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# Naloxone supply and overdose prevention in mainstream healthcare services

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***Preventing and responding to opioid overdose in Victoria: Developments and Opportunities***

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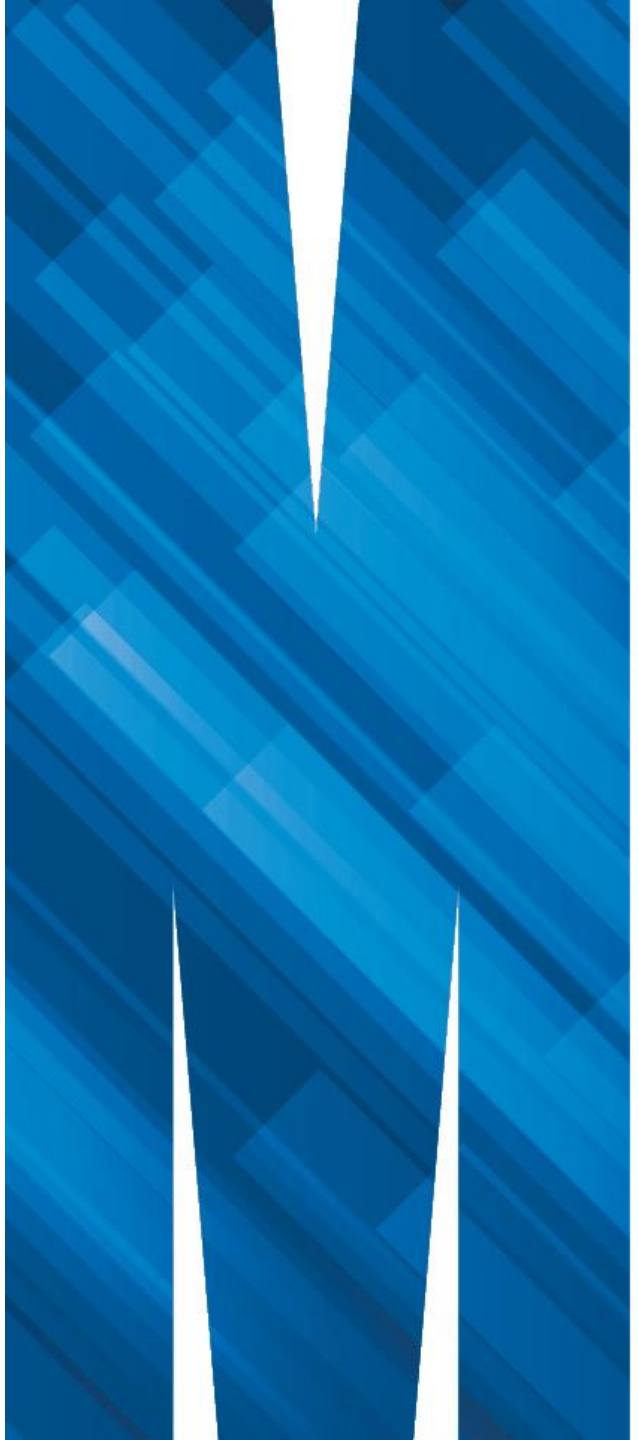

# WHY OVERDOSE PREVENTION IN MAINSTREAM SETTINGS?

Most overdoses (70%) involved prescribed opioids which are supplied through primary care / community pharmacy

Relatively little overdose prevention outside harm-reduction specific programs (low naloxone prescribing, few OTC requests)

**Challenge: how to  expand overdose prevention in mainstream healthcare?**

- **Which populations?**
- **What are the barriers?**
- **How do we make this core business / routine practice?**

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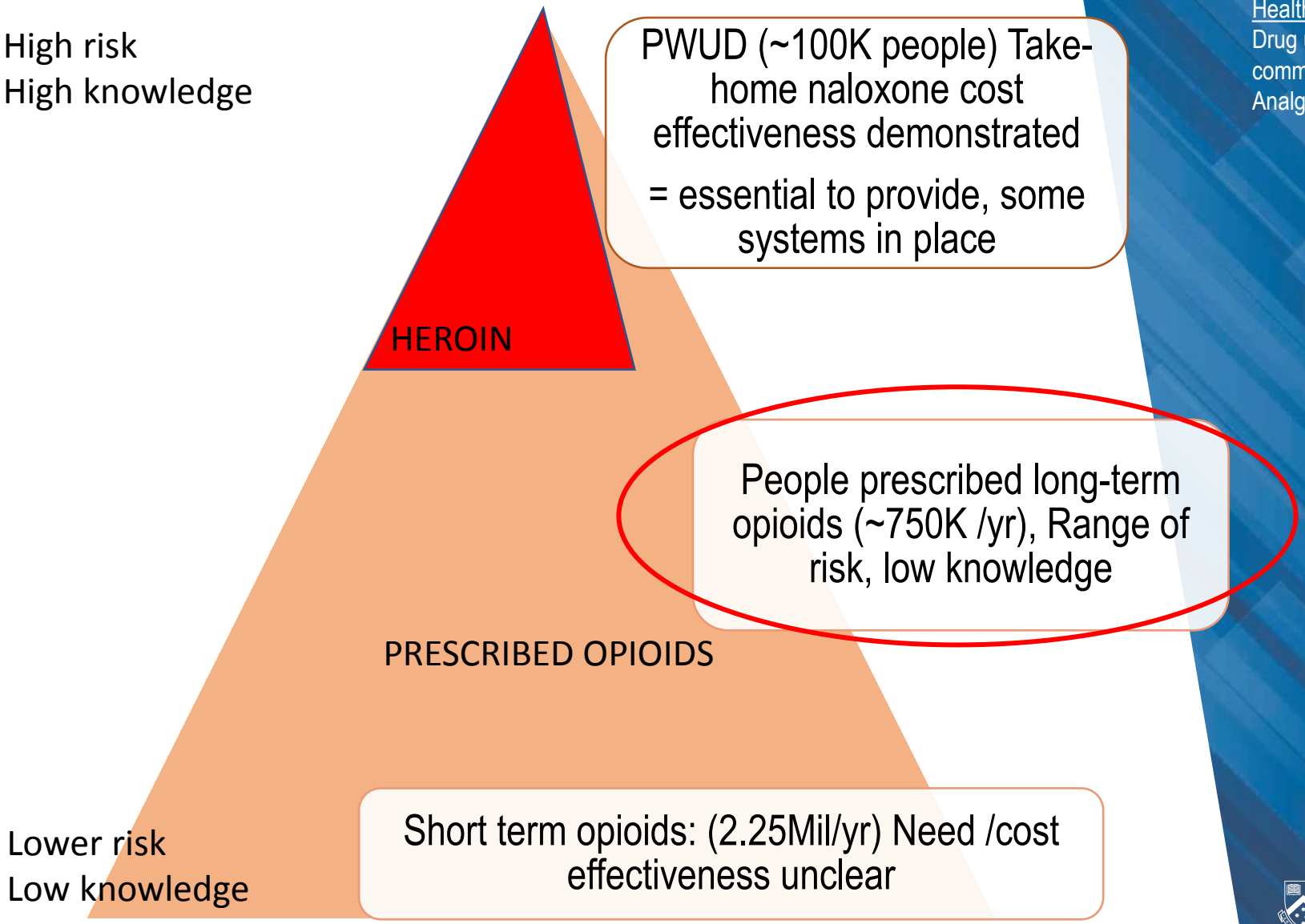
# Opioid-use-risk-knowledge pyramid

- 3 broad (not mutually exclusive) groups (oversimplification)
- require prevention strategies, based on knowledge and risk




Larney, S., et al. (2017). "Estimating the number of people who inject drugs in Australia." BMC Public Health **17(1): 757.**
Drug utilisation sub-committee (DUSC). Opioid Analgesics: Overview. 2014.

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POINT cohort – Degenhardt et al

# LONG-TERM OPIOIDS FOR CHRONIC PAIN

**History of overdose:**

- **One in five** (17.2%, n=261)

Concurrent benzodiazepine use:

- One in three (34.0%, n=515)

Higher opioid dosages (≥50 MME/day)

- Half have morphine equivalent dose of ≥50mg (n=733)

History of substance use disorder

- One in three report lifetime alcohol use disorder (30.7%, n=465)
- One in five report opioid use disorder (17.6%, n=267)

- High prevalence of risk factors
- Risk not just related to 'misuse'
- No systematic way to identify / respond in routine care

Meeting any CDC naloxone criteria = 78% (unpublished – Campbell 2018)


Nielsen et al (2015). Benzodiazepine use amongst chronic pain patients prescribed opioids: associations with pain, physical and mental health and health service utilization. Pain med *16(2), 356-366.*
Larance et al (2016). Pain, alcohol use disorders and risky patterns of drinking among people with chronic non-cancer pain receiving long-term opioid therapy. *Drug and Alcohol Dependence*
Campbell et al (2015). Correlates of pharmaceutical opioid use and dependence among people living with chronic pain: Findings from the Pain and Opioids IN Treatment (POINT) study. *Pain Med. 16(1745-1758*
Nielsen et al. (2018). "Knowledge of Opioid Overdose and Attitudes to Supply of Take-Home Naloxone Among People with Chronic Noncancer Pain Prescribed Opioids." Pain med

# CHRONIC PAIN PATIENTS PERCEPTIONS: NALOXONE

- Most would expect, or appreciate being offered naloxone
- Yet ..most can not identify signs of opioid toxicity (<50% correct)
- Most cannot understand the questions (e.g. OOKS)

*We need to change how we think about overdose prevention so it is appropriate for this population → can't just translate peer-led models*

(e.g. messaging 'don't use alone' & 'test a small amount first' doesn't make sense)

= missed opportunity in mainstream healthcare setting

Nielsen, S., et al. (2018). "Knowledge of Opioid Overdose and Attitudes to Supply of Take-Home Naloxone Among People with Chronic Noncancer Pain Prescribed Opioids." Pain medicine

# WHY HAS NALOXONE FAILED TO TRANSLATE TO PHARMACY?

**Low knowledge, moral hazard and st**

- Most support overdose preventi

*……but like you might come to … have to treat him or give him s… through what is happening wit… metropolitan NSW)*

*…the addict… might see it as a s… 29 years, metropolitan, VIC)*

*I wouldn't say I was a hundred per cent comfor… contact with them really, physical contact (ID13; …harmacist, 30-39 years, regional NSW)*

- 3 challenges

→ address **lack of knowledge**

→ address **stigma**

→ address structural barriers (**time, cost**)

- Currently, focus on PWUD, **missing obvious patients** prescribed opioids

Olsen et al Why aren't Australian pharmacists supplying naloxone? Findings from a qualitative study (Under review)

Nielsen et al (2016) Community pharmacist …wledge, attitudes …nfidence … naloxone for …eversal. …11 (12)

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# Different Take-home Naloxones (THNs)

Some overlap, but essentially different approaches depending on who the actors are:

- require different dialogues and challenges
- differ in terms of the 'problem' they are addressing
- cant just translate from peer-led models


| Characteristic | PWUD | People prescribed opioids |
|---|---|---|
| Naloxone message | 'you can save a life' | 'your medication (that I am giving you) could kill you' (medicolegally complicated) |
| Complexity | 'If you witness an overdose …' | No shared understanding of 'overdose', low baseline knowledge of naloxone / OD signs& symptoms for patient and healthcare professional<br>Not just 'misuse' – drug therapy problems (core business in pharmacy) |

# Making overdose prevention core business in mainstream healthcare settings

1. Address stigma and other structural barriers to overdose prevention and treatment – challenge the status quo where services deny treatment for certain conditions .. **start with those already in mainstream services**
2. Engineer systems where it is easier to consider overdose risk than not to
   → Leverage technology to identify risk: e.g. high opioid dose, prescribed benzodiazepines (Work underway, Safescript coming)
3. Design and test brief interventions for these environments (language, technology, cost) tailored to **different populations** = implementation research

*'What works where, and why?'*



# Ontario Naloxone Program for Pharmacies

- Signage on front door/counter
- Normalise for customers and staff = core business
- Contributors to success
  - Funding
  - Training
  - Fit-for-purpose product
  - Broader approach to stigma

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# OVERDOSE PREVENTION – WHOSE RESPONSIBILITY IS IT?

- Epipen analogy: key factor in allergy care plans is addressing risk
  - Shared responsibility to make environment safe → E.g. no peanut butter sandwiches at school
  - No blame is placed on the person with the allergy
- We need a **shared responsibility** for comprehensive overdose prevention in mainstream heathcare:
  - safer opioid prescribing
  - opioid agonist treatment (biggest impact on mortality)
  - in addition to developing systems for routine identification of overdose risk and take-home naloxone in pharmacies, primary care and ED settings
  - **Naloxone is the start – not the solution – need to address drivers of overdose**

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# OUR OPIOID ECO-SYSTEM IS CHANGING

- Prescription drug monitoring will bring this into sharp focus
  - Treatment pathways
  - Less diversion (less 'leaky' opioid system?)
- Rising heroin related deaths already observed
- Illicit fentanyl?* - not yet, but remains a threat
- Urgent need to increase reach of prevention *and treatment*, esp in rural / regional areas where pharmacy/primary care is key

→ Work in partnerships to change the way we think about overdose prevention

*Barratt, Latimer, Jauncey. Tay & Nielsen (2018). Urine drug screening for early detection of unwitting use of fentanyl and its analogues among people who inject heroin in Sydney, Australia. Drug & Alcohol Review. In press. Accepted 020918

# Questions?

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