

The needle and the damage done

Canberra groups want to follow a Chicago lead with a drug to counteract heroin overdoses,
LOUIS ANDREWS writes

HEROIN shooting galleries are, by their nature, a hive of sordid tales. But according to Doctor Sarz Maxwell, medical director of the Chicago Recovery Alliance, they produce the occasional good news story.

"We have a story of one of them, he and his wife were there and five people overdosed simultaneously," she recalled.

"They had all gone to the same place and bought from the same batch of dope, and they all went down."

A heroin user's worse nightmare: five fellow users on the verge of death in your house.

"And as [the wife] told me, she said 'I kept loading up syringes with naloxone, and I kept passing them on to him', and they saved them all," Maxwell said.

Naloxone, an opioid antagonist which reverses the effects of an opiate overdose, is no new wonder drug. Emergency departments and paramedics in Australia and overseas have used the drug to treat overdoses for decades.

For the past 10 years, however, organisations like Maxwell's Chicago Recovery Alliance have been taking a more radical approach to naloxone dispensation.

Maxwell is in Australia this week for the 2010 Australian Drugs Conference hosted in Melbourne by harm minimisation advocates Anex.

In 2000 the Chicago centre started quietly prescribing the treatment to "potential overdose witnesses" – drug users and their friends or family.

Heroin addicts are traditionally reluctant to call ambulances, for fear of legal consequences. They're also more likely to have witnessed an overdose than anyone.

A heroin overdose is rarely an instantaneous thing.

"What usually happens is that five minutes to ten minutes after the injection, the person is gradually becoming more and more somnolent," Maxwell explained.

That somnolence scarcely raises eyebrows. But during an overdose the sedation becomes deeper over the next five minutes, and the victim's breathing slows.

"And if it's not intervened on, within another five to ten minutes breathing could stop altogether."

A timely dose of naloxone can quickly reverse the slowing of the breathing, the sedation and hypertension.

"We're trying to do with overdose what having the epipen did for bee-bites, and people who were allergic to insect bites," he said.

"People who would go into that anaphylactic emergency would often be dead before the ambulance got there."

Already operating as a needle exchange and outreach service, with Maxwell as their own medical professional, "we didn't have to go through a whole lot of permissions



Canberra harm minimisation advocates are pushing for a peer-based naloxone pilot project.

and political things – we just started doing it".

There are now more than 50 similar programs in the United States.

The Chicago Recovery Alliance have distributed about 35,000 multi-dose vials of naloxone since 2000, each one enough to treat up to ten potential overdose victims.

The alliance prefers intramuscular injections rather than intranasal doses: "It's purely an economic thing."

A nasal spray dose costs about \$US12. The multi-dose vials distributed at the Chicago needle exchange cost about \$3 for up to 10 doses.

The ingenuity of drug users being what it is, there is a black market.

Clients take their free doses from the exchange and sell them on to other users.

Academic reviews suggested making naloxone available in the heroin-using community could help reduce the number of killer overdoses.

"We underprice them – we give it for free," Maxwell said.

"However, if they're providing a service of getting a bunch from us and then going where people shoot and having it available to them then, that's a service and if they're providing it I have no problem with them being paid."

About the time the Chicago Recovery Alliance became among the first US services to prescribe

the drug to non-medical practitioners, there was a concerted push for a trial program in Australia.

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Then came the "heroin drought", and a decline in opioid overdoses, and the argument lost

traction. But, partly prompted by an increase in prescription opioid overdoses in recent years, Canberra harm minimisation advocacy groups are now calling for the territory to pilot the first peer-based naloxone program in Australia.

Last week Canberra Alliance for Harm Minimisation and Advocacy, a drug users' support group acting under the auspices of the Alcohol, Tobacco and Other Drug Association ACT, proposed the ACT Government adopt a two-year pilot.

They are seeking \$200,000 to give the drug to 200 drug users and potential overdose witnesses.

Of more than 900 overdoses the ACT Ambulance Service attended last year, heroin was responsible for just 13 per cent.

But, as alliance director Nicole Wiggins attested, Canberrans still die from heroin overdoses. About four months ago, a Canberra man in his mid-20s died as his partner, reluctant to summons help, watched on.

"His partner didn't call an ambulance because his partner had warrants [out for his arrest]," Wiggins said.

"Had his partner had naloxone, he could have used that naloxone to save his life."

But would readily-available naloxone make addicts even less likely to dial triple-zero?

Maxwell rejected the suggestion.

"We did a short survey [at the Chicago needle exchange], and found about 20 per cent of people, before naloxone availability, were calling 911 or calling the ambulance," she said.

"After naloxone availability, that number stayed exactly the same."

Internationally, the approach has raised serious liability concerns about drug users treating other drug users for overdoses.

Naloxone proponents argue it is safer than more readily available prescription medication counterparts. Maxwell said it was "safer than sugar water for an unconscious person".

Medical literature says overdose is possible if excessive quantities are used; there is the risk of an allergic reaction; and as with any medicine side effects may occur.

The Canberra Alliance for Harm Minimisation and Advocacy proposal notes the Civil Law Act would need to be changed to protect drug users from litigation.

But Maxwell believes liability concerns are a smokescreen for a more deep-rooted issue.

"It's a nice term, and it sounds like something a doctor should be worried about," she said.

"But whenever someone says to me, but what about liability, I know what they're really saying is, why bother with these people anyway?"

"Liability? Who's going to sue? For what? And this is not a litigious population. Here in the United States, which is a very litigious country, there's been no hint, at any naloxone site, of any kind of liability concern. The concern is intervening with heroin addicts. People would rather they were dead."