10 Year Housing and Homelessness Plan Overdose Prevention with Naloxone

Includes:

Final Report

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Overdose Prevention with Naloxone

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Abstract

The purpose of the present project was to research where there are take-home Naloxone programs worldwide, identify how Naloxone is administered in these communities and understand how the programs got started to potentially adopt a program in Peterborough, Ontario. After researching global programs, 5 were selected and sent an email questionnaire to gather information. The results showed that programs require national or provincial funding, only a doctor can prescribe the kits, injection is the most common method to administer the Naloxone and peers are the best option for training the at-risk individuals on proper use of the kits. The information obtained from the interviews allowed me to make recommendations on how to begin a take-home program in Peterborough. First there must be funding. Then, doctors need to create prescriptions for the kits that individuals can have after completing training. With the creation of a program, overdose deaths will be reduced in Peterborough.

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Key Terms

Addiction - compulsive need for and use of a habit-forming substance (as heroin, nicotine, or alcohol) characterized by tolerance and by well-defined physiological symptoms upon withdrawal (1)

Drug Strategy - recommendations for action and identify pathways to improve prevention, harm reduction, treatment and enforcement efforts in the community (2)

Intranasal - method of Naloxone delivery via a nasal spray (3)

Intravenous - method of Naloxone delivery via injection (3)

Medical Directive - an indirect physician order to allow patient care to be accomplished more quickly (eg. allowing those who are likely to overdose to have access Naloxone if they have received proper knowledge on how to use the medication when needed) (2)

Naloxone - aka Narcan, a safe medication with no abuse potential that ejects heroin and other opioids from receptors in the brain, reversing an opioid overdose (2)

Needle Syringe Programs - program intended to slow the spread of AIDS among IV drug users, in which a governmental or charitable agency exchanges sterile needles for dirty, potentially HIV-contaminated needles used by IV users when 'shooting' heroin or other substances (4)

Opioids - family of drugs that have morphine-like effects for the medical use of relieving pain (2)

Overdose - an amount of a drug or medicine that is too much and usually dangerous (5)

Introduction

The purpose of the present project was to build a database containing the details of the creative delivery methods of Naloxone as an opiate overdose prevention tool throughout the world. The availability of Naloxone has not yet been increased to a take-home level in Peterborough, Ontario (2). It was my duty to research the medical directives and the historical processes behind other countries and jurisdictions who have Naloxone programs and can distribute it to opiate users who are at risk of overdosing. This project was necessary since substance use has been identified by the Peterborough Drug Strategy as a main area of concern.

I worked with Kerri Kightly, the Strategy Coordinator, from the Peterborough Drug Strategy to complete this project. This organization is based on the four pillars of: prevention, harm reduction, enforcement and treatment to improve the health, safety and well being of all citizens in the County and City of Peterborough (2). This made-in Peterborough strategy aims to reduce the harm substance abuse has on the individual, their family and the community.

Opiates are a class of drug that include morphine, heroin, methadone, percocets and OxyContin (2). The City of Peterborough has had a growing opioid problem since 2007 as opiates slowly became the drug of choice over crack cocaine (4). As I conducted my research, I discovered some alarming statistics related to opiate use in Peterborough. The Peterborough Drug Strategy has identified that there is an average of 17 overdose deaths in Peterborough city and county per year (5). Also, between 2008 and 2010, 40% of all overdoses involved opiates and in 2011, Peterborough paramedics assisted 208 patients whose primary problem was an overdose (5). According to the Peterborough Social Planning Counsel, in 2008, 35 out of a total of 63 robberies in Peterborough were found to be directly related to drug use (4). An article titled "Illicit use & treatment for opioid dependence: challenges for Canada and beyond" published in

the Canadian Journal of Psychiatry, stated that as of 2009, Peterborough has the second highest rate of hepatitis C per capita in Ontario (5). This was mainly believed to be from the sharing of needles from intravenous drug use. In 2010, one quarter of all drug overdoses in Peterborough were due to opiates (4). Opiates became even more popular in Peterborough beginning in 2012 due to OxyContin being taken off pharmaceutical shelves (5). The Four Counties Addictions Services Team identified that the age of opiate users ranges from 12 to over 35 (6). This is a large range of users which makes it difficult to focus on a specific group of individuals to target and help. If Peterborough's opiate problem is not dealt with soon, more risks will be introduced to the city. This includes: more deaths, an increase in crime rate, loss of public confidence and negative moral towards officers who are currently trying to deal with the issue (6). Citizens will likely feel that officers are not doing their job properly when in reality, the issue of opiate users is too big for officers to handle alone although they are doing what they can.

As mentioned before, to prevent more people from overdosing, take-home Naloxone kits are needed. Naloxone works as an opiate antagonist when a person overdoses. When a person has taken a lethal amount of an opiate, that opiate blocks the receptors in the brain (7). When the receptors are blocked, the individual shows signs of an overdose. These signs include reduced or no breathing, reduced heart rate, unconsciousness and blue lips (7). When Naloxone enters the person's system, it bumps the opiates off the brain's receptors (7). This allows the person to regain consciousness and resume proper breathing and heart rate. Naloxone can be administered either intramuscularly or intranasally. The intramuscular method is currently the only legal method allowed in Canada (8). The cost of take-home kit in Canada is approximately $25 (9). The cost can be broken down as follows: $12 for the Naloxone, $3 for other components such as gloves and needles and $10 for distribution costs (9).

Naloxone also has other associated benefits with its use. It is a great tool to use because it has no abuse potential. The user will not become addicted to Naloxone. As well, if an individual overdoses more than once, Naloxone will work every time on that individual if administered in time. This is because people do not develop a tolerance to Naloxone. A final benefit is that Naloxone is easy to use, once an individual is properly shown how to administer it. Due to this, people who are likely to witness an overdose should have access to the kit too. The overdosed individual is unconscious and therefore needs someone else to give them the Naloxone. Most people do not use alone which is why this method of having trained peers is effective.

Take-home Naloxone kits are needed in Peterborough to save lives. Without them, Peterborough's opiate problem will only grow and cause more damage to the city. To identify the best approach for starting a program, I found answers to the following 3 questions: Where are there take home Naloxone programs throughout the world? How is Naloxone accessed or distributed in these communities? What is the medical directive (or historical community process) to Naloxone distribution in the communities being studied? By gaining answers to my research questions, I developed recommendations for beginning a program in Peterborough so the number of opiate deaths in Peterborough can be reduced.

Methods

I began the present project with research. I started with researching what Naloxone is, how to use it and how it works. This information was found by looking at the naloxoneinfo.org site and discussed previously in the introduction.

Once I had an understanding of Naloxone, I moved on to researching where programs were worldwide. I did this with a Google search for Naloxone programs. From this, I got a grasp of the locations of successful programs. I determined what a successful program was based on whether or not the program had its own website to share its information. Specifically, I looked at detailed information provided about the program. This included information on how the program came to be, who can prescribe or administer the drug, what form of Naloxone the kit included and how the program has had a positive impact on the community. I chose this criteria because it aided me when I created my recommendations for starting a program in Peterborough.

From the worldwide information I gathered, I created a report document for my host supervisor, Kerri Kightly, outlining the various take-home Naloxone programs. After she had read it, we both decided upon the key programs on which to focus. We chose programs that had various methods of access to Naloxone, various ways of administering Naloxone and programs that had successfully decreased the number of opiate overdoses because of take-home kits. Kerri and I identified 3 country-wide programs in Scotland, Estonia and Australia, 1 provincial-wide wide program in British Columbia, Canada, and 2 city-specific programs in Edmonton, Alberta Canada and in Baltimore, Maryland, United States. After that was decided, I went back to each program's website to obtain their email addresses. I chose to contact them each by email because it was universal.

Before emailing each program's organization, I developed what I was going to send to them. This included an introduction of myself, what I am doing and why. Next came a list of questions I developed that would provide me with the details I need to adopt a program in Peterborough. The draft email can be seen in Appendix A. After getting my email interview approved by my host supervisor, professor and Community Based Education representative, I sent the email out to the various programs on January 22nd, 2014, requesting a response by February 7th, 2014. I received generous responses from all programs except Baltimore. I received responses from Edmonton on January 30th, 2014, (Appendix B), Estonia on February 5th, 2014 (Appendix C) and I conducted a phone interview with a representative of the British Columbia program on February 5th, 2014, as well (Appendix D). I received a response from Australia's Alcohol Tobacco and Other Drug Association Act (ATODA) that suggested I contact the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) in Australia since they are the organization that delivers training and partners with general practitioners to prescribe Naloxone. I emailed CAHMA my interview questions on February 2nd, 2014 and received a response on February 3rd, 2014 (Appendix E). ATODA also gave me responses to my questions that applied to them, which can be found in Appendix F.

I sent a reminder email to the Scottish program on February 10th, 2014, since I was responded to on January 23rd, 2014, stating that I would receive a response from them at a later date. On March 5th, 2014, I received an email response from the Scottish program (Appendix G). From all of these resulting responses, I created my recommendations of best practices for developing a Naloxone take-home program in Peterborough.

Results

The results of the project can be seen through Appendixes B-G.

In summary, take-home Naloxone programs have been successful in reducing and reversing opiate overdoses around the world. Since Naloxone is a medical drug, it must be prescribed to an individual by a medical doctor or physician in order for the at-risk individual to have it.

Some programs require the at-risk individual and/or individuals who are likely to witness the overdose, such as family members and friends, to complete a training session before the individual is prescribed the drug. The training can include information on how to recognise an opiate overdose, how to administer the Naloxone, what the risk factors are for an opiate overdose and how to receive more kits if necessary. A couple of the programs studied suggest that training be done by peers of the users. In other words, have people that previously had a substance use problem themselves teach the targeted audience. This provides a level of credibility with the at-risk users and encourages them to obtain a kit.

The funding for a program comes from either the country's national government or provincial government, depending on whether a program is country-wide or specific to an area within a country.

The most-commonly used method of administration for the kits is the injection method. Some kits contain pre-filled syringes while others contain vials of the drug and empty syringes that need to be filled. Again, the full results can be seen in Appendixes B-G.

Discussion

The results of the project gave clear answers to my initial research questions. I discovered where there are take-home Naloxone programs throughout the world, I identified how Naloxone is accessed and distributed within these programs and I gained information about the historical community process that led to Naloxone being available in the communities I chose to study. All of the corresponding information can be found in Appendixes B-G. This allowed me to make recommendations for best practice and rural delivery methods of Naloxone. The recommendations are discussed below.

Receiving responses from all of the programs I contacted allowed me to outline what needs to be done in order to create a take-home Naloxone program in Peterborough, Ontario. The 1st thing that needs to happen is funding. Funding would likely come from the Ontario Ministry of Health since Canada does not have a country-wide program. To obtain this funding, the Ontario Ministry of Health needs to be contacted by the Peterborough Drug Strategy and convinced that Peterborough has an opiate problem that can be greatly reduced with a take-home Naloxone program. I believe informing the Ministry of Health of the statistics presented earlier in the report along with the success stories of other programs could influence them to provide funding. If funding is ever provided, it would likely be for injection kits since they are the most effective and least-expensive. It would be great to be provided with pre-filled syringes in the kit so that administration can occur quicker but as of right now, all programs in Canada contain the vial of Naloxone and empty syringes in the kits.

Next, physicians within Peterborough would need to be informed about Naloxone and how the kits work so they can prescribe them to individuals in need. This again would likely be done by the Peterborough Drug Strategy. After medical doctors are on board with the program,

people who will train the at-risk users need to be selected. This can include physicians if some users do go to the hospital looking for help but it can also include nurses or peers as mentioned before. It is important for the trainers to be approachable, non-judgemental and knowledgeable so that the individuals coming to receive the training feel comfortable. This is why it was suggested that trainers be peers of the users so that they feel comfortable when going through the process of obtaining a kit. There also needs to be a system put in place for how an individual receives the prescription after completing the training. The most realistic method I think is having a trainer sign-off on a pre-written prescription after the individual completes the training. This is similar the method that Streetworks uses in Edmonton, Alberta as they have a registered nurse sign-off on the prescription.

The final step in creating a take-home program is making the targeted population aware that this is an option for them. The Peterborough Drug Strategy works closely with the local police and so I'm sure that both parties know individuals who could benefit from a kit. Once these individuals are reached, I think it would easily spread by word of mouth that this life-saving medical drug is available to at-risk individuals.

If a take-home Naloxone program does develop in Peterborough, it would be important to inform first responders about the kits as well. As Ash from British Columbia brought up in my interview with her, first responders will likely confiscate a kit if they arrive at a scene and see someone using it. This is because they would see someone stabbing the overdosed individual with a syringe and assume the worst when really that individual is trying to save the overdosed individual's life. So if first responders are aware that people will be carrying these kits with them and know what they look like, this problem will easily be avoided.

In a perfect world it would also be awesome to see Naloxone available to all first responders. Paramedics do have Naloxone in the ambulance but if police officers could carry it with them in their vehicles, it may help in saving lives since they could arrive at an overdose scene first. Although this would require more funding and even changes to legislation, it would be more beneficial to users if they overdose and no kit is available or nobody is there to administer the Naloxone.

Even better would be having Naloxone available over the counter at pharmacies. If pharmacists could inform an individual about its use, Naloxone could be in the hands of more people. It is great to have Naloxone prescribed to the user, but it is up to someone who witnesses the overdose to use the kit. If friends and family members can have their own Naloxone kit, it would be beneficial to the user in case they do not have their kit with them even though they should have it with them at all times.

It is my hope that this project can help with the creation of a take-home Naloxone program in Peterborough, Ontario. It has been identified that Peterborough has an opiate problem and members of the community are dying because of it. A take-home Naloxone program would reduce and potentially eliminate these deaths which would benefit the community as a whole and be a step in the right direction towards diminishing Peterborough's drug use problem.

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Appendix A - My e-mail interview questionnaire

Hello,

My name is Meghan Zettler and I am a fourth year university student pursuing a Forensic Science honours degree at Trent University in Peterborough, ON, Canada. As part of my final year, I am working with the Peterborough Drug Strategy to research successful take-home Naloxone kit programs worldwide so that these medical directives can be learned from and hopefully can be adopted here. Learning more about your program would be immensely helpful. Please answer the following eleven questions to help me with my research.

Give your name and title within the organization.

Give a brief overview of the organizations purpose and/or mandate.

What are your specific duties within the organization?

Give a brief history about how the distribution of Naloxone was initiated.

What are the medical directives behind the distribution of Naloxone in your area?

In what ways does the organization distribute naloxone? (e.g. injection, nasally)

Who can administer/prescribe naloxone kits and how did they obtain this ability?

Where does the organization obtain funding from?

Has your organization been successful in reducing the number of opiate overdoses in your community? How do you measure this? Do you have any corresponding statistics?

What are the future goals of your program?

Do you have any suggestions or advice for an organization that is just starting a program?

Thank you for your time and consideration. If you have any questions or concerns please feel free to contact me via email or phone (contact info below). As this research project is time sensitive, I am requesting a response by Friday February 7th. If you are interested in receiving a copy of the final report please let me know and I will be happy to share it with you in May 2014.

Meghan Zettler

Email: meghanzettler@trentu.ca

Appendix B - Edmonton's Response DATE

Hi Meghan,

My name is Mathew Wong, I am Nurse Educator at Streetworks, Edmonton's Needle Exchange Program. Here at Streetworks, I head the Overdose Prevention Program, the first community based naloxone distribution program in Canada. I suppose this introduction counts as an answer to question #1, so I will jump onto the others for you.

2. Streetworks, Edmonton's needle exchange program, is based on the principles of harm reduction, health promotion, and primary health care. The Streetworks Harm Reduction approach would be defined as a set of non-judgmental strategies and approaches, which aim to provide or enhance the skills, knowledge, resources and support people who inject drugs and sex workers (target population) need to live safe and healthier lives. People become connected to agency staff that they trust, and the staff can then help them navigate the complex medical and social service systems such as detox and treatment centers.

3. In addition to managing, promoting, and executing our Overdose Prevention Program, as a nurse in an inner city community centre, I have several other duties as well. Our program has a nurse's station which acts as a gateway for the most basic and essential of health services for a marginalised population the faces many barriers towards that health care. We provide STI and blood borne pathogen testing, wound care, immunisations, physical assessments, referrals and advocacy. Much of our work involves education and empowerment, not only for our clients we serve, but also for professionals and students alike.

4. Our program began as a pilot research project in 2005. It was headed by an emergency physician , Dr. Kathryn Dong, and Streetworks program manager, Marliss Taylor, along with several other inner city physicians. The issue of overdose was brought to the attention of these

individuals when they saw firsthand how many overdoses were happening and how little concrete surveillance was happening. The program was modeled after Chicago Recovery Alliance's overdose prevention program, the first of its kind in the United States. After an 18% reversal rate in the first year, Streetworks continued to fund the essential program.

5. Currently there is no widespread medical directive for the distribution of naloxone in Alberta. We are currently able to distribute naloxone solely due to an inner city physician's eagerness and willingness to support the program by prescribing and overlooking the program. After a client comes in, gets trained, he is handed a kit with a special prewritten prescription for the naloxone that is cosigned by a Registered Nurse. Several regulatory bodies such as CARNA, the RN nursing body Alberta, were consulted to ensure that these practices fit within the RN's scope of practice.

6. Naloxone is distributed in the injection formulation in 0.4mg/ml single use glass vials. In the kit we provide 3 mL syringes with 25 gauge 1 inch needles for administration. Currently, in Canada, intranasal naloxone is not yet available. (There are also a great deal of cost associated with intranasal naloxone, ie. the intranasal adapter costs approximately 4 dollars for each piece).

7. As mentioned earlier, in our program, our lone inner city physician is the prescriber, and the nurses cosign his prescription to distribute it. In order to receive the naloxone kit, clients must complete the training session with an RN.

8. The original pilot project was funded from what was formerly known as Canada's Drug Strategy. From 2007 after, the program was taken into the core Streetworks programing. Two thirds of Streetworks funding comes from the Alberta Community Council on HIV, and one third comes from Alberta Health Services.

9. Our successes come in many forms. Overdose training in and of itself is a very empowering tool. We have several clients who have drastically changed their patterns of drug use after completing the training, and some have even quit all together. In terms of stats, our stats are quite humble compared to larger scale programs across Canada and the United States. As of today, we have trained 167 individuals and renewed training for 72, so far we have 24 reported successful reversals thus far. This successful overdose reversal rate of 10% is very consistant with all other community based naloxone distribution programs. However, just as a note, due to nature of our work and the clients we serve, coming back and reporting what happened to people and their kits is a difficult task.

10. There is the hope in Alberta that eventually the legal and political landscape is in place to allow for overdose prevention training and naloxone to be in the hands of every single person that needs it (That includes the friends, family and people who love people who use drugs, and also professionals like police officers). There is also the hope that at a societal level, stigma of drug use and drug overdose death is eliminated so that fathers, mothers, brothers and sisters can mourn for their loved one without discrimination.

11. Stats and evidence can be a powerful tool, however, you will find that in Canada, surveillance of overdose is extremely fragmented and lacking. There are sadly so many whose lives have been deeply impacted by drug overdose death. It is here, in these stories of tragedy and triumph, that many programs and policy makers have found their successes.

If you have any further questions, please do not hesitate to ask. I would be very interested in seeing your final report.

Cheers,

Mathew Wong RN, BScN

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Appendix C - Estonia's Response

Dear Meghan,

please find responses below, after the questions.

Give your name and title within the organization.

Aljona Kurbatova

Head of the Infectious Diseases and Drug Abuse Prevention Department

National Institute for Health Development

Give a brief overview of the organizations purpose and/or mandate.

The National Institute for Health Development is a government established research and development body collecting, connecting and providing reliable national information from a multitude of sources, related to the health of the Estonian population. We engage in public health related research and health promotion as well as development and implementation of disease prevention programmes and activities. More information: http://www.tai.ee/en/about-us/national-institute-for-health-development

What are your specific duties within the organization?

The main aim of our department is implementation of national strategies and action plans on drug addiction, HIV and tuberculosis prevention, as well as initiation and implementation of national and international cooperation projects. more information: http://www.tai.ee/en/about-us/departments/infectious-diseases-and-drug-abuse-prevention-department

Give a brief history about how the distribution of Naloxone was initiated.

In recent years Estonia has had the highest rate of overdose related deaths in EU. The preparations for the launch of naloxone programme started in the beginning 2012 when first

seminar on the topic took place and partners from different institutions exchanged their ideas on possible design of the intervention.

The take home naloxone program in Estonia was launched in September 2013. The program started with training on naloxone/ overdose prevention and naloxone distribution medical doctors who then continued to educate target groups and provide them with naloxone kits.

The program became possible thanks to the joint effort of different governmental agencies (including State Agency of Medicines, National Health Board), drug treatment and harm reduction organizations who joined the program lead by National Institute for Health Development to elaborate the best model for Estonia. Initiative was supported by international colleagues from Eurasian Harm Reduction Network and Scotland.

What are the medical directives behind the distribution of Naloxone in your area?

There are no special medical directives. Work is organised based on the Medicinal Products Act and Organisation of Healthcare Services Act.

In what ways does the organization distribute Naloxone? (e.g. injection, nasally)

Naloxone kits with pre-filled syringes. The Prenoxad Injection is used.

Who can administer/prescribe Naloxone kits and how did they obtain this ability?

According to the national legislation only medical doctors can prescribe naloxone.

As in Estonia it is not possible to distribute naloxone for civil society organizations. Legislation supports only distribution of the naloxone by medical doctors as it is a prescription drug. Therefore the program is structured so that healthcare institutions, mostly drug treatment agencies (doctors), and needle-syringe programs (NSP) work in collaboration. NSPs spread the information among the target groups, recruit trainees and arrange trainings at least once a week. Doctors come to the NSP to conduct the training and after the training and knowledge test they

distribute naloxone. No prescriptions are actually written, but so-called patient lists are generated and distribution of naloxone is documented according to national legislation.

Where does the organization obtain funding from?

Programme is fully funded from state budget (by national government).

Has your organization been successful in reducing the number of opiate overdoses in your community? How do you measure this? Do you have any corresponding statistics?

Naloxone programme starte in Estonia 4 month ago, therefore it is too early to make any conclusions.

What are the future goals of your program?

Increase is planned both in number of sites and kits in the next years. It is planned to distribute at least 1000 kits per year and to gradually involve all harm reduction services in the program.

Do you have any suggestions or advice for an organization that is just starting a program?

It takes time and patience to find the most suitable program design and legal possibilities, however there is always a solution. Often it is not necessary to elaborate a completely new service or change the law. As much as possibe take-home naloxone programs have to be based or linked to already existing harm reduction and drug treatment services.

Kind regards,

Aljona Kurbatova

Head of the Infectious Diseases and Drug Abuse Prevention Department

National Institute for Health Development

Appendix D - Phone Interview with British Columbia

M - Meghan speaking

A - Ashraf speaking

M - Uhm ok, before we start, are you ok with me recording this?

A - Yes that's fine.

M - Ok perfect. Uhm ok so can we just begin with you giving your name and your title within the organization?

A - Mhmm my name is Ashraf Amlani and I am the Harm Reduction Epidemiologist at the BC Centre for Disease and Control

M - Awesome, thank you. Uhm could you give me a brief overview of BC's uh organization and their purpose and the mandate?

A - Mhmm we have a, in BC we have a centralized harm reduction program so all of our harm reduction supplies are distributed through BC's CDC and we have sites in the communities that are authorized by our 5 regional health authorities to order supplies through us and uhm they send in the orders and we provide the supplies and that way we can keep track of how many supplies are being uhm distributed across the province and then because we are also uhm the centre for disease control and keep tabs on community disease numbers so we can relate back the supply distribution patterns to the trends in HIV, Hep B and Hep C cases across the province especially in uhm injection drug using populations. Uhm overall our program seeks to reduce harms associated with and kind of substance use and so we offer a wide variety of supplies for safer injection safer inhalation and overdose prevention.

M - Ok awesome thank you. Uhm do you, specifically yourself, have any like duties within your organization?

A - In terms of what?

M - Uhm just like what you would do on a daily basis.

A - So I coordinate the Take Home Naloxone program uhm and I'm also one of the 2 people that manage the entire harm reduction program so pretty much anything to do with harm reduction comes under my portfolio.

M - Ok awesome, thank you. The website actually answered a lot of my questions I had in the email, which is awesome and the article I found about the uh the like numbers about the overdoses that you didn't know about, that was really interesting. Uhm, so a couple of the questions I couldn't find answers to were uhm where does the program obtain its main funding from?

A - So we're funded uhm through the BC Ministry of Health. Uhm yea so our funding come directly from the Ministry of Health and we actually uhm work really closely with our ministry partners so uhm we have one of the committees that I uhm that my boss does lead in harm reduction, she co-chairs with uhm the director of problematics substance use at the ministry and they both co-chaired harm reduction strategies and services committee which uhm includes members from the different regional health authorities as well as people from the ministry and from the BC centre for disease control and we basically meet 4 times a year and come up with uhm the strategy for the province. What the needs are, how our services are being delivered, what our supplies numbers look like where we need to kind of put in more energy where we need to maintain the program. And uhm once a year what we do is we actually invite people who use drugs into our meeting so we have a face-to-face meeting usually in spring uhm and we invite uhm each health authority representative to bring 2 people who use drugs from their uhm region to come to our meeting and actually help inform our planning. So they mention thing to improve

our process so we can then be held accountable for what we're doing but also uhm know that, the impact of our services is sort of whether they're meeting the needs of the population that we're trying to serve.

M - Oh ok that actually answers another one of my questions which was just like getting the information out to the users that like this option is available to them but that's really cool that they go to the meetings and stuff. Uhm yeah, another question I have is the new site registration form that you guys have on the website, is that specifically for BC only?

A - Yes it's for the program because we are BC only program. Uhm, yeah. Unfortunately you have to be within BC in order to be able to get kits from us but we, having said that, we uhm actually provide a lot of our material in terms of uhm the context that's available on the website and the training materials to other groups that are starting Take-Home Naloxone programs in other regions.

M - Right.

A - So I'm part of, I don't know if you've heard but the Canadian Drug Policy Coalition has an overdose working group and so they've got people from across the region that are either in the mix of starting a take-home naloxone program or some sort of overdose prevention program or already have a program in place and uhm it's a mix of community-based agencies and uhm provincial organizations like ourselves so uhm it very much is a place where for all of us to kind of explore how we can move this further.

M - Yea my host uh organization was telling me about that too so I've been looking into that as well. Uhm, another question I have is I know your kits use the uhm injection form of naloxone, uhm, has your program ever considered using the intranasal method?

A - So it’s my understanding that the intranasal naloxone is actually not, uhm what is it, authorized for use in Canada by Health Canada so the only Health Canada approved product that’s available in Canada is the Naloxone for injection. So that’s why we don’t have the.

M - Right. Uhm well that’s interesting I didn’t know that. Well that kinda sucks.

A - Yea and well in terms of ethically too is that it’s a little bit different and so I think that the intranasal Naloxone is about 70 or so percent as affective as the intravenous Naloxone so it’s actually better, quicker to use the intravenous Naloxone.

M - Oh ok.

A- Having said that a pre-filled syringe would be wonderful.

M - Yea.

A - But we don’t have that either.

M - Yea I know, when I was researching like programs across the world I noticed that some programs do have the pre-filled uhm syringes so I’m trying to get information from them on how they got that option.

A - Yea in terms of Canada, we’re really behind on this policy and we, I mean we have 1 medicine manufacturer, right, that is up until very recently we only had one manufacturer that provides, that actually produces Naloxone so they have a monopoly on what form to patten and how much they want to charge for it and all of that so.

M - Right. Uhm, ok, uhm what are the future goals of your program?

A - Uhm, I think just expanding to reach all the populations that can benefit from it. We’re in a place where we’re sort of, we’re still, we’re continuing to evaluate how we’re doing and how we can make the program better.

M- Right

A - And how we can continue it so uhm yeah I think just, we're fairly new, we've only been around for about 18 months so we're still working out the kinks and figuring out where we need to focus on with the ...

M - Right ok that leads into my next question. If you have any suggestions for a program that's looking to just start-up.

A - Uhm, a couple of things, I think uhm when we started the program, we uhm, we really tried to make sure that we uhm connected with the community and the kits that were put together were actually some refer to people who use drugs as peers because we actually try to include them a lot in our uhm in our work and so we actually uhm when the kits were assembled went to peers and your know, kind of train them and ask them if this was appropriate and you if they were, what their interest level was and how when we were preparing training materials sort of got their input on the material so i think uhm including uhm communities and people who are using drugs in the conversation while you're developing the program is I think really important.

M - Right.

A - Uhm and another thing that I would point out is definitely uh connecting with the if it's like a local program, like we're a provincial organization, so it's a little bit different than a local program, but definitely connecting with police, and uhm the local law enforcement and paramedics because they can inform your 1st responders in general so we've had some incidences where police have either confiscated kits because they didn't know what was in them.

M - Oh.

A - Right because sometimes they'll just see people carrying these kits around and they're like well you're carrying drugs in them and so they'll confiscate the kits because they think there's a lot of education that has to happen around you know these kits are containing a life-saving drug,

you shouldn't be confiscated uhm you know, start engaging police in that conversation and then also engaging other 1st responders because a lot of times people don't understand that actually people that use drugs are capable of saving each other's lives.

M - Right.

A - Uhm and so you know if a paramedic shows up to respond to an overdose, and there's someone there stabbing someone else with a needle, they're just going to be like what the hell are you doing to that person, right? That tends to be the first response and you don't want that because this person has just saved someone else's life so you want them to actually be able to tell the paramedic this person went down, like I just gave him a shot of naloxone, called you guys, like there has to an information transfer from the person that delivered Naloxone to the paramedic or 1st responder that shows up and that can't happen when the paramedic is yelling get away from that person right?

M - Right.

A - So there has to be a lot of education and engagement at the community level.

M - Right do the uhm, do the 1st responders and paramedics in BC do they carry naloxone within the ambulance?

A - Yea they do.

M - Ok.

A - So the paramedics have it uhm the fire I don't think the fire departments do but the paramedics for sure carry Naloxone.

M - Ok, that's good to know.

A - Yea and we had asked Vancouver police about whether they would be because some places in the US, the police actually carry Naloxone asked Vancouver the police department, but they

were supportive of the program in general, but they didn't see themselves playing a medical role responsible and os they don't want to have to carry the Naloxone and i don't think they carry epi-pens either. Not sure, but.

M - Oh ok. I think it would be useful for them to carry it.

A -I think so too but they didn't think to see themselves in that role so.

M - hm. Uhm also did you find it like challenging to uhm, like make the, these users like uhm like I don't know how to really word this, to like make them feel ok with like going and getting these kits like introducing them to them like were they open to it, I mean it's obviously successful so like they're open to it and they're like willing to do to it but was kind of hard to get it started?

A - I think it depends a lot on how you approach it and who you're talking to. I think there are people that are uhm fairly experienced at and have been using drugs for a long time and have seen a lot of overdoses and those people uhm or have been around people who have overdosed and so they tend to be a bit more I think uhm responsive and open to new ideas like oh I could learn how to do this, this is so easy like i think they want to know more they want to get involved and there are other people who just are very new to drug use and this is not something that they have heard about or have been around or you know so i think people are at different stages.

M - Right.

A - Uhm and in terms of like the outreach and conversation, like we have about 35 sites across the province and it looks really different in different places so in some settings like there are outreach nurses that go out and as part of their outreach work they train people on how to prevent overdoses and tell them about the program and then there is nurse practitioners that can actually carry the kit with them and prescribe it on the spot or in other settings if there's just a nurse they

tell people you know, kind of do the education and then tell them to go into a clinic so that they can see a prescriber who can write the prescription for Naloxone so that's sort of the other barrier in our...Naloxone is a prescription only medication.

M - Right.

A - And so it can only be prescribed to the person who is using drugs so for instance the family members of a person who is using drugs can't necessarily get the kit, they can get the training, and at the end of the day like if their friend overdoses, so they're having an overdose they may very well the person that ends up administering the Naloxone but the kit is prescribed out to the person who is using the opiates just like any other medication would be. so there tends to be some challenges around that.

M - Do you think it would be beneficial if like people who are likely to witness the overdose could be given the kits as well?

A - I think that would be ideal, right? And I mean I think that would be ideal. In Italy they have naloxone available over the counter.

M - Ok.

A - It's not even a prescription only medication only right? You can just buy it over the counter.

M- Mhmm

A - So it's just uhm just having to do things and our rules around it. We've, uhm, our program has engaged our local BC colleges of physicians, colleges of pharmacists and college of nurses uhm to try and figure out whether nurses can dispense or uhm prescribe, well they can't really prescribe but if nurses can dispense naloxone kits or whether uhm pharmacists might be able to and then be able to change the scheduling of the drug so that the pharmacists are out in the community right so it would be easy enough for someone to just come in and be like hey I need

naloxone or for a pharmacist to notice that someone has a really high opioid does or is taking multiple medications and may be at risk of overdose. And so to then talk to that person and be like hey like we have this drug it's called Naloxone and incase something happens to you, here's how you use it here's what you should do to prevent an overdose. They can play that education role then they can dispense the naloxone to the person. Uhm we haven't been very successful with trying to commit pharmacists to do that because even though pharmacists are willing to do the education and change the scheduling, they don't want to do it because Naloxone is not covered under the provincial formulary. So in BC, uhm Naloxone is not paid for by Pharmacare or by Medicare so that would mean that the pharmacists would do the education like hey here's this awesome drug, it can save your life but here's a bill for $50 just to buy this drug and so they don't want to be in that situation to do that so then we run back and had the conversation with the ministry of health and say hey can we add it to the formulary and so they're going through their process of review right now uhm so I mean I think that there are and people understanding the importance of it and are working to amend the system to make it easier but meanwhile we're just dealing with these sort of policy issues.

M - Right.

A - So its been, those are all kind of different challenges around accessibility.

M - Yeah that's kinda been uhm like one of the issues my host has been telling me about. She's just so frustrated that it's such a useful medication but it's just not available yet and it's just like she doesn't understand why the Ministry of Health just won't like finally make it more available and stuff.

A - So what's your host organization that you're working for again?

M - Uhm it's the Peterborough Drug Strategy.

A - And that's out East?

M - Yes.

A - Cool.

M - Yea. It's a pretty new uhm organization too, they just started in 2008 I believe and so yea this project is actually really exciting if all my research helps to get a program started in Peterborough.

A - Mhmm that's great.

M - Yea. Uhm, so that pretty much answers all my questions I had.

A - Cool, I'm going to tell you about one more thing that we do that wasn't in your questions and probably won't see it on our website either.

M - Ok.

A - We, I manage a community advisory board uhm for our take home naloxone program and so what we have done actually I said as I mentioned community engagement was part of our process and actually there were a few individuals that were uhm involved in the beginning that kind of helped us initiate the program and so as we've grown, we've just added our take home naloxone site coordinators into the community advisory board and then we have a couple other people from the community that are uhm interested in staying connected and staying involved and so we have a teleconference every quarter and it's a chance for everybody to kind of get an update on what's happening in their sites and uhm and discuss any challenges and brainstorm some strategies. So i think it just helps boost morals and sites that are just new and starting out help them understand how other people have managed to do it and make some connections between programs that are a bit more established and programs that are fairly new and uhm it helps them to understand what their local challenges are so that as a provincial entity we can

come up with either strategies for them or find resources for them that can kind of help them in their work so.

M - Right.

A - We see ourselves as more of a supportive role in that way.

M- Mhmm.

A - So that's uhm thats really helpful.

M - Ok awesome. Thank you.

A - Cool.

M - Uhm yea so thank you so much for taking the time to talk with me and help me answer some questions that I had.

A - For Sure.

M - It'll definitely help my research a lot.

A - Excellent and I'd love to see a copy of your final report whenever it's done if you don't mind sending it to me.

M - Yea for sure.

A - That would be great.

M - Yup it'll be done in may so.

A - Ok.

M - Yea I'll definitely forward a copy to you.

A - Excellent.

M - Alright.

A - Ok well if you have any other questions just uhm shoot me an email or give me a call.

M - Ok sounds good.

A - Ok take care.

M - Thank you.

A - Bye.

M - Bye.

Appendix E - Australia's Canberra Alliance for Harm Minimisation and Advocacy Response

Hi Meghan

Thank you for your inquiry. I will try to answer your questions as best I can.

Q1 & 2 My name is David Baxter and I am an education and outreach worker for the Canberra Alliance for Harm Minimisation & Advocacy (CAHMA). CAHMA is a peer-based drug user organization that is run by and for people who use illicit drugs and people who are in treatment for illicit drug use. We provide advocacy, referral and education and information services to our clients following the principles of harm reduction. CAHMA is located in Australia's capital, Canberra. CAHMA employs five staff. For more information about CAHMA, please see our website http://cahma.org.au/about.html

Q3 Specifically my duties include designing and delivering harm reduction-based training programs for injecting drug users and people on opioid maintenance treatment (i.e. methadone and buprenorphine). I also script and present a weekly radio show that is broadcast on our local community radio station. I also conduct outreach programs among Canberra's drug using community.

Q4 Canberra's naloxone program was the first of its kind in Australia and was the result of several years of lobbying. The program was implemented by a stakeholders' committee called I-ENAACT (Implementing Enhancing Naloxone Availability in the Australian Capital Territory). I-ENAACT had representatives from research organisations, drug and alcohol treatment sector organisations, the ambulance service, the local government (Canberra, like Washington DC, is not part of a state but is its own separate jurisdiction – the Australian Capital Territory), illicit

drug users, pharmacists, doctors (both from general practice and from the government's drug and alcohol program) and other health professionals. Much of the process of establishing I-ENAACT, lobbying the government and making the naloxone program a reality was driven by Nicole Wiggins who was CAHMA's manager at the time (I can see if I can put Nicole in touch with you if you like – she no longer works at CAHMA and is living on the other side of the country but she could probably tell you a lot more about the origins of the Canberra naloxone program than I can).

After getting the approval of all the relevant stakeholders and securing government funding for a pilot program to provide naloxone kits to 200 people over tow years who are deemed to be at risk of opioid overdose and train them in its use, the first naloxone training courses started in March 2012. The pilot program is being evaluated by researchers at the Burnet Institute – a medical research organization. The training courses take 2-3 hours and trainees are taught the risk factors for opioid overdose (e.g. reduced tolerance after a period of abstinence, mixing with other drugs – particularly benzodiazepines and alcohol, poor general health etc); how to recognize the symptoms of opioid overdose; how to give first aid to an opioid overdose victim (with or without naloxone); how to perform CPR and M2M resuscitation; how naloxone works; how and where to administer an intramuscular naloxone injection; and legal aspects of using naloxone on someone for whom it is not prescribed.

This last point is an important one as naloxone is a Schedule 4 medicine in Australia which means that it can only be supplied when prescribed by a doctor. However, people are unlikely to use it on themselves as overdose victims are seldom aware of the fact that they are overdosing. In

this case, someone who uses their naloxone to save someone else are protected by Good Samaritan laws.

At the end of the training session trainees are given a short exam. Their completed exams are "marked" by a general practitioner who then signs off on their prescription. The trainees are provided with the kits then and there.

The training course is delivered by CAHMA staff with the assistance of a registered nurse. The GP usually only arrives at the end of the session to check the exams and sign the prescriptions. Trainees are paid $25 and their naloxone kit is provided for free. The kit contains:

- 5X 0.4 mg doses of naloxone in mini-jets (originally the doses were supplied in 0.4mg ampoules and the kits contained 5X 3ml syringes and 5X 23 gauge needles – naloxone in mini-jets only appeared in Australia about a year ago)
- A sharps container
- A foldout sheet/brochure with a brief guide to responding to overdoses
- Disposable latex gloves
- Skin-cleaning swabs (isopropanol)
- A face mask for performing M2M resuscitation

The kit is contained in an ordinary pencil case.

Q5 I'm not really sure what you mean by "medical directives". As I mentioned before, naloxone is a Schedule 4 medicine in Australia which means that it requires a doctor's prescription. This

was a moot point until the start of the Canberra program, naloxone was never prescribed to members of the public in Australia and was generally only carried by paramedics and hospitals. While in theory there is no reason why someone can't just get a prescription for naloxone from their family doctor, in practice they would probably find it difficult to get the prescription filled as only a few pharmacies stock naloxone and they are generally pharmacies that have an arrangement with a program such as ours.

Q6 At present our program only supplies naloxone in injectable form. I gather that the World Health Organization will soon be researching the evidence of comparative efficacy between intramuscular and intranasal naloxone although I don't know how long it will be before they report.

Q7 Only medical doctors can prescribe naloxone. At present the only people in Canberra who have been prescribed naloxone are people who have completed our training course and regard themselves as being "at risk" of suffering an opioid overdose.

Q8 CAHMA receives its core funding from the Australian federal government's Department of Health and Ageing. CAHMA also receives some specific program/project funding from the ACT government. The funding for the pilot naloxone program comes from the ACT Government. We also occasionally get one-off grant money.

Q9 As I mentioned earlier, the ACT pilot naloxone program, which was funded to provide naloxone to 200 people, is being evaluated by researchers from the Burnet Institute (I can try to

get one of the researchers in touch with you if you like). Trainees from the program are encouraged (paid $40) to attend follow-up interviews about three months after their training session. People who use their naloxone to reverse an overdose are also interviewed. As the pilot program has not yet finished (it will finish next week), there has been no formal evaluation published yet. However, at CAHMA we have received anecdotal reports of over 20 overdose reversals in the two years that the program has been running.

Q10 Ideally CAHMA would like to continue to deliver overdose management training to people who use opioids (either legally or illicitly) as part of the process of providing naloxone to members of at-risk populations. The provision of naloxone to potential overdose witnesses and victims is fairly new in Australia and, like any novel intervention, is getting quite a bit of media attention. The success of the Canberra program has seen other jurisdictions commence their own programs. However, we believe that it is important that potential overdose witnesses be trained in the full gamut of first aid responses to overdose rather than relying exclusively on the handy availability of naloxone. Furthermore, teaching members of a marginalized and heavily stigmatized community how to look after themselves and their friends and family can have other positive outcomes in ways that are difficult to quantify. Certainly, helping to save someone's life can really boost the self-esteem of our program's "graduates".

CAHMA have also delivered naloxone training to inmates of the ACT prison. Although we can't give them their naloxone kits until after they've been released, this is a population that is particularly susceptible to overdose.

Q11 An aspect of the training program that has resonated strongly with trainees is the fact that the training is delivered by peers who have first-hand experience with managing opioid overdoses. Peer-delivered education programs have a level of credibility in the eyes of the target audience that other education programs lack. As the target audience is a group that can be difficult to engage with and reluctant to discuss issues relevant to their drug use (for the simple reason that it's illegal and they fear getting into trouble), having this credibility in the eyes of the beholder has generated a lot of local interest in our program. While I understand that Peterborough is only a small city and may not have a peer-based drug user group, there is certainly a peer-based drug user group in Toronto which has a good reputation for delivering harm reduction-based education and training to illicit drug users. I would hope that they would be only too happy to assist you.

Anyway. It's the end of the day here and I have to go home (It's about 105 degrees farenheit outside – are you jealous?). I will try to get onto Nicole Wiggins and one of the guys from the Burnet Institute for you if you like although I suspect that you won't get much info from the Burnet Institute until they publish their evaluation of our pilot program and the programs that are operating in Sydney and Perth. If I think of anything important that I've left out I'll let you know. In the meantime I hope that I've provided the sort of information that you were seeking. If not, please don't hesitate to contact me again.

All the best

David

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Appendix F - Australia's Alcohol Tobacco and Other Drug Association Act's Response

Hi Meghan,

Please see response to questions below (noted that these are provided within the context of the information that is public on the ACT program that is run by CAHMA). All of the information has been taken from the program description: http://www.atoda.org.au/wp-content/uploads/FINAL-Program-Description-Naloxone-August-2012v-4-2-2.pdf

Kind regards,

Amanda

1. Give your name and title within the organisation.

Amanda Bode, Project Manager, Alcohol Tobacco and Other Drug Association ACT (ATODA)

2. Give a brief overview of the organizations purpose and/or mandate.

The Alcohol Tobacco and Other Drug Association ACT (ATODA) is the peak body representing the non-government and government alcohol, tobacco and other drug (ATOD) sector in the Australian Capital Territory (ACT). ATODA seeks to promote health through the prevention and reduction of the harms associated with ATOD.

ATODA works collaboratively to provide expertise and leadership in the areas of social policy, sector and workforce development, research, coordination, partnerships, communication, information and resources. ATODA is an evidence informed organisation that is committed to the principles of public health, human rights and social justice.

3. What are your specific duties within the organisation?

Project management and implementation across a range of workforce development, policy and representational activities.

4. Give a brief history about how the distribution of Naloxone was initiated.

This initiative was the first in Australia to distribute Naloxone to potential overdose witnesses with the intention of making it a fixture of the response to the harms caused by opioids. Making Naloxone available to potential overdose witnesses is consistent with an Australian culture of resuscitation and first aid. Increasing the availability of Naloxone in the community is analogous to the introduction of public access defibrillators through Project HeartStart Australia or supplying persons with an allergy an epi-pen for use in case of an allergic reaction. There is support from General Practitioners and heroin users in the ACT to participate in a program to expand availability of Naloxone. Individuals should be promoted to act in ways that save lives, even when such actions incur some risks. The risks, in the case of Naloxone, are minimal. Therefore; a Committee of key stakeholders was established to lead the process of establishing a program to expand Naloxone availability in the ACT.

5. What are the medical directives behind the distribution of Naloxone in your area?

I dont understand exactly what you are asking for here? Do you mean the medical requirements? If so, this program requires that the Naloxone be provided on prescription (schedule 4) to at risk individuals who successfully complete a training program.

6. In what ways does the organization distribute naloxone? (e.g. injection, nasally)

The Naloxone provided is in a mini jet for intramuscular injection.

7. Who can administer/prescribe naloxone kits and how did they obtain this ability?

For the purpose of this program, General Practitioners prescribe the naloxone. The naloxone is prescribed to the opioid user to be administer to them in the event of an overdose (to be administered by a peer or family member / friend).

8. Where does the organization obtain funding from?

Currently, ACT Health (ACT Government) funds the program.

9. Has your organization been successful in reducing the number of opiate overdoses in your community? How do you measure this? Do you have any corresponding statistics?

An interim evaluation has just released key findings.

See http://www.health.act.gov.au/publications-reports/reports/alcohol-and-other-drug-reports/naloxone for more information. This finds that there were 23 succesful reported opioid overdose reversals from the 140 participants training to date.

10. Do you have any suggestions or advice for an organization that is just starting a program?

There is a significant body of knowledge being built around program establishment. Perhaps reviewing some of the work to date in the ACT may be useful: http://www.atoda.org.au/policy/naloxone/

Amanda Bode

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Appendix G - Scotland's Response

Hi Meghan,

I do apologise for the length of time it has taken me to respond.

Please see the attached link which will give you a summary of the events that took place prior to the introduction of the national programme.

http://www.sdf.org.uk/drug-related-deaths/critical-incidents-and-naloxone-training-in-scotland-brief-timeline/

The programme delivering is currently undergoing a period of evaluations, which will hopefully be published at the end of March.

I hope this is useful but please do not hesitate to get back in touch if you require further information.

Best wishes,

Kirsten

National Naloxone Coordinator