# Expanding Access to Naloxone Consultation Response

FULFILLING LIVES
LAMBETH
SOUTHWARK
LEWISHAM

COMMUNITY FUND

Fulfilling Lives Lambeth, Southwark and Lewisham.
Fulfilling Lives in Islington and Camden

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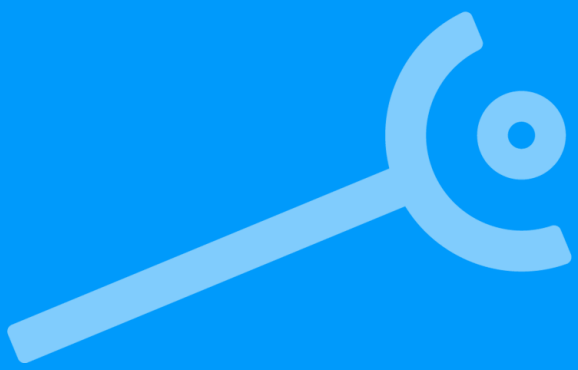

Fulfilling Lives Lambeth, Southwark and Lewisham is funded by The National Lottery Community Fund and is part of the National Fulfilling Lives Programme. This is a £112 million investment over 8 years supporting people who are experiencing multiple disadvantage; the people we work with have a combination and interconnected needs of mental ill-health, are homeless/or at risk of homelessness, substance use and/or contact with the criminal justice system.

We acknowledge that the system doesn't work for everyone – particularly people who experience greater levels of disadvantage.

Certitude is the lead agency of the programme, delivering the programme in partnership with Thames Reach and strategic partners; South London and Maudsley NHS Trust and the three boroughs of Lambeth, Southwark and Lewisham.

Our three core aims are:

- Co-production: Giving equal value to the voices of both the decision makers and the people we support, so that all opinions are heard and respected equally.
- Service delivery: Working alongside people and services learning and testing different interventions to change the lives of people experiencing multiple disadvantages for the better – now and in the future.
- System change: Making an impact on the way people are supported – by influencing policy and practice, locally and nationally.

## About this consultation response

This document presents the evidence Fulfilling Lives LSL submitted for the Department of Health and Social Care's Health Strategy consultation in September 2021. The consultation sought insights on the following key thematic areas:

- Accessibility to Naloxone
- Naloxone distribution
- Other services
- Administering Naloxone
- Distributing Naloxone in our services
- Perceived Benefits and Risks
- Potential risks impacting people with protected characteristics.

Our submission presents evidence and insights from the programme in line with these key themes. We also present 'calls to action' for consideration from the Department of Health and Social Care.

# 1. Introduction

This is a joint response from Fulfilling Lives Lambeth Southwark and Lewisham (FLLSL) and Fulfilling Lives in Islington and Camden (FLIC). Fulfilling Lives is a £112 million investment by The National Lottery Community Fund (TNLCF) over 8 years in local partnerships in 12 areas across England, supporting people experiencing multiple disadvantage (defined as experience of two or more of homelessness, substance use, contact with the criminal justice system and mental ill-health). We believe that "no person is hard to reach but systems can be hard to access". We aim to influence the system to change the lives of people experiencing multiple disadvantages for the better – now and in the future. We believe in the importance of co-production and giving equal value to the voices of both decision makers and the people we support, so all opinions are heard and respected equally. FLLSL and FLIC are the two local Fulfilling Lives programmes based in London, providing a critical local lens to the national Fulfilling Lives programme.

We believe that to develop effective policies, those with current and former lived experience of the policy issue faced must be central in the process of policy development and be given an equal voice in legislative change. As such, this response reflects the insights and expertise from those with lived experience of substance use and practitioners from all levels of the organisations. This was captured through interviews, surveys and focus groups and presents a range and depth of knowledge to inform the consultation. It also draws on wider research and evidence from peer-reviewed journals and national datasets.

There is consensus amongst people with lived experience and professionals that naloxone is difficult to access in the event of an opiate overdose and we believe that policy should change to make it easier to access and save lives. We support the Department of Health and Social Care's (DHSC) proposal to expand access to naloxone through outreach, day centres and accommodation-based services. However, we believe that expansion should be more ambitious in its scope in order to reach all those who may need it, especially hidden or marginalised communities; multiple access points are needed to reach as many opiate users as possible. As one person with lived experience commented, *"everyone that works with or has contact with someone who uses [substances] should be able to carry naloxone, to make it easy to get".*

People with lived experience told us about people they knew who had died of an opiate overdose and believed this could have been prevented had someone had naloxone, known how to use it and had the confidence to do so and call an ambulance. One man described a situation in which a friend overdosed,they were waiting 22 minutes for the ambulance to arrive; fortunately his life was saved but it could have been a different outcome.

Some people with lived experience were unsure of where to get naloxone, one person pointed out that to get the drug, you need to have a knowledge of services and/or be receiving support. In the past they have needed naloxone and *"not known where to get it".* Others with former experience of opiate use said that they were not aware of. These experiences highlight the importance of naloxone being available to those who are not accessing services, as well as those who are. One person described that, in her experience *"nobody was ever on their own, they were always either in twos or threes, always...they'd always earn together and use together".* This means that there is the opportunity for peers to administer naloxone on each other in the case of overdose and highlights the importance of having it available.

Alongside easier access to naloxone, knowledge and confidence to administer naloxone should be supported so that it is used in the case of overdose and the appropriate actions are taken such as calling an ambulance; we believe that increased access to naloxone should be accompanied by an amnesty policy whereby those seeking medical attention for drug-related injury or harm including overdose are protected from repercussions from the criminal justice system such as arrest. The changes to naloxone distribution should also be delivered in the context of a wider harm minimisation strategy.

The effectiveness of giving out naloxone is supported by the literature, one study found that 80% of those given naloxone kits still had them at a 6-month follow up and reported a high level of knowledge on the risk of overdose (Gaston et al., 2009). As an intervention, naloxone is successful, safe and effective. This supports the proposal to expand access to naloxone and supporting this with the right training so that people are able to use it appropriately. Training should be trauma-informed and recognise the trauma that can result from experiencing or witnessing an overdose, aftercare should be made available.

Currently, drug services are a key distributor of naloxone. This means that those who are not accessing drug services are not being offered it. There are some groups who experience greater barriers to accessing drug and alcohol services including women. As such, these groups may have less opportunities to access naloxone. The DHSC should take into account the gendered experience of substance use and ensure that naloxone distribution strategies are trauma-informed and co-produced with those with lived experience.

# 2. Accessibility of Naloxone

Naloxone should be available to anyone who is associated with or around those who may overdose; as expressed by someone with lived experience, "*it has to be with people who are going to be in those circles*". People with lived experience highlighted that this is not just those who are already accessing drug treatment and/or other services, but also those who are using opiates but not accessing services. As one person said: "*it's got to be more readily available, and it's got to be available in the right places, to the right people who need it and unfortunately that isn't the people who look for help, that's the people who are in it [currently using substances], uninterested in looking for help but will go and get clean needles or will access some food or a bed for the night*". Having multiple points of access would provide the best opportunity to reach as many people as possible. It is not usually professionals that administer naloxone but friends or associates of the person who has overdosed and so all services who come into contact with those using opiates should be able to give out naloxone. We believe that all the services and professionals mentioned above should be able to give out naloxone, but that some would have more opportunities for impact.

Services for those experiencing homelessness or rough sleeping are key points of contact for those using opiates. A large proportion of those experiencing homelessness use drugs or alcohol; Homeless Link data shows that 46% of those living in hostels and 54% of those rough sleeping use substances or alcohol or are in recovery. Office for National Statistic (ONS, 2019) data shows that in 2019 37.1% of deaths of homeless people were related to drug poisoning. Extending exemptions to outreach, day centres and accommodation-based services would, therefore, prevent deaths from overdose. However, these services only reach a proportion of those using opiates and so distribution should also take place in other settings such as migrant support centres and services for those involved in sex work. Outreach services should be able to give out naloxone and should support this by showing people how to use it; having access is not enough, people need to be confident in administering it.

Pharmacists were highlighted as a key point of contact with the system that is accessed by those who may not be in treatment for opiate use but go to pharmacies for needle exchange: *"it [naloxone] should just be given out, in the bag, when you go to get the needles, it should just be in the bag – it's that simple"*. Whilst the current exemptions mean that pharmacists can distribute naloxone without prescription, the experience of those using substances is that they are not being given naloxone at pharmacies. DHSC's strategy should support pharmacists to dispense naloxone to those accessing pharmacists for opiate replacement prescriptions or clean needles and promote awareness of this amongst those using opiates.

If a woman using opiates becomes pregnant, Children's Social Care will frequently commence pre-birth child protection proceedings. Services that wrap-around the woman are often required to participate in this process, for example drug teams may be required to share results from drug screenings. In our experience, this can de-centre the woman within existing support systems, with the focus on the unborn child, and can lead to a break-down of trust in professional relationships. During pregnancy, women often experience increased stigma and shame, which is a further barrier to accessing services. Drug use often escalates in pregnancy due to pressure from services and the threat of child removal, and there is an increased risk of overdose after birth. In our experience, midwifery teams can be one of the only services that sustain a relationship with the woman and offer an opportunity for naloxone to be distributed.

Nurses working in drug services, day centres or other locations where they may come into contact with those using opiates such as services for those involved in sex work should be able to give out naloxone.

Probation services should be able to give out naloxone; there is an increased risk of overdose after relapse which may occur when someone leaves prison if they have been abstinent during time in prison. Alongside this, there is a need for education and amnesties as there is concern amongst individuals on licence that carrying naloxone could be perceived as an indicator of relapse or opiate use, which may cause issues with probation or attract attention from the criminal justice system. Prison officers should also be able to give out naloxone; following release from prison, men are 29 times and women 69 times more likely to die than the general population in the first 2 weeks of release from prison (Sondhi et al, 2016). This also supports the extension of naloxone to services supporting those recently released from prison such as resettlement teams.

People with lived experience highlighted that there may be concerns amongst opiate users about receiving naloxone from Police Officers, with one person saying that it could "*trigger paranoi*a" as people might perceive that, if they accept naloxone, they would "*be on the police's radar*". The need for the expansion of naloxone needs to be accompanied by education and an amnesty policy whereby those who seek medical attention for drug-related injury or overdose are protected from arrest and prosecution.

# 3. Naloxone distribution

As a service supporting people experiencing multiple disadvantage, t majority of the people we support (93%) use substances including heroin and are at risk of overdose. As the DHSC will be aware, the number of deaths from drug-related causes has increased over the last 20 years; this includes opiate related deaths which have increased by 73% since 2012 (ONS, 2021).

We are a key point of contact within the system for people experiencing multiple disadvantage, so if services such as ours were able to give out naloxone, this would increase the availability of naloxone to those who need it. As an outreach service, if the regulations permitted, we would definitely carry and distribute naloxone. This would enable us to get naloxone to the people we support who as previously described are at risk of overdose.

There have been previously challenges for local Fulfilling Lives programmes in carrying naloxone due to the medication policy of the providers. The DHSC should therefore support organisations to get the right policies and procedures in place so that outreach services would be confident in carrying, storing, and distributing naloxone if and when the proposals are implemented.

Feedback from practitioners and those with lived experience highlighted a preference for nasal naloxone, even though injectable naloxone is currently the only option.

In this response, it is also essential to highlight the trauma that can result from experiencing or witnessing an overdose. Training, education, and information around naloxone needs to be trauma-informed, recognising the trauma that can result from these experiences. It should also be mindful that discussing substance use can be triggering for those using or in recovery. One person we support who *"wants to stay away from drugs"* commented that they did not want to receive naloxone training because it would be *"too triggering".*

# 4. Other services

People with lived experience and practitioners suggested other settings where supplying naloxone would reach more people using substances, particularly those who may not be accessing the services cited in the above questions.

- Violence Against Women and Girls (VAWG) services and services supporting those involved in sex work. These are key points of contact within the system for those who may not be accessing other services. Women experiencing VAWG or involved in sex work are more likely to be using substances.
- Sexual health services.
- Black Asian and Minoritisedspecific services.
- Libraries - Someone with lived experience highlighted that they frequently accessed public libraries when homeless and when in active addiction. They also highlighted that toilets in Libraries are often accessed as spots to use in, as they are one of the few settings that offer some, limited privacy and clean facilities for people experiencing street homeless.
- Job centres.
- Food banks- this was highlighted as somewhere that someone using might go to even if they are not accessing other services
- Religious or faith groups - leaders of faith groups can be trusted members of the community - *"They need to do it [reach out to Muslims struggling with substance use] through the mosques – meetings with the Imam etc".*
- Migrant support centres and modern slavery charities.
- Recovery peers/peer mentors – P2PN (Release 2020) - this was also highlighted by people with lived experience - that if those using, or formerly using, who were part of the drug using community could give out naloxone to their peers, or could take it to drug using. hotspots/drug houses, then the naloxone would be where it is needed when someone overdoses. Peer to peer naloxone distribution is also supported by Release (2019).
- *"On phone boxes they should have more information [about substance use support]- put notices up where people who take drugs are going to see them".*
- *"In doctors' offices they should have more available information [about substance use support".*
- Peer support groups - Narcotics Anonymous, Alcoholics Anonymous, Cocaine Anonymous etc - this is a place where people may have trusted relationships, is peer to peer support and if someone relapses after a period of abstinence are at increased risk of overdose.
- LGBTQIA+ communities.
- Public transport workers - i.e. TFL tube/bus drivers etc: Someone with lived experience highlighted that many people rely upon public transport infrastructure as a place to sleep when street homeless.
- At local hotspots - e.g. Heathrow Airport.

Expanding the services that can give out naloxone will decrease the incidence of opioid overdose and drug-related deaths because it will give greater access to naloxone to those who need it and those who are present when someone overdoses. In most situations, it would not be a professional administering naloxone, but a friend or acquaintance of the person who has overdosed, often who is also using substances. Therefore, it is these groups of people who should have easy access to naloxone.

People with lived experience have been in situations where someone they are with has overdosed but naloxone has not been available and had someone had naloxone with them, lives could have been saved. One man described a situation in which his friend overdosed and was *"dead for 22 minutes"* whilst waiting for the ambulance and he wished he had had naloxone then. Others knew of deaths due to overdose in houses where drugs were sold or used where others present did not contact emergency services for fear of repercussions with the police. Had naloxone been available, lives could have been saved.

This also highlights the importance of increasing access to naloxone alongside education and training and in the context of an amnesty policy, to protect those seeking medical attention for overdose or drug-related injury from arrest or prosecution. Otherwise, even if naloxone is more widely available, people may not feel confident to use naloxone and/or may be afraid of the repercussions of carrying or administering naloxone.

The services that have the most contact with those using opiates are the ones likely to have the biggest impact in terms of reducing deaths from overdose. As previously described, services supporting those experiencing homelessness or rough sleeping are a key point of contact for those using opiates; a high proportion of those experiencing homelessness use substances and this can be a cause and consequence of homelessness. We believe that if these services were able to hand out naloxone this would be highly effective in reducing deaths from opiate overdose.

In addition to the services outlined, we believe that peer-to-peer naloxone distribution would be highly effective in getting naloxone to the places it is needed. This was highlighted by those with lived experience as being the most effective option for naloxone distribution and preventing overdoses; some people were excited about this as a possibility. One woman described an ideal situation being one in which naloxone could be distributed into the houses where drugs are sold and used, as this is where overdoses often occur. Release (2019) report that peer-to-peer naloxone distribution through specialist services, community-based venues, outreach, and homes of peers. We believe this would be an effective way of distributing naloxone and saving lives. Research has found that peer-to-peer naloxone distribution is an effective, affordable, and efficient method of getting naloxone to those most likely to be present when someone overdoses (EuroNPUD, 2019).

# 5. Administering Naloxone

We do not believe that there are any significant risks associated with the administration of naloxone in either nasal or injectable form and that distributing naloxone is a safe and effective method of preventing overdose. Wider research supports this; a study in the USA between 1999 and 2013, over 150,000 naloxone kits were given to those using substances and their families, reversing over 26,000 opioid overdoses and saving lives.

However, practitioners and people with lived experience did perceive some risks or have some concerns about administering injectable naloxone, although these are perhaps rooted in misinformation or lack of knowledge or confidence - these are described in the response to Question 10. This again highlights the importance of increasing access to naloxone alongside support to improve knowledge and awareness of naloxone and how it is used and in the context of an amnesty policy, otherwise there is the risk that although there is wider access to naloxone it is not administered in the case of overdose.

All practitioners and people with lived experience had only been offered injectable naloxone and most were not aware that nasal naloxone exists. Some practitioners reported concerns about sustaining accidental needle injuries whilst administering injectable naloxone. There was a perception across practitioners and those with lived experience that nasal spray would be more attractive and could be associated with less risk than injectable naloxone. This may improve uptake or willingness to use naloxone. Research has found that nasal naloxone is as effective as injectable naloxone (King's News Centre, 2017) so should be considered as an alternative.

Some people with lived experience felt that the size of injectable naloxone kits are a barrier to carrying them around in their pocket. A trial to overcome this was undertaken in Lambeth where keyrings with ampoules of naloxone were given to those who were injecting substances so they would have a dose of naloxone on their person. This is only given to those who access the needle exchange, so they have clean needles for administering naloxone. This is an innovative solution to this problem and the keyrings were very popular and increased uptake of naloxone (Release, 2019).

# 6. Distributing Naloxone in our Organisations

FLIC team members reported mixed responses on the injectable naloxone training they received. Training should be detailed, include demonstrations of how to administer naloxone and be given in the context of wider harm minimisation strategies and awareness. Training should give team members the opportunity to ask questions and address common myths surrounding naloxone and its use. Alongside practical training on naloxone, team members must be given clear messages about the organisational policy and legal framework for distributing and using naloxone. The need for education is highlighted in the wider literature; research found that some Prison Officers believed distributing naloxone at the point of release from prison could act as a potential incentive or encouragement for using opiates when back in the community rather than viewing it as a harm reduction measure to reduce deaths (Sondhi et al 2016). As will be described in Question 10, there are a number of perceived risks associated with naloxone including myths about withdrawal. These highlight the importance of training around naloxone for both practitioners and staff and those using substances or with lived experience.

There should also be training offered to those using substances who are being offered or given naloxone and this should differ for those at different stages of recovery. Again, this should be linked into wider harm minimisation strategies and tools.

As previously mentioned, training and education around naloxone must be trauma-informed, recognising the trauma that can result from experiencing or witnessing overdose and/or naloxone administration. Training should acknowledge the different experiences of those receiving it and the impact these may have had.

# 7. Perceived benefits and risks

There were some concerns or perceived 'risks' associated with use of naloxone that were highlighted by those with lived experience and/or practitioners including; a perception that carrying naloxone would lead to criminalisation and/or stigma from services, perceived risks associated with withdrawal, and concerns about causing accidental harm.

Some people - both practitioners and those with lived experience - had concerns about the nature and impact of withdrawal experienced when naloxone is used, and the risks that this poses to both those administering and receiving naloxone. Some of these concerns appeared rooted in misinformation and stigmatising mythos, such as a belief that naloxone causes an intense withdrawal that triggers uncontainable, hyper-aggression. Other concerns emerged from a lived experience of tension arising from a disconnect between the experiences of those administering naloxone and those receiving it. One person with lived experience noted: "*They don't realise they are overdosing, they are so happy and safe. You*

*give it to them and they are just pissed off. The Paramedic had to tell him to be nice to me; I saved his life*!''. Another discussed the acute trauma that they experienced when responding to an overdose, stating that "*it doesn't go away*". This indicates the need for improved aftercare, including therapeutic support and conflict resolution, for all involved in an overdose.

Some people also disclosed concerns that the experience of withdrawal associated with use of naloxone could trigger high-risk use and injection practices. Several studies have found that withdrawal increases preoccupation with drug use and weakens consideration of possible risk (Hughes, 2004), leading to an increased probability of high-risk use practices. (Mateu-Gelabert et al, 2010). However, there is no evidence linking use of naloxone with increased high-risk drug use. On the contrary, the scientific consensus is that naloxone is safe, effective, and saves lives; naloxone is short-acting, cannot do harm, and withdrawal does not need to be long-lasting (Bennet et al, 2020). We believe it is essential that concerns relating to withdrawal are acknowledged and addressed comprehensively through training and public health messaging, to encourage use of naloxone.

One woman with lived experience disclosed concerns that distribution of injectable naloxone could lead to misuse and cause accidental harm. This was because she had known someone who had a fixation with needles as a result of their heroin use. However, this is again based on a misconception about injectable naloxone as the needles come pre-filled.

These perceived risks highlight the importance of training and education programmes to ensure that people feel confident in using and administering naloxone and have the correct and factual information. This includes both people using substances and practitioners and staff.

An additional risk factor identified by respondents was a concern that carrying naloxone would result in stigmatisation and/or criminalisation from support services. As previously noted, someone with lived experience reported concerns that receiving naloxone from the Police risked exposure to criminalisation as [they would] "*be on the Police's radar*''. To address this, they recommended that "*workers should be able to dispense* [Naloxone] *anonymously*". We support this recommendation and believe that this also speaks to the importance of implementing medical amnesty and *"good samaritan"* policies (Release, 2019).

This concern was heightened for those who are abstinent, and/or those who had recovered from physical dependency but still used opiates sporadically. People we support who are abstinent or have decreased substance use stated that they did not need or want access to naloxone, despite an increased risk of overdose associated with these use patterns (Frank et al, 2015), one man commented "*"I'm not using at the moment, so I don't want it or need it [naloxone]. I want to stay away from drugs, so why do I need it?"* . As Sondhi et-al note, this appears to relate to a static conceptualisation of 'abstinence'; '*a belief that once abstinence is achieved, any acknowledgement that future drug use is a possibility represents a sign of lack of commitment to recover*y' (Sondhi et al, 2016). Many respondents situated themselves as *'distinct from traditional heroin users*' (Frank et al,

2015) and external to opiate-using networks and, therefore, did not identify that they were exposed to risks relating to overdose and/or accidental harm. As Frank et al (2015) note, despite histories of high-risk use and multiple experiences of overdose, many people we work with struggled to access information on '*overdose awareness, avoidance and response strategies, in particular the use of naloxone'*. We believe that this indicates the need for targeted interventions to reach people in recovery and those not accessing treatment services, this should include training and public health messaging.

# 8. Potential risks impacting people with protected characteristics

Patterns of substance use and access to services are culturally contingent and intersect with wider inequalities (Kulesza et al, 2016). For example, women we work with report feeling *'doubly stigmatized''* as people with dependency issues, and for divergence from normative gender(ed) roles. This results in a marginalisation from treatment support, into privatized'hidden'' spaces where they are less likely to access outreach support (Kulesza et al, 2016). The women we work with experience specific barriers to accessing drug services including feeling unsafe in mixed environments where associates, partners, and men that they have experienced violence from are, and lack of flexibility in opening hours/appointment times which are impossible to attend when, for example, involved in street-based sex work. One woman commented on the need for *''a female run [drug] support service - for females only - only women staff and women attendees. Some females will not go to the support centre because there are males working there.''*

This is supported by research; the hyper-transient and under-visible nature of women's homelessness results in under-representation within homelessness settings (Betherton et al, 2018). In 2020 14% of rough sleepers were female and the majority of people accessing accommodation (64%) and day centres (81%) were male (MHLCG, 2021), (Homeless Link, 2021). The proportion of women accessing accommodation (28%) and day centres (19%) remains relatively low. This would indicate that the proposed amendments to extend exemptions are more likely to reach men. It is therefore is necessary to develop a gender-informed distribution strategy, and for exemptions to be extended to incorporate services most in contact with women, such as Domestic Violence charities (IDVAs/ISVAs), Rape Crisis Centres, Housing Officers, and assertive health teams (i.e. sex-work outreach services).

Data identifies further issues for people that identify as LGBTQIA+, who are under-represented within both day centre and accommodation settings, and for young people, who constitute only 14% of day-centre attendees (Homeless Link, 2019). Older people are under-represented within accommodation-based services, representing 14% of service users. We believe that it is essential that naloxone distribution is targeted at places

where people that identify with these groups have contact with the system, such as: LGBTQIA+ specialist services, youth services, and specialist health-care services.

People from Black, Asian and Minoritised groups (BAME) are disproportionately impacted by homelessness. In 2019/20, a quarter (24%) of people making homelessness applications to identified as BAME, despite constituting only a tenth (11%) of households (MHCLG, 2020). People that identified as BAME are under-represented in services, constituting 18% of those accessing accommodation and 16% accessing day centres (Homeless Link, 2020). As Polly Neate notes (Homeless Link, 2020), this is symptomatic of a "*deep inequality and systemic racism*" that renders BAME communities more vulnerable to homelessness, and under-served within essential support services. This indicates that proposals to extend naloxone dispensing to accommodation services and day-centres are more likely to reach white and non-BAME communities.

We believe that the proposals will increase the accessibility of naloxone to individuals with protected characteristics. However, as the above data indicates, this must be linked to strategies for redressing inequalities in the provision of health, housing, social care, and drug services. Consultation should be undertaken at local, regional, and national levels with community advocates/leaders, experts by experience, and specialist organisations to identify tailored strategies for embedding naloxone within marginalised communities.

Expanding access to naloxone is one element of a wider harm-minimisation agenda to reduce opioid-related deaths and injury (Release, 2020). This must be part of a whole-system approach, which addresses health inequalities and risk determinants on practice and policy levels. This needs to be tied to legislative changes, such as abolishing the system of NHS charges, removing the 'rough sleeping rule' as a ground for deportation, and ending the no recourse to public funds condition that pushes so many people into destitution. These policies create administrative and material barriers to accessing health, social care, and other statutory support, which disproportionately impact Black, Asian, and Minoritised communities and women (Wooley, 2019)(CAB, 2020). As services operating in London, where 45% of those rough sleeping are non-UK nationals (MHCLG,2021), we have witnessed the consequences of these policies, and the culture of fear they produce, which further marginalises non-UK nationals from support. This is supported by research (see Morgan, 2021). Therefore, it is necessary for exemptions to extend to migrant support centres, MSE and trafficking teams, and migrant specialist organisations. Furthermore, expanding access to naloxone must co-occur with efforts to improve access to health systems; for many individuals with protected characteristics, this necessitates the provision of high-quality immigration advice and advocacy support. Finally, health education and training should be provided in easy-read and translated formats, to reach those with communication or language-based needs.

# 9. Bibliography:


Bretherton, J., & Pleace, N. (2018). Women and rough sleeping: A critical review of current research and methodology

Drainoni, M. L., Koppelman, E. A., Feldman, J. A., Walley, A. Y., Mitchell, P. M., Ellison, J., & Bernstein, E. (2016). Why is it so hard to implement change? A qualitative examination of barriers and facilitators to distribution of naloxone for overdose prevention in a safety net environment. *BMC research notes*, *9*(1), 1-14.

EuroNPUD (2019) Peer-to-Peer distribution of naloxone: technical briefing. Available at: https://static1.squarespace.com/static/58321efcd1758e26bb49208d/t/5cc1d2ddec212dfb576a2c36/1556206418155/EuroNPUD_Technical_Briefing_P2P_Naloxone_web1.pdf

Frank, D., Mateu-Gelabert, P., Guarino, H., Bennett, A., Wendel, T., Jessell, L., & Teper, A. (2015). High risk and little knowledge: overdose experiences and knowledge among young adult nonmedical prescription opioid users. *International Journal of Drug Policy*, *26*(1), 84-91.

Gaston, R. L., Best, D., Manning, V., & Day, E. (2009). Can we prevent drug related deaths by training opioid users to recognise and manage overdoses?. *Harm Reduction Journal*, *6*(1), 1-8.

Homeless Link (no date) Health Needs Audit – explore the data. Available at: https://www.homeless.org.uk/facts/homelessness-in-numbers/health-needs-audit-explore-data

King's News Centre (2017) Concentrated naloxone nasal spray as good as injection. Available at: https://www.kcl.ac.uk/archive/news/ioppn/records/2017/11-november/concentrated-naloxone-nasal-spray-as-good-as-injection

Kulesza, M., Matsuda, M., Ramirez, J. J., Werntz, A. J., Teachman, B. A., & Lindgren, K. P. (2016). Towards greater understanding of addiction stigma: Intersectionality with race/ethnicity and gender. *Drug and alcohol dependence*, *169*, 85-91.

Office for National Statistics (2019) Deaths of homeless people in England and Wales: 2019 registrations. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2019registrations

Office for National Statistics (2021) Deaths related to drug poisoning in England and Wales: 2020 registrations. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2020

Release. (2019). Saving Lives: Best practice guidance on the provision of naloxone for people who might experience or witness an opioid overdose.

Shirley-Beavan, S., Roig, A., Burke-Shyne, N., Daniels, C., & Csak, R. (2020). Women and barriers to harm reduction services: a literature review and initial findings from a qualitative study in Barcelona, Spain. *Harm Reduction Journal*, *17*(1), 1-13.

Sondhi, A., Ryan, G. & Day, E. Stakeholder perceptions and operational barriers in the training and distribution of take-home naloxone within prisons in England. *Harm Reduct J* **1**3**,** 5 (2016). https://doi.org/10.1186/s12954-016-0094-1

Sondhi, A., Ryan, G., & Day, E. (2016). Stakeholder perceptions and operational barriers in the training and distribution of take-home naloxone within prisons in England. *Harm Reduction Journal*, *13*(1), 1-8.

UK Drug Policy Commission (UKDPC), July 2010. ISBN 978-1-906246-17-

Wheeler, E., Jones, T. S., Gilbert, M. K., & Davidson, P. J. (2015). Opioid overdose prevention programs providing naloxone to laypersons—United States, 2014. *MMWR. Morbidity and mortality weekly report*, *64* (23), 631.

Woolley, A. (2019). Access Denied: The Cost of the ‘No Recourse to Public Funds’ Policy. *London: Unity Project*.