Barriers and enablers to take-home naloxone access in Australia: A scoping review

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Introduction: *Since 2012, take home naloxone (THN) has become a key overdose prevention strategy in Australia. Rescheduling naloxone to 'Pharmacist Only' in 2016, followed by the national THN program in 2022, expanded free community access through pharmacies and other participating services. However, no comprehensive synthesis has examined barriers and enablers to provision/uptake, or their implications for workforce capability and equitable access.*

Methods: *A scoping review was conducted using JBI methodology examining Australian studies published from 2016 onwards involving providers, consumers at risk of opioid overdose and system stakeholders. Electronic databases and grey literature were searched. Two reviewers independently screened studies and extracted data. Findings were synthesised narratively using the Capability-Opportunity-Motivation Behaviour (COM-B) model [1].*

Results: *From 765 studies, 29 were included, comprising 4,451 participants (3,193 consumers, 1,258 providers). Consumer access to THN was influenced across all COM-B domains. Limited awareness and training (n=11 studies), stigma (n=10), cost (n=7), and fear of legal consequences (n=6) reduced Capability, Opportunity, and Motivation. Improved knowledge (n=14), training access (n=11), stigma-free, cost-free, and easily accessible services (n=6 each), and recognition of THN's life-saving benefits (n=6) supported engagement.*

For providers, barriers included limited training (n=8), concerns about encouraging risk-taking behaviours (n=6), and stigma (n=5) that hinders Capability and Motivation. Key enablers facilitating Capability, and Motivation were training, knowledge, and confidence (n=4 each), and belief in THN effectiveness (n=3).

Discussion and Conclusions:
THN provision and uptake are shaped by behavioural, structural, and workforce factors. Improving workforce capability through training and evidence-based education, alongside reducing stigma and legal concerns, may strengthen THN access and equitable implementation

Implications on communities, practice, and policy:

THN access may be strengthened through stigma reduction, community education, expanded community-based distribution, routine integration into healthcare settings, and consistent workforce training to support equitable national implementation.

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Reference

1 Michie S, van Stralen MM, West R. The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science.* 2011;6:42.