Following our look at the poor distribution of life-saving drug naloxone in the last issue, David Gilliver **hears about a successful pilot project in the West Country that supplied it on an outreach basis to those most in need**

Back from the brink

'It's very cheap to save a life,' says Rhian Hills. She's talking about naloxone, the opioid antagonist that can reverse the effects of overdose if administered quickly enough. Despite its proven life-saving properties, however, naloxone's distribution is patchy and inconsistent. There is no national strategy and it remains, as the authors of our feature in the last issue pointed out, largely limited to 'brave clinicians and user groups who plough a lone furrow without national guidance, support or coordination' (*DDN*, 1 December 2008, page 12).

Hills was joint commissioning manager at Wiltshire DAAT at the time of an innovative pilot scheme in 2007. While Wiltshire wasn't the first area to launch a naloxone pilot, it was the first to supply it on an outreach basis to clients not already in treatment and therefore traditionally hard to access, as well as the first to provide evidence to the NTA on its effectiveness. 'Previous pilots had done it from treatment centres,' she says. 'We were reaching people who'd had no intention of going into treatment.'

In the six months from April 2007 onwards, nearly 50 service users – including 25 heavy opiate users – were trained in overdose recognition and response and supplied with naloxone in pre-filled 400mg minijets. The genesis of the pilot, says the DAAT's harm reduction lead, Mick Webb, was the absolute consensus on the part of service users that naloxone was something they wanted. 'We had a meeting with service users from 16 different DAAT regions and there was unanimous agreement,' he says. 'To have two service user reps agreeing on any one thing is quite unusual, so to have representatives from the whole of the South West speaking in unison was really powerful. That set the pace – it was unanimous service user consensus that really drove it.'

The pilot proved initially difficult to get off the ground, but resistance was overcome by service user determination and tenacity. 'We took a paper to the joint commissioning group with service user reps – if it wasn't for user involvement the project wouldn't have worked,'

says Hills. 'The sheer commitment and determination of service users helped not only to put the project in place, but more importantly saved lives.'

It quickly became a multi-agency project, with the Wiltshire ambulance service and police on board alongside the Wiltshire users forum and a number of professionals who gave their time free of charge. 'That was very much capturing the spirit of harm reduction,' says Mick Webb. 'We had this raft of well-paid professionals saying "let's get this off the ground" – it was all above and beyond their roles.'

The aim was not only to reduce drug-related deaths but also to use the project as a platform for other harm reduction work, particularly increasing awareness of blood-borne viruses and encouraging testing, as well as helping to map the main areas where overdoses were taking place. 'It was a fantastic way to get people engaged,' says Hills. 'They wanted to be tested for hep C, vaccinated for hep B – it was an overall harm reduction initiative, not just about saving lives.'

Two lives, however, were saved during the course of the pilot, as verified by the ambulance service. 'It was important that we had the ambulance service validate that,' says Mick Webb. 'We were emotionally involved in the project so it was nice to have an objective viewpoint.'

The simple act of entrusting service users to administer naloxone made them much more open to the range of other harm reduction messages, Webb believes. 'It created a platform for information to be received as well as delivered – the empowering effect of the training and supplying someone with naloxone, and the boost in confidence and self belief that brings about, meant people became much more receptive to other information. If your self-esteem's been around your ankles and suddenly you're in a position to save a life then clearly you're going to feel quite different.'

The project used word of mouth and traditional street networks to engage with clients, boiling down research findings into easily understood messages. 'The most remarkable thing about the pilot was its outreach basis,' says Gordon Morse, the prescribing GP and one of several professionals to provide services free of charge. 'Doing this on an outreach basis hits the target audience – people already in established treatment, as in other pilots, should be more stable and less likely to overdose anyway. But it also therefore introduced the difficulties of getting people to prescribe for them, because they're very risky people and very often you have to go out to them. We had to be quite creative about that.'

Some of those trained were on DRRs or street homeless, but carers were also involved in the scheme, including a man who had watched his brother overdose time and again. 'He knew it was only a matter of time, but he'd realised there was a project that gave a damn,' says Mick Webb. 'Even with quite hardened drug workers, moments like that do take the rug out from under you a little.'

As the law stands, naloxone is a prescription-only drug but is permitted by law to be administered by anyone with appropriate training – the problem is getting hold of it to administer in the first place. Feedback from service users and all the other partners involved was overwhelmingly positive, so why is naloxone use so patchy – where does the resistance come from? 'The people throwing up the barriers and arguing against it were other professional drug workers who didn't like the idea of drug users being given a drug to inject,' says Mick Webb. 'Even a simple process of putting a minijet together and giving an inter muscular injection to save a life – they thought it was irresponsible.'

There was also a good deal of concern around the potential legal consequences, he says. 'It was frustrating hearing "what happens if something goes wrong?" over and over again. What's going wrong is that people are dying of drug overdoses. Then there were the professionals who said "I don't care – I'd rather be in court having saved someone's life than at an inquest". Negative stereotypes about service users and their capabilities also played a part, he believes. 'People were saying service user involvement was a really good idea but when it came down to it there was no trust there. People are skilful at saying the right things but when it comes to action, and validating service user involvement, it falls short.'

'The irritating thing is that this drug is completely safe,' says Gordon Morse. 'You can squirt it in someone's eye and it's not even going to sting. It's completely harmless, so why it's a prescription only medication is an anachronism. And, because it's off patent, there's no financial will from big pharma to change its product registration, because that's very costly. But if people are upset about dishing out needles or injectable drugs then you can also give the stuff nasally.'

'Everyone carries their nose around but not everyone has good quality veins,' says operations manager at Great Western Ambulance Service, Steve Blackmore, whose service uses pre-filled MADs (mucosal atomisation device) to spray naloxone in the noses of overdose patients – best used when patients can be observed in hospital afterwards as it tends to wear off faster than when administered by minijet. 'It's a quick hit, whereas if you're trying to get a vein it can be ten, 20 minutes before it takes effect. If you've got a patient in severe respiratory distress or even respiratory arrest it's an ideal route.'

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So, from an ambulance service point of view, would rolling out naloxone use across the country save lives? 'It would definitely make a difference to the number of fatal overdoses,' he says. 'If we could persuade someone to finance it we could be saving lives on a regular basis. The pilot was a really important initiative – allowing our paramedics and technicians to safely give an antidote has got to be good news.'

The company that manufactures the minijet, UCB, is also now redesigning the device into an all-in-one unit with a fixed pin, removing the need to give out needles with naloxone and the associated fears that they could become diverted. In that case why is it taking so long to get naloxone to all the people who need it? 'I think partly it's about getting the clinical governance in place,' says Rhian Hills. 'It's new, and that's frightening for people – it takes time to get a joint commissioning group on board. And it's about fear, partly of the public response.'

So are there any indications that attitudes are starting to change? 'I think a lot are probably quite ingrained,' says Mick Webb. 'One of the most common questions was "if someone's got naloxone won't that encourage them to have bigger hits?" We've tried to find evidence of that and we can't – we haven't found any evidence of irresponsible use of naloxone at all. There's a lot of political correctness around service user involvement but the reality is there's also a lot of hidden dissent, and I think that's through all tiers of drug treatment. Naloxone is a life-saving intervention. It clearly works, and it's a treatment specific drug – it doesn't do anything else except reverse an overdose, so why has it been such a stuttering start? I think the system needs to look within itself, shine a light over this dissent and get it addressed.'

But surely something with such life-saving potential will become universally available sooner or later? 'I think ultimately it will, but we need to drive that – I don't think it will happen by osmosis or simply because it's a good idea,' he says. 'People need to become proactive – there's more evidence emerging that it saves lives, and no evidence emerging that people are using it irresponsibly.'

'It's a completely safe drug that can only be given out by a licensed prescriber, which is potty,' says Gordon Morse. 'It's a real problem, all for want of a change in regulations. I'm not being a maverick here – I'm not saying we should be legalising crack cocaine or anything – but this is a complete no brainer, which is what's so infuriating. Doctors shouldn't even be involved, nurses shouldn't be involved – this stuff should be freely available at needle exchanges.'

Hear more from Mick Webb at 'Voices for Choices' on 29 January. Visit www.drinkanddrugsnews.com for details.