and other matters). It is important to challenge these myths and reduce fears.

*“Then there are all these stories some of which are urban myths some of them could have some truth about it by saying someone was arrested and charged with manslaughter”- Addiction Staff 1, Belfast Trust.*

#### *Misunderstanding of risks amongst current users of opioids*

- 5.27. Whilst there may be risks among all those who consume opioids, one service noted injecting drug users were more likely to take up the offer of the THN kit. Staff were particularly concerned that those who use codeine or other over the counter opioid preparations did not believe they were at risk of overdose and, thus, refused the opportunity to obtain a THN kit.

*“Providing the information and the intervention makes them more focused. Particularly quite a lot of our patients, now increasingly over the past few years, would be using over the counter opiates, codeine medication, and they wouldn't beware that they could overdose on that, and they become more blasé with their attitude, there have been deaths in our community with the use of this medication”- Addiction Staff 2, Western Trust.*

*“It's been offered to everyone on my case load, but there are a lot of them who are away from drugs and really don't associate with anyone that uses drugs and didn't think they needed it. There were others who were codeine users who felt they didn't need it even they probably do.”- Addiction Staff 11, Northern Trust.*

- 5.28. Other clients refuse to engage with the programme as they do not believe they have a need to hold a naloxone kit. This may be because they are not currently using, or are on a methadone substitution programme. However, many services are undeterred, and continue to ask all clients they believe might be at risk (even in the future). This can be for a number of reasons including those given below.

*“Some people will say I am not using so I don't need it. It can depend on how big an impact overdose had on people. Some of our patients would see themselves as stable and, in fact, they are saying I am not moving in those circles and I don't want this. Then we have people who are stable and don't move in those circles but have lost friends and they would be keener to take the naloxone.”- Addiction Staff 1, Belfast Trust.*

- 5.29. To address awareness of need among current users, some services offer the training and ask individuals to come back if they would like a naloxone kit. However, there is a risk that individuals lose the paperwork confirming their training and they would need retrained.

*“Initially we were offering naloxone to injecting drug users who were still quite chaotic. We then rolled it out to anybody that presented to the service who had been abusing opiates... we do the naloxone training with them, we discuss it first and ask them to go away and think about if they want naloxone”- Addiction Staff 4, Western Trust.*

*“Where we would have difficulty we would have people turning up and saying they have had the training but they aren't able to provide the paper work and we then end up doing it again with them and in fact when you go through it again with them, it's quite clear then they have been trained and without the paperwork we cannot supply the Naloxone as under the PGD they have to have the paperwork.” Addiction Staff 1, Belfast Trust*

- 5.30. Clients were mindful about how obtaining a THN kit may be perceived as part of their treatment. A client may see taking a THN kit as a) influential in the success of their treatment or therapeutic relationship, b) influential on their perceived ability to meet their treatment goals, or c) it might imply a service provider did not believe the client was abstinent or could meet abstinence goals. Where possible, staff try to address these issues in their conversations with clients and to stress the benefits of the THN scheme to the community.

*“There is the classic argument no I am trying to stay away from that now so no I don't want that on me it might give me a temptation to use, which you can understand, and for the service user who doesn't want their relatives to know, I am carrying naloxone kit and that implies continued use... The OST [Opioid Substitution Team] have particular had a number of people who have refused, as we have very few. I think it maybe to do with their role, they are there to monitor people urines and samples that have heroin in them as part of the care pathways in the programme so if then if a person is offered naloxone people being cautious might see that as is this them testing me out ? If I say yes does that imply I am using.”- Addiction Staff 6, Belfast Trust.*

### *Sex differences*

- 5.31. Staff outlined a range of sex differences. One addiction staff member noted that female sex workers and homeless males were of particular concern due to increased heroin use. Others noted more males seen at treatment centres than females, with one staff member citing around a 70/30 ratio of males to females. However, it appeared naloxone was more acceptable among females than males. Future research may wish to explore the separate needs of males and females.

*“I think males tend to think I am on a substitute prescribing programme, I have got away from injecting and I don't want to take it, I am done with that. They cannot see the need to have it for emergency situations; whereby the females tend to think yes, I hope I will never use it but will keep it just in case. They seem to be a bit more accepting of it. “- Addiction Staff 4, Western Trust.*

*Being able to respond to specific needs for different services*

- 5.32. Treatment service providers identified a number of specific needs for particular HSC trust areas. An ability to be responsive to these specific needs is helpful along with information about who these individuals approach for guidance or support. These included a) language barriers (e.g. for one service provider, many of their clients spoke Portuguese, and they may have benefited from language assistance), b) barriers around carrying all the training kit in primary care clinics or other restricted environments (carrying resuscitation demonstration equipment, notes, and other parts of the training), and c) the paperwork when individuals need to work across different settings.

*“People are so busy and there are so many changes going on. People have other things on their mind and they don’t often think about doing naloxone training or initial assessment, and all the forms we have to fill out it can take someone an hour and a half, two hours to complete them and then to put naloxone training on top of that. It’s very difficult, especially when you are meeting somebody for the first time. It may be putting it into the service as a step by step process. We try and have it now that the admin staff are the ones that deal with them, photocopy them and send off the forms to say that they have been trained, we are trying to do that now”- Addiction Staff 11, Northern Trust.*

*Being able to carry naloxone as an outreach staff member*

- 5.33. Issues with supply include being able to carry naloxone around as they fulfil the functions of their role as an outreach worker.

*“What I think should be allowed because we visit those facilities we should be carrying it, currently we are not permitted to carry it and I think that’s a gap, we are providers of health care. Nurses should absolutely have naloxone at all times on our person, in our cars, in our nursing bag and that’s not allowed currently”- Addiction Staff 8, Belfast Trust*

*“I would prefer if we kept our own supply of naloxone and it didn’t require a nurse to access it, but practically we are working with what we have got. I don’t want to be critical of it, the positive is whenever we go for re supply it gives us an opportunity to talk to our nursing colleagues about what’s going on, it’s always better to widen the gateway. I can’t see how that would be a threat or a risk especially with specialist workers who are highly trained and accountable.” - Addiction Staff 5, Belfast Trust.*

Others’ echoed that some staff who are working in the community may be more effective if they were able to carry naloxone on their person.

*“As long as the quality of the supply and the monitoring of it is good, I think it should be widened as far as we can. Pharmacists should be given it too, some of our homeless workers, some of them are very skilled, street outreach should be carrying*

*them and I think the police should be, widen the gateway for needle exchange for naloxone supply which can only be a good thing”- Addiction Staff 6, Belfast Trust.*

### *Benefits of peer distribution*

- 5.34. The importance of peer distribution was emphasised as a way to get high risk individuals not engaged in treatment services a THN kit. Formalising this route, including a means by which a kit could be issued from someone named on the Patient Group Direction (PGD), would be advantageous.

*“I think what tends to happen is the patients we see aren't necessarily high risk and they know more people that are high risk and what they will tend to do is say I know so and so and I will then give them the training and whatever you do with the naloxone is up to you afterwards. It's mainly because there are those people who do not want to access statutory services so we are getting it out there but in more around about way, it's more like peer distribution.” – Addiction Staff 10, Southern Trust*

*“I come across people weekly that don't have naloxone kits and wont spare the time to be trained it's the younger age group. We find among the younger people that they are a lot more careless than the previous generation of heroin users, maybe to encourage more mature users to actually intervene and that those happen to be honest. It's back to empowering the more mature service users.”- Addiction Staff 3, Belfast Trust.*

*“I would like to promote one of my staff and /or another service user to give them more autonomy to take it forward and to get more service users involved. It's that group that have the ability to access those we can't access, especially for those clients and families that are the hidden population and who are not coming forward, that is an issue. The hidden population we know that they are out there like outreach services that we don't have but Belfast does, it's trying to get the message out there even via our needle exchange your relying on word of mouth.”- Addiction Staff 7, South Eastern Trust.*

*“[What would improve the uptake of naloxone] Credibility, demonstrating that we are credible, they know that their mates are credible. They know their mates OD prevention strategies, which are not necessarily right, but they have credibility. So it's about us getting credibility and that can only happen through the dissemination of the message which can be done through peer to peer support. So that's one way I think we could roll it out if we empowered users themselves and friends users themselves to train other people.”- Addiction Staff 3, Belfast Trust.*

### *Difficulties in assisting those who use on their own*

- 5.35. Some staff raised the issue about those who use opioids alone. It was suggested this may partly relate to stigma about using (or using again after a period of abstinence). This might be addressed by training, for example, that they may wish to tell someone that they plan to use at a certain time, but this may not work for all.

*“We have one guy who we have given the kit to but he always goes away and uses on his own”- Addiction Staff 4, Western Trust.*

*“There are challenges especially when people use alone”- Addiction Staff 6, Belfast Trust.*

### *Concerns about losing the quality of the existing service*

- 5.36. There were concerns about whether job cuts or other reorganisation in the health services would jeopardise the scheme.

*“People here are quite enthusiastic about doing it, when they get the time at the moment with everything going on in the service it has probably slowed up because people aren’t sure what’s happening with their jobs and if they have one or not”- Addiction Staff 11, Northern Trust.*

### *Recommendations for a greater role of community needle exchange pharmacies*

- 5.37. Addiction staff suggested expanding the programme to pharmacies would assist in engaging the harder to reach clients who are not accessing treatment services.

*“There is that element where you are preaching to the converted as their people are already engaged in treatment already... People who are best placed would be the community needle exchange pharmacists as they are well placed and they do some great bridging work.” – Addiction Staff 2, Western Trust.*

*“The challenge is to target that group, if that’s in needle exchanges, or through peer user to user programmes, so it can be fed out into the community for people who aren’t actively using services; they are the most challenging group”- Addiction Staff 8, Western Trust.*

*“If we were able to take it out of tier 3 and take it into a lower level and into the emergency rooms as well, we have colleagues that work in the emergency department in the 2 local hospitals and they have done the one day training, they can offer the advice but cannot give the kit out, also the pharmacy dispensing in the needle exchanges that would get it out to those that need it most”- Addiction Staff 10, Southern Trust.*

*“The most obvious places would be those with high risk clients like community pharmacy needle exchange”- Addiction Staff 1, Belfast Trust.*

*“...the more hoops you have to jump through, the less likely it will be fed out there. So you need people out there that have that opportunistic face to face contact. Needle exchange pharmacies are key... It’s percolating the information out and include service user groups to meet the people who aren’t being reached.”- Addiction Staff 8, Western Trust.*



## *A general need for better education and knowledge about naloxone*

- 5.38. There was a recommendation to improve general knowledge about naloxone, through knowledge transfer, or through advertising/leaflets. This is not just to reach those who use opioids but also their families. However, there were no specific suggestions about particular outlets that would reach those who are currently unaware.

*“I have had a mother come back to me saying I can't believe you're giving her needles, I did explain what it was for, it's the layperson's view of what naloxone is really.”- Addiction Staff 4, Western Trust.*

*“Maybe it was advertised through pharmacy needle exchange, and in GP Surgeries saying that naloxone and training is available, there is no advertising of naloxone through the media or anything.”- Addiction Staff 5, Northern Trust.*

*“Most of ours would be word of mouth, its people who are engaged with our service who maybe have talked to other people. The more people you can get to take the naloxone the better chance you have of saving someone's life. I' m wondering if some kind of publicity initiative might help it spread out there, if it was freely available”- Addiction Staff 11, Northern Trust.*

## **Successes identified by the Northern Ireland Ambulance Service (NIAS)**

- 5.39. A NIAS representative was interviewed to discuss their perceptions. NIAS staff in the field (Emergency Medical Technicians) and on the telephone have a key role to play in the programme in providing advice to callers, and preserving life at the scene of an overdose.
- 5.40. Overall, the NIAS representative confirmed that the ambulance service is supportive of the Take Home Naloxone initiative stating, *“I think it is the right direction to travel”*.
- 5.41. The NIAS representative confirmed that they considered the THN pilot to be a good programme supported by quality training. The NIAS is not resourced to contribute to the day to day training; however, they offered practical support in terms of having staff help out with the provision of slides on the ambulance perspective (and particularly in relation to how NIAS liaises with the PSNI in matters of overdose). They are also keen to hear about any negative experiences people may have had involving NIAS staff, so the service can continually improve.

## Challenges identified by NIAS

*The importance of indicating an overdose situation/presence of naloxone to NIAS telephone staff*

- 5.42. The representative noted there can be problems if the caller does not immediately identify an overdose situation when speaking to NIAS telephone operatives. Protocols used are designed to establish whether someone is conscious, breathing, or if they have a pulse as the primary concern. Help and support to the person administering naloxone and their patient will be more effective if the patient is immediately identified as experiencing an overdose. Immediate identification increases the chance to save the patients' life.

*"I think the training originally included what to expect when you call an ambulance service and that they have to be specific from the word go, that this is an overdose incident and that you have the Take Home Naloxone kit"*

One example from the beginning of the programme was identified when an individual did not identify an overdose situation, were unable to indicate they had naloxone, and had (not) administered it. The tape recording of the incident was reviewed for lessons learned.

*"...we had some difficulties at the start regarding an incident where one of the clients collapsed and a friend had tried to use the naloxone on him. But having listened to the tape recordings of it, it was evident he really didn't have a clue what he was talking about and as a result it went pear shaped because our standard ambulance protocol would include: is somebody conscious, is somebody breathing... if somebody is not conscious or breathing, we will usually have a question is there a defibrillator to hand. On this occasion the person calling had the box of naloxone as he described as a yellow box and didn't know what it was"*

*The misunderstanding that police will be called to every overdose event*

- 5.43. It was noted callers may not wish to identify the situation as an overdose because they believe the police may be called to the scene. The NIAS representative clarified the position of the service; they do not call the police to report drug use or an overdose as this would be a breach of confidentiality. However, PSNI officers may be the first responder on the scene.
- 5.44. If there is a sudden death, there is an obligation to call the police. However, they clarified this is not related to "*calling the police and getting people into trouble*", but rather an opportunity to explain an unexpected death.

*"It's important to highlight why an ambulance needs to be called and to reassure people in the training that we do not automatically call the police, just because*

*somebody is a drug user, in fact that's in our terms a breach of confidentiality. If it is a sudden death then we are obliged to call the police"*

### **Successes identified by staff working in the prison setting**

- 5.45. Three staff members were interviewed as part of their views on the THN scheme. One of these was a representative from the ADEPT team, and two were health professionals who provided clinical addiction support in prison.
- 5.46. Overall views of the THN scheme were positive, and it was viewed as a core component of the service provision.

*"It's another tool in our arsenal. We have really valued the training it's on our tick box of treatments. We see it as a vital part of our service, it's essential..."- Clinical Addiction Team Staff Member 2*

- 5.47. Prison staff said THN kits supplied upon discharge from prison had been saving lives of those released. Some staff described it as essential life-saving medication.

*"We do get reports back in from guys that have used it successfully. We get positive reports from a number of patients, not just one or two, there have been several"- Clinical Addiction Team Staff Member 1*

*"People I have received feedback from, prisoners that have used it on others, that it has saved lives. Family members have used it on them. They keep a kit at their mother's house, another at their girlfriend's house, they carry one with them, and it's actually viewed quite positively. We see it as essential, we say its life saving medication; they recognise the importance of having it." - Clinical Addiction Team Staff Member 2*

### *Successes in supplying kits to individuals*

- 5.48. Giving out the THN kit to individuals on release was made easier by using the Patient Group Direction to put the naloxone into the named patient's property.
- 5.49. The ADEPT team were credited with being responsive if someone's court date was coming up quickly. This was not always possible, but for the most part it seemed to address the needs of high risk clients before release. All staff were committed to getting it out there to those who required it, and were keen to hear of any instances where the service provided has been less than expected.

## Challenges identified by staff working in the prison setting

### *Reaching all of those who would benefit*

- 5.50. There were some concerns the scheme was not reaching all who would benefit due to a lack of understanding of what naloxone is and what it is used for.

*“In terms of understanding within the prison setting and outside of what naloxone is in Northern Ireland it’s still very minimal and there definitely needs to be more education as to what it is. There have been attempts to increase the publicity, but there needs to be more”- ADEPT Staff Member*

- 5.51. There were also concerns at the start of the scheme that those who were not in substitute prescribing were not reached. As the scheme expanded, there were concerns about getting the THN packs out there.

*“Initially there was a massive barrier; we couldn't get people who weren't on substitute prescribing to be provided any naloxone. What we decided was that those at higher risk weren't getting what they required, and that today seems to be an issue in terms of getting the clinical addictions team to prescribe the naloxone to people they do not know. It has changed a little bit now and people at a higher risk are being provided with the naloxone, however, we have quite a long waiting list for people to engage with the clinical addictions team, and there isn't that much substitute prescribing in the custodial sentence. We would have quite a high up-take of self-referrals.”- ADEPT Staff Member*

### *Legal issues and probation*

- 5.52. Naloxone was implicated in violation of the terms of probation for one individual. The possession of naloxone was (incorrectly) viewed as an indicator of continued use of opioids and association with substance users, rather than a responsible approach to saving lives in their wider community. This suggests the scheme may have negative connotations in probation services rather than demonstrating a responsible attitude. This myth puts the success of the THN scheme at risk.

*“There were a couple of the guys who had breached their probation because they were in possession of naloxone, and because they were in a hostel environment, and hadn't said that they were in possession of it. There is still enough dubiousness about it. Also I think there is a big thing, a lot of people who want to address their substance use it gives them an excuse to go out and use again and be around those types of people.”- ADEPT Staff Member*

- 5.53. Another issue was raised about the PSNI finding the needles. For example one staff member in the prison mentioned “...being found with needles. Police for example will find them and take them apart looking for illicit drugs.” The fear of legal consequences are an important barrier to success in this client group, and like with other client groups myths around legal consequences need to be addressed.

## *Improving access*

- 5.54. There was some indication that ADEPT and the Clinical Addiction Team did not integrate their work together as closely as might be preferred by both parties. There was some concern this would result in individuals falling between the two services, and result in reduced effectiveness of the scheme.

*"I would have liked it to have been delivered by the addiction teams, that was a management decision to move that to ADEPT, so it feels very disconnected. So if we were delivering it ourselves it would be easier to get an idea with what is happening. There are minimal lines of communications between the two services, if we identify that someone needs naloxone training we would refer then to ADEPT and they would complete it, and then they would refer them back to it's quite a number of interfaces. There is not a good line of communication, we don't use the same systems, they don't have access to our clinical records, so it's not ideal."- Clinical Addiction Team Staff Member 1*

- 5.55. There were also some capacity issues raised relating to either handing out kits or signing prescriptions. They stated:

*"It's hard to get the number through that we possibly should be"- ADEPT Staff member.*

Supply in prison is complicated by issues exclusive to the prison service such as length of sentence or when individuals are on remand. However, staff in the prison service (including ADEPT and the Clinical Addiction Team) are keen to hear about any issues which might help develop their systems (and in particular, if someone 'fell through the net' in terms of efficient supply).

- 5.56. A staff member mentioned training everyone up who has a history of drug misuse as a positive step.

## **6. Overall evaluation of the THN scheme: summary and points for consideration**

- 6.1. The aim of this evaluation was to establish whether the current model of naloxone provision and training across all Health and Social Care (HSC) Trusts in Northern Ireland is sufficient and identify areas for development.
- 6.2. The research objectives were:
- To establish whether training for community addiction and homeless shelter/hostel staff is sufficient and identify gaps or other training needs.
  - To establish whether opiate users feel they are appropriately trained in the use of naloxone and to ascertain their experience in accessing, using or replacing the kits.
  - To explore challenges and barriers to the uptake of naloxone kits and possible ways of expanding naloxone provision to those not registered with community addiction teams.
- 6.3. The following subsections summarise the findings in relation to these three objectives. Responses regarding changes required to the current model (e.g. gaps or other training needs, possible ways of expanding provision) are summarised under points for consideration.

### **Is training for staff sufficient and effective?**

- 6.4. Addiction staff praised the Train the Trainer (TTT) provision; it provided important information and skills as required. There were no issues raised in applying the training to train other individuals in either a group or one to one setting. The demands for retraining were mixed, some retrained in house, some had attended further sessions, and others required some retraining. These needs depended on the nature of the service in which addiction staff worked, however, provision of details of training and retraining sessions might be helpful.
- 6.5. Hostel staff were trained in either TTT or Opioid Overdose Response Training (OORT). The information and practical content of both courses was praised. Hostel staff indicated a greater preference for TTT training as it would facilitate a more efficient service, and have the potential to save further lives by reaching those not in treatment. As Hostel staff cannot access THN kits under the Patient Group Direction (PGD), pathways to obtaining a THN kit would be helpful for their local area. Hostel staff were proactive in obtaining retraining. Hostels prepare for the high risk of overdose with personal protective equipment and protocols kept to hand. Some hold

naloxone on behalf of named clients, and feel empowered to assist in an overdose situation.

- 6.6. Prison staff were also complementary about the TTT provision they had received. They used exclusively group training to train others and may wish to consider one to one under certain circumstances; some clients may feel uncomfortable being taught in a group setting. Prison staff were unaware of retraining opportunities at present.
- 6.7. Staff agreed the scheme responds to a real risk of overdose and a pressing community need. There was evidence from all groups interviewed that naloxone was saving lives in Northern Ireland. There is a strong commitment to the continuation of a high quality THN scheme; staff believed it is necessary, and are committed to further improvements. The scheme and the provision of training had wider benefits including building partnerships between keyworkers/staff and clients and reducing stigma.
- 6.8. The THN scheme should be viewed as a community asset with benefits arising from both a) increasing naloxone availability in the community and b) training and education alongside the distribution in reducing the risk and saving lives.

**Is service user training sufficient? What was the experience in accessing, using or replacing the kits?**

- 6.9. All of those interviewed felt very confident they could use naloxone in an emergency. There were no concerns about any aspect of the training. Some indicated they would like a refresher course but were unsure as to where to go, as they were no longer engaged in treatment services.
- 6.10. Service users confirmed it was easy to obtain a kit through their keyworker. Some were unsure about how to replace their kit on expiry if they were no longer engaged with treatment services. Resupply was best facilitated through good record keeping and contact with opioid users (both inside and outside of treatment).
- 6.11. Three instances were described in which naloxone was required from the 18 individuals interviewed. The first used their Cardiopulmonary Resuscitation (CPR) but was unable to administer naloxone as the syringe was broken in the process. The patient survived. The second did not have naloxone on their person but the Northern Ireland Ambulance Service arrived in time to administer naloxone and save their life. The third used their training in CPR and naloxone administration to save the individuals life.
- 6.12. The Northern Ireland Ambulance Service (NIAS) plays a key role in supporting service users in opioid overdose situations. They can be most effective in supporting the THN initiative if they are informed at the start of the emergency call that a) the

patient is experiencing overdose and b) either naloxone is present or has been administered. Telephone staff are happy to support the caller in the administration of naloxone at the scene should they need help.

### **Challenges to the uptake and use of naloxone kits**

6.13. The main challenges to accessing the scheme or using the kits are:

- Those who might benefit are not engaged with treatment providers. They may be uninterested in treatment, do not require treatment, or have completed treatment.
- Fear of legal consequences from either probation or police services. This is both the “hassle” of the interaction, and any subsequent consequences (such as stop and search) from carrying naloxone or engaging with the scheme.
- Do not believe they are at risk (either because they are an over the counter opioid user rather than an injecting user, because they no longer use, they are on opioid substitution programmes, or they no longer associate with other people who use opioids).
- Concerns among service users with children about social services involvement.
- Lack of knowledge about the scheme, particularly young people and rural communities.
- Naloxone is not kept on the person, or is not in the same location in which it is required, or a resupply is not obtained (either after use or after expiry of kit).

### **Successes and challenges of the programme**

6.14. The main successes were improving relationships between clients and staff, passing on life skills, empowering service users to save lives, responding to a need in the community to reduce opioid related fatalities, and building partnerships.

6.15. The main challenges arise from: interagency working and communication; fear of legal consequences (from police and/or probation services); reaching those not engaged in treatment but who would benefit; dispelling myths about who is at risk; identification of an overdose situation to Northern Ireland Ambulance Staff (NIAS); and legislation which prevents hostel staff and community healthcare professionals from being supplied THN.

6.16. The THN scheme is a community asset. The THN scheme facilitates saving lives and empowers the members of the community where it is located. Successful



prevention of overdose deaths has an impact on families and associates of service users, and reduces impact on healthcare and other statutory services.

### **Points for consideration**

*Expand the role of hostel staff, health professionals in outreach positions, peers, pharmacies, and GPS in the Take Home Naloxone Initiative*

- 6.17. Support and seek to obtain a Letter of Comfort to facilitate the holding of a THN kit for use on an as yet unnamed individual where their job role involves working with people using opioids<sup>2</sup>.
- a. **Hostel staff**, though uniquely placed to provide naloxone in an emergency, are limited by the current PGD because they cannot hold a kit for use on an unnamed individual. Hostels may be the only 'formal' setting providing support/care attended by a client, particularly for those with more chaotic lives, and so have a key role to play in reducing opioid overdose deaths.
  - b. Those who work in **outreach healthcare positions**, i.e. they travel between locations frequently, would also benefit from being able to hold kits on their person or in their car for use on as yet un-named individuals.
- 6.18. Expanding and encouraging access to TTT training for certain groups including
- a. Expanding and encouraging access to TTT training programmes for hostel staff.
  - b. Develop processes for Peer TTT training to improve the reach of the scheme to currently hidden populations of those at risk, dispel myths around overdose, and overcome barriers to THN uptake.
- 6.19. Consider and explore a greater role for pharmacies and general practice to widen access to the THN scheme by providing both OORT and THN kits to clients at risk of opioid overdose.

### *Promoting the THN scheme*

- 6.20. Consider advertising to increase the reach of the scheme (in particular to young people and rural communities). Advertising in needle exchange pharmacies, GP surgeries, hostels, in prison, and on relevant online sources may raise awareness.
- 6.21. Consider the use of the PHA website or other appropriate online resource to distribute information. For service users it could provide information about why they

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<sup>2</sup> See previous footnote: this facility will become available from 1<sup>st</sup> October 2015

should access the scheme, training, retraining, and the supply of naloxone. For staff, it could improve communication by illustrating responsibilities as part of the scheme, training and retraining opportunities, and the mentoring support. This may be more important as the scheme expands to ensure smooth communication and continued success of the scheme. Encourage and promote retraining events for those trained in TTT and OORT as the THN scheme continues to develop.

- 6.22. Continuing Professional Development Accreditation for the TTT and OORT course should be explored if not already available.
- 6.23. Encourage individuals to keep naloxone on their person, and in particular to take it to places where opioids are used. Thus, training and promotional activity must address existing myths: legal consequences and the role of NIAS and PSNI in emergency; risks posed by over the counter opioids; lack of knowledge about other contributing factors (e.g. polydrug use, or use after a period of abstinence).

#### *Strengthen the processes of the THN scheme*

- 6.24. Ensure those trained in TTT (including hostel staff) are aware of a route for their client to obtain a THN kit in their local area from someone named in the PGD.
- 6.25. Assist keyworkers in setting up processes and procedures for resupply. Ensure any expansion of the scheme (e.g. community needle exchange pharmacies) have plans for resupply. Consider present record keeping and if other options might help facilitate resupply or retraining service users (e.g. a central register).
- 6.26. Both staff and service users universally reported the quality and the credibility of the training and trainers. The continued success of the THN scheme to reduce opioid related deaths depends on maintaining the high quality training provision.
- 6.27. In relation to training, re-emphasise the need to identify an overdose situation clearly to NIAS telephone staff and to indicate the presence of naloxone.

#### *Build strong interagency partnerships*

- 6.28. Work in partnership with the Police Service Northern Ireland and Northern Ireland Probation Service to ensure staff, particularly those with a client-facing role, have a greater awareness of the legitimacy of naloxone as a medication. There may be a need to explore what training the police or probation service receive in relation to naloxone use and distribution.
- 6.29. Assist prison service in establishing protocols should naloxone not be available immediately upon release. Increase partnership working between the Clinical Addiction Team and ADEPT at identifying and training those at risk (including former users).

- 6.30. Support staff with service specific needs (e.g. translation services) where it is feasible to do so.
- 6.31. Stress the importance of the scheme to all parties as a community asset that improves community access to naloxone and provides valuable harm reduction advice which can save lives.

*Monitor the scheme*

- 6.32. Service users should be encouraged to report any adverse events or experiences (with dates and times) to the relevant organisations or through service user representatives to continually improve the THN initiative.
- 6.33. For NIAS to consider recording the number of cases where THN was used as this is not currently auditable and if it is possible to design a system similar to protocols that are in place for the use of other drugs, for example adrenalin. In wider roll out, questions about the use of naloxone could be added to the International Academy of Dispatch Protocols and the software used by Ambulance Control.
- 6.34. Consider continued monitoring of the scheme to ensure the value to the community is documented.

## Appendices

### Appendix 1: Interview schedule for service users

#### **Evaluation of the Take Home Naloxone scheme Service users who have received take home naloxone**

Interviews started with a discussion of the following:

- The purpose of the research and why they were contacted (reminding service users about the form filled out when they were issued their kit over six months ago).
- Their responses are anonymous, and will only be shared with the (named) research team.
- Responses will be used to inform a report to the Public Health Agency about the Take Home Naloxone scheme, but quotes will not identify individuals.
- We will be recording the call to make sure we have accurate information.
- Participants will be asked if they have any questions and asked to consent to taking part.

**1. How did you get your naloxone kit?**

**2. Did you find it easy to obtain a kit?**

Yes (Go to Q3)

No

What would make it easier?

**3. When you received your kit and the training/ instructions, how confident did you feel about using the kit after the training?**

Very confident

Somewhat confident

A little confident

Not at all confident

**4. Have you been in a situation where you thought the naloxone kit was needed?**

No (Go to Q7)

Yes (Go to Q4)

**5. Please tell us who was the naloxone kit needed for?**

Personal use

Someone else, who?

.....

**a) Who injected the naloxone?**

Self

Mother / father / sister / brother

**b) If not self: What were your reasons for not using it?**

- Partner
- Other drug user
- Member of staff – who?

**c) Was the ambulance service called?**

- Yes
- No

Why did you not call the ambulance service?

**6. At the time when your naloxone kit was used, ...**

**a) Can you say what happened / what was your experience or what were you told?**

*(Probe: difficulties with kit, success of intervention, etc)*

**b) Did you experience any of the following?**

	Yes	No
Delays in administering naloxone	<input type="checkbox"/>	<input type="checkbox"/>
Something missing from the kit	<input type="checkbox"/>	<input type="checkbox"/>
Syringe not working properly	<input type="checkbox"/>	<input type="checkbox"/>
Fear of using the kit	<input type="checkbox"/>	<input type="checkbox"/>
Fear of using CPR	<input type="checkbox"/>	<input type="checkbox"/>
PSNI attended	<input type="checkbox"/>	<input type="checkbox"/>

**7. Have you been able to replace your kit after this event?**

No

Why not?

Yes

How long did it take you to replace your kit?  
Why?

If lengthy delay: Has this caused any problems  
(e.g. needed again but nothing in place)?

**8. In general, do/did you have any concerns about using ...**

a) the kit?

- No  
 Yes →

If YES, what were they?

b) CPR?

- No  
 Yes →

If YES, what were they?

**9. Do you feel the training you received adequately prepared you for giving the naloxone and performing CPR?**

a) naloxone

- Yes  
 No →

If NO, what do you think could have prepared you better?

b) CPR

- Yes  
 No →

If NO, what do you think could have prepared you better?

**10. Do you know roughly when your kit expires?** Yes  No

a) Have you planned what you will do before your kit expires?

b) Have you planned what you will do after your kit expires?

**11. Would you know anyone who hasn't got naloxone who might benefit?**

- No  
 Yes →

If YES: Why did they not get naloxone?

**12. What would make it easier to access naloxone?** *Probe: Getting naloxone alongside needles in pharmacy, Peer-led naloxone training for people at risk, What are the barriers to easier distribution?*

**13. Where did you find out about the Take Home Naloxone Scheme?**

**14. Where do you keep your naloxone?** Prompt: do you carry it on your person all the time? If not why not?

**15. We are interested in finding out how many drug users might benefit from your naloxone training. Around how many people do you know might be at risk of overdose or who might benefit?**

- 0-10; 11-20; 21 or more

**16. Would you like to make any other comments or suggestions?**

**Thank you for your time.**

## **Appendix 2: Interview schedule/discussion guide for hostel staff**

### **Evaluation of the Take Home Naloxone scheme Hostel staff**

Interviews started with a discussion of the following:

- The purpose of the research and why they were contacted
- That their responses are anonymous, and will only be shared with the (named) research team.
- Responses will be used to inform a report to the Public Health Agency about the Take Home Naloxone scheme, but that any quotes will not identify individuals.
- We will be recording the call to make sure we have accurate information
- Participants will be asked if they have any questions and asked to consent to taking part.

#### *Section 1: Background information*

- 1. Trust or area**
- 2. Employer**
- 3. Job Title**
- 4. Briefly describe what your job involves**
- 5. Briefly what is your role/role of your agency in the Northern Ireland THN programme?**
- 6. What training have you received in relation to Naloxone**
  - a) None*
  - b) Opioid overdose response training*
  - c) Train the trainer training*
  - d) Any other training (please state and briefly describe)*
- 7. Is there any training you would like to receive in relation to Naloxone?**

#### *SECTION 2: Evaluating training (ask referring to training attended in Q6)*

- 8. When and where did you attend this training session? On what basis were you selected for training?**
- 9. How effective did you feel the training you received was?**
- 10. For OORT only: Did the training cover all information required to teach you about CPR or the administration of take home naloxone? (yes/no). If no, what else might you have benefitted from or what concerns or queries do you have?**
- 11. For TTT only: Did the training cover all information required to teach an individual about Opioid Overdose Response Training (yes/no). If no, what else might you have benefitted**

**from or what concerns or queries do you have?** *Probe how useful training materials received were (e.g. Patient Group Direction or Protocol?)*

**12. Do you think you might need refresher training either now or in the future? If so when, if not why not? & How often?**

*Section 3: Hostel specific questions*

**13. Does your hostel/agency currently hold Naloxone/has it ever held Naloxone? How did it get to be there?** *Probe: was it held for a resident, left behind by accident etc?*

**14. Where are the kits held?**

**15. If someone took an opioid overdose in your hostel, would you be able to quickly access naloxone to administer to them? Please explain**

**16. Have you or anyone else administered a kit kept in your agency? If so was it on the named patient or someone else?**

**17. Have there been any barriers to your hostel/agency holding THN packs?**

**18. Do you have any concerns about your hostel/agency holding THN packs?**

**19. Do you or other staff members have access to a face mask/pocket face mask/keyring face shield for use in giving emergency breaths? Would access to these make you feel more confident about administering rescue breaths in an overdose situation?**

*Section 4: General questions about the scheme*

**20. How well do you think the THN programme is working? What would make it more effective?**

**21. What are the challenges to recruiting individuals to take up Naloxone kits?** *Prompt: How to reach those most vulnerable/those who don't engage with drug treatment services. Also recruitment challenges, for example attitudes of people at risk, attitudes of others (including family, carers, colleagues), fear of police, loss of tenancy, fear of being identified as a drug user, size and nature of kit, location/nature of programme delivery.*

**22. How might naloxone provision be expanded to those not registered with community action teams?**

**23. Is there anything else you would like to add?**

**Thank you for your time**



### Appendix 3: Interview schedule/discussion guide for addiction staff

#### Evaluation of the Take Home Naloxone scheme Addiction staff

Interviews started with a discussion of the following:

- The purpose of the research and why they were contacted
- That their responses are anonymous, and will only be shared with the (named) research team.
- Responses will be used to inform a report to the Public Health Agency about the Take Home Naloxone scheme, but quotes will not identify individuals.
- We will be recording the call to make sure we have accurate information
- Participants will be asked if they have any questions and asked to consent to taking part.

#### *Section 1: Background information*

1. Trust or area
2. Employer
3. Job Title
4. Briefly describe what your job involves
5. Briefly what is your role/role of your agency in the Northern Ireland THN programme?

#### *Section 2: Evaluating Train the Trainers Training*

6. When did you attend the TTT training session? On what basis were you selected for training?
7. Did the training cover all information required to teach an individual about Opioid Overdose Response Training (yes/no). If no, what else might you have benefitted from or what concerns or queries do you have? *Probe how useful training materials received were (e.g. Patient Group Direction or Protocol?)*
8. How confident do you feel in training others?  
Very confident   
Somewhat confident   
A little confident   
Not at all confident
9. Did you receive any support from the mentoring scheme? If so, did you find it useful? If not, would you have benefitted?

**10. Do you think you might need refresher training either now or in the future? If so when, if not why not? How often?**

**11. Who did you train and how many?**

service users		service user representatives		other staff	
yes	no go to Q12	yes	no	yes	no
n=		n=		n=	
<b>Did you train service users</b>					
Individually					
or in groups					
<b>Were there any challenges?</b>					

*Section 3: General questions about the scheme*

**12. How well do you think the THN programme is working? What would make it more effective?**

**13. What are the challenges to recruiting individuals to take up naloxone kits?**

*Prompt: How to reach those most vulnerable/those who don't engage with drug treatment services. Also recruitment challenges, for example attitudes of people at risk, attitudes of others (including family, carers, colleagues), fear of police, loss of tenancy, fear of being identified as a drug user, size and nature of kit, location/nature of programme delivery.*

**14. How might naloxone provision be expanded to those not registered with community addiction teams?**

**15. Do you have anything you would like to add?**

**Thank you for your time.**

## **Appendix 4: Interview schedule/discussion guide for Northern Ireland Ambulance Service representative**

### **Evaluation of the Take Home Naloxone scheme NIAS representative**

Interviews started with a discussion of the following:

- The purpose of the research and why they were contacted
- That their responses are anonymous, and will only be shared with the (named) research team.
- Responses will be used to inform a report to the Public Health Agency about the Take Home Naloxone scheme, but quotes will not identify individuals.
- We will be recording the call to make sure we have accurate information.
- Participants will be asked if they have any questions and asked to consent to taking part.

- 1. Job Title**
- 2. Briefly describe what your job involves**
- 3. Briefly what is your role/role of your agency in the Northern Ireland THN programme?**
- 4. What training have you received in relation to Naloxone?**
- 5. How have you used the training in your work?**
- 6. Was it useful? *If not how could it be more useful?***
- 7. Would any additional or alternative training relating to take home naloxone be useful to you or any of your colleagues?**
- 8. Are you aware of any impact the THN pilot has had on the work of the Ambulance service? *Probe: For training of Ambulance Staff, for frontline staff, for management, for telephone operators?***
- 9. Is there anything the THN scheme could do to have a positive impact on the work of the Ambulance Service in relation to opioid overdose situations?**
- 10. What is the protocol regarding THN use given by telephone operators at present?**
- 11. How well do you think the THN programme is working? What would make it more effective?**
- 12. Is there anything else you would like to add?**

**Thank you for your time.**

## Appendix 5: Interview schedule/discussion guide for prison or ADEPT staff

### Evaluation of the Take Home Naloxone scheme Prison and ADEPT staff

Interviews started with a discussion of the following:

- The purpose of the research and why they were contacted
- That their responses are anonymous, and will only be shared with the (named) research team.
- Responses will be used to inform a report to the Public Health Agency about the Take Home Naloxone scheme, but quotes will not identify individuals.
- We will be recording the call to make sure we have accurate information.
- Participants will be asked if they have any questions and asked to consent to taking part.

#### *Section 1: Background information*

1. Area
2. Employer
3. Job Title
4. Briefly describe what your job involves
5. Briefly what is your role/role of your agency in the Northern Ireland THN programme?

#### *Section 2: Evaluating Train the Trainers Training*

6. When did you attend this training session? On what basis were you selected for training?
7. Did the training cover all information required to teach an individual about Opioid Overdose Response Training (yes/no). If no, what else might you have benefitted from or what concerns or queries do you have? *Probe how useful training materials received were (e.g. Patient Group Directive or Protocol?)*

8. How confident do you feel in training others?

Very confident

Somewhat confident

A little confident

Not at all confident

9. Did you receive any support from the mentoring scheme? If so, did you find it useful? If not, would you have benefitted?

**10. Do you think you might need refresher training either now or in the future? If so when, if not why not? How often?**

**16. Who did you train and how many?**

service users		service user representatives		other staff	
yes	no go to Q12	yes	no	yes	no
n=		n=		n=	
<b>Did you train service users</b>					
Individually					
or in groups					
<b>Were there any challenges?</b>					

*Section 3: General questions about the scheme*

**11. How well do you think the THN programme is working? What would make it more effective?**

**12. What are the challenges to recruiting individuals to take up Naloxone kits?**

*Prompt: How to reach those most vulnerable/those who don't engage with drug treatment services. Also recruitment challenges, for example attitudes of people at risk, attitudes of others (including family, carers, colleagues), fear of police, loss of tenancy, fear of being identified as a drug user, size and nature of kit, location/nature of programme delivery.*

**13. How might naloxone provision be expanded to those not registered with community action teams?**

**14. Are those leaving prison taking up their kits? How do you know if they have taken up the kit?**

**15. Is there anything else you would like to add?**

**Thank you for your time**