

Implementing Expanded Naloxone Availability in the ACT (IENAACT)

Program Description

August 2012 v.4.2*

***Versions may change following regular mandatory reviews.**

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Background

Opioid overdose is a continued and substantial contributor to death, disability, and injury among individuals who misuse opioids in the Australian Capital Territory (ACT). Since 2000, reduced heroin availability has drastically reduced the number of fatal and non-fatal heroin overdoses in Australia. This period, however, has also seen a substantial increase in the number of prescriptions for pharmaceutical opioids, such as MS Contin and OxyContin. The diversion of these pharmaceutical opioids, and their use in conjunction with other depressant drugs, such as alcohol, benzodiazapines and heroin, present a current and ongoing risk of overdose morbidity and mortality in the ACT.

Current research and professional opinion, both national and international, indicate the merit of implementing a public health program for use in the ACT to reduce opioid morbidity and mortality. Since the 1990s, there have been repeated calls from researchers, public health professionals, advocates, and user groups to initiate programs allowing those at risk of opioid overdose access to prescribed naloxone (Narcan®), a Schedule 4 opioid antagonist used to reverse the effects of opioid overdose. As a Schedule 4 drug, naloxone requires a prescription. Distribution of naloxone for bystander-administration programs operate internationally, including the United States where programs were operating legally in 17 states by 2008 (Kim, Irwin and Khoshnood, 2009). The proposed program to expand naloxone availability in the ACT builds on the international evidence demonstrating naloxone distribution programs' safety and effectiveness.

Naloxone is widely used in Australia and internationally by paramedics and emergency room staff in cases of suspected opioid overdose. Naloxone is an opioid antagonist. It does not produce any intoxication and appears to have no effect on people who don't have opioids in their system (Dean et al., 2010, p. 526).

The administration of naloxone by lay people who have undertaken training in opioid overdose and response has been found to be remarkably safe and effective (Kim, Irwin and Khoshnood, 2009; Lenton et. al. 2009a; Green et al. 2008). Studies show that none of the common concerns about naloxone distribution (e.g. unsafe administration of naloxone, problems with re-intoxication where longer acting opioids have been used, or more risky drug use if heroin were to be seen as less dangerous) eventuated (Green et al. 2008).

As of 2010 there were 155 programs operating in 16 U.S. states with 53, 339 naloxone kits having been dispensed and 10,194 overdose reversals reported (Wheeler 2010). The evidence indicates that making naloxone available to opioid users for administration by appropriately trained potential overdose witnesses such as peers of people who inject opioids, family and friends, can be a safe and effective intervention to prevent opioid overdose fatalities (Lenton et. al. 2009a; Lenton et. al. 2009b).

National/ACT Policy Context

Expanding naloxone access through a peer distribution program is consistent with a philosophy of both harm reduction and consumer participation evident in alcohol and drug policy in the ACT and broader national research and policy contexts:

- Consistent with and progresses actions related to increasing and providing support for peer-based models of delivery from the *ACT Alcohol, Tobacco and Other Drug Strategy 2010 – 2014*, see in particular actions 20 and 50;

- Consistent with the principles of consumer participation in health services, including drug treatment services, and cognisant of the correlation between the peer education model and improved consumer participation (AIVL 2011, see Pharmacotherapy Services 6.3.1, p.69)
- Consistent with the *National Heroin Overdose Strategy* that states ‘It is important to engage drug users in the development of strategies as this may enhance uptake and effectiveness, and accordingly drug users, and drug user organisations have an important role to play in this Strategy.’ (CDHAC 2001, p.4)
- Supported in *Responding to pharmaceutical drug misuse problems in Australia. A Matter of Balance. A review of the literature supporting the development of Australia’s National Pharmaceutical Drug Misuse Strategy* (Nicholas et. al., 2011).
- Consistent with the underpinning principles of people in custodial settings having the ‘right to health services, prevention, education, and health promotion initiatives that are equal to those applying to the broader population’ and ‘continuing care’ emphasised in the *ACT Adult Corrections Health Services Plan 2008 – 2012, p. 7*;
- Consistent with and progresses the objective to provide ACT prisoners with ‘effective health care during and after periods in custody’ from the *A New Way: The ACT Aboriginal and Torres Strait Islander Health and Family Wellbeing Plan 2006 – 2011, see in particular strategy and outcome 26, p. 16*; and
- Supported in the Burnet Institute (2010) *Evaluation of Drug Policies and Services and Their Subsequent Effects on Prisoners and Staff Within the Alexander Maconochie Centre*. It recommends exploration of a program to distribute naloxone to prisoners on release to reduce post-release opioid overdose mortality (Recommendation 68);

Need

Of the burden of disease and injury in Australia due to illicit drug use, a large proportion (57% in 2003) relates to mortality (Begg et. al 2007, p. 88). For those who survive, non-fatal overdose has been linked to a range of morbid conditions including cardiac complications and cognitive impairment (Warner-Smith et. al. 2002). It is now also likely that cancer mortality is a longer-term risk of opioid users, largely owing to the sequelae of hepatitis B and C infections (Randall, Degenhardt, et. al. 2011). Nationally, in 2003, approximately 15% of the deaths attributable to illicit drugs were from opioid and poly-drug overdoses, as were some 33% of the disability-adjusted life years (DALYs) (Begg et al 2007, p. 89).

The latest national mortality data cover deaths registered in the 2007 calendar year (Roxburgh & Burns 2011):

- Of the 976 deaths in which illegal drugs were determined by coroners to be the underlying cause of death (drug-induced deaths), 512 or 52% were determined to be accidental, i.e. overdoses. (Note that in 240 of the drug-induced deaths (25% of the total) the intent was undetermined. Many of these would have been overdose deaths.)
- With regard to the accidental drug-induced deaths, i.e. overdoses, opioids were recorded as the underlying cause in 299 (58%) of cases.

- Nationally there were 299 accidental opioid (overdose) deaths, 31% of all drug-induced deaths. Seven occurred in the ACT that year. These seven deaths were 2.3% of the total opioid overdose deaths, whereas the ACT has just 1.6% of Australia's population.

The following table shows overdose deaths in people aged 15 to 54 years.

**Number of accidental deaths due to
opioids among those aged 15-54 years,
ACT and Australia, 1988-2007**

<i>Year</i>	<i>ACT</i>	<i>Australia</i>	<i>% ACT</i>
1988	2	351	0.6
1989	2	307	0.7
1990	0	321	0.0
1991	2	250	0.8
1992	4	336	1.2
1993	5	374	1.3
1994	3	425	0.7
1995	13	582	2.2
1996	17	557	3.1
1997	9	713	1.3
1998	14	927	1.5
1999	11	1,116	1.0
2000	10	938	1.1
2001	12	386	3.1
2002	8	364	2.2
2003	17	357	4.8
2004	2	357	0.6
2005	np	374	--
2006	np	269	--
2007	6	266	2.0

*np means that the data were not published in order to protect privacy

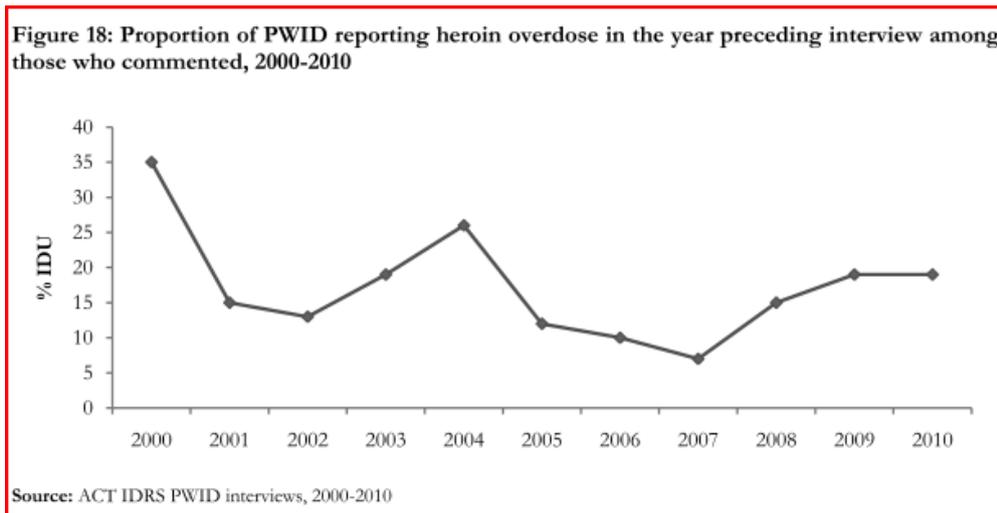
Sources: McDonald, D 2008, *The extent and nature of alcohol, tobacco and other drug use, and related harms, in the Australian Capital Territory, February 2008*, Social Research & Evaluation Pty Ltd, Canberra.; Roxburgh, A & Burns, L 2009, *Drug-induced deaths in Australia, 2006 edition*, National Drug and Alcohol Research Centre, UNSW, Sydney; Roxburgh, A & Burns, L 2011, *Drug-induced deaths in Australia, 2007 edition*, National Drug and Alcohol Research Centre, UNSW, Sydney; and author's calculations.

The Illicit Drug Reporting System (IDRS) provides self-report data on the overdose experiences of ACT people who use illicit drugs. The authors report (Spicer, Arora, & Burns 2011, p. 54):

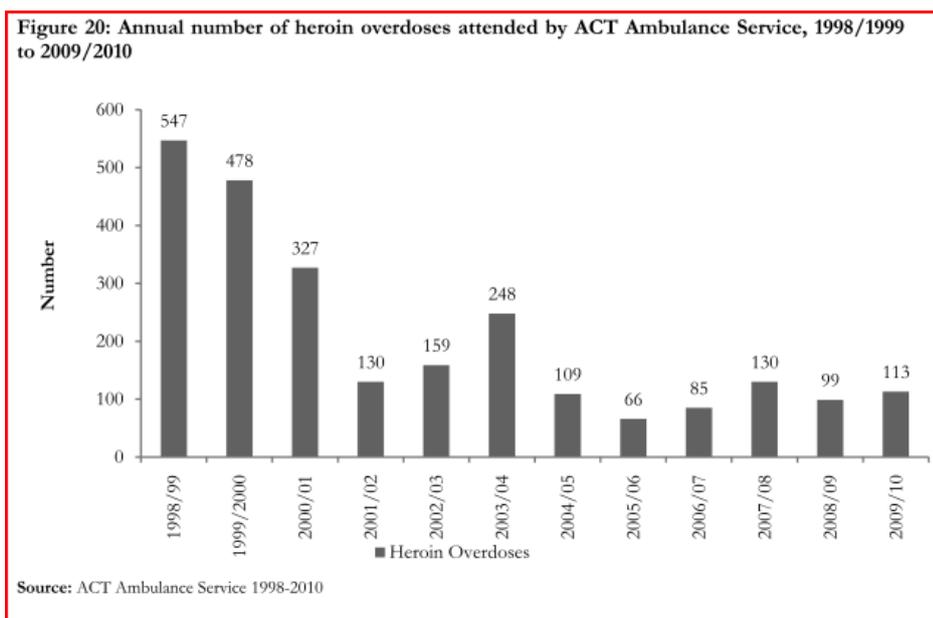
In 2010, 48% of participants reported having overdosed on heroin at least once at some point in their lives, a decrease from 54% in 2009.

Sixty percent of participants who reported ever having overdosed on heroin reported having overdosed one to 5 times, 23% reported having overdosed between 6 and 10 times and 17% reported 11 or more times. The median time to last heroin overdose was 60 months, or five years (range 5-396 months).

As can be seen from Figure 18, in 2010, 19% of participants reported having overdosed on heroin in the year prior to the interview; the same proportion as in 2009. No participants reported overdosing on heroin in the past month.



The same source provides information on ACT Ambulance Service callouts. During the 2009/10 year there were 888 callouts for overdoses, 113 or 13% of which were heroin overdoses, an increase on the 99 heroin overdose callouts in the previous year, but far fewer than recorded during the heroin glut years prior to 2001:



Source: Spicer, B, Arora, S & Burns, L 2011, *Australian Capital Territory drug trends 2010: findings from the Illicit Drug Reporting System (IDRS)*, Australian Drug Trends Series no. 57, National Drug and Alcohol Research Centre, University of New South Wales, Sydney, p. 55.

The argument for expanding the availability of naloxone as an opioid overdose intervention stems from the understanding that:

- People who inject drugs commonly experience overdose;
- People in certain sub-populations are at increased risk of opioid overdose (e.g. those recently released from prison or opioid detoxification programs, Strang et. al. 2003)
- Overdoses are often witnessed by people who can respond;
- Peers of people who inject opioids and family members are keen to respond to overdoses if they occur;
- There is usually a significant time window, typically around an hour, between overdose and death when resuscitation is not attempted, providing time for an effective overdose response to be initiated; and
- Peers of people who inject opioids, family members and others can successfully respond to assist in the management of overdoses among people who inject drugs.

An Australian review of the literature on potential overdose witness administered naloxone was undertaken by Lenton and Hargraves in 2000 (Lenton and Hargraves, 2000). They concluded that making naloxone available to opioid users for peer administration showed promise in reducing the number of fatal overdoses as part of a comprehensive overdose response.

The Australian National Council on Drugs, in a series of position papers addressing heroin-related overdose, supported these claims and nominated a number of options to increase the availability of naloxone. One of these options was to '[d]istribute Naloxone widely, for use by injecting drug users and the peers of people who inject opioids, families and friends.' (ANCD 2001, p. 2)

If warnings of an influx of heroin into Australia over the coming years prove to be warranted (ANCD, 2009), fatal and non-fatal opioid overdoses are likely to increase. Consequently, it is in the interests of the community and the ACT Government to implement strategies to reduce opioid overdoses now, so that they can be evaluated and refined before the number of overdoses increases further.

Aims

The primary aim of expanding naloxone availability in the ACT is to reduce opioid overdose morbidity and mortality through:

- Increased effectiveness of interventions in opioid overdose management;
- Provision of comprehensive overdose management training;
- Provision of prescribed naloxone to eligible participants in the program; and
- Reduction in opioid overdose through overdose prevention education.

The broad aims of the program are consistent with a philosophy of both harm reduction and consumer participation evident in health service policy in the ACT and in broader national policy contexts. The program assists in raising community awareness of and responsiveness to managing overdose.

Design

The program centres on the provision of naloxone on prescription (a Schedule 4 opioid anagonist used to reverse the effects of opioid overdose) to at-risk individuals in the ACT who successfully complete the training program to be administered by a peer or family member/friend in the event of an overdose.

Naloxone is a Schedule 4 drug and as such requires a prescription. Its route of administration is primarily by intramuscular injection. The program includes a training component for opioid users, peers of people who inject opioids, or family or friends. People who inject opioids, their family members or friends are taught to administer naloxone intramuscularly within a comprehensive overdose response education program. Opioid users who successfully complete the training program are prescribed naloxone to be administered to them in the event of an overdose.

Potential targeted priority sub-populations

Individuals not in treatment, those combining opioids with alcohol or benzodiazepines, and those with a recently depleted tolerance to opioids are also at elevated risk (ANCD 2001). These risk factors help to identify priority populations for opioid overdose prevention strategies in the ACT. These populations include: people exiting prison, people exiting opioid detoxification, people exiting opioid maintenance therapy, and Aboriginal and Torres Strait Islander opioid users.

Targeted sub-populations include clients of specific services, their family and friends:

- Alexander Maconochie Centre (AMC) inmates prior to or upon release from detention (at increased risk of overdose in the period immediately following release from detention)
- Aboriginal and Torres Strait Islander People (overrepresented in prison population)
- Clients accessing ACT Needle & Syringe Program (NSP)
- Clients accessing/exiting ACT Alcohol & Drug Program (ADP) Opioid Treatment Service (OTS) and withdrawal unit.
- Clients accessing/exiting other rehabilitation facilities.

People exiting prison

People with a history of opioid dependence are at an elevated risk of overdose in the four weeks immediately following release from prison (Merrall et al. 2010). Incorporating a comprehensive overdose prevention strategy for at-risk prisoners in the period prior to release, combined with increased access to naloxone among non-incarcerated opioid users, is likely to have an impact on the number of fatal opioid overdoses in this population (Wakeman 2010). Opioid users who are due for release from the Alexander Maconochie Centre are therefore an important priority group.

Aboriginal and Torres Strait Islander opioid users

The number of Aboriginal and Torres Strait Islanders who inject drugs is increasing as a proportion of the total injecting drug using population (DoHA 2009, p. 163). Additionally, this group is less likely to be in treatment and more likely to be incarcerated than other opioid

users (NIDAC 2009). Aboriginal and Torres Strait Islander people are often at an elevated risk of overdose compared with other populations. Aboriginal and Torres Strait Islander people should be considered a priority group for any opioid overdose prevention program.

Others

Opioid injectors that do not fit under the categories of Indigenous injectors or recently released prisoners will be the third target group for a naloxone intervention. This group includes people on pharmacotherapy programs, people injecting heroin and injectors of other opioids such as licitly and illicitly obtained prescribed opioids. These include clients accessing the ACT Needle & Syringe Program (NSP) and clients accessing the ACT Alcohol & Drug Program (ADP) detoxification service.

Participation

The program focuses on 200 participants. They include opioid users, peers of people who inject opioids, or family or friends who may witness an overdose. This is considered the optimal number for the two-year initial program within the resources of funding and personnel and within the timeframe.

The training is being conducted over a two-year period with 200 participants. The training for opioid users and other potential overdose witnesses is being conducted in groups with a maximum of 10 people trained in each group. The program aims to complete one course each month with 10 people being trained and then eligible participants who successfully complete the training being prescribed naloxone on reaching a level of competence and assessment. In order to train 200 people a total of 20 training sessions will be conducted over the 2 year period.

Methods of recruitment

Different recruitment methods used reflect the needs and networks of the different target groups and the different settings in which the training and prescription takes place. This also takes into consideration the structures of the Alcohol, Tobacco and Other Drug (ATOD) sector in terms of governance, training and professional development. Recruitment of opioid users is achieved through word of mouth peer networks, advertisement and promotion through the ACT ATOD sector in particular through Needle and Syringe Programs (NSP), pharmacotherapy and residential rehabilitation programs. Recruitment of specific population groups is achieved through established networks and contacts. Recently released prisoners are recruited utilizing established networks and partnerships through Canberra Alliance for Harm Minimisation and Advocacy (CAHMA). Community organisations that work with ex-prisoners such as Prisoners Aid ACT are included in the recruitment strategy. Indigenous opioid users are recruited utilising networks through The Connection (CAHMA's Indigenous Program) and established links with Winnunga Nimityjah Aboriginal Medical Service and Gugan Gulwan Youth Aboriginal Corporation. Community organisations that work with indigenous people involved with the criminal justice system will additionally be included in recruiting priority populations. These agencies include the Aboriginal Justice Centre and the Aboriginal Legal Service.

Recruitment strategies include:

- Information provided by peers of people who inject opioids through existing peer networks, such as CAHMA, the Pharmacotherapy Advocacy & Action Team (PHAAT) and The Connection;
- Word of mouth through peer networks;
- Information fliers in targeted settings that provide services for opioid users, and organisations that support families and friends of opioid users;
- Information sessions to stakeholder groups and in targeted settings (see below for further details about settings);
- Promotion through the ACT ATOD sector ebulletin, targeted at workers to support engagement and recruitment amongst users, peers of people who inject opioids ,and families;
- Promotion to opioid users, their family and friends through radio, such as 2XX News From the Drug War Front;
- Program information articles written in newsletters (such as the ACT Medicare Local, Pharmacy Guild, Junkmail);
- Web page developed with information about the program, the governance and how to access; and
- Regular agenda items through sector governance structures, including the ACT ATOD Chief Executive Officers / Executive Directors Group; ACT ATOD Workers Group; and the Opioid Treatment Advisory Committee (OTAC).

Participation Experience

Participants experience a training program provided by trainers that include CAHMA staff and Volunteers who hold current Senior First Aid Certificates & Certificate 4 Workplace Training and Assessment. Trainers have significant experience as workers in the alcohol and other drug field and are members of Implementing Expanded Access to Naloxone in the ACT (I-ENAACT).¹ Aspects of the training course are supported by clinicians as required, including the support of the GP prescriber. The Training Program is adapted from the international models such as that of the Chicago Recovery Alliance in the United States (CRA, ND).

Participant experience takes the following steps:

1. Recruitment to participate in program (see above)
2. Trainees invited to participate in the course evaluation.
3. Training workshop (some variations dependent on delivery setting):
 - a. Registration of participants
 - b. Medicare card or other ID required

¹ Trainers must be members of, and approved to use the program by, the IENAACT Committee. IENAACT reserves the right to withhold consent to use the Training materials from any third party unless appropriate permission to use has granted. Requests for permission to use any of the Training materials related to the program must be directed to the Secretariat, IENAACT.

- c. Participant information form and consent form given to participants on arrival at workshop
 - d. Consent forms signed and provided to facilitator
 - e. Participant locator form completed
 - f. Pre-questionnaire completed
 - g. Training program undertaken, facilitated by CAHMA
 - h. Post-questionnaire completed
 - i. Consultation with GP Prescriber with post-questionnaire results
 - j. Consultation bulk-billed with medicare card
 - k. Prescription issued to eligible participants
 - l. Naloxone issued on prescription to eligible participants
4. Follow up interview, 3-6 months after training, and including re-prescription for naloxone if required

Delivery Settings

Participants can access the program in a number of settings. This approach targets populations who access different treatment and support settings. Variations to approaches across some settings accommodate the needs/demands of the different settings. For sessions run at Winnunga Nimmityjah Health Service, an Aboriginal Health Worker co-facilitates with CAHMA.

Delivery of training is flexible to the setting and the population being targeted. Training is provided in the ACT at CAHMA and at other selected ATOD and indigenous agencies.

Training Program

A description of the Trainers and the Trainers' preparation program is provided in Appendix 1.

A comprehensive overview of the Training Program to be delivered to opioid users and other potential witnesses of overdose is provided in Appendix 2.

Evaluation

An evaluation will be undertaken to provide new knowledge about the implementation of expanded naloxone availability in the ACT context. Four core evaluation questions will be answered:

1. Can naloxone be used appropriately by people in a non-medical setting within the ACT context?
2. Does the program result in successful overdose reversals?
3. Does the program have any unintended consequences, either positive or negative?
4. Should the program continue and, if so, what changes in the program and its contexts are desirable?

Sub-questions include the following

1. Does the program have a sound theory of change and program logic?

2. To what extent was it implemented as intended? Did it change in response to identified needs and/or changing contexts?
3. What did the program cost?

Data sources

- Pre- and post-training questionnaires to assess changes in attitudes, levels of confidence, knowledge and skill among trainees in relation to managing overdose, including through the use of naloxone;
- A follow-up interview by telephone or face-to-face with people prescribed naloxone three to six months following training and when replacement doses of naloxone are dispensed;
- The follow-ups entail semi-structured interviews in which data is collected on participants' experiences of opioid overdose (overdosing themselves and/or being present when someone else overdosed), use of naloxone, other resuscitation actions taken, ambulance and police involvement, resuscitation facilitating and impeding factors, unanticipated consequences (both positive and negative), impacts (if any) on their own drug use and treatment experiences, etc;
- Interviews with a range of key stakeholders who are not participants in the training program (e.g. senior officer of the ACT Ambulance Service) to ascertain their perceptions of the program.

Data analysis

A mixed methods data analysis strategy will be employed (Cresswell 2003; Teddlie & Tashakkori 2009). This means that both quantitative and qualitative data will be collected. The concurrent triangulation mixed methods strategy will be employed, with the following core characteristics:

- The data collection is concurrent
- The integration of the quantitative and qualitative data occur at the interpretation stage
- The purposes are to cross-correlate and corroborate within the single study.

Most of the data collected in the evaluation will be in a quantitative format. They will be analysed using a statistical package such as EpiInfo or SPSS (Statistical Package for the Social Sciences). Univariate statistics such as frequencies and measures of central tendency and dispersion will be produced on key variables. Bivariate analysis will be undertaken, such as cross-tabulations.

The qualitative data derived from the semi-structured interviews will be analysed using QSR NVivo, ATLAS.ti, or similar. The analysis will commence with open coding and then move, if the data are rich enough, to axial or theoretical coding. By these means, the main themes in the qualitative data will be ascertained and, where appropriate, related to the information derived from the quantitative data.

The data will be presented in the main report on the evaluation and in the summary flyer in textual, tabular and graphical formats.

Australian First

This program is the first in Australia to distribute prescribed naloxone to those who are at risk of overdose to enable trained potential overdose witnesses to respond. Ensuring the support of the ACT community for the program is important. There is support from General Practitioners and opioid users in the ACT to participate in a program to expand availability of naloxone.

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 (St. John Ambulance, launched in 2004) or supplying persons with an allergy an epi-pen for use in case of an allergic reaction. 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 and will be addressed as part of the comprehensive overdose response training that is part of the design of the initiative.

The Expanding Naloxone Availability in the ACT (ENAACT) committee of key stakeholders established in 2010 led the process of developing a program to expand naloxone availability in the ACT.

Subsequent to the program launch in December 2011, the implementation of the program is being overseen by the Implementing - Expanding Naloxone Availability in the ACT (IENAACT) Committee which provides expert guidance and support to the program to expand naloxone availability in the ACT.

The IENAACT Committee membership includes:

- ACT Ambulance Service
- Pharmacy Guild of Australia – ACT branch
- Alcohol Tobacco and Other Drug Association ACT (ATODA)
- AOD Policy Unit, ACT Government Health Directorate
- Professor Paul Dietze, Burnet Institute
- Canberra Alliance for Harm Minimisation and Advocacy
- Dr Tuck Meng Soo, Interchange General Practice and ACT Medicare Local
- Professor Simon Lenton, National Drug Research Institute
- Social Research & Evaluation
- Winnunga Nimmityjah Aboriginal Health Services
- Dr Anna Olsen, University of New South Wales

The IENAACT Committee activities include:

- Supporting the trainers/training package for the trainers

- Advice to development of the training program to be delivered by trainers to peers of people who inject opioids and other potential witnesses of overdose
- Provide support to trainers delivering the program;
- Providing input into the program's evaluation design and implementation;
- Engaging with the ACT Government and additional stakeholders regarding the program;
- Identifying and engaging with stakeholders who could inform / be involved in the Committee and / or program;
- Activities are conducted in accordance with a communication strategy that may include media activities.
- There is agreed means of communication, including the need for discussion of information at meetings prior to making information public. Committee discussions are confidential to the Committee unless other agreements are made.
- Coordinate communication with key stakeholders regarding the implementation of the program and Committee progress including:
 - ACT ATOD sector and inter-state ATOD services interested in the area;
 - ACT community members;
 - ACT Minister for Health;
 - Alcohol, Tobacco and Other Drug Strategy 2010 - 2014 Evaluation Group;
 - ACT Government Health Directorate;
 - Australian National Council on Drugs;
 - Alcohol and other Drug Council of Australia;
 - Australian Injecting and Illicit Drug Users' League (AIVL);
 - Anex; and,
 - Other identified stakeholders.
- Participate in other activities as determined by the Committee and through consultation with stakeholders.

Appendix 1: Overdose and Naloxone Trainers

Trainers include CAHMA staff and Volunteers who hold current Senior First Aid Certificates & Certificate 4 Workplace Training and Assessment. Trainers have significant experience as workers in the alcohol and other drug field and are members of I-ENAACT.² Aspects of the training course are supported by clinicians as required.

Trainers' preparation includes acquiring knowledge in three key areas–

- A. Background to the naloxone project, including international precedents
- B. Principles of peer and adult education
- C. Content of training program for Opioid injectors, peers of opioid injectors and Other Potential Overdose Witnesses – as per Appendix 2

Trainers acquired knowledge

1. Information about Overseas (OS) programs

- Success of overseas programs

2. Aims of the program

Reduction in opioid overdose morbidity and mortality;

Achieved through:

- Increased effectiveness of interventions in opioid overdose management;
- Provision of comprehensive overdose management training;
- Provision of take-home naloxone to eligible participants;
- Reduction in opioid overdose through overdose prevention education;

3. Context

- Overdose in ACT
- Brief history of development of program
- CAHMA submission
- ATODA Submission
- ENAACT

4. Priority Populations

Rationale why these specific target groups

Three population groups will be specifically targeted for naloxone intervention

- Aboriginal and Torres Strait Islander people,
- People recently released from prison and
- Other opioid users

Potential Overdose Witnesses include four groups:

- People who inject opioids
- Peers of people who inject opioids
- Friends/families/carers
- Workers/services

5. Outline of how program will work

- Recruitment strategies

² Trainers must be members of, and approved to use the program by, the IENAACT Committee. IENAACT reserves the right to withhold consent to use the Training materials from any third party unless appropriate permission to use has granted. Requests for permission to use any of the Training materials related to the program must be directed to the Secretariat, IENAACT.

- Training program delivery methods and settings
- Areas to be covered in training program for priority population and other potential overdose witnesses
- Pre and post test questions
- Medical assessment by medical officer including naloxone quiz
- Provision of take home naloxone kits contents
- Take home educational resources – fact sheets, pocket cards etc
- Evaluation component

6. Trainer skills

Principles of peer education

- Group dynamics
- Lived experience
- Incorporating prior knowledge of participants
- Addressing myths and inappropriate management strategies in respectful and positive manner.
- Communication skills
- Dealing with difficult situations participants and/or questions

7. Legal issues & Confidentiality

Legal Issues

- Schedule 4 drugs
- Process for receiving Dr's prescription
- Prescription – who it's for and who can administer
- Medical forms

Confidentiality and privacy

- Legislative requirements for recording personal information
- Program registration forms

8. Evaluation component of program

- Evaluation strategy
- Evaluation questions
- Researchers/interviewers
- Informed consent
- Requirements for evaluation component (forms to be filled out)

9. Information on opioids and other commonly used drugs

- Drug categories
- Opioids
- Heroin pharmacology
- Knowledge of poly drug use
- Pharmacology of commonly mixed drugs
- Effects on Central Nervous System
- Myths about certain drugs
- Why drug combinations are used

10. Physiology of Overdose (OD)

- What is an overdose
- What happens to the body during OD
- Morbidity resulting from OD

11. Risk Factors for OD

- Knowing the risk factors for overdose and strategies to address each risk.
- Low or reduced tolerance- strategies to address
- Using alone- strategies to address
- Health factors -strategies to address
- Mixing with other drugs- strategies to address
- Strength or purity -strategies to address
- Injecting- strategies to address

12. Recognition of Overdose

- Signs and symptoms of overdose
- What not to do in an overdose
- Risk factors for overdose symptoms being missed
- Strategies for ensuring overdose symptoms are not missed
- Personal accounts of overdose where early and late symptoms have been missed
- Myths about overdose symptoms – snoring; sleeping it off
- FAQs on overdose

13. Naloxone – Pharmacology & General Information on Naloxone

- Naloxone general information
- How naloxone works
- Safety issues
- Storage and shelf life
- Frequently asked questions on naloxone
- Dispelling naloxone myths
- Addressing common concerns of naloxone
- Providing personal stories and accounts of experiences with naloxone
- Effective facilitation of discussions of participant’s personal experiences with naloxone

14. Naloxone – Dose levels and Routes of Administration

- Why going with intramuscular (IM)?
 - Pro’s and cons of IM
 - Other routes of administration.
 - IV and nasal
 - Pro’s and cons of IV and Nasal
- Dose levels of naloxone –
- Used in OS programs
 - Used locally by ACT Ambulance
- Advantages of following US and ACT dose levels
- Greater acceptance of program
 - Established record of success

15. Overdose response

- Dropped: A DVD Resource for Responding to Heroin Overdose and Amphetamine Intoxication (Govt. of WA, 2012)
- Step by step response with naloxone
- “SCARE ME” video from US

16. Calling an Ambulance - List of information and tips on calling an ambulance

17. Recovery Position

- How to put someone in recovery position
- Step by step with pictures- handout
- Demonstrating recovery position in training environment

18. CPR

- When to give CPR
- Steps in CPR
- Demonstration of CPR steps

19. Rescue Breathing

- Step by step
- Training people in rescue breathing
- Airway management
- Prevention of choking

20. Administration of Naloxone

- Step by step administering naloxone
- Preparing naloxone for injection
- Supervising someone after being given naloxone
- Practising injecting oranges for training

21. Protocols for replacement doses

22. Blood Borne Viruses (BBV) and Universal precautions

- Standard infection control procedures
- Blood and body spills
- Infection control while giving first aid
- BBV issues for educators
- Handling used needles and syringes
- Needle stick injury management
- Hepatitis C and other BBV's

Appendix 2: Over Dose training Course Outline for Opioid injectors, peers of opioid injectors and Other Potential Overdose Witnesses

The training course contents are outlined below. The training course will take approximately 2-2.5 hours dependent on the number of participants attending and allowing for practical demonstrations and sufficient time for discussion and questions on all topics areas.

1. Introduction and Overview of Training program

- Overview of program

2. Aims of the program

- Reduction in opioid overdose morbidity and mortality

3. Evaluation of program

- Participant info and consent forms
- Pre training Quiz

4. Information on opioids and other commonly used drugs

- Drug categories
- Opioids

5. Physiology of Overdose

- What is an overdose

6. Risk Factors for Overdose

Knowing the risk factors for Overdose and strategies to address each risk.

- Low or reduced tolerance- strategies to address
- Using alone- strategies to address
- Health factors -strategies to address
- Mixing with other drugs- strategies to address
- Strength or purity -strategies to address
- Injecting- strategies to address

7. Recognition of Overdose

- Signs and symptoms of overdose
- What not to do in an overdose
- Risk factors for overdose symptoms being missed
- Strategies for ensuring overdose symptoms are not missed
- Personal accounts of overdose where early and late symptoms have been missed
- Myths about overdose symptoms – snoring; sleeping it off
- FAQ”S on overdose

8. Naloxone – General information on naloxone

- Naloxone General Information
- How naloxone works
- Safety issues
- Storage and shelf life
- Discussions of participant’s personal experiences with naloxone

- 9. Naloxone – administration**
 - Dose levels
 - Route of Administration
 - Prescription use
- 10. Overdose response**
 - DRSABCD
- 11. Calling an Ambulance**
 - List of information and tips on calling an ambulance
- 12. Recovery position**
 - How to put someone in recovery position
 - Step by step demonstration
- 13. Rescue breathing**
 - Step by step demonstration
 - Airway management
 - Prevention of choking
- 14. Administration of Naloxone**
 - Step by step administering naloxone
 - Preparing naloxone for injection
 - Demonstration of naloxone packs
 - Supervising someone after naloxone is administered
- 15. Protocols for replacement doses**
- 16. Blood Borne Viruses (BBV) and Universal precautions**
 - Standard infection control procedures
 - Blood and body spills
 - Handling used needles and syringes
 - Hepatitis C and other BBV's
- 17. Dropped: A DVD Resource for Responding to Heroin Overdose and Amphetamine Intoxication (Govt. of WA, 2012)**
- 18. Prescription supply of naloxone – Eligibility determined through**
 - Post Training Quiz
 - Medical Consultation
- 19. Collection of naloxone kit**
 - Naloxone kit provided to eligible participants
 - Participant payment

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