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Drug harm reduction in the City of Melbourne: improving access to naloxone

**Prepared by: Samantha Colledge-Frisby^{1,2}, Louisa Picco³,
Suzanne Nielsen³, Paul Dietze^{1,2}**

1 Burnet Institute, Melbourne, Australia

2 National Drug Research Institute, Curtin University, Western Australia, Australia

3 Monash Addiction Research Centre, Monash University, Melbourne, Australia.

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Executive summary

City of Melbourne commissioned the Burnet Institute and Monash Addiction Research Centre to undertake the 'Drug Harm Reduction in the City of Melbourne' project. The [Future Melbourne Committee meeting](#), held on Tuesday 21 November 2023, resolved to improve access to naloxone, a medicine that reverses opioid overdoses. This was in response to the increase in opioid overdoses in the City of Melbourne. The project included a review of available evidence on opioid overdose response and best practices, expanding access to the opioid overdose reversal drug naloxone, and consultation with key stakeholders from a broad range of sectors and services about how to improve responses to opioid-related overdose and access to naloxone in the City of Melbourne. This report presents:

- A background statement.
- An overview of overdose education and TNH provision.
- Findings from the review of available literature.
- Summary of the roundtable discussion.
- Recommendations for improving opioid-related overdose response in the City of Melbourne.

At the time of writing the report the Victorian Government released their [Statewide Action Plan to Save Lives and Reduce Harm](#). This plan includes strategies designed to increase access to naloxone that align with some of the strategies and recommendations of this report. Where appropriate, this alignment is indicated.

The report included a **background statement** on the prevalence of opioid-related overdoses within the City of Melbourne, City of Melbourne's commitment to reducing opioid-related overdoses, and its current course of action.

The **overview of overdose education and naloxone provision** section discussed the effectiveness of naloxone in reversing opioid overdose and how its availability has been expanded through initiatives such as so-called 'take-home naloxone' (THN) programs which involve distributing naloxone to laypeople who may witness overdoses and training them in its use. In Victoria, THN was first available through small, targeted programs. However, in 2022 the Australian Government began investing \$19.6 million over 4 years to deliver a Pharmaceutical Benefits Scheme (PBS) subsidised THN program nationally through which naloxone is now available over-the-counter, without a prescription and at no cost, via participating community pharmacies. This PBS program also underpins the Victorian THN program that was established in late 2023, through which, other services (e.g. drug treatment services) can apply to be an 'Authorised Alternative Supplier' so their staff can distribute THN directly to potential overdose witnesses.

The **literature review** and **roundtable discussion** were guided by three questions:

1. Who should be able to access naloxone?
2. Where should naloxone be available from?
3. What are the barriers to naloxone access in the City of Melbourne?

Key findings from the **literature review** indicate the range of people who are at risk of overdose (e.g. people who use heroin, are on opioid agonist treatment, have been released from prison) and who may be present at an overdose (e.g. friends, family, first responders), highlighting that these groups should have access to naloxone. The review identified key access points, some of which were established, such as clinical settings, and others that were more novel, such as some first responder groups, and dispensing machines. A range of broad barriers to naloxone access were identified from the literature review that included recipient-level barriers, particularly barriers experienced by vulnerable or marginalised groups, in addition to a broader lack of knowledge and awareness of where to access naloxone from; distributor level barriers relating to stigma and perceptions about naloxone; and system level barriers such as naloxone shortages, implementation barriers and legal/policy barriers to distribute, carry and administer naloxone.

The **roundtable discussion** elaborated on the literature review. In addition to the key populations who should have access to naloxone identified within the literature review, participants identifying people who use drugs other than opioids (for example, people who use stimulant drugs like methamphetamine and people attending festivals who may use drugs) as an additional key population that should have access to naloxone. For specific key populations such as people recently released from prison, custody or courts, and people who are unstably housed, a range of specific interventions within the City of Melbourne were identified through these discussions.

Additional touchpoints identified via the roundtable discussion included train stations, public toilets, toilets within pubs and clubs, libraries, parks, car parks, festivals and events, hotels and motels reception areas, casinos and supermarkets. Specific groups within the community who were identified in these discussions as being able to help provide increased capacity for response if they carried naloxone included Protective Services Officers, authorised officers/ticket inspectors, security staff (e.g. outside entertainment venues), taxi drivers/rideshare operators and other outreach services such as the City of Melbourne Daily Support Team.

Roundtable participants identified additional system level barriers, including an absence of coordinated advocacy, unclear insurance and liability issues, a fragmented service system, which includes a complex multidisciplinary workforce, and a lack of promotion and positive awareness around naloxone, which are needed to normalise and de-stigmatise overdose response.

Based on the literature review and roundtable discussion, our **recommendations** are as follows:

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| 1. Advocate for the training of first responders, including police officers, fire fighters, paramedics, and other occupational groups likely to witness overdoses in overdose response, on naloxone administration, and THN distribution. |
| 2. Support efforts to reduce stigma towards people who are at risk of opioid-related overdose, through stigma reduction programs and potential media campaign. |
| 3. Advocate for the monitoring and evaluation of efforts to scale-up THN and its availability. |
| 4. Encourage the evaluation of naloxone effectiveness and impacts in the community using research. |

5. Support and influence the potential locations for naloxone supply and dispensing within CoM.

Acronyms

AOD: Alcohol and other drugs

ARC: Australian Resuscitation Council

CBD: Central business district

COPE: Community overdose prevention education

DOPE: Drug Overdose Prevention/Peer Education

NSI: Naloxone Subsidy Initiative

OAT: Opioid agonist treatment

PBS: Pharmaceutical Benefits Scheme

THN: Take-home naloxone

WHO: World Health Organization

Definitions

Alcohol and other drugs: a broad category of substances that can alter a person's mood, perception, and cognitive functions.

Brief interventions: structured, client-centred, non-judgemental counselling by a trained person using 1-4 sessions of shorter duration (typically 5-30 minutes)¹.

Central nervous system depressants: drug classes (e.g., benzodiazepines, alcohol, sedatives) that slow down brain activity, causing the muscles to relax and breathing to slow.

Laypeople: a person who does not belong to a particular profession or who is not expert or versed in a field.

Naloxone: a medicine that temporarily reverses the effects of opioids².

Opioid: a compound resembling opium in addictive properties or physiological effects.

Opioid agonist treatment (OAT): the administration of thoroughly evaluated opioid agonists, by accredited professionals, in the framework of recognized medical practice to people with opioid dependence for achieving defined treatment aims³.

Peers: people with lived or living experience of drug use.

Safer supply: the use of prescribed medications as a safe alternative to the toxic illegal drug supply, e.g. prescribed heroin or fentanyl provided as an alternative to street-based heroin or fentanyl.

1. Background statement: City of Melbourne's response to increasing opioid-related overdoses

Naloxone is a medicine that is used to reverse the effects of opioids, particularly in the case of opioid overdoses⁴. The Future Melbourne Committee meeting, held on Tuesday 21 November 2023, resolved to improve access to this medicine in the City of Melbourne. This action was prompted by an increase in heroin-related overdoses in the Melbourne municipality noted in the "Victorian overdose deaths" [report](#) released by the Coroner's Court in October 2023. This report showed that the City of Melbourne had the highest rate of heroin-related overdoses of any municipality in Victoria. The death rate more than doubled, from nine people in 2021 to 24 people in 2022⁵. This increase is also reflected in other data sources: analysis of Turning Point's AODstats, which examines alcohol and other drug (AOD)-related harms in Victoria, showed that there were 390 heroin-related ambulance attendances in the City of Melbourne during the 2021-22 financial year⁶, a 22% increase from the previous financial year⁶. Similarly, a not-for-profit community outreach team operating in the City of Melbourne observed a sharp increase in non-fatal overdoses between September 2022 and February 2023⁵.

In response to these recent increases in opioid overdoses, the City of Melbourne engaged the Burnet Institute and the Monash Addiction Research Centre to conduct the *Drug harm reduction in the City of Melbourne* project with its focus on improving access to naloxone.

The project aimed to:

- (1) Review available evidence around local government responses to drug-related harms, focused on opioid overdose responses, in particular naloxone access.
- (2) Conduct a consultation Roundtable with key stakeholders on how to best frame the City of Melbourne's response, particularly in relation to enhancing access to naloxone in the community.

This focus on naloxone access reflects that current strategies are suboptimal and that other key opioid overdose responses (i.e., opioid agonist treatment [OAT] and drug checking services) are important, but either have been planned or are available to constituents in the City of Melbourne.

This report provides an overview of:

1. Overdose education and naloxone distribution in Victoria, and Australia more broadly.
2. Findings from the rapid literature review, pharmacy/service audit and Roundtable undertaken for the project.
3. Recommendations to the City of Melbourne to help reduce opioid-related overdose fatalities in Melbourne municipality by improving access to naloxone.

At the time of writing this report the Victorian Government released their [Statewide Action Plan to Save Lives and Reduce Harm](#). This plan includes strategies designed to increase access to

naloxone that align with some of the strategies and recommendations of this report (particularly the plan to trial naloxone dispensing machines in a range of locations across Victoria). Where appropriate, this alignment is indicated.

Further details of the work undertaken, including the complete findings from the rapid literature review can be found in the Appendices of this report.

2. Overdose education and naloxone provision

Overdose education was traditionally targeted towards people at risk of overdose, with an aim to educate participants about key overdose risks (e.g., concomitant use of central nervous system depressants such as benzodiazepines) and limited responses. Studies have shown limited effectiveness of this approach in reducing opioid-related overdose or reducing risk behaviours⁷. In Australia, this kind of program has since been superseded by *overdose education and naloxone distribution or take-home naloxone (THN) programs*.

Naloxone, an opioid antagonist that reverses the effects of opioids, has been used to reverse overdoses for more than 40 years⁸. It is remarkably effective and has limited abuse potential or side effects. Established THN programs distribute naloxone to laypeople who may be present at an overdose to provide a more immediate response⁹. Such community responses to opioid-related overdose have been endorsed by the World Health Organization (WHO)¹⁰. The WHO recommends that 90% of relevant target groups (e.g. people who use opioids) should have received training for overdose risk and management, with 90% of those trained receiving naloxone, and 90% of those carrying naloxone with them or having it close to hand¹¹. Studies have shown that THN programs can achieve these targets, even when implemented in low-to-middle income countries¹².

In Victoria, THN first commenced with a small-scale implementation of a pilot overdose education and naloxone distribution program in 2013¹³. Prior to this pilot, overdose education was provided as a sole intervention, but as indicated there were mixed results when evaluated, with education alone not appearing to reduce harm. The Drug Overdose Prevention/Peer Education (DOPE) program was initiated by Harm Reduction Victoria. This initial work demonstrated the feasibility of THN program implementation in Victoria and led to the Government-supported Naloxone Subsidy Initiative (NSI) that commenced in 2017. By 2020, this involved some 27 outlets. The NSI supported naloxone distribution through a range of agencies, most commonly primary needle-syringe programs, operated by 21 different organisations. THN outlets used one of two mechanisms of supply, involving prescription, over-the-counter supply, or both, with all training provided under this program using a Brief Intervention format. In both cases, the NSI covered the cost of naloxone so that it was free for the client (with around \$300,00 allocated in 2020). The DOPE program continues to operate in Victoria alongside a second program operated by Pennington Institute (the Community Overdose Prevention Education [COPE] program). COPE trains workers within agencies on naloxone distribution. DOPE trains potential witnesses (primarily people who use drugs) and links them to naloxone supply sources.

In 2022, the Australian Government began investing \$19.6 million over 4 years to deliver a Pharmaceutical Benefits Scheme (PBS) led THN program nationally¹⁴. Under this program, originally piloted in Western Australia, South Australia and New South Wales, pharmacists can claim the cost of naloxone through the PBS program portal and receive a dispensing fee to cover the costs of pharmacy provision. In late 2023, the [Victorian THN Program](#) was established to enable implementation of the Commonwealth's program in Victoria¹⁴. It aims to improve the mechanisms by which THN is distributed in the community by approved organisations and workers¹⁵, building on the distribution previously supported by the NSI.

The Victorian THN program adds to existing channels funded under the Australian Government program that includes over-the-counter naloxone in local pharmacies or with a prescription from a medical or nurse practitioner. For a service other than a pharmacy to participate in the Victorian program, it must be approved by the Victorian Government as an 'Authorised Alternative Supplier' and follow the conditions of program participation as specified in the state guidelines. Approved organisations may order naloxone at no cost, and trained staff in the organisation can supply it. Approved workers must work or volunteer in a role listed in the Government approval and follow the conditions of program participation as specified. Due to the very recent implementation of the Victorian program, there is currently no complete, and easily available list of access points for naloxone. However, there is a list of [pharmacies](#) who have signed onto the Commonwealth program.

Mandatory training for the Victorian THN program covers: risk factors and overdose prevention; recognising an opioid overdose; overdose response, including contacting emergency services, administration of all types of naloxone, and the use of the recovery position. It also includes how to effectively communicate information on overdose response and the use of naloxone to consumers being supplied naloxone; and legislative information relating to the supply and possession of naloxone (i.e., who can supply naloxone, the legal status of naloxone carriage and authorised service providers).

The current framework of free naloxone supply from the Australian Government and support for naloxone training and rollout from the Victorian Government provides a suitable basis for achieving the WHO targets listed on page 7. Although, it is not currently known whether these targets are being achieved or monitored in Victoria. Evidence from a cohort of more than 1200 people who inject drugs (recruited across Melbourne from 2008 onwards, SuperMIX cohort) indicates that only 40% had received THN training from 2008 to 2021, despite a much higher proportion witnessing an overdose¹⁶. This suggests that there is a large gap between the reach of existing THN training and WHO targets.

3. Review and Roundtable findings

As indicated, the City of Melbourne has committed to increasing access to naloxone among those at risk of an opioid-related overdose and others who may witness an overdose and be able to respond⁴.

In response, the work for this project addressed the following guiding questions:

1. [Who should be able to access naloxone?](#)
2. [Where should naloxone be accessible from?](#)
3. [What are the current barriers and facilitators to naloxone access in the City of Melbourne?](#)

As indicated, the project involved a rapid literature review and consultation roundtable, as outlined below.

Rapid literature review. The literature review included a search of the peer-reviewed literature identifying systematic reviews of naloxone distribution and access published from 2014 onward. Targeted searches were also conducted to identify primary research on innovations in THN distribution. National and international experts were consulted to identify further opportunities and additional evidence to help inform these guiding questions (refer to Appendix A1 for further methodological detail on the review strategy and A2 for more detailed findings from the review). In addition, to assess the extent of availability of THN in the City of Melbourne, an audit of pharmacies, local hospitals, and other services was undertaken (presented in Appendix A3).

Roundtable. Melbourne's Lord Mayor Sally Capp invited alcohol and other drug experts from key organisations to a consultation Roundtable on Wednesday 27th of March 2024 at the Melbourne Town Hall. Roundtable participants provided their knowledge, ideas and experience on guiding questions through a mix of focused discussion and small group work. Participants were provided with a draft of the literature review and audit findings prior to the roundtable to help guide discussion. The list of invited organisations is provided in Appendix A4.

This report presents a summary of the literature review along with additional findings that emerged from roundtable discussions in relation to each of the guiding questions above, along with additional suggestions to improve access to naloxone identified during the project. As indicated, the Victorian Government's [Statewide Action Plan to Save Lives and Reduce Harm](#) was released at the time of writing this report and reference to the plan is made as appropriate.

3.1. [Who should be able to access naloxone?](#)

Literature review findings summary

The results of the rapid review combined with local knowledge of mortality patterns within the City of Melbourne, suggested that THN should be accessible to the following populations due to their increased risk of overdose: people using/injecting heroin¹⁷⁻²³; opioid agonist treatment

recipients^{17-19, 23}; people on opioid withdrawal programs^{18, 23}; people recently released from prison^{18, 19, 24-26}; people using concomitant central nervous system depressants^{18, 23}; overdose patients in hospital^{18, 27, 28}; and those with unstable housing¹⁸.

Other key populations that represent potential carriers of naloxone who could administer it to a person experiencing an overdose in the community were: police members and fire fighters^{19, 22, 27, 29-34}; peers³¹; and family, friends, or carers of people who use opioids^{18, 23}. The evidence suggests that THN training is acceptable and feasible among these populations, and that they could readily respond to an overdose if they carried naloxone.

In relation to first responders, there is a growing body of evidence about the utility of equipping them with naloxone for overdose response. For example, a recent pilot conducted in Western Australia, training police officers in overdose awareness and naloxone administration, found nearly 100% of participants felt confident in responding to an opioid overdose and would administer naloxone²⁹. In New York, police officers and fire fighters were trained in naloxone administration and reversed >80% of 800 overdoses over a two-year period (12% had unknown outcomes due to the individual being transferred to emergency departments)³⁰. The carriage of naloxone by police has now been expanded to many parts of the United States and Scotland^{33, 34}.

Roundtable discussion

The roundtable discussion supported findings from the literature review in terms of the populations who should have access to naloxone. In addition to these populations, people who use drugs other than opioids (for example, people who use stimulant drugs like methamphetamine and people attending festivals who may use drugs) were also identified as a key population that should be explored in relation to naloxone access. It was suggested that these groups may be increasingly likely to witness or experience an opioid overdose in the context of changes in drug supply.

The roundtable discussion also considered specific interventions within the City of Melbourne that target key populations including:

People recently released from prison, custody or court:

Discussions around naloxone distribution from Melbourne Assessment Prison following release suggested inconsistent on-release THN provision. Participants suggested that naloxone should routinely also be made available to those who require it and are released directly from court or police cells.

Patients released from opioid detoxification programs

It was agreed that naloxone should be accessible to people discharged from opioid withdrawal or detoxification programs (including when people self-discharge and on early discharge). Suggestions included providing education to people on discharge, particularly around the increased risk of overdose if they recommence opioid use.

People who are unstably housed

Youth projects opportunistically trains peers on overdose response and the use of naloxone. Currently, they use a voucher system for naloxone distribution (i.e., people are given a voucher to go and collect naloxone rather than being directly supplied with it). These vouchers are not always used, and there was a clear preference for directly providing naloxone which is possible under the new Victorian scheme. It is not clear whether other outreach services within the Melbourne CBD carry naloxone. Discussions with cohealth service providers after the roundtable indicated that they currently provide THN to clients who request it. This outreach work has been nominated as a specific target for enhancement under the Victorian Government's [Statewide Action Plan to Save Lives and Reduce Harm](#), but operational details are not yet available.

3.2. Where should naloxone be accessible from?

Literature review findings summary

There are many established clinical settings providing THN: pharmacies^{23, 35-38}; drug harm reduction services¹⁸; alcohol and other drug treatment services²⁵; primary care^{19, 25, 39, 40}; and hospital and emergency departments^{17, 19, 25, 31, 41-43}.

There is also evidence that first responders could be an access point for THN^{19, 27, 30-32}. For example, naloxone distribution has been piloted among ambulance services in Western Australia whereby paramedics provide opioid overdose education and naloxone (also termed 'leave-behind' naloxone) at overdose events³². The pilot found the 'leave-behind' intervention was associated with naloxone administration before ambulance arrival at subsequent overdose events. This resulted in speedier overdose reversal, as well as increased patient discharge at the scene (i.e. people who had received naloxone in the community prior to ambulance arrival were well enough that they did not need to be transported to a hospital) by nearly 10%, reducing impacts on hospital resources.

Additional access points identified in the review include upon release from prison and through dispensing or vending machines^{24, 44-47}. Dispensing or vending machines distributing THN have been established in parts of the United States⁴⁵⁻⁴⁷. All-hours access is a critical facilitator⁴⁵. A 24-hour, seven days a week accessible dispensing machine distributing a range of harm reduction equipment, was placed outside near a local harm reduction organisation in Cincinnati Ohio (population 310,000). Within the first 12-months of operation, 3,360 doses of naloxone were distributed, equating to 69% of all naloxone distributed within the county. It was estimated that the dispensing machine was responsible for 288 overdose reversals among a sample of 78 naloxone recipients who responded to surveys⁴⁷. In Clark County, Nevada (population 2.2 million), naloxone dispensing through these machines resulted in an estimated 15% reduction in opioid-related fatalities when compared to the expected trend for the first year post-implementation⁴⁶.

Roundtable discussion

In addition to the touchpoints identified by the literature review, a range of additional settings were identified. These settings included train stations, public toilets, toilets within pubs and clubs, libraries, parks, car parks, festivals and events, hotels and motels reception areas, casinos and supermarkets. Overall, there were suggestions to include naloxone as a standard item wherever other established points of medical intervention were located (e.g. alongside public defibrillators and/or first aid kits), and in dispensing machines or in ways that are otherwise easily accessible places within other identified settings. Participants discussed the need to better leverage the role of pharmacies for local naloxone distribution and engage GPs to prescribe naloxone to people at high risk of opioid-related overdose.

In response to the review findings, first responders were identified as a key touch point for naloxone for response during discussions. All Victorian ambulances currently carry naloxone for emergency response, but it was suggested that other first responders such as police and fire services could carry naloxone for response. Fire Services Victoria are actively developing processes for the carriage of naloxone as part of their standard first response equipment while Victoria Police are awaiting further developments in other Australian states before developing these. Ambulance Victoria are actively examining ways in which to provide naloxone.

Roundtable participants also identified specific groups within the community who would be able to help provide increased capacity for response if they carried naloxone. Protective Services Officers, authorised officers/ticket inspectors, security staff (e.g. outside entertainment venues), taxi drivers/rideshare operators and the City of Melbourne Daily Support Team as additional groups of people who should have access to naloxone for response. These people would not necessarily distribute THN but could be supplied naloxone to carry as potential overdose witnesses.

The Roundtable participants identified some key enablers for increasing the range of places that naloxone can be made available from. These included:

- The existence of the Australian Resuscitation Council (ARC) [guidelines](#) that now include provision for naloxone by laypeople as part of the resuscitation response, thereby enabling naloxone use to be considered a routine component of first aid response and first aid kits.
- Updated documentation (e.g. [policies and procedures](#)) reflecting the ARC guidance is needed for different professional groups could support implementation. Developing templates organisational use means that these can be easily duplicated/adapted to minimise the work needed to develop guidance for each new organisation looking to implement THN.
- Developing fit-for-purpose training for different groups in the community that are not part of the traditional harm reduction workforce was identified as a key enabler, given that current training is aimed at people with harm reduction knowledge/background. This

means training will need to reflect the level of expertise of specific target groups such as Protective Service Officers, security staff, etc.

- Clarity around what (if any) changes would be required to the Victorian Guidelines and/or Australian Government program so that funded naloxone can be accessed through the additional access points identified.

3.3. What are the current barriers to naloxone access in the City of Melbourne?

Literature review findings summary

Recipient level barriers

For people at risk of overdose, several individual-level barriers were identified in the rapid review. First, a higher proportion of marginalisation or vulnerability may inhibit THN access and carriage. For example, those who experience physical barriers due to a disability and/or without accessible means of transport, on low-incomes, or living in unstable housing⁴⁸. Second, a lack of awareness of naloxone, its availability and purpose, or where to access it from could be inhibiting demand for the product^{35, 48}. Finally, participant receptivity may be a barrier to THN access; however, this has only been reviewed from pharmacists' perspective^{35, 38}. Pharmacists perceived some patient-level barriers to be: a lack of interest in naloxone; resistance due to a lack of personal relationship with the pharmacist; and a lack of confidentiality³⁸.

Distributor level barriers

Stigma around opioid use is a major barrier to THN access. Stigmatising attitudes towards people who are at risk of overdose was a key barrier preventing potential distributors from engaging in THN programs or carrying naloxone⁴⁹. Normalised societal stigma also inhibited distribution due to fear of offending opioid patients by offering or recommending naloxone^{35, 38, 39}. Individuals seeking naloxone also feared being stigmatised by healthcare providers and the community which impacted on their ability/comfort to request or participate in THN programs^{2, 35, 48}.

Perceptions of naloxone have also acted as barriers to access. For example, the misconception that naloxone availability leads to riskier drug use, termed risk compensation^{2, 20}, is an identified barrier for some professional groups supplying naloxone. However, risk compensation has not been evidenced in the literature^{20, 50}. There are also concerns that administering naloxone will lead to aggression from the recipient going through withdrawal⁴⁸. However, a recent study investigating this found anger was less likely to be reported when participants communicated positively with the person who had overdosed, and more likely when participants criticized, chastised, or berated the person who had overdosed⁵¹. Further, an Australian study found the prevalence of either anger or withdrawal were very low with standard THN doses⁵².

Nevertheless, training around THN administration that addresses communication with the person who has overdosed will likely be helpful in addressing this concern.

Finally, lack of knowledge or awareness about overdose, naloxone, and the THN program were common barriers to access by distributors. This may extend to a lack of means to upskill staff on THN programs such that they would be knowledgeable enough, and comfortable, to train

potential recipients³⁵. Primary care physicians also expressed concerns about knowledge and resourcing to adequately educate their patients on THN administration and overdose awareness^{38, 39}.

Mass media campaigns that address overdose prevention may be an important tool for reducing stigma. In Scotland, the *'How to Save a Life'* campaign was rolled out in 2021 and raised awareness of the signs and symptoms of overdose, encouraging the public to carry THN⁵³. An evaluation of the campaign found that engagement was high (>57 million impressions) and positive (96% had positive view). It led to >40,000 visits to the campaign website and >3000 clicks to order a free naloxone kit⁵³. An online anti-stigma intervention has been developed and evaluated in Australia⁵⁴. In this evaluation, the online intervention led to a reduction in stigmatising attitudes about people who inject drugs⁵⁴.

System level barriers

Recent evidence around site and system-level barriers to THN access largely comes from the United States. For clinical settings, site-specific barriers were cost, time constraints, workflow and the roles and responsibilities of the distributor^{38 23, 25, 35}. Where THN programs exist, there have been stock issues and broader naloxone shortages documented in the literature^{37, 42, 47}.

Implementation barriers have been described for emergency departments specifically^{25, 42}. For example, clinical staff (doctors/nurses) could not agree on who should provide THN training when the public health worker who usually provided the education was no longer on shift.

There are legal and policy barriers reported in the evidence from countries outside Australia. Liability concerns exist for individuals wanting to distribute, carry or administer naloxone^{18, 35, 55}. Inadequate protocol or policy development have limited the scope for scale-up or wider distribution of naloxone^{2, 38}.

Roundtable discussion

Additional barriers identified through the roundtable discussion included:

- An absence of coordinated advocacy on expanding access to naloxone.
- A lack of proactive pharmacy support and promotion of naloxone availability.
- The absence (and need for) a coordinated mass-media campaign on opioid-related overdose and response, helping to normalise and de-stigmatise overdose response in particular.
- A lack of clarity around the insurance and liability issues facing workers who carry naloxone and use it in overdose response.
- Fragmentation in the way the service system works including recent loss of expertise in the relevant sections of the Victorian Government.
- The diversity and complexity of the workforces involved.
- Major myths around naloxone distribution and use (e.g. risk compensation described above) within minorities in some professional groups such as medical professionals.
- Currently it is unclear who is distributing naloxone, how much is being distributed and who is accessing it within the City of Melbourne. Access to coverage data to monitor

access and ongoing evaluation is critical. Suggestions were also made about identifying ‘hotspots’ where harm reduction posters could be displayed, increasing access points and providing information on specific pharmacies which stock naloxone or other locations where naloxone may be available.

3.4. Additional findings

- Coordinated messaging campaigns were identified as a key enabler to increase knowledge, acceptability and promote naloxone use. Simple messaging about naloxone use (e.g., ‘you just need a nostril and a thumb to save a life’) and the breadth of potential witnesses in the community (e.g., even my nanna has naloxone) could be used to normalise naloxone and help educate the public. Such campaigns could include information on the signs and symptoms of opioid overdose and how to respond.
- Availability of naloxone and instructions on its use as a standard part of emergency management protocols and planning at sporting, entertainment, and other public events.

4. Recommendations for consideration

Most overdoses in City of Melbourne are among people using heroin and other illicit opioids. Naloxone is available in the City of Melbourne, but coverage is limited due to social-structural (e.g., stigma towards people who use drugs) and connected individual-level (e.g. housing instability) barriers. Scale-up is urgently needed through increased availability and accessibility at all hours. The recent implementation of the Victorian THN program, underpinned by Australian Government funding, provides a platform for achieving these aims.

The recommendations below, drawn from the literature review conducted for the project as well as subsequent discussions at the Roundtable, are designed to build on endorsed harm reduction and treatment approaches already supported by the City of Melbourne.

Our recommendations are listed in Table 1:

Table 1. Recommendations for City of Melbourne to increase access to naloxone

Recommendation
1) Advocate for the training of first responders, including police officers, fire fighters, paramedics, and other occupational groups likely to witness overdoses in overdose response, on naloxone administration, and THN distribution.
2) Support efforts to reduce stigma towards people who are at risk of opioid-related overdose, through stigma reduction programs and potential media campaign.
3) Advocate for the monitoring and evaluation of efforts to scale-up THN and its availability.
4) Encourage the evaluation of naloxone effectiveness and impacts in the community using research.

5) Support and influence the potential locations for naloxone supply and dispensing within CoM.

Supporting information/Rationale:

Recommendation 1: A recent overdose is the most critical risk factor for a subsequent overdose⁷⁸. The evidence suggests that training first responders in naloxone administration, and their onward distribution of naloxone, may be highly effective^{19, 22, 27, 29-34}. These efforts could be supplemented by working to ensure outreach services and other occupational groups who may be likely to witness an overdose carry naloxone and are trained in overdose response.

Recommendation 2: Stigma and discrimination are major barriers to help seeking for people who use drugs. Specific, evidence-based anti-stigma interventions have been developed^{54, 56} and are required to address stigma as a key barrier to help-seeking by people who use drugs, and provision of healthcare and overdose response by those in the community (including those employed in first-responder and general healthcare roles).

Recommendation 3: Overdose response strategies are only effective when they reach the target populations involved. Ongoing audits of services that have higher contact with priority populations are essential for understanding how current efforts are progressing and the extent of THN coverage. This information will also be important for determining demand for ensuring adequate stock and supply.

Recommendation 4: Overdose response strategies are only effective when they are effectively used by the target populations involved. Existing studies that already routinely collect data on naloxone access and use can be efficiently leveraged to monitor progress (e.g. [the Illicit Drug Reporting System](#) and the [SuperMIX cohort](#)), in addition to bespoke data collection to determine the effectiveness of specific access points. Targets for naloxone access and use within City of Melbourne should be set and monitored, aligned with the WHO targets¹⁰.

Recommendation 5: Naloxone is included in ARC's first aid [guidelines](#). It should therefore be made routinely available through emergency response kits and public defibrillators that are available in various locations across the City of Melbourne. Dispensing machines offer 24-hours, seven days a week, anonymous service provision thereby alleviating several barriers to THN access⁴⁵⁻⁴⁷. Some of these changes will require a change of current [Victorian legislation that states](#) that medicine cannot be dispensed through a dispensing machine. Importantly, the Victorian Government's [Statewide Action Plan to Save Lives and Reduce Harm](#) aligns with this recommendation by including reference to an initiative to trial dispensing machines in Victoria.

Appendices

A1. Methods

In conducting this project, a search of peer-reviewed and grey literature sources was conducted along with an audit of pharmacy, service and hospital naloxone sources available in key areas of Melbourne municipality.

The strategy included targeted searches of recent peer-reviewed systematic (or similar) reviews published since 2014. It was out of scope to conduct a full peer-reviewed search of all overdose prevention strategies. Author expertise informed the search domains that were included.

To this end a search on overdose education and naloxone distribution was conducted through PubMed using key search terms. Search terms included 'naloxone', 'THN', 'distribut*', and 'review' to identify systematic, scoping, and rapid reviews. Reviews were included if they provided information on one of the guiding questions about THN: i) populations who should be supplied naloxone; ii) access points that should dispense naloxone; iii) barriers to naloxone access or THN program implementation. Once collated, information was extracted from the reviews that pertained to each of these questions and summarised. Where information was unavailable from reviews, targeted searches were conducted in peer-reviewed databases. Where local information was needed, targeted searches were conducted through organisation websites.

Two key, international experts were contacted by the project team to provide feedback on the findings and recommendations of the literature review.

In conducting the [pharmacy audit](#), a team member called individual pharmacies and documented their response to: current naloxone availability (including by formulation); whether the pharmacy typically stocked naloxone; and what the demand for naloxone was. In the [hospital audit](#), key contacts from Alfred Health, the Royal Melbourne, and St Vincent's were emailed for information.

The final report was developed based on the available evidence, the specific context of opioid-related overdoses with the City of Melbourne, and stakeholder/expert contribution through the Roundtable process. The remainder of these appendices details the initial review and audit findings along with the questions used to guide Roundtable discussions.

A2. Rapid literature review

This rapid review has three guiding questions:

[Who should be able to access naloxone?](#)

[Where should naloxone be accessible from?](#)

[What are the current barriers to naloxone access in the City of Melbourne?](#)

In answering these questions, the peer-reviewed literature was searched to identify systematic reviews of THN distribution and access published since 2014. Targeted searches were also conducted to identify primary research on more novel components of THN distribution.

Guiding question 1: Who should be able to access naloxone?

Table A1 presents a summary of available evidence from the rapid literature review. When this evidence is considered in the context of what is known about overdose harms in the City of Melbourne, we anticipate that scaling up access for people using/injecting heroin, on OAT, using concomitant central nervous system depressants, and who are unstably housed will provide a targeted response to some of the highest risk groups given the local overdose context (see Table A1 for references). While there are other populations that were identified in the peer-reviewed literature (i.e. patients prescribed opioids with chronic pulmonary, renal or hepatic disease), we are unaware of any evidence to suggest these groups have been implicated in the opioid-related overdose deaths observed within the City of Melbourne.

Other key populations identified from the peer-reviewed literature that may represent potential populations who could supply naloxone, or administer it to a person experiencing an overdose in the community, were police officers, fire fighters, peers, and family, friends, or carers of people who use opioids (see Table A1 for references). The evidence suggests that these populations are willing to be trained in THN administration and could readily respond to an overdose if they carried naloxone. The evidence suggests that THN programs that enrol these populations are feasible and acceptable.

The [Commonwealth](#) and [Victorian Government](#) THN programs make naloxone available to members of the community. While these programs make THN available, they do not ensure high access levels among priority populations, nor do they currently have a mechanism for monitoring coverage across the different potential witnesses to opioid overdoses.

First responders (excluding ambulance), such as police officers and fire fighters, do not carry naloxone in Victoria. A recent pilot conducted in Western Australia, training police officers in overdose awareness and naloxone administration, found nearly 100% of participants felt confident in responding to an opioid overdose and would administer naloxone²⁹. In New York, police officers and fire fighters were trained in naloxone administration and reversed >80% of 800 overdoses over a two year period (12% had unknown outcomes due to the individual being transferred to the emergency department)³⁰. The carriage of naloxone by police has now been expanded to many parts of the United States and Scotland^{33, 34}.

Table A1. Summary of evidence related to populations who should be able to access THN

Identified population	Supporting evidence
People who use or inject heroin and other opioids extra-medically	17-23
People prescribed high-dosage pharmaceutical opioids	18, 19, 23, 25, 35
People on OAT and people diagnosed with opioid use disorder	17-19, 23
Patients prescribed opioids with chronic pulmonary, renal or hepatic disease	18, 23
Patients attending the ED for overdose	18, 27, 28
People recently released from prison	18, 19, 24-26
People using opioids concurrently with antidepressants, benzodiazepines, or alcohol	18, 23
Patients released from opioid withdrawal programs	18, 23
People who are unstably housed	18
Law enforcement officers and fire fighters	19, 22, 27, 29-34
Peers	31

Identified population	Supporting evidence
Family, friends or carers of people who use opioids	18, 23

Guiding question 2: Where should naloxone be accessible from?

Table A2 presents a summary of available evidence from the rapid literature review. Access points include pharmacies, hospitals, first responders, primary care, alcohol and other drug services, harm reduction services, primary care, outreach and post-release programs, and vending machines.

THN distribution has been piloted among ambulance services in Western Australia whereby paramedics leave behind THN at overdose events³². The pilot found the 'leave-behind' intervention increased naloxone administration before ambulance arrival at subsequent overdose events, as well as increased patient discharge at the scene by nearly 10%. Other first responders, such as police officers and fire fighters, do not distribute THN in the City of Melbourne, but would likely have similar success to paramedics given high exposure to overdose, and success of similar programs established internationally^{19, 27, 30-32}.

Vending machines distributing THN have been established in parts of the United States⁴⁵⁻⁴⁷. All-hours access is a critical facilitator⁴⁵. A 24-hour, seven days a week accessible vending machine, which distributes a range of harm reduction equipment, was placed outside near a local harm reduction organisation in Cincinnati Ohio (population 310,000)⁴⁷. Within the first 12-months of operation, 3,360 doses of naloxone were distributed, equating to 69% of all naloxone distributed within the county. The vending machine was responsible for at least 288 overdose reversals among 78 naloxone recipients in the county, who re-enrolled in the dispensing machine program in the county⁴⁷. In Clark County, Nevada (population 2.2 million), naloxone dispensing through vending machines resulted in immediate reduction in opioid-related fatalities⁴⁶.

Additional settings for THN access

Paramedics in the City of Melbourne carry and administer naloxone to people who have overdosed; however, they do not currently distribute THN to laypeople or people at risk of an overdose. Information on the extent to which other workers involved in an outreach capacity distribute THN was limited at the time of the audit.

We did not identify evidence of dispensing machines distributing any harm reduction services in City of Melbourne (including sterile injecting equipment). Dispensing machines with sterile injecting equipment are available in other local government areas (e.g. Corio Community Health and North Richmond Community Health).

Table A2. Summary of evidence-based access points and availability in the City of Melbourne

Identified touch point	Evidence
Pharmacies	23, 35-38
Police	29, 30, 57
First responders (paramedics and fire fighters)	19, 27, 30-32
Harm reduction services (e.g. needle-syringe programs and supervised injecting facilities) and outreach settings	18
Alcohol and other drug treatment services (excluding those captured under harm reduction above)	25
Primary care	19, 25, 39, 40
Emergency/temporary housing shelters	
Hospitals and emergency departments	17, 19, 25, 31, 41-43
Prisons, justice/correctional settings, and post-release programs	24, 44
Vending machines	45-47

Guiding question 3: What are the current barriers to naloxone access in the City of Melbourne?

Based on the peer-reviewed evidence, there were a number of cited barriers to accessibility of THN, summarised in Table A3.

Barrier 1: Stigma

Stigma was the most commonly identified barrier to naloxone supply. Some distributors held negative attitudes about people who use illicit or extra-medical opioids that prevent them from being involved in THN programs⁴⁹. While described as a minority, the view among pharmacists, was the perception that naloxone availability will bring “undesirable” clientele into their business and have subsequent effects on their patronage. Stigmatising beliefs also impacted potential first responders, such as emergency or hospital staff, willingness to respond to an overdose or carry a THN kit⁴⁹. Normalised societal stigma was a barrier, such that clinicians (i.e., pharmacists, primary care providers) feared offending opioid patients by offering or recommending naloxone^{35, 38, 39}. Individuals seeking naloxone’s own perception of stigma, or being stigmatised, by healthcare providers and the community impacted on their ability/comfort to request or participate in THN programs^{2, 35, 48}.

Mass media campaigns that address overdose prevention may be an important tool for reducing stigma. In Scotland, the ‘*How to Save a Life*’ campaign was rolled out in 2021 and raised awareness of the signs and symptoms of overdose, encouraging the public to carry THN⁵³. An evaluation of the campaign found that engagement was high (>57 million impressions) and positive (96% had positive view). It led to >40,000 visits to the campaign website and >3000 clicks to order a free naloxone kit⁵³. An online anti-stigma intervention has been developed and evaluated in Australia⁵⁴. In this evaluation, the online intervention led to a reduction in stigmatising attitudes about people who inject drugs⁵⁴.

It is likely that stigma acts as a significant barrier to THN access in City of Melbourne. Among a cohort of people who inject drugs recruited from across greater Melbourne (SuperMIX), participants reported sometimes (30%), often (17%), or always (11%) experiencing stigma related to their injecting drug use⁵⁸. No evidence of dedicated anti-stigma programs was found addressing stigma about people who use drugs in the City of Melbourne, but some stigma-reduction work is likely the focus of local services. Ongoing coverage of the proposed supervised injecting facility in the CBD has likely increased stigma for people who use or inject drugs, which is known to reduce help seeking⁵⁹.

Barrier 2: Attitudes towards naloxone

Two common attitudes that act as barriers to naloxone access or program implementation are beliefs about the effects of naloxone itself. The first is the misconception that carrying naloxone leads to riskier drug use, termed risk compensation^{2, 20}. A systematic review identified that there was no change in heroin (or any other substance use) after naloxone access among people who use drugs²⁰. A recently published study using data from SuperMIX also identified that there was no increase in injecting frequency after THN access (as would be expected if there were evidence of risk compensation)⁵⁰.

The second is the perception that the withdrawal people experience from receiving naloxone will result in aggressive behaviour⁴⁸. A recent study investigated this issue and found that withdrawal symptoms and anger may actually be unrelated phenomena⁵¹. The study found that anger was less likely to be reported when participants communicated positively with the person who had overdosed, and anger was more likely when participants criticized, chastised, or berated the person who had overdosed⁵¹. They also found that withdrawal symptoms were unrelated to anger. Although this study was small, training around THN administration that address communication with the person who had overdosed will likely be helpful to address this concern. Further, an Australian study found the prevalence of either anger or withdrawal were very low with standard doses used with THN⁵².

Barrier 3: Population vulnerabilities

One review discussed barriers that may exist for populations who experience vulnerabilities and marginalisation in accessing THN from pharmacies⁴⁸. These barriers include stigma, noted above, in addition to physical barriers for those with a disability and/or without accessible means of transport, on low-incomes, or living in unstable housing⁴⁸. That THN may get lost, misplaced, or left behind during periods of transient housing was a barrier to ongoing naloxone carriage to ensure it would be available at the time of an overdose. The same review discussed the

importance of making THN available in common spaces of low-income housing, to better facilitate access to naloxone by this population.

In January 2024, an estimated [75 people](#) were sleeping rough on the streets of Melbourne's CBD each night. For every person sleeping rough, it is estimated there are an additional 21 people who are experiencing homelessness in City of Melbourne⁶⁰. Those sleeping rough are unlikely to have reliable spaces for storage of naloxone and are a key population who may benefit from readily accessible naloxone in public spaces and/or services that address barriers to naloxone possession.

Barrier 4: Knowledge and awareness

Lack of knowledge or awareness about overdose, naloxone, and the THN program were common barriers to access by distributors and individuals. For distributors, this extended to a lack of means to upskill staff on THN programs such that they would be knowledgeable enough, and comfortable, to train potential recipients³⁵. Primary care physicians also expressed concerns about knowledge and resourcing to adequately educate their patients on THN administration and overdose awareness^{38, 39}.

Among potential THN recipients, barriers to access were a lack of awareness of what naloxone is, its availability and purpose, or where to access it from^{35, 48}. For example, some patients may not know that they can access THN from their pharmacist³⁵.

The expansion of the Commonwealth funded THN program in Victoria was announced in December 2023, however the Commonwealth program did not fund implementation efforts to increase knowledge or uptake. Efforts made to increase public awareness of this are required to address this barrier. Ongoing work by Harm Reduction Victoria, cohealth, other outreach services and the Pennington Institute has supported the scale-up of THN training in the community. It is important to assess the extent to which further upscaling is needed in City of Melbourne. As an indication, the Illicit Drug Reporting System (an annual sentinel survey recruiting people who inject drugs from capital cities in Australia) reported that 79% of people who inject drugs in Melbourne were aware of naloxone, approximately equivalent to the proportion of people reporting recent heroin use⁶¹.

Barrier 5: Participant receptivity

Three reviews cited participant receptivity as barriers to THN access, although two were from the pharmacists' perspective^{35, 38}. For example, pharmacists perceived some patient-level barriers to be: a lack of interest in naloxone; resistance due to a lack of personal relationship with the pharmacist; and a lack of confidentiality³⁸.

There has been limited dedicated work to determine how these receptivity barriers apply in City of Melbourne and should be assessed at roundtable. Receptivity to THN will likely depend on who is supplying it. Among SuperMIX participants who had received THN training, most reported this was delivered by an AOD or outreach worker (45%), Harm Reduction Victoria (30%), a peer worker (6%), or community health centre (10%)¹⁶. Only 5% of people reported training through a GP and <2% accessed THN training through a pharmacist¹⁶. However, a study conducted in New South Wales found that among clients of AOD treatment and harm reduction services, most were willing to get THN from their GP (65%) or community pharmacy (80%)⁶². Participants were equally willing to access THN from a needle-syringe program (80%), AOD service (78%), supervised injecting facility (75%), peer-based organisation (74%), detox service (67%), or residential rehab (65%).

Barrier 6: Policy, systems and site limitations

Recent evidence around site and system-level barriers to THN access largely comes from the United States. For clinical settings, site-specific barriers cited were cost, time constraints, workflow and the roles and responsibilities of the distributor^{23, 25, 35}. Where THN programs exist, there have been stock issues and broader naloxone shortages documented in the literature^{37, 42, 47}.

Implementation barriers have been described for emergency departments specifically^{25, 42}. For example, clinical staff (doctors/nurses) could not agree on who should provide THN training when the public health worker who usually provided the education was no longer on shift.

There are legal and policy barriers reported in the evidence from countries outside Australia. Liability concerns exist for individuals wanting to distribute, carry or administer naloxone^{18, 35, 55}. Inadequate protocol or policy development have limited the scope for scale-up or wider distribution of naloxone^{2, 38}.

The Commonwealth and the Victorian Government’s THN programs fund the supply of THN, alleviating the barrier of cost. These national and state programs overcome the legislative barriers that exist around access for common touch points experienced in other parts of the world. Full implementation of this program is still underway in Victoria. That said, there is an ongoing legislative barrier to consider, current state legislation states that medications cannot be made available in vending machines limiting the scope of THN distribution⁶³.

Table A3. Summary of barriers to THN access and implementation and relevance to City of Melbourne.

Identified barrier	Evidence
Stigma	2, 18, 35, 38, 39, 48, 49
Attitudes towards naloxone	20, 48, 51
Vulnerable populations	48
Overdose/naloxone awareness and knowledge	2, 18, 35, 38, 39, 42, 48, 64, 65
Participant receptivity	35, 38
System/site-specific barriers	2, 18, 23, 25, 35, 37, 38, 42, 47, 55

A3. City of Melbourne naloxone availability audit

Available access points in the City of Melbourne

Additional local contact was undertaken to provide context for the review of the literature on access points. This involved contacting local pharmacies and hospitals and examining known relevant services located in the City of Melbourne.

Pharmacy audit

Nineteen pharmacies in City of Melbourne jurisdiction (3000 postcode) were called and asked if they stocked intranasal (Nyxoid), intramuscular pre-filled syringes (Prenoxad), or ampoules of naloxone (see Table A4). **Note that not all pharmacies that were contacted consented to have information published, so some pharmacies may not be represented.** Respondents at 13 pharmacies indicated they had signed onto the Commonwealth's national THN program (an additional two were unsure), and 14 currently or usually stocked some formulation of naloxone. Table A4 summarises the pharmacy audit findings.

Table A4. Pharmacy audit results

Pharmacy	Type			Demand indicated*
	Nyxoid	Prenoxad	Ampules	
HealthSmart Pharmacy Alfred Hospital	Yes (1-2)	No	Yes	1 every 1-2 months.
Chemist Warehouse Manchester Unity Building	No	No	No	
Chemist Warehouse Bourke St	Yes (OOS)	No	No	3-4 occasions.
Chemist Warehouse, Bourke and King Street	No	No	No	
Chemist Warehouse, Flinders Street	Yes (OOS)	No	No	Last month: 3-4 people.
Chemist Warehouse, William Street	Yes (12)	No	No	Order ampules as requested. Limited demand.
Chemist Warehouse, Melbourne Paramount Centre	No	No	Yes	0
Collins Place Pharmacy	Yes (1)	No	Yes	Not often, one every few months.
Creelman's Pharmacy	Yes (4)	No	No	Not a lot of demand.
HealthSmart Pharmacy VCCC	Yes (3)	Yes (OOS)	No	3 in Jan, 4 in Dec, 1 in Nov.
Terry White Chemmart Melbourne Central Pharmacy La Trobe Street	Yes (10)	Yes (OOS)	Yes (Narcan)	Demand is up and down, enquiries come through the methadone program.
My Chemist Elizabeth Street	Yes (1)	No	No	Only started stocking in January due to recent demand.
Priceline Pharmacy - QV	Yes (OOS)	No	No	In the past year a couple of people but not high demand.
Priceline Pharmacy - Bourke Street West	Yes (6)	Yes (2)	No	1 a week (mostly to people on methadone program).
Ramsay Pharmacy Melbourne CBD	Yes (2)	No	No	1 person every 2 months.
Chemist Warehouse Spencer Street Outlet Centre	No	No	No	Not provided.
Treasury Pharmacy	No	No	No	No demand.
Chemist Warehouse Melbourne Central	Yes (30)	No	No	20 a month.

Table note. Not all pharmacies that were contacted consented to have information published, so some pharmacies may not be represented. OOS: out of stock. * Demand indicated in February 2023.

Hospital audit

There are two public hospitals in City of Melbourne (the Royal Melbourne and the Alfred Hospitals), and one hospital that City of Melbourne residents would likely access (St Vincent's Hospital in Fitzroy). Alfred Hospital is an approved

participating site to supply Nyxoid free-of-charge. Eligible Alfred patients are people: with opioid use disorder; presenting with or at risk of OR witness to opioid-related overdose; and patients with opioid poisoning, overdose or intoxication within 90 days AND require an opioid upon discharge. The Royal Melbourne and St Vincent's Hospital are both on the list of participating sites in Victoria (29). It is unclear the extent to which they distribute THN and to whom, an audit of this information is currently underway.

Community health providing drug-related services

Desktop review of services based in the City of Melbourne indicated the following:

cohealth provide wraparound services operating in the City of Melbourne, (open 9am-10pm Mon-Fri, and 10am-6pm Sat-Sun). Their website indicates that they provide THN training on site. The cohealth website indicates that THN is unavailable from the City of Melbourne site. However, other cohealth sites (e.g. Collingwood) have THN.

The Living Room (open 9:30am-4pm Mon-Fri, 11am-4pm Sat, and 7pm-10:30pm Wed-Sun for afterhours service) are a primary health service providing free healthcare and other support to individuals who are at risk of, or experiencing, homelessness. Their website indicates that their 'foot patrol' outreach team provide naloxone training.

The Salvation Army Project 614, (7am-9am Mon, Wed and Fri, 10pm-3am Fri-Sat) provide coffee, food, hygiene essentials, counselling, support with housing and legal issues, and other healthcare. This service does not indicate on their website whether they distribute THN.

Additional service consultation will be integrated into the consultation roundtable processes undertaken for this project.

A4. Organisations represented at the Roundtable and contributed through consultation.

Invited organisation
Ambulance Victoria
St Vincent’s Hospital: Addiction Medicine
Royal Melbourne Hospital: Addiction Medicine
Fire Rescue Victoria
Health Projects
Alfred Hospital: Addiction Medicine
cohealth
Victoria Police
North Richmond Community Health
Harm Reduction Victoria
Youth Support and Advocacy Services
Penington Institute
Yarra Drug and Health Forum
Melbourne City Council
City of Melbourne
Pharmaceutical Society of Australia
People with lived experience of overdose and/or naloxone use

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