Release's response to the Department of Health and Social Care's Consultation:

Expanding access to naloxone: supply and emergency use

March 2026

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Release is the UK's centre of expertise on drugs and drug laws. The organisation was founded in 1967 and provides legal support, representation and drugs advice to people with a history of drug use or who are impacted by drug laws. Release also campaigns for evidence-based drug policies founded on principles of public health and human rights, seeking to reduce the harms faced by people who use drugs.

Release undertakes research analysing the impact of laws and policies on people who use drugs both within the criminal justice and health spheres. We have published multiple papers highlighting racial disparities in the policing and prosecution of drug offences in the UK, as well as demonstrating the global experience of drug decriminalisation. Our clients' experiences drive our policy work: we respond to Government proposals and consultations that impact the lives of the people we work with. This includes responding to housing policies, social welfare policies and other relevant areas.

Release is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations; a part of the Vienna NGO Committee on Narcotic Drugs (VNGOC) and the New York NGO Committee on Drugs (NYNGOC).

Release's response to the consultation on expanding access to naloxone is broadly supportive of any proposals which aid the adoption of the lowest possible threshold for naloxone supply throughout the UK.

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Response to consultation questions:

1. Expanding the route 1 list of services and professionals

We are proposing to add 3 types of services into the route 1 list of professionals and services who can supply naloxone for future use without needing a prescription. They are:

- hostels for people experiencing homelessness
- day centres for people experiencing homelessness
- outreach services for people experiencing homelessness

This is with the intention of expanding access to naloxone for people at risk of opioid overdose.

a. To what extent do you agree or disagree with the proposal to enable hostels for people experiencing homelessness to supply naloxone without a prescription through route 1?

- Strongly agree
- **Agree**
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

b. To what extent do you agree or disagree with the proposal to enable day centres for people experiencing homelessness to supply naloxone without a prescription through route 1?

- Strongly agree
- **Agree**
- Neither agree nor disagree

- Disagree
- Strongly disagree
- Don't know

c. To what extent do you agree or disagree with the proposal to enable outreach services for people experiencing homelessness to supply naloxone without a prescription through route 1?

- Strongly agree
- **Agree**
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

We are proposing to bring requirements for pharmacists supplying take-home naloxone in line with other route 1 suppliers by amending regulation 253 of the HMRs so that pharmacists are not required to make a record of such a supply.

d. To what extent do you agree or disagree with the proposal?

- Strongly agree
- **Agree**
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

e. If you have any further comments on these proposals, please include them here. (Optional, maximum 250 words)

Unhoused people are at disproportionately high risk of drug-related death, it is essential that all homelessness services can supply naloxone for future use as part of a broad harm reduction offer. However, to effectively address opioid overdoses in this group (and in the general population) naloxone should be as widely and easily available as

possible. Emerging findings from research Release is conducting in London and other UK sites confirm that people who use drugs are often excluded from hostels and day centres due to perceived anti-social behaviour and breaches of drug-related policies, among other reasons. Although some of those excluded may still be engaged by outreach services, we know that these services often struggle to reach women and young people that avoid bedding down in public spaces. Due to these indirect and direct exclusions, the linking of naloxone supply to specific services in the current legal framework is inherently problematic. To make sure all people experiencing homelessness have consistent access to naloxone, the Government should reform the HMR to enable supply to anyone at risk of, or likely to witness, an overdose - this should be the legal threshold for the lawful supply of naloxone. Otherwise, the government will continually have to expand the permitted list as it becomes clear it is not sufficient to meet the needs of the populations at risk. This will require more consultations, more legislative reform, when we need to be able to agilely respond to the crisis of drug related deaths among unhoused people.

2. Clearly enabling organisations whose employees are at risk of opioid contamination to procure and stock naloxone for emergency use

We are proposing to amend the legislation to clarify the definition of drug treatment services.

This is to end the uncertainty about whether certain organisations are able to procure naloxone for emergency use if they have concerns about opioid contamination or accidental exposure in a workplace. These organisations may include government enforcement authorities, such as Border Force and the National Crime Agency and private bodies performing public functions, such as lab testing facilities.

This is essentially a technical change that is not expected to have a direct impact on members of the public who are not performing specialist activities.

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a. To what extent do you agree or disagree with this proposal?

- Strongly agree
- Agree
- **Neither agree nor disagree**
- Disagree
- Strongly disagree
- Don't know

b. If you have any further comments on this proposal, please include them here. (Optional, maximum 250 words)

[No comments]

c. Aside from government enforcement authorities and lab testing facilities, do you know of any other organisations whose employees are at risk of opioid contamination who may benefit from procuring naloxone for emergency use?

- Yes
- **No**

d. Please explain your answer. (Optional, maximum 250 words)

We are unaware of any organisations whose employees are at risk of opioid contamination as an occupational hazard and reject that enforcement authorities' employees are at risk.

The likelihood that emergency responders face a clinically significant exposure to synthetic opioids is extremely low (see 2017 ACMT and AACT Position Statement) and as we have seen in the United States, this line of misinformation justifies "hyper-punitive criminal laws, wasteful expenditures, and proposals to curtail vital access to pain pharmacotherapy" (Beletsky et al 2020). Despite years of evidence surmounting this myth, in the United States police and paramedics have continued to believe they are at

risk of opioid toxicity (Winograd et al 2020). In the Winograd et al 2020 study, the authors show that a brief training effectively corrects this misconception. This form of intervention will be more cost-effective, and would contribute to a reduction in stigma on the topic of opioid overdose.

If we adopt a wider interpretation of the question of employee risk and opioid contamination, then all organisations employing people in the UK will have employees who might be at risk of opioid contamination – not as an occupational hazard but because drug use is widespread and synthetic opioids are contaminating multiple illicit drug supplies.

This is why we are calling for reform to the HMR to adopt the lowest possible threshold for naloxone supply, England, like Scotland and Wales, should adopt a national naloxone programme, centrally funded, ensuring wide availability of click and deliver programmes, and peer outreach.

3. Creating a new route of supply

We are proposing to amend the legislation to enable organisations and services to supply naloxone for public emergency use using the delivery model of a locked box.

a. To what extent do you agree or disagree with the proposal to enable the supply of naloxone through a publicly accessible emergency locked box, which can be accessed in the event of an opioid overdose?

- Strongly agree
- **Agree**
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don’t know

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b. To what extent do you agree or disagree that enabling the supply of naloxone through a publicly accessible emergency locked box model would be a helpful tool in increasing public awareness of naloxone?

- Strongly agree
- **Agree**
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

If a publicly accessible emergency locked box model was introduced, we propose the box would be supplied and operated as part of:

- the NHS
- another service that is funded wholly or partly by the appropriate national authorities or a local authority
- arrangements with the appropriate national authorities or local authority (that already have well established governance and training requirements)

c. To what extent do you agree or disagree that (if introduced) the publicly accessible emergency locked boxes should be supplied and operated by organisations that provide an NHS or other publicly funded service?

- Strongly agree
- **Agree**
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know
- Not applicable - I disagree with the proposal to introduce a publicly accessible emergency locked box model

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d. To what extent do you agree or disagree that (if introduced) the supply of naloxone in a publicly accessible emergency locked box should include both nasal and injectable naloxone products?

- Strongly agree
- **Agree**
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know
- Not applicable - I disagree with the proposal to introduce a publicly accessible emergency locked box model

e. If you have any further comments on these proposals, please include them here. (Optional, maximum 250 words)

[No comments]

4. Comments on the full legislation

The consultation document provides a summary of the proposals in the draft legislation. We have also included the draft statutory instrument to enable respondents to see the full detail. We welcome further thoughts on the finer detail of this legislation.

a. If you have any further comments on the detail of the draft legislation, please include them here. (Optional, maximum 500 words)

As outlined above we believe that legislative reform that simply adds organisations to Route 1 is burdensome, and unable to respond in a timely manner to existing and emerging risks within specific populations. We propose that the Regulations are amended to permit supply of naloxone by anyone who is engaged with someone who is likely to experience or witness an overdose.

Suggested amended text below:

237B.—(1) Regulations 214(1) and 220 do not apply to the supply of a naloxone product by an individual who is:

(a) to supply a naloxone product to another person in circumstances where it may be needed by that other person, or by a person or a category of person for whom it was supplied to that other person, for the purpose of saving life in an emergency;

(b) to administer a naloxone product to themselves or to supply or administer it to another person for the purposes of saving life in an emergency.

There is a presumption that the individual is supplying naloxone for either purpose laid out in (a) and (b) above.

In the absence of wider reforms we call for the inclusion of Further and Higher education institutions, including Student Unions.

The significant rise of synthetic opioids necessitates a proactive approach to naloxone distribution to mitigate the increased risk of overdose and death. Synthetic opioids are present not only in the heroin supply, but also in illicitly sourced benzodiazepines, as well as other controlled drugs used by this group. The dangers of unexpected overdose and drug-related deaths among these populations is therefore now much greater than it was at the time of the previous consultations. Young people who may not recognise these risks are far less likely to be engaging with drug and alcohol services, community pharmacies, or the other proposed services.

In addition, we are also concerned that peer distributors under the current likely permitted route of being "engaged" with drug treatment services could be dissuaded from providing naloxone. This requires that local naloxone providers must keep a record of all persons employed or engaged by them who are able and trained to provide medicinal products that contain naloxone hydrochloride. Individuals with relevant lived

or living experience with drug use may wish to support organisations through supplying naloxone as a peer but may also have reasonable concerns that being registered on the local naloxone provider's list could make their connections to drug using communities public. As such either our proposed legislative reform of permitting supply to someone likely to experience or witness an overdose, or an additional definition exception reflecting the role this group should be added to the S1.

We further support that naloxone be reclassified as a pharmacy only medicine, and not a prescription only drug, so that anyone who feels it necessary for them to obtain naloxone can do so without the barrier of getting a prescription or registering with an organisation listed in the proposed regulations.

b. Do you think the proposals risk impacting people differently, or could impact adversely on any of the protected characteristics covered by the public sector equality duty set out in section 149 of the Equality Act 2010 or by section 75 of the Northern Ireland Act 1998?

- **Yes**
- No
- Don't know

Please explain your answer. (Optional, maximum 250 words)

While the addition of services to the list of organizations permitted to supply through route 1 does not in and of itself adversely impact any particular group, the manner in which the current legal framework ties access to naloxone to a restricted list of specific services is problematic from an equalities perspective. These services are not accessed to the same extent by different groups of people experiencing homelessness. For example, the most recent census of women who were rough sleeping found that only 43% of those who completed the census access any homelessness service. Research from the Albert Kennedy Trust shows that only a third of young people who are LGBT+ sought support from services when they experienced homelessness, and over half of respondents reported experiencing discrimination for being gay or trans at the hands of services in general. Emerging findings from our own research into barriers to homelessness support experienced by people who use drugs suggest that being

neurodiverse can also put individuals at greater risk of being excluded from homelessness services, for example for anti-social behavior. Reforming the HMR to adopt the lowest possible threshold for entities to supply naloxone would increase access to naloxone among groups who are more likely to be excluded (either directly or indirectly, for example due to fear of discrimination) from services permitted to supply under route 1.

5. 'Rural proofing'

In Northern Ireland, any new or revised policies must be 'rural proofed' in line with the Rural Needs Act (NI) 2016. The Department of Health (Northern Ireland) has assessed this and does not consider that these policy proposals will affect people differently if they live in rural areas in Northern Ireland.

a. Do you agree or disagree with this assessment?

- Agree
- **Neither agree nor disagree**
- Disagree
- Don't know

b. Please explain your answer. (Optional, maximum 250 words)

We agree with the assessment that the policy proposals listed here will not differently impact rural residents in Northern Ireland, however we believe that the existing exemptions in the Human Medicines Regulations are not 'rural proofed' and that the proposals here are not enough to equalise naloxone access outcomes for rural dwellers.

The still-present limitations on who can supply naloxone will harm rural residents who reside further from access points or are more impacted by local community stigma if witnessed going into a drug service. While locked boxes may help to improve equity in overdose outcomes, criminalisation and stigma may still deter rural dwellers from contacting locked box service operators or emergency services.